The Preparation of Nurse Unit Managers for Their Role

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Abstract

Background and purpose of the study

The professionalisation of nursing saw the emergence of nurses in management roles including that of the Nurse Unit Manager (NUM). These NUMs are usually experienced in their designated clinical area. However, they are now expected to have business and management skills. Some nurse leaders with whom the researcher discussed her proposed research before its commencement and a review of the literature, indicated a gap in the research on how NUMs could better prepare for their role, what needs to be included in management and leadership courses, and more importantly, how NUMs acquire the necessary skills. This study investigated how case writing can be used as a professional development tool to help existing NUMs improve their skills and how it will help aspiring NUMs prepare for their role.

The aims of this study were: (1) to identify how well prepared NUMs are for assuming their role; (2) to identify the skills required for the role of the NUM; (3) to identify the management challenges of the NUM's role; (4) to identify the barriers in acquiring the skills required for the role; and (5) to explore how reflection through case writing can improve skills.

Methods

Three primary samples: NUMs, ANUMs (Associate Nurse Unit Managers) and RNs (Registered Nurses) participated in this study. The study utilised both qualitative and quantitative methodologies by employing in-depth interviews and a survey. Case and commentary writing was also employed with NUMs.

Results

The findings of the study show that NUMs were promoted to their positions by chance and not by conscious choice, or pre-chosen by management having been perceived to have the leadership and management skills for the role. Although NUMs found leadership workshops and courses very helpful, they found it difficult to put the knowledge gained into practice. They commented that they valued the knowledge they gained from reading and commenting on other NUMs' case scenarios. Methods and results of the study will be discussed in more detail in the thesis.

Declaration

I, Josefina Talavera, declare that the PhD thesis entitled “The Preparation of Nurse Unit Managers for Their Role” is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signature 

Date: 16/10/2018

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Abbreviations

ANUM	Associate Nurse Unit Manager
BLS	Basic Life Support
CNS	Clinical Nurse Specialist
CPD	Continuing Professional Development
EAP	Employee Assistance Program
ED	Emergency Department
EFT	Employed Full Time
MLQ	Multifactor Leadership Questionnaire
NUM	Nurse Unit Manager
PD	Professional Development
PDP	Professional Development Plan
RN	Registered Nurse

Chapter 1: Introduction to the Research and the Nurse Unit Manager

1.1 Introduction

The professionalisation of nursing saw the emergence of nurses in management roles including that of the Nurse Unit Manager (NUM). These NUMs are usually experienced in their designated clinical area. However, they are now also expected to have business and management skills (Duffield et al., 2001; McCallin & Frankson, 2010). The responsibilities of NUMs have expanded, and many studies address their increasingly complex management role and preparation for the role. Past studies (Bondas, 2006; Duffield et al., 2001; Kleinman, 2003; Mathena, 2002; McCallin & Frankson, 2010) have suggested that NUMs need to have further education and training aside from nursing to prepare them for the role. However, what needs to be included in leadership courses remains controversial (Pickerell, 2014) as well as concerns from nurse executives about whether the content of postgraduate education is relevant to the needs of the health care industry (Gaskin, Ockerby, Smith, Russell, & O'Connell, 2012). Some nurse leaders themselves, and a review of the literature identified a gap in the research on how NUMs could better prepare for the role, what needs to be included in leadership courses, and more importantly, how NUMs acquire the necessary skills (Gaskin et al., 2012; Kleinman, 2003; Pickerell, 2014). Some nurse leaders suggested a need for new, innovative and effective training methods (Gallo, 2007; Shaffer, 2003) and more research studies that address informal methods of learning (Griscti & Jacono, 2006).

There is a paucity of research studies that address how professional development incorporating case writing can help develop and prepare NUMs for their role. Thus, this study investigated how case writing could be used as an alternative to face-to-face mentoring and as a tool to help existing NUMs improve their skills and help aspiring NUMs prepare for the role. Although case narratives have been used in professional development by some

researchers who are leaders in the field (Cathcart & Greenspan, 2013; Duffield, 2005; Frank, 2003; Mackoff, Glassman, & Budin, 2013), none of these studies examined non-face-to-face peer collaboration. The use of case writing as a learning strategy for NUMs will be addressed in Chapter 3.

Since the NUM's role centres on leadership and the leadership style of NUMs has profound influence on staff job satisfaction and retention, and the delivery of care and health outcomes of patients (Azaare & Gross, 2011; Kleinman, 2004; McGuire & Kennerly, 2006), NUMs' management styles were explored. The NUM's role encompasses both leadership and management and they are expected to be adequately prepared. The differences between leadership and management will be addressed in Chapter 2. However, because leadership and management are interwoven in the NUM's role and overlap with each other, the concepts of leadership and management in this study were used interchangeably or considered synonymous, as occurs in the literature.

This study was conducted in a teaching hospital in Melbourne, Australia. The hospital consists of three hospitals that are located in three different places in Melbourne. The hospital offers services in emergency medicine, intensive care, medical and surgical services and also subacute care and ambulatory clinics. For ethical reasons, the name of the hospital had been withheld. Due to the small sample size and ease of identification, the wards where NUMs, ANUMs and RNs worked and demographic data were deleted to preserve confidentiality.

1.2 Who is a Nurse Unit Manager (NUM)?

The NUM is a registered nurse who is responsible for managing a particular ward. It is one of the most difficult and complex management roles in the health care system (Thrall, 2006), as NUMs act as a conduit between staff on the hospital ward and upper management (Thrall, 2006). The NUM's position combines leadership, management, clinical and teaching roles

(Australian Nursing and Midwifery Federation (Vic Branch), 2013). They are the drivers for the performance of the ward (Arnold & Nelson, 2004), and represent the voices of staff nurses as well as those of upper management on the ward (Chase, 2010; O'Neil, Morjikian, Cherner, Hirschkorn, & West, 2008). The NUM has a 24 hour responsibility for the management of a ward (Thrall, 2006). The difficulties and complexities of their role will be discussed further in section 1.3 (Roles of a NUM).

The title of NUMs is varied in the literature. For example, they are referred to as: (1) Nurse Managers (Bonner & McLaughlin, 2014; Clark-Burg, 2013; DeCampli, Kirby, & Baldwin, 2010; Heller et al., 2003; Heuston & Wolf, 2011; Kleinman, 2003; Mathena, 2002; Paliadelis, 2013); (2) Ward Managers (Bolton, 2005); (3) Front Line Managers (Arnold & Nelson, 2004; Dearmon, Riley, Mestas, & Buckner, 2015; Lee & Cummings, 2008); (4) Nurse Leaders (MacPhee, Skelton-Green, Bouthillette, & Suryaprakash, 2012); (5) Charge Nurse Managers (McCallin & Frankson, 2010); (6) First-line Nurse Managers (Bondas, 2009); and (7) Nurse Unit Managers (Duffield & Franks, 2001; Manning, Jones, Jones, & Fernandez, 2015; Paliadelis, 2008). In Victoria, Australia where this study was conducted, the front-line manager is referred to as the Nurse Unit Manager. Thus, for the purpose of this study, the title of Nurse Unit Manager (NUM) will be used. As defined by the Australian Nursing and Midwifery Federation (Vic Branch) (2013, p. 1), "The Nurse Unit Manager is a registered nurse/midwife with responsibility for a ward, unit, service or team. The ward or unit should not exceed 30 beds and critical care units should not exceed 12 beds".

1.3 Roles of a NUM

The transition of nursing from the Nightingale era to the professionalisation of nursing has considerably changed the role of NUMs. Thus the NUM's role has become more demanding and more complex (Hyrkas, Appelqvist-Schmidlechner, & Kivimaki, 2005). Taylor and

Kramer (1985) identified three periods in the changing role of NUMs evolving from (a) head nurse from 1900 to 1940 to that of (b) departmental head from 1941 to 1970 to that of (c) nurse manager from 1971 to 1980. The head nurse from 1900 to1940 was responsible for the supervision of patient care on the ward. Staff under the supervision of the head nurse were usually students (Taylor & Kramer, 1985).

According to Taylor and Kramer (1985), from 1941 to 1970, there was a demand for skilled nurses due to the advancement and development of new treatments. Due to a nursing shortage, licensed practical nurses, nurses' aides, Red Cross aides and gray ladies came into the scene to fill the shortage. The gray ladies were American Red Cross volunteers who provided non-medical care such as writing letters, reading to patients, giving out books, and shopping for patients (Watson, 2013). During this period, the emergence of other specialist groups was evident such as physical therapists, respiratory therapists, and inhalation therapists. The emergence of these specialist groups meant an increase in responsibilities for the head nurse. The head nurse during this period was responsible for the coordination and assignment of staff, ordering supplies, maintaining schedules and supervising patient care.

During the 1970s, there were major reforms in the health care system. For example, the decentralisation of management and the head nurse became the nurse manager. In addition to former responsibilities as head nurse, the nurse manager had expanded responsibilities and was in charge of budgeting and financial management, recruiting and retaining staff, and scheduling and coordination (Taylor & Kramer, 1985).

In the 1990s, Flarey (1991) and Sullivan et al. (1994) were already forecasting the expanding roles of nurses. Since then, the role of a NUM has become much broader, more complex and requires multiple skills (Huston, 2008; McCallin & Frankson, 2010), and

correspondingly, workloads have increased (Lee & Cummings, 2008) with the breadth of role change (Surakka, 2008).

There is clear evidence from the literature that the roles of NUMs have significantly changed with broader responsibilities (Baker et al., 2012; Bonner & McLaughlin, 2014; Clark-Burg, 2013; Hill, 2004; Lee & Cummings, 2008; McCallin & Frankson, 2010; Meyer et al., 2011). The NUMs are the essence of, and most important to, the health care environment (DeCampli et al., 2010; Stewart, 2013) and their role is seen as one of the most difficult and complex in the health care setting (DeCampli et al., 2010; Thrall, 2006).

NUMs are responsible for effective, direct patient care, and for providing management and leadership for staff (McCallin & Frankson, 2010) in order to improve the quality of nursing care and patient outcomes (Clark-Burg, 2013; Lee & Cummings, 2008). NUMs are now responsible for more administrative roles such as writing reports, formulating the budget for the ward and preparing rosters (McCallin & Frankson, 2010; Meyer et al., 2011). NUMs are responsible for the education of staff to promote professional development and personal advancement (Lee & Cummings, 2008). They must ensure that the work environment is safe, has adequate facilities and equipment, and must adhere to quality assurance guidelines (Gallo, 2007; Lee & Cummings, 2008; McCallin & Frankson, 2010).

Queensland Health (2008), for example, undertook a survey of the role of NUMs in Queensland, and reported that the role of the NUM had increased considerably over the previous 10 years. The survey revealed that the role of NUMs involved leadership responsibilities in the areas of patient flow, standards of care, being a driver of a model of care, patient and family advocacy, and discharge planning. NUMs are responsible for the general management of staff, budgeting, maintenance of equipment and for communicating with other stakeholders. NUMs have the responsibility to maintain clinical governance such as occupational health and safety, risk management and reporting, investigation of complaints

and incidents and accreditation. The role also involved leading the team, being a role model to their staff, and managing professional development staff. The Australian Nursing and Midwifery Federation, which is the largest union in Australia, has published a position description (Appendix 1) for the role of the nurse/midwife unit manager (Australian Nursing and Midwifery Federation (Vic Branch), 2013). Based on the position description, the role encompasses leadership, management, clinical and teaching roles. As a manager and leader, the NUM is responsible for: recruitment of new staff and retention of staff; encouraging staff to engage in education for professional development while being responsible for maintaining financial data and management of the ward budget. The NUM must ensure that occupational health and safety policies are adhered to by staff to minimise or eliminate risks for both staff and patients. As a clinician, the NUM is expected to use their clinical knowledge to make judgements and decisions with regards to the quality and type of resources required for clinical services for optimal care. As an educator, the NUM must have a good knowledge of current trends, research and policies, and use evidence-based practice to improve the quality and safety of patient care (Australian Nursing and Midwifery Federation (Vic Branch), 2013).

Baker et al. (2012) conducted a study in their organisation in Greenville, North Carolina to gain a better understanding of nurse managers' current responsibilities and to examine the nurse managers' perceptions of, and the frequency of performing, specific key responsibilities and the level of expertise in meeting their role. Their study confirmed the complexity and variety of the role of NUMs. They were involved in both clinical and administrative roles including: doing ward rounds and communicating urgent issues, attending meetings, reviewing and analysing financial reports, addressing patient satisfaction and complaints, reviewing the daily schedule, talking to patients, and implementing process improvement plans among other roles. Baker et al. (2012) also found that nurse managers with less than five years of experience spent more time in mentoring charge nurses, providing

indirect patient care, doing rounds on the unit, talking to patients and families, and spending time meeting with senior executives and nurse leaders. Nurse managers with more than five years of experience spent less time in these roles but spent most of their time preparing and delivering disciplinary action (Baker et al., 2012). These findings are reflected in the study by Bonner and McLaughlin (2014). They conducted 12 workshops over a year for a group of 10 nurse managers in acute mental health inpatient settings in one NHS (National Health Service) trust in England. The nurse managers engaged in exercises to examine their roles and leadership styles. Bonner and McLaughlin (2014) noted that their roles were complex and difficult to define and may vary depending on the type of ward that was managed. They also found that the participants were unclear about their role priority as to whether it was managerial or clinical. The participants in their study reported that administrative tasks had increased and they were concerned as to how this had impacted their ability to lead their staff. Similar findings were revealed in the study by Lord, Jefferson, Klass, Nowak and Thomas (2013) in Western Australia. Theoretical sampling was used in this study and data were collected through interviews and focus groups in Western Australia's public health system. The participants in their study commented on how the lack of role clarity in their workplace had hindered effective decision making and leadership. There was the existence of multiple, tightly defined roles that led to confusion about where authority and accountability resided. Nursing leadership was perceived by some participants as separate from management. Some nurse leaders perceived that leadership was associated with clinical rather than management roles. Nurse leaders felt the need to be more involved in clinical roles to practise leadership. These findings from the study by Lord et al. (2013) reinforce the complex intersection or overlapping concepts of leadership and management.

Shirey, Ebright and McDaniel's (2008) study of a hospital system in the Midwestern United States that involved five nurse managers, revealed that nurse managers described their

role as clearing houses, gatherers, and disseminators of information for key stakeholders. The nurse managers in their study further described their role as a sensor that allowed them to recognise problems before they became more serious. In addition, the nurse managers spoke about or alluded to the unrealistic expectations of their role. For example, there were unrealistic expectations such as: they had to "put out fires" (p. 127) but also meet the expectations of having time for strategic planning and innovation, for producing results on short notice, for making major changes in their wards under constrained budgets, and for performing house supervisory duties. Nurse managers described some additional roles as "the invisible work" which included work behind the scenes such as the procurement of resources or other tasks that they cannot delegate (Shirey et al., 2008). These tasks tended not to be noticed and appreciated when they were done. Nurse managers also saw themselves performing multiple tasks, attending multiple meetings, and expressed guilt that they "could not be all things to all people" (Shirey et al., 2008 p. 128). They expressed concerns about lagging behind and being unable to control their work due to multiple demands and priorities (Shirey et al., 2008). All participants in their study felt overwhelmed about the nature of their role and work–life imbalance that impacted greatly on their families. Since nurse managers were responsible for their ward 24 hours, seven days a week, they reported that they were constantly worried, which they termed a "restless mind" (Shirey et al., 2008, p. 129) and this affected their mental health. Nurse managers reported they had difficulty sleeping, experienced shortness of breath, palpitations, tense muscles and physical exhaustion as a result of stress from work.

Skytt, Ljunggren, Sjoden and Carlsson (2008) conducted a study in Sweden that explored the front-line manager's role from four perspectives, that is, from the front-line managers', registered nurses', assistant nurses' and department heads' perspectives. Their study found that perception of the front-line manager's role differed for each group. They

reported that the front-line managers and RNs perceived that the NUM's responsibility for staff and day-to-day work was very important. Providing information to staff to keep them well informed and to give them opportunities to participate was emphasised. Accordingly, the current study explored the role of NUMs from the perspectives of NUMs, ANUMs and RNs.

Similarly, the study by Feather and Ebright (2013) identified how staff RNs perceived their nurse manager's role. Feather and Ebright posed a question about whether the nurse managers were able realistically to attend to the breadth of their role. Their study found there was a disconnection between what RNs perceived as the nurse managers' role, and how it related to their daily work, which demonstrated a lack of understanding of the nurse manager's role by RNs. The latter expressed concern that the nurse manager was not visible on the ward and did not play a role in their everyday job of providing patient care. RNs viewed their nurse managers' role as task oriented, for example, attending meetings, but did not perceive their nurse managers to be employee oriented and engaged, for example, in building employee relationships and improving teamwork. Cipriano (2011) described the nurse managers' role as "command central" whereby they provided support, recognition, timely information, advocacy for patients and their families, and encouraged professional growth and development among staff. Additionally, they noted that nurse managers collaborate with other multi-disciplinary teams such as doctors, social workers, therapists and others who all contribute to patient care (Cipriano, 2011).

1.4 Promotion to NUM

The traditional model of promoting nurses to management roles was based on their clinical expertise, their skills in organising patient care, and their ability to communicate with doctors and allied health professionals. But these skills are not enough to succeed as a leader (Arnold & Nelson, 2004; Doria, 2015; Heller et al., 2003; McCallin & Frankson, 2010;

Oroviogoicoechea, 1996; Sanders, Davidson, & Price, 1996; Tilley & Tilley, 1999; Titzer, Phillips, Tooley, Hall, & Shirey, 2013). McCallin and Frankson (2010) argued that clinical expertise does not equate to being a good manager. This reinforces Ofori and Toor's (2008) and Ellis and Abbott's (2013) beliefs with regards to informal leaders who display the qualities of leadership but not necessarily of managers. Some nursing leaders in the mid-1990s have suggested moving away from this tradition and some authors saw a need for graduate education to prepare them for change (Flarey, 1991; Oroviogoicoechea, 1996; Sullivan et al., 1994; Tilley & Tilley, 1999). McCallin and Frankson (2010) concurred that this traditional practice had been going on for many years and it had to change. With the expanded and more complex roles of NUMs today, it is clear that NUMs who were appointed in the 1990s took on a role that was different from the current role (Sellgren, Ekvall, & Tomson, 2008).

The continuing ill-preparedness of NUMs for their role is evident in the literature and research studies show that NUMs feel unprepared for challenges within the role (Arnold & Nelson, 2004; Douglas, 2008; Duffield & Franks, 2001; Gaskin et al., 2012; Heller et al., 2003; Mathena, 2002; McCallin & Frankson, 2010; Mrayyan, 2004; Queensland Government, 2008; Townsend, Wilkinson, Bamber, & Allan, 2012). Staff nurses were often thrust into the position without any preparation and that left them unprepared to function effectively in the role (Heller et al., 2003). Duffield and Franks (2001) conducted a study to investigate the role and preparation of NUMs in Australia. They found that nurse managers were promoted based on their clinical expertise and credibility rather than their management potential. As a result, many NUMs were unprepared for their administrative, business and management roles. Duffield and Franks (2001) stated that one of the weaknesses in the Australian health care system was the lack of willingness for senior health executives to take responsibility in ensuring that NUMs receive appropriate educational preparation. Similarly,

McCallin and Frankson's (2010) study of the role of charge nurse managers in New Zealand revealed they were appointed for the position without the necessary management skills. McCallin and Frankson (2010) interviewed 12 nurse managers to investigate their experiences as charge managers. They found that nurse managers had difficulty performing their job because the role was unclear. The role was more diverse than the job description and charge managers found that the role was much bigger than anticipated. Although nurse managers were expert clinicians, they were novices in management. They found they had the skills in managing patients and their families, but they did not have the skills to manage staff. In addition, McCallin and Frankson (2010) highlighted that the majority of nurse managers did not have basic business management skills. Most nurse managers learnt on the job, seeking help from others, while others were resistant to learning these skills. Another finding from their study was work overload. Nurse managers were overwhelmed by multiple demands in the role and expectations to accomplish these tasks in too little time. They shared a concern that it seemed impossible to find organisational support and so they were responsible for finding solutions to their problems.

This is echoed in the study by Townsend et al. (2012) in a hospital in Australia. They found that current ward managers had landed in the position by accident and did not have any preparation for the role. Townsend et al. (2012) interviewed 14 ward managers. Only two of those interviewed said they had a conscious career plan of becoming a ward manager. The other 12 ward managers mentioned factors such as luck, or upper management identifying them as appropriate for the role. Some participants mentioned they were acting as ward managers and they assumed the position when former ward managers decided not to come back to the position.

The path to becoming a NUM is not always a straight one. As Townsend et al. (2012) stated, the current managers in their study landed in the position accidentally. This is

confirmed in the Australian study on front-line managers by Duffield and Franks (2001), who stated that nurses inherited the role by chance and not by active choice, or having been chosen by others as having management potential. Bondas (2006) on the other hand found in her study, involving 68 Finnish nurse leaders, that nurses entered the role through four different paths which she called: 1) the Path of Ideals, 2) the Path of Chance, 3) the Career Path and 4) the Temporary Path. Bondas (2006) described the Path of Ideals and the Career Path as active paths because there was an active choice made by nurse leaders to be in the position. Although the Path of Ideals and the Career Path are both considered active paths, they differ in the sense that in the Path of Ideals, the nurse leader had a conscious choice, a personal drive and was prepared educationally, continuing to improve and seek new knowledge. They also believed in themselves as capable leaders and had visions of creating a culture and environment that was favourable for patients and staff to grow. On the other hand, for the Career Path, although there was a conscious choice to become a leader, there was no educational preparation or knowledge-seeking, but instead these nurses were motivated by interests and ambitions. These leaders felt there was more to nursing than being a bedside nurse and wanted to leave the heavy workload of bedside nursing. According to Bondas (2006), these nurses described themselves as being leaders since childhood, having the instinct to lead, and further described themselves as informal leaders of their ward even before they were appointed. This reinforces the belief of Ofori and Toor (2008) that a leader can be any staff member who has leadership qualities. Ellis and Abbott (2013) also agreed that leaders and managers are different people. A leader may not be a NUM but can be any staff member who takes on team leadership.

Bondas (2006) described the Path of Chance as a passive path because the leaders did not make an active choice nor planned to be a leader. In the Path of Chance the leaders were appointed to the role because somebody made the decision for them. They were basically

thrust into the role because somebody had to do it and no one else could. Leaders who took this role also described themselves as having other leaders who mentored them and persuaded them to take on the role (Bondas, 2006). Furthermore, these leaders described themselves as having the clinical expertise and years of experience on the ward to undertake the leadership role. Nurse leaders who entered through the Temporary Path described their path as a leader substitute or as undertaking a trial period from which they could withdraw if they did not want the role and with the possibility of returning to their former position. Bondas (2006) concluded that most nurse managers assumed the role via the Path of Chance or Temporary Path.

The study findings of Jarnigan White (2015) concur with those of Bondas (2006). Jarnigan White (2015) conducted a study to explore the motivations of nurse managers for seeking the role. The study was conducted in one of the health care systems in California. There were five nurse managers who participated in this study. Jarnigan White (2015) found that the decision of the nurse managers to take up the role was either a planned or unplanned move. Three of the participants sought the role of nurse manager while the other two participants waited to be asked to take up the role. For those participants who planned their move, some commented that the nurse manager's role was a way for them to do more for their community as well as for themselves, that they were destined to be in the leadership role, and also as an opportunity to make a difference. Some commented that they pursued further studies to prepare themselves to move to the next level of their career. These comments reflected Bondas' (2006) description of the Path of Ideals and Career Path. For those who did not plan their move, the participants accepted the nurse manager position because the opportunity arose. Some commented that there were other leaders who influenced them to take up the role. Another participant inherited the role because no one wanted it. One other participant took the role because she was already an acting nurse

manager when her previous manager moved to another role. These comments reflected Bondas' (2006) description of the Path of Chance and Temporary Path.

In a survey by Queensland Health (2008), it was found that NUMS did not have the knowledge to manage the business side of the ward and struggled when seeking funding and resources for their ward. The NUMs identified that they needed support in business, clinical, information management, human resources, administration, and quality and safety in order to improve their skills and to consider remaining in the position. The NUMs also identified that although leadership workshops and courses were helpful, it was difficult to put the knowledge gained into practice. Some clinical nurses who were acting as NUMs during the study said that they were not interested in applying for a permanent NUM position, citing being inadequately prepared for the role as one of the reasons. Similarly, Sherman (2005) undertook a study to determine the factors that influenced the decisions of younger nurses to accept or reject nursing leadership positions. Her study was conducted in 14 health care organisations in South Florida. There were 48 nurses who participated in this study whose ages ranged from 22 to 42 years and who were not in formal nursing leadership positions. Sherman (2005) found that although younger nurses did see potential in nursing management roles to make a difference for both patients and staff, they viewed the nurse manager role as unattractive. Issues of concern for rejecting the nurse management position were inadequate compensation for the role and lack of true decision-making power. Hearing negative feedback from their nurse managers such as: the role is stressful, lots of responsibilities, and long hours for not much money, were considered factors for rejecting nursing leadership roles (Sherman, 2005). Shirey et al. (2008) expressed concern that younger nurses perceived the role of nurse manager as undesirable and that younger nurses asked "Why do you do this? Is it worth it?' (Shirey et al., 2008, p. 128). Doria (2015) stated there were other options for nursing advancement other than nursing management such as education, research, publishing,

and occupational health nursing. These options further complicate the recruitment of nurse leaders. This concurs with the study by Atsalos and Greenwood (2001) in Western Sydney, Australia where one of the themes that emerged in their study was the need for leaders to boost their confidence and motivation. Lin, Wu and White (2005) suggested that job requirements for NUMs should be systematically analysed to prepare successful training programs. Further, Brown, Fraser, Wong, Muise and Cummings (2013) stated that organisations need to invest in training and supporting suitable candidates for nurse managers' roles. In the present study, the ANUMs and RNs were included to gather their perceptions of NUMs and their preparation for the role.

Paliadelis, Cruickshank and Sheridan (2007) conducted a study on 20 NUMs in Australia and found they lacked the proper education and training for the role. Their study showed that NUMs received very little support from their organisations to help them transition from their clinical role to the NUM role, and they were not able to access formal support. Instead, these NUMS gained support from their nursing colleagues and learned from experience through trial and error. McCallin and Frankson (2010) found in their study that in organisational management, the charge nurse managers in New Zealand had minimal or no training, or training that was premature or too late. Often, front-line managers learned through trial and error that resulted in them struggling to adjust and becoming vulnerable in their roles. They commented that this was no longer practical and reasonable. Similarly, Gaskin et al. (2012) conducted a study in Melbourne, Australia and found that the NUMs and their directors of nursing expressed concern about the lack of preparation for the NUM position. The NUMs in their study indicated that they had insufficient skills related to staff recruitment, personnel management, financial matters, leading organisational change and the development of project briefs. They also reported they only had brief orientation for the role and little professional support. Gaskin et al. (2012) reported that NUMs used trial and error in

dealing with issues. They sought the support of other NUMs and their directors of nursing to deal with the challenges, but reported they avoided seeking assistance because they did not want others to know they were not capable of resolving issues. In a recent study by Townsend et al. (2012) in Australia, it was found that ward managers landed in the position accidentally, were unprepared and relatively unsupported. They suggested that nurse executives needed to properly select and appropriately develop staff skills before appointing them ward managers. This is echoed in the study by Duffield et al. (2001) in New South Wales, Australia that more than half of first-line managers had no assistance during the development of their careers. Hill (2004) found in her study that for new managers, it was a process of learning from experience and found experience a tough teacher, because these managers faced real problems with real consequences, not simply case studies presented as training exercises.

The expanding role of NUMs has impacted on the recruitment and retention of NUMs. Queensland Health (2008), for example, recognised the difficulty of recruiting and retaining NUMs especially when their job satisfaction was low. Their study also revealed that some of those clinical nurses who were acting as NUMs were not interested in applying for the position and 36% of current NUMs expressed a desire to leave the position. The lack of supported education and training for the role affects succession planning. Duffield and Franks (2001) stated that in Australia, there is a lack of responsibility by senior health managers to ensure that NUMs receive appropriate and necessary educational preparation for succession. Queensland Health (Queensland Government, 2008) reported that NUMs felt their potential for growth within the role was limited because of the lack of mentoring relationships.

During the 1990s, some authors (Oroviogoicoechea, 1996; Tilley & Tilley, 1999) identified that without adequate training and education, the task of a NUM could be overwhelming and with their expanding roles, challenges would become more intense

(Mathena, 2002). Mrayyan (2004) suggested that NUMs should be educationally prepared to assume their roles and responsibilities in order to fulfil organisational goals while Hurley and Linsley (2007) suggested new models of preparing NUMs for their leadership roles. McCallin and Frankson (2010) also agreed that the preparation of charge nurse managers for the role should include training in education and in business management.

With the expanding role of nurse managers, the call for the preparation of nurse leaders has continued. According to Huston (2008), there was a need to prepare nurse leaders for 2020 and it was suggested that it was essential to start in 2008 to create educational and management programs to ensure competencies for 2020 were acquired. Bondas (2006) stated that in order to develop skilled and competent nurse leaders, the recruitment of NUMs needed serious attention.

1.5. Aims

It is evident from the literature that the demands of the NUM role have increased over the years. However, it is also evident that their preparation has lagged behind. The aims of this study were: (1) to identify how well prepared NUMs are for assuming their role; (2) to identify the skills required for the role of the NUM; (3) to identify the management challenges of the NUM's role; (4) to identify the barriers in acquiring the skills required for the role; and (5) to explore how reflection through case writing can improve skills.

In order to address these aims, two primary research questions were formulated to guide me in data collection and data analysis.

1.6. Primary questions

1. How could NUMs better prepare for their role?
2. What makes a NUM an effective leader?

1.7. Significance

This research helps us understand the factors that impact upon NUMs' preparedness for their role and more importantly, how to gain the skills needed to perform their role. There is very little research about the use of case writing as a tool where NUMs and aspiring NUMs can improve their skills. Previous studies have reported that time and lack of relieving staff were two of the most common barriers reported to professional development (Courtney, Yacopetti, James, Walsh, & Montgomery, 2002; Crosby & Shields, 2010; Kleinman, 2003; Mathena, 2002; O'Neil et al., 2008). Nurse leaders do not have the time to develop their leadership and management skills due to many competing priorities (Acree, 2006).

Shaffer (2003) argued that yesterday's way of thinking and training methods may not work in a dynamic health care setting and so therefore there was a need for new, innovative and effective training methods. Gallo (2007) later agreed that traditional ways of training staff nurses to management positions may not prepare them to be effective leaders. Griscti and Jacono (2006) stated a need for more research studies that address informal methods of learning. While there is an abundance of strategies and methods to prepare nurse managers for their role, these approaches do not draw upon lived experiences of nurse managers and do not focus on peer coaching and learning (Mackoff et al., 2013).

Mentoring has been suggested by nurse leaders to help and support other NUMs. Although mentoring can provide feedback upon which the leader can reflect, mentoring in health care organisations can be difficult, costly and have barriers such as lack of willingness from other staff to act as mentors (D'Cruz, 2002). and the many competing priorities and other demands on the time of mentors (Acree, 2006; DeCampli et al., 2010).

The results of this study will help nurse executives in developing and addressing the use of case writing as a new approach to develop and support new and aspiring NUMs and to

supplement face-to-face mentoring, or as an alternative to face-to-face mentoring when mentors are not available.

1.8. Thesis outline

This thesis contains six chapters. Chapter 1 discussed the study's objectives to investigate gaps in the research in relation to the preparation of NUMs for their role. The chapter described who the NUM is and the different titles associated with this role. A description of the NUM's role and how they were promoted to the position was also presented. The aims of the study, research questions and the significance of the study were also presented.

Chapter 2 comprises a literature review to gain insight from other studies conducted on the role and preparation of NUMs, in particular in nursing leadership and management. The literature review also includes preparing new NUMs for their leadership/management role, clinical knowledge as a necessity for NUMs, and barriers to professional development. The literature review will be utilised to compare and substantiate the findings of this research.

Chapter 3 explores case writing as a learning strategy for NUMs and aspiring NUMs. Case writing as a form of reflection, the components of case writing and case writing as a learning strategy are explored. A literature review on case and commentary writing is also included.

Chapter 4 outlines the methodology of the study. It describes the setting of the study, the recruitment of participants, forms of data collection, software used to analyse data and ethical considerations.

Chapter 5 presents the results and the discussion of findings from the structured interviews, questionnaire, case writing and commentaries. In the discussion of findings, literature relevant to the findings is highlighted. The chapter consists of several sections representing each of the aims of the study.

Chapter 6 summarises the theoretical framework of the study, conclusion and recommendations, areas for further research, implications for nursing management and implications for undergraduate education.

1.9. Chapter summary

Chapter 1 discussed the background of the study, who a NUM is, the roles of the NUM and how NUMs are promoted. It is evident from the literature that the NUM's role has changed considerably over the years. However, it is also evident that NUMs are frequently thrust into the position with little or no preparation. The aims, research questions and significance of the study were also presented. In order to gain insight into previous research on the preparation of NUMs for their role, Chapter 2 includes a review of a range of relevant literature.

Chapter 2: Literature Review

2.1. Introduction

This research investigates the preparation of NUMs for their role. The review of literature in Chapters 1 and 2 was extended from January 1985 to May 2018 in order to compare the NUM's role and their preparation for their role at different times, and to determine how research on these areas progressed over time. A literature search was undertaken using CINAHL, Medline OvidSP and PubMed data bases and Google Scholar was used as a search engine. Summon, a search engine which provides simultaneous searching and linking over multiple library resources, was also used. Additional references were sourced through references used by authors of articles reviewed. A broad range of search strategies were used. The search terms were Nurse Unit Manager, front line managers, preparation of nurse unit managers, role of nurse unit managers, leadership theories, nursing management, case writing, case narratives, reflection, reflective practice, experiential learning, professional development and barriers to professional development.

Since the NUM's role centres on leadership and management, a literature review was conducted focusing on leadership and management, leadership styles practised in nursing management, preparation of NUMs for their role, and the effect of leadership style on staff performance and satisfaction. A literature review was also conducted in relation to barriers in furthering NUMs' training to gain insight into factors that hindered their development. Finally, a literature review was conducted in regard to the use of case writing to help develop and prepare NUMs for their role. Accordingly, this literature review will devote separate sections to the following topics: 1) leadership versus management, 2) leadership theories, 3) nursing management style and its implication for job satisfaction, 4) Preparing NUMs for the

leadership/management roles, 5) Clinical knowledge and 6) barriers to professional development.

There are extensive discussions based on leadership in nursing. Research into the relationship between management and leadership in general and from specific disciplines, such as business, engineering, education and the military, is drawn upon to gain further insights for this thesis.

2.2. Leadership and management

It is important at this point to draw a distinction between leadership and management before discussing leadership theories. Confusingly, leadership and management are sometimes used interchangeably. Some scholars believe that leadership and management are synonymous but many also believe that they are distinctly different concepts (Ellis & Abbott, 2013; Hersey & Blanchard, 1993; Kotter, 1990; Ofori & Toor, 2008; Rost & Amarant, 2005; Zaleznik, 1977). Jennings, Scalzi, Rodgers and Keane (2007) reviewed the content of nursing administration and nursing leadership courses in the US to identify similarities and differences between competencies for nurse leaders and nurse managers. The authors reviewed 140 articles and they found that the concepts of leadership and management were not well delineated. They also found there was a considerable overlap of common competencies between leadership and management. The authors stated that this finding might indicate a lack of discrimination between leadership and management, or that the traditional distinction between leadership and management had narrowed. As stated earlier, leadership and management are interwoven in the NUM's role and overlap. This makes it difficult to delineate the concept of leadership and management for NUMs. Thus, in this present study, leadership and management were used interchangeably or were considered synonymous.

John Kotter (1990) is an internationally renowned management and leadership theorist. In his book, *Force of Change: How Leadership Differs From Management*, Kotter makes a distinction between leadership and management. Kotter describes management as being able to cope with complexity while leadership is about being able to cope with change. Management pays particular attention to details, planning, budgeting, eliminating risks, efficiency and measuring results (Kotter, 1990). Jackson (2008) describes management as being focused on systems, order and control. Leadership on the other hand, pays particular attention to innovation and taking risks to implement strategies (Kotter, 1990), focusing on the larger picture to create a vision for the future, focusing on people's values and then eventually leading these people to implement change (Jackson, 2008; Kotter, 1990). The management processes create consistency and order to produce consistent results while leadership may produce movement where leaders are seen to create change (Kotter, 1990). D'Cruz (2002) argues that management is about planning, taking action and measuring results while leadership is about having a vision for the future and motivating others. According to Jackson and Parry (2011), leadership is one of the processes of management that includes planning, controlling and organising.

Rost (1993) and Zaleznik (1977) who are also regarded as leadership experts, agree that leadership and management are different. Rost (1993) defines leadership as " an influence relationship among leaders and followers who intend real changes that reflect mutual purposes" (p. 102). Rost (1993) however defines management as "an authority relationship between at least one manager and one subordinate who coordinate their activities to produce and sell particular goods and/or services" (p. 145). According to Rost (1993), leadership is a relationship between leaders and followers which is based on influence. Influence is multidirectional, in that influence can flow from all directions, where leaders influence other leaders and followers and vice versa. Management however is unidirectional and top-down.

Rost (1993) stated that in leadership, influence is noncoercive and anyone can have the freedom to join in or drop out of this relationship. In contrast, management is an authority relationship that allows the use of coercion. Managers may have the power or authority to enforce others to get things done whereas leaders are focused on how to engage people to get things done (Ellis & Abbott, 2013). In Rost's definition (1993) of leadership, it is essential that leaders and followers intend real changes. In management, however, managers and subordinates produce and sell goods and services just as NUMs and nurses need to provide quality care to patients. Finally, in leadership, the intended changes reflect the mutual purpose of what leaders and followers want. In management, the changes result from the coordinated activities of managers and subordinates arising from independent goals they have mutually agreed upon to get the job done (Rost, 1993). Hersey and Blanchard (1993) agree that leadership is about influencing other people to achieve a common goal while management is working with other people to accomplish an organisational goal.

Yukl (2010), another leadership theorist, contends that leadership and management are different. Managers tend to value stability and order while leaders value flexibility. Managers value efficiency and avoid taking risks while leaders value innovation and adaptation. Managers may be impersonal and focused on short-term results while leaders care about their staff and have longer-term views with regard to objectives and strategies. Yukl (2010) further explains that while managers are concerned about how things get done with people performing better, leaders are concerned with how people value things and then get people to agree on how things should be accomplished. Managers are concerned with doing the right thing and efficiently while leaders do the right thing with effectiveness (Bennis & Nanus, 1985).

According to Zaleznik (1977), managers and leaders are two different people in terms of their attitudes regarding goals and aspirations and, importantly, in the way they form

relationships with others. Zaleznik (1977) explains that managers' goals are out of necessity to get the job done while leaders' goals arise from their desire to innovate for change. Ellis and Abbott (2013) also agree that leaders and managers are different people. A leader can be any staff member on the hospital ward who displays the qualities of leadership (Ofori & Toor, 2008), who leads the team but is not necessarily the NUM (Ellis & Abbott, 2013). So a person can be an informal leader without necessarily being a manager and a manager can be a manager without leading. Therefore, a person can have a designation as a manager but without subordinates (Yukl, 2010). According to Carroll (2006), there are two different types of leaders: the formal leader, who is in a position of authority, and the informal leader, who has leadership traits but is not formally recognised by the organisation. Brilliant (1986) also pointed out that managers have official designation to be in authority and informal leaders may not have official designation, but may exercise leadership because they have referent or power to lead, such as those who have expertise, knowledge or exclusive accessibility to information. Similarly, Northouse (2009) made a distinction that there are leaders assigned formally by the organisation and emergent leaders who exercise leadership, but with no formal title within the organisation. Differentiating leaders and managers may cause difficulties in measuring, testing, assessing, hiring and developing potential leaders (Kotterman, 2006).

Although Kotter (1990) made a distinction between management and leadership, he also acknowledged that there are similarities between the two. Both managers and leaders are involved in decision making, recruiting people and building relationships to achieve a plan and finally getting these people to accomplish the job. Ofori and Toor (2008) have suggested that organisations need people who have both managerial and leadership capabilities. They further suggested that the best manager is someone who is also seen as a leader to his

followers, with Jackson and Parry (2011) maintaining the view that the key task of management is leadership.

The question here is, “Can NUMs be leaders and at the same time be managers?” and the answer is, “yes”. The ever-changing nature of the health care system means that NUMs have to cope with its complexities, which requires that NUMs have to create and manage change in order to cope. As Kotter (1990) noted, management is about being able to cope with complexity whilst leadership is about being able to cope with change. In order for the NUM to survive and to function efficiently, they should have the skills of both manager and leader (Manfredi, 1996). The NUM is the head and manager of the ward and is also a team leader of the health care staff on the ward (Sellgren et al., 2008). And thus being both a leader and a manager, the NUM is involved in establishing direction, aligning resources and motivating people (Kotterman, 2006). As discussed in Chapter 1, the leadership role of the NUM includes: (i) effective, direct patient care, patient flow, standards of care, (ii) providing management and leadership of staff (Clark-Burg, 2013; Lee & Cummings, 2008; McCallin & Frankson, 2010; Queensland Government, 2008); (iii) being a role model to staff, as well as (iv) a driver of a model of care, (v) patient and family advocate, with the capacity also (vi) to motivate staff to achieve a common goal (Manfredi, 1996; Queensland Government, 2008). Additionally, NUMs are responsible for leading teams to achieve the best quality care and outcomes for patients, educating staff to promote professional development and personal advancement, and introducing innovation (Lee & Cummings, 2008; Queensland Government, 2008). In executing the managerial role, the NUM is responsible for administrative roles such as writing reports, doing the budget for the ward and drawing up rosters (McCallin & Frankson, 2010; Meyer et al., 2011; Queensland Government, 2008). They must ensure they maintain clinical governance, such as occupational health and safety, that the work environment is safe, that there are adequate facilities and equipment, that equipment is

properly maintained, and must adhere to quality assurance requirements such as risk management and reporting, investigation of complaints and accreditation (Gallo, 2007; Lee & Cummings, 2008; McCallin & Frankson, 2010; Queensland Government, 2008). The link between management and leadership is clear in how NUMs set the culture for interpersonal relationships in all aspects of direct and indirect patient care delivery and in setting the culture for trust, respect, change, teamwork, whether it be with patients, their families, staff, allied health, doctors or others (Srsic-Stoehr, Rogers, Kelly Wolgast, Thomas Chapman, & Douglas, 2004).

2.3. Leadership theories

NUMs should be familiar with and understand leadership theories and styles, in order to select and adapt the most suitable and productive approach for dealing with different situations (Bernhard & Walsh, 1990; Marriner-Tomey, 2004). NUMs need various leadership styles they can adapt to guide their actions in relation to actual needs, situations and circumstances during continuous change processes in the health care system (Clark, 2009; Salmela, Eriksson, & Fagerström, 2012).

Theories of leadership have been classified into five approaches by Yukl (2010). First, the trait approach which includes the Great Man Theory and the Trait Theory, assumes that some people are born with traits such as personality and skills that distinguish them from others as good leaders. Second, the behaviour approach involves what leaders actually do, such as how they cope with demands to identify leadership behaviours. Third, the power-influence approach examines different strategies used by leaders to influence the attitudes and behaviours of followers such as the Charismatic Theory. Fourth, the situational approach investigates the contextual factors such as the nature of the task, the environment and the followers' characteristics and this includes Situational Theory, Contingency Theory and Path-

Goal Theory. Finally, the integrative approach involves a combination of the different approaches mentioned above.

2.3.1.Great Man Theory

The Great Man Theory was based on the philosophy that some men are born with the necessary characteristics to be great and lead, while others are born to be led (Bernhard & Walsh, 1990; Marriner-Tomey, 2004). This theory claims that leadership was inherited and thus being the son of the king would somehow ensure that the son would have the capabilities to lead (Bernhard & Walsh, 1990). However, this theory had become unappealing because not all those who assumed the role were capable as leaders (Bernhard & Walsh, 1990) and, because it assumed that leaders are born and not made, it suggests that leadership cannot be learned and developed (Marriner-Tomey, 2004).

2.3.2. Trait Theory

Unlike the Great Man Theory that maintains that traits are inherited, Trait Theory revolves around the concept that leaders are endowed with certain traits that make them greater than their followers (Bernhard & Walsh, 1990) and knowing when to put theory into practice, which can result in success (Chase, 2010). It means that people should have the right or sufficient combination of traits to become good leaders (Clark, 2009). Some of the leadership traits that were identified were personality, motives, values, skills, enthusiasm, ambition, aggressiveness, decisiveness, self-confidence, intelligence, dependability, and participation in social activities (Bernhard & Walsh, 1990; Marriner-Tomey, 2004; Northouse, 2009; Stogdill, 1974; Yukl, 2010). While it was found that leaders should possess the above traits, the results were ambiguous (Bernhard & Walsh, 1990). There was no clear indication which traits were more important and which traits were needed to be acquired to be a great leader (Marriner-Tomey, 2004). Stogdill (1974) found that some leaders may have all the described

characteristics, others may only have one while others may have none at all. The positive aspect of trait theory was that leadership could be learned, that is, the traits suggested can be obtained through learning and experience (Bernhard & Walsh, 1990; Marriner-Tomey, 2004).

2.3.3. Charismatic Theory

Charismatic theory revolves around the premise that leaders with charisma are able to lead because of their inspirational personality traits, they have special charm and appeal, make self-sacrifices, take personal risks, and make others feel better in their presence (Marriner-Tomey, 2004; Northouse, 2009; Yukl, 2010). They inspire, have enormous impact on others and build relationships by stirring strong feelings of loyalty and enthusiasm to reach common goals (Marriner-Tomey, 2004; Northouse, 2009). Charismatic leaders have exceptional powers of influence that give them the capacity to do extraordinary things (Northouse, 2009). Leaders with charisma promote a vision that is highly unconventional, but still within the limits of acceptance by followers. This gives an impression that the leader is extraordinary (Yukl, 2010). However, because charisma is an intangible feeling, some may sense it while others do not (Marriner-Tomey, 2004).

2.3.4. Situational Theory

Situational theory suggests that the leader's traits vary according to varying situations. A person may be a leader in one situation but could be a follower in a different situation depending on the leadership required for the situation (Marriner-Tomey, 2004). According to Marriner-Tomey, factors that influence leadership style include: personality traits of the leader, the required performance of both the leader and followers; the attitudes, needs, and expectations of the leader and followers; the degree of inter-personal contact possible; time pressures; physical environment; organisational structure; the nature of the organisation; the

state of the organisation's development; and the influence of the leader outside the group (2004, p. 171).

2.3.5. Contingency Theory

In Contingency Theory, a leader's style can be successful or unsuccessful depending on the situation. The effectiveness of the leadership style depends on different contingencies which include how much confidence the followers have in the leader, the task involved, whether it is difficult to define, and the clarity of its goal and the position power which refers to how much authority is inherent in that position (Marriner-Tomey, 2004).

2.3.6. Path-Goal Theory

Robert House (House, 1971) based the Path-Goal Theory on the expectancy theory. In the expectancy theory, people perform as they do because they expect a favourable outcome based on their behaviour. In the Path-Goal Theory, the leader employs a leadership style depending on the characteristics of the employee and environment (House, 1971). The leader takes into consideration the employees' needs and experiences to get them motivated. Employees who are more experienced may prefer a leader who is more task-oriented and who has less control over them, while less experienced employees may prefer a leader who is more considerate of the employee's wish to succeed (House, 1971; Marriner-Tomey, 2004). According to Clark (2009), there are three leadership styles that a leader may employ depending on the needs of the follower. First, a leader can employ a supportive style to motivate staff and make the job more interesting when the task involved is stressful, boring and dangerous. Second, a directive approach is suitable when the job is complex and unstructured, and staff inexperienced. Lastly, an achievement-oriented style is best when the task is complex, but staff are experienced and able to complete the task successfully.

2.3.7. Servant leadership

According to Greenleaf (2007), a great leader must be a servant first. A servant leader is someone who listens and responds to the needs of followers. The servant leader makes it a priority to provide service and help the followers to reach their potential. Spears (2004) identified the following 10 characteristics of servant leaders:

1. Listening. The servant leader endeavours to listen intently to others and be receptive of what is being said.
2. Empathy. The servant leader is able to understand what other people are going through.
3. Healing. The servant leader recognises that certain circumstances can cause emotional pain to some people and the servant leader should be able to help in the healing process.
4. Awareness. This includes not only general awareness but also self-awareness. The servant leader is able to view and interpret most situations and act accordingly.
5. Persuasion. Another characteristic of a good servant leader is to be able to convince and not coerce the followers for compliance.
6. Conceptualisation. The servant leader is able to look beyond day-to-day problems and to be creative solving problems in any given situation.
7. Foresight. The servant leader is able to reflect from past experiences, has a great understanding of the present situation and able to plan for future directions.
8. Stewardship. The servant leader recognises that he has a commitment to serve others and to foster persuasion rather than coercion.
9. Commitment to the growth of people. The servant leader has the responsibility to help the followers reach their potential.

10. Building community. The servant leader is able to foster building a community within a given institution.

2.3.8. Shared leadership

"Shared leadership refers to a team property whereby leadership is distributed among team members rather than focused on a single designated leader" (Carson, Tesluk, & Marrone, 2007, p. 1217). In shared leadership, team members contribute to one another to bolster effectiveness (Carson et al., 2007). In the health care setting, although there are different teams such as doctors, nurses and allied health, they all work together ideally for the common goal of positive patient outcome.

2.3.9. Connective leadership

In connective leadership, the leaders realise that a greater result is achieved by integrating the abilities of others through collaboration, cooperation, coordination and collegiality. It works on the premise that the whole is greater than the sum of its parts (ANCC, 2006 p. 1 as cited in Chase, 2010). NUMs collaborate and coordinate with doctors, physiotherapists, social workers and others to achieve the best results in providing high quality patient care.

2.3.10. Transformational leadership

Leaders who practise transformational leadership inspire, motivate, act as role models, provide intellectual stimulation and encourage employees to self-manage (Bass, 1985; Marriner-Tomey, 2004). Leaders are seen to have the charisma to lead (Bass, 1985). Transformational leadership promotes staff development, attends to the needs and motives of followers, provides intellectual stimulation and encourages followers to be creative. The leader is a role model who provides direction and promotes self-management (Marriner-Tomey, 2004). In transformational leadership, the followers are motivated to exert extra effort, to do more than what is expected of them (Yukl, 2010).

2.3.11. Transactional leadership

In transactional leadership, there is a contingent reward for followers who have met the expected performance (Marriner-Tomey, 2004). Transactional leadership is based on social-exchange theory which implies that there are social, political, and psychological benefits to be had in any relationship, including that of leader and follower; and that these benefits are reciprocal (ANCC, 2006, p. 1 as cited in Chase, 2010). It is an exchange of stance, where the needs of the followers are identified and given rewards in exchange for meeting the expectations of accomplishing a goal (Marriner-Tomey, 2004).

2.3.12. Full Range Leadership Theory

The Full Range Leadership Theory is one that is widely used incorporating a range of leadership behaviours measured by the Multifactor Leadership Questionnaire (MLQ) (Avolio & Bass, 2004). There are three leadership styles identified in the MLQ: transformational, transactional and passive/avoidant behaviour. These three styles consist of nine behavioural attributes. Transformational consists of five leadership attributes, namely: idealised attributes, idealised behaviours, inspirational motivation, intellectual stimulation and individual consideration. Transactional leadership consists of two attributes consisting of contingent reward and management-by-exception (active). Passive/avoidant behavior consists of two attributes consisting of laissez-faire leadership and management-by-exception (passive) (Avolio & Bass, 2004).

According to Avolio et al. (2004), an effective leader is one who exhibits a combination of transformational and transactional leadership styles. Further, the authors also suggested that leaders who display both transformational and transactional leadership styles have more positive outcomes in terms of staff satisfaction, staff effectiveness, and willingness to exert

extra effort for the organisation. Leaders who display a laissez-faire style of leadership have more negative outcomes.

2.4. Nursing management style and its implications for job satisfaction

As this study is about NUMs, it is important to examine management styles used by NUMs in the health care setting. It is paramount that NUMs recognise their personal philosophy of leadership because this will affect how staff will respond to them, how staff will respond to their work and how staff will perceive them as effective leaders (Northouse, 2009). The leadership style of NUMs has profound influence on staff job satisfaction and retention, and the delivery of care and health outcomes of patients (Azaare & Gross, 2011; Kleinman, 2004; McGuire & Kennerly, 2006). Leadership style is an important factor for staff to accept change and motivate them to achieve a high quality of care (Azaare & Gross, 2011). Nurse managers are responsible in supporting and motivating staff. Their leadership styles are a contributing factor in a staff member's decision to stay or leave and seek employment elsewhere (AbuAlRub & Alghamdi, 2012)

There are three different leadership styles which all relate to the degree of freedom allowed or control exerted over subordinates: autocratic, democratic and laissez-faire styles (Bernhard & Walsh, 1990; Northouse, 2009). In the autocratic style, the leader has maximum control over subordinates. The leader alone has the overall overview of the situation, exerts control over the group and does not allow communication and interaction among the group (Bernhard & Walsh, 1990; Northouse, 2009). By contrast, in the democratic style, leaders work with subordinates rather than controlling them, treat them fairly and do not put themselves above them (Northouse, 2009). The leader allows group interaction to facilitate the work (Bernhard & Walsh, 1990). In the laissez-faire style, the leader gives complete freedom to subordinates, has limited participation and only intervenes when needed

(Bernhard & Walsh, 1990). The laissez-faire style has been labelled as nonleadership by Northouse (2009). It should be noted that these styles overlap often with each other, that is, a leader can exhibit more than one style depending on the situation. A leader may be authoritarian in some situations but may be democratic in others (Northouse, 2009). NUMs deal with different situations and aside from their staff; they also deal with other stakeholders such as doctors, allied health, other NUMs and upper management. In all these instances, the NUM may use different leadership styles.

Transformational and transactional leadership were first developed by Burns (1978). Bass (1985) added to Burns' original concept to help explain how transformational leadership could be measured in terms of the leader's influence on followers. Bass (1985) developed the Multifactor Leadership Questionnaire (MLQ) to measure both transformational and transactional leadership and also laissez-faire leadership. This instrument is still widely used by researchers in the health care system. Transformational leadership refers to the intrinsic, personal style of leadership that is characteristic of visionary leaders who care about their staff and encourage them to achieve their best. Transformational leaders are able to demonstrate charismatic behaviours to motivate, excite, activate and empower others. Transactional leadership, on the other hand, is a form of management that ensures that objectives are achieved and deadlines met. Transactional leaders set goals, give direction and try to manipulate and control situations. Transactional leaders work on rewards such as recognition, merit increases, bonuses that can be given or withheld according to employee performance. Leaders who exhibit a laissez-faire style of leadership monitor work performance and correct it as needed and they deal with issues only when problems occur. The three outcomes which are included in the MLQ are: Extra Effort (EEF) by followers, the Effectiveness of leader's behaviour (EFF) and the Satisfaction (SAT) of followers with their leader (Avolio & Bass, 2004; Bass, 1985). A review of the literature reveals that the

leadership styles predominantly used in nursing management are transformational, and to a lesser degree servant and authentic (AbuAlRub & Alghamdi, 2012; Bowles & Bowles, 2000; Cowden, Cummings, & Profetto-McGrath, 2011; Doody & Doody, 2012; Edmunds, 2014; Kallas, 2011; Lindholm, Sivberg, & Uden, 2000; McGuire & Kennerly, 2006; Suliman, 2009). The common factor among these leadership styles is the ability of the NUM to achieve high job satisfaction scores among their staff (Kallas, 2011).

Bowles and Bowles (2000) conducted a comparative study of transformational leadership in nursing development units and conventional clinical settings in the United Kingdom. The nursing development units were conceived as centres of nursing excellence, innovation and leadership development. Their main objective was to identify which first-line nurse managers in nursing development units and non-nursing development unit settings demonstrated transformational leadership behaviours. The authors used the Leadership Practices Inventory based upon the model of transformational leadership. This inventory was used to gather data piloted as a postal questionnaire and used for telephone interviews. Bowles and Bowles (2000) found that leaders from the nursing development units displayed more transformational behaviours than those working in conventional clinical settings.

Bormann (2011) undertook a descriptive survey study to describe the relationship between perceived leadership behaviours of nurse managers by their staff and overall staff job satisfaction. This was conducted in an acute care hospital in southern United States that was applying for Magnet status, and consisted of 500 registered nurses and 15 nurse managers. Magnet hospitals are those recognised for excellent nursing care with high rates of recruitment and retention of nursing staff (Cross, 2013). Magnet status hospitals are recognised for their transformational leadership and opposition to passive-avoidant leadership (ANCC Magnet Recognition Program, n.d. cited in Bormann, 2011). Borman's study aimed to answer three research questions. The first question was about the relationship between staff

perception of the nurse manager's leadership behaviour and facets of staff job satisfaction. The MLQ 5X short form was used to determine staff perception of their nurse manager's leadership style (transformational, transactional and laissez-faire or passive-avoidant). The Abridged Job Descriptive Index (aJDI) was used to measure the facets of staff job satisfaction that included work, pay, promotion, supervision and co-workers. Bormann (2011) found there was a strong positive relationship between transformational leadership and staff satisfaction with supervision, and found a strong negative relationship with passive-avoidant leadership and staff supervision. There was also higher satisfaction with co-workers, work on present job and pay, but least satisfaction with job promotion.

Edmunds (2014) had similar findings to Bormann (2011). Edmunds (2014) conducted a study at a Magnet designated health care facility in Northeast Ohio to determine the relationship between nurse managers' perceptions of their leadership style, and the perceptions of their respective directors, and direct report registered nurses. The MLQ5X short form was used for the survey. There were eight nurse managers, four directors and 68 staff nurses who completed the survey. The directors rated nurse managers higher on transformational leadership, while staff nurses rated nurse managers almost the same on transformational and transactional leadership. Nurse managers rated themselves lower than directors but higher than staff nurses for transformational leadership. Nurse managers rated themselves lower for transactional leadership compared to the directors', which may indicate that nurse managers were expected to meet transactional requirements such as budgets and quality standards. Edmunds' findings (2014) also revealed a positive correlation between transformational leadership style and outcomes for extra effort, effectiveness and satisfaction. And she found a negative correlation between passive-avoidant leadership behaviours and the three outcomes included in the MLQ, as described earlier.

Cowden et al. (2011) conducted a systematic review on leadership practices and staff nurses' intentions to stay in their positions. Their findings supported Bormann's (2011): that transformational leadership style resulted in greater intentions to stay. They also found that a leadership style that is task-focused, such as management by exception whereby the NUM watches and searches actively for deviations from standards and procedures to avoid deviations (Avolio & Bass, 2004), resulted in lower intentions to stay.

Rad and Yarmohammadian's (2006) study of 12 Isfahan University Hospitals explored the relationship between managers' leadership styles and employees' job satisfaction. There were a total of 814 employees who participated in this study: 665 employees, 127 first-line managers or department heads, 11 middle managers or hospital managers and 11 senior managers or hospital presidents. They used Rensis Likert's model of leadership styles for their conceptual framework. Likert's model consists of four practices that leaders may use to influence the performance of employees and the organisation. These practices include exploitative, authoritative, benevolent and participative. The questionnaire has 15 items that determine a manager's employee oriented dimension and 20 items that determine the task-oriented dimension of leadership style. The job satisfaction questionnaire was used to assess the level of job satisfaction among employees. This consists of nine sub-scales: salaries, fringe benefits, recognition, promotion, communication, working conditions, nature of the job, supervision and co-workers. In contrast with Bormann (2011), Rad and Yarmohammadian (2006) found in their study that the leaders predominantly practised the participative style of leadership. There was a significant correlation between the use of leadership behaviours and job satisfaction. The employees rated their managers as more task-oriented while managers rated themselves as more employee-oriented. Whereas in Bormann's findings where there was higher satisfaction with work on present job and pay, the findings in Rad and Yarmohammadian's study (2006) showed less satisfaction with pay,

benefits and work conditions. Rad and Yarmohammadian (2006) suggested that these needs should be met before employees think about participating in their organisation's management process. Bormann (2011) and Rad and Yarmohammadian (2006) both agreed there was more employee satisfaction with the nature of the job, co-workers and supervision type and less satisfaction with job promotion. According to Rad and Yarmohammadian (2006), participative management is not always a good management style. In their study, participative leadership did not improve the hospital's effectiveness and efficiency based on the inefficiency rating of active beds. They suggested that managers should take into consideration organisational culture and employees' maturity when selecting leadership style, and concluded that participative style was not effective in the 12 Isfahan University Hospitals.

The second question Bormann (2011) explored was the relationship between staff perception of nurse manager leadership behaviour with overall staff job satisfaction. Bormann (2011) used the Abridged Job in General (aJLG) questionnaire, which was the best predictor for intention to quit. The study revealed a positive relationship between transformational leadership behaviours and overall job satisfaction. However, comparing the results from the survey using the MLQ, which measured the leader behaviours and outcomes of leadership with the published norms by MLQ, the results in Bormann's study indicated that staff perceived their nurse managers as less transformational and less transactional than the norm and more passive-avoidant. Bormann (2011) did not offer an explanation as to why staff perceived their nurse managers as more passive-avoidant. Hersey and Blanchard's (1993) suggestion that staff require less task orientation as their level of maturity increases may offer an explanation. Staff require less supervision and direction when they are more experienced (Sellgren, Ekvall, & Tomson, 2006). Similarly, a systematic literature review on the influence of nursing leadership on nurse performance by Brady and Cummings (2010)

revealed that nurses viewed autonomy as affecting their motivation and ability to perform. In their study, nurses who had gained the trust of their nurse managers experienced more autonomy in performing the scope of their practice. Explanations by Hersey and Blanchard (1993), Brady and Cummings (2010) and Sellgren et al. (2006) are in agreement with the Path-Goal Theory of leadership whereby more experienced staff may prefer a leader who is more task-oriented and less controlling (House, 1971).

The third question that Bormann (2011) explored was the relationship between facets of staff job satisfaction and overall staff satisfaction. The aJDI questionnaire was used to measure individual staff job satisfaction and the aJLG questionnaire was used to measure job satisfaction for all staff. The aJLG reflects staff feelings toward their jobs and all aspects of job satisfaction. Bormann found there was a strong relationship between overall job satisfaction and individual staff job satisfaction. Furthermore, the study revealed a significant difference in terms of staff years of experience in relation to leadership style. Staff with five or less years of clinical experience had stronger relationships with transformational leadership whereas staff with 11 or more years of experience did not show a significant relationship with any style of leadership. This finding may suggest that those with five years or less experience were greatly influenced by leadership behaviours while those with 11 years or more were not. There was a significant relationship between overall job satisfaction of both nurse managers and staff and transactional leadership behaviours. This finding contradicts the suggestions by Bass and Avolio (2004) that transactional leadership is a positive form of leadership and that good leaders exhibit both transformational and transactional behaviours. Bormann (2011) suggested that the reasons for this may include role expectations for the nurse manager to exhibit transactional behaviours such as compliance to policies and procedures, rules and regulations and to perform evidence based practice. In another earlier study, Kleinman (2004) found that transactional leadership

behaviour of active management by exception had a negative effect on staff retention. Kleinman's finding is also in contrast to Bass and Avolio's (2004) suggestion that transactional leadership is a positive form of leadership. The results of the study conducted by AbuAlRub and Alghamdi (2012) are congruent with the results of Bormann (2011) and Kleinman (2004). AbuAlRub and Alghamdi (2012) conducted a study in the Western Region of Saudi Arabia where 308 nurses participated to explore the impact of leadership styles on nurses' satisfaction and intention to stay. The study used a descriptive correlational design. The Multifactor Leadership Questionnaire (MLQ-5X), Job Satisfaction Survey (JSS), the McCain's Intent to Stay Scale and a demographic data form were used to collect data. The results showed that staff perceived their managers as more transformational leaders. They also found that a transformational leadership style enhanced the level of job satisfaction of nurses. Further, their results revealed that perceived transactional leadership style had a negative influence on nurses' job satisfaction. However, their study did not find a relationship between leadership styles and intention for nurses to stay in their jobs. The researchers also indicated that those who were more satisfied with their job intended to stay longer in their current position and there was a lower turnover rates with transformational leadership style.

Lindholm, Sivberg and Uden (2000) conducted a study with three Swedish hospitals to explore the meaning, exposition and application of nurse managers' leadership styles within the organisational culture of a changing health care system. Interviews were conducted with 15 nurse managers. They identified four leadership styles including the formation of hierarchical authority, hierarchical adjustment, a career approach and devotional approach. The hierarchical authority was more transactional. The nurse managers in this group worked within a hierarchical system of management and did not have any intentions of moving away from the current management system. The formation of a career approach was more

transformational. The nurse managers in this group were more supportive of their staff and shared their power with capable co-workers. The hierarchical adjustment and devotional approach are a mix of both transformational and transactional. The hierarchical group alternated between transformational and transactional leadership styles. The managers in this group allowed their staff to grow and develop and they delegated responsibilities to staff, but they also interfered. The nurse managers who used the devotional approach also used a mix of transformational and transactional styles of leadership. They had strong motivation to uphold the nursing culture in their management approaches. It was found that those nurse managers who exhibited mainly transformational or transactional leadership styles had fewer management problems than those with a combination of transformational and transactional approaches. The researchers explained that those managers who exhibited a distinct leadership style were perceived as distinct leaders by their followers. Those who exhibited a mix of leadership styles were found to have more problems in trying to keep control of changes in hospital practice or trying to motivate staff in developing traditional activities while at the same time coping with change. These findings are in contrast to Bormann's (2011) who found that transactional leadership behaviours had a negative effect on overall job satisfaction, but are in agreement with the suggestion of Bass and Avolio (2004) that transactional leadership is a positive form of leadership. However, Lindholm et al. (2000) found that those who used a mix of transformational and transactional models had more management problems contradicts the suggestion by Bass and Avolio (2004) that good leaders exhibit both transformational and transactional leadership styles. Sellgren et al. (2006) also found in their study that staff preferred managers with distinct leadership behaviours than those with vague leadership styles. Sellgren et al. (2006) surveyed 66 nurse managers and 770 subordinates at the Karolinska Hospital in Stockholm, Sweden. They used the CPE (change, production, employee) model to explore preferred leadership behaviour.

Their study revealed that staff preferred managers with clearer leadership styles. Sellgren et al. (2006) also commented that leadership behaviours were poorly explored in health care.

McGuire and Kennerly's (2006) study aimed to clarify the link between the use of transformational and transactional behaviours by nurse managers and the development of organisational commitment by registered nursing staff. The study was conducted in 11 hospitals in the Midwest region in the United States of America. The sample consisted of 63 nurse managers and 500 registered nurses. For the nurse manager to be included in the study, at least five of their 15 registered nurses or more must have reported directly to them. Two versions of the MLQ Form 5X were used in this study. The leader form was completed by nurse managers for self-assessment of their leadership style and the rater form was completed by staff to determine the leadership style of their managers. The result of self-assessment was then re-examined and compared to staff perceptions of managers' leadership styles. Their study found that nurse managers rated themselves higher on transformational style but staff rated their managers as more transactional. McGuire and Kennerly's (2006) explanation for this result was that the nurse managers may be struggling with the concept of transformational leadership. It could also be the effect of work environments such as hospitals and health care organisations that are bureaucratic in nature and do not enable transformational leadership to be exercised fully. They also found significant correlations on all subscales on the MLQ except for the transactional subscale labelled as management by exception (active). Their findings are consistent with transformational leadership theories (Avolio & Bass, 2004) except for the positive correlation between contingent reward, which is a transactional attribute, and organisational commitment. The researchers also found that Idealised Influence, which is also called charismatic, was the strongest transformational leadership attribute. These leaders are admired and trusted by their followers. Staff respond favourably to managers who are role models, and who demonstrate integrity and ethical and

moral values (McGuire & Kennerly, 2006). There was no significant correlation between self-assessed leadership style and organisational commitment of staff in the study by McGuire and Kennerly. The lack of correlation may suggest that staff had a different perception of leadership style of their manager compared with the manager's self-assessment. This disparity may have been due to role differences, past work experiences and other experiences with past management. Nurse managers perceived by staff as transformational, demonstrated higher organisational commitment. When transactional leadership was used, staff were more likely to fulfil employment contracts. However, the nature of the job of nurse managers and the environment is embedded in transactional characteristics (McGuire & Kennerly, 2006). McGuire and Kennerly asserted that nurse managers who effectively maintain a composite style of transformational and transformational characteristics are able to maintain stability and smooth running of the ward. This is in contrast to the findings of Rad and Yarmohammadian (2006) who found that those who exhibited a mix of transformational and transactional characteristics had more management problems than those whose leadership style was distinctly transformational or transactional.

Williams et al. (2001), using a focus group and a survey of 20 ward managers and 27 senior nurses in the United Kingdom, found that the effective nurse manager is one who achieves a balance between transformational and transactional leadership. Unlike Burns (1978) who set transformational and transactional leadership as opposites, Avolio and Bass (2004) argued that transformational leadership augments the effects of transactional leadership on the efforts, effectiveness and satisfaction of subordinates. Avolio and Bass (2004) proposed the Full Range Leadership Theory where leaders should display both transformational and transactional behaviours but in differing amounts, and this is supported by the study findings of McGuire and Kennerly (2006). In order to ensure the smooth operation of any nursing unit and to maintain the stability of an uncertain health care

environment, the NUM must effectively handle the duality of the role as a transactional and transformational leader. Transformational leadership is usually practised in personnel management such as coaching and mentoring while transactional leadership is practised by NUMs whose roles require them to be accountable for processes such as budgets, productivity and quality monitoring (McGuire & Kennerly, 2006). This concurs with the study findings of Williams, McGee and Bates (2001). Using a focus group and a survey of 20 ward managers and 27 senior nurses in the United Kingdom, they found that a nurse manager was more effective when there was a balance between transformational and transactional leadership.

McGuire and Kennerly (2006) supported Hirst's (2005) study that in order to be an effective leader, it is essential to have the ability to motivate. Hirst also placed importance on building relationships between the NUM and staff and treating staff holistically, recognising the various aspects of their lives. Marrying the needs of staff with the needs of the organisation can lead to an advantage for everyone (Hirst, 2005). And there is readiness from staff to expend considerable effort for the organisation and their strong desire to stay on the job (McGuire & Kennerly, 2006). Hirst suggested that a good transformational NUM would gather staff to talk, encouraging free flow of information and ideas. Leaders who can provide intellectual stimulation can encourage their staff to be more creative in producing positive results (McGuire & Kennerly, 2006). A transactional NUM, on the other hand, will gather staff to simply deliver a message as a task to be done (Hirst, 2005). According to Heuston and Wolf (2011), a successful nurse manager should possess the following transformational skills: "inspire a shared vision" by getting staff to align their ward's vision to that of the whole organisation; "challenge the process" by allowing staff to try new ways; "model the way" by acting as a role model to their staff; "enable others to act" by coaching and

mentoring staff to be able to do things themselves; and "encourage the heart" by giving individualised recognition (Heuston & Wolf, 2011, p. 250).

A study by Ghorbanian, Bahadori and Nejati (2012) explored the relationship between managers' leadership style and emergency medical technicians' job satisfaction. They used the self-rater MLQ for managers to rate their leadership style and the rater's MLQ for staff to determine the leadership style of their managers. They also used the Job Descriptive Index to measure job satisfaction levels. Participants included 21 managers and 87 emergency medical technicians from 23 stations in Isfahan City, Iran. Their findings showed that both managers and staff shared the same perception of their leadership style as more transformational. In terms of job satisfaction, there was a strong relationship between transformational and transactional leadership styles and overall job satisfaction. This concurs with McGuire and Kennerly's (2006) results that nurse managers were more effective when they exhibited a mix of transformational and transactional leadership styles.

Raup's (2008) study of 15 Emergency Department (ED) nurse managers and 30 staff nurses in the United States, aimed to determine leadership styles used in the ED and influence on staff turnover and patient satisfaction. Using the MLQ, the survey revealed a lower staff turnover with transformational compared to non-transformational leadership style. Similar to Ghorbanian et al's (2012) study, it was found that nurse managers who exhibited a transformational style were older and were in their positions for more years than those nurse managers who were more non-transformational. Raup explained that those nurse managers with more experience had attended more leadership training than those of lesser experience. However, there was no significant relationship between nurse managers' leadership styles and patient satisfaction. Raup's explanation (2008) was, this was possibly due to the nature of patient's condition, and staff nurse who provided direct care to the patient may have been the major source of patient satisfaction.

Failla and Sticher's (2008) study in Southern California explored perceptions of leadership styles to determine the effect of transformational leadership on job satisfaction. A total of 92 employees participated which included 15 nurse managers and their respective nursing staff. They used the MLQ to measure the leadership style of managers and the Index of Work Satisfaction Questionnaire to measure job satisfaction which included pay, autonomy, task requirements, interaction, professional status and organisational policies. Their study finding concurs with McGuire and Kennerly (2006) and Kleinman (2004) where managers rated themselves higher on transformational leadership than their staff rated them. The finding may indicate that while nurse managers want to be recognised as transformational leaders, they may not be exhibiting the characteristics of transformational leadership. Failla and Stichler (2008) stated a need to close this difference in perception and nurse managers needed to occasionally seek feedback from their staff with regards to their leadership styles. Failla and Stichler (2008) noted a correlation between both transformational and transactional leadership styles with total job satisfaction. This finding supports McGuire and Kennerly's (2006) suggestion that a blend of both transformational and transactional behaviours are necessary for staff job satisfaction. This could also be related to the nature of the health care environment where nurse managers are expected to comply with the organisation's policies, budget and productivity which are transactional in nature (Failla & Stichler, 2008).

Gabel (2013) reviewed the characteristics of transformational leadership and described their appropriateness for medical education and health care settings. This review is also appropriate for NUMs in several ways. The first characteristic is Idealised Influence. The NUM acts as a role model, is visionary and is the one who upholds further organisational missions in the workplace. The second characteristic is Inspirational Motivation. NUMs should be able to communicate visions, principles and explain adherence to the organisational

mission effectively. NUMs should be able to motivate staff accordingly. A third characteristic identified was Intellectual Stimulation. NUMs exhibiting this characteristic challenge their staff to solve difficult problems and encourage them to come up with new solutions such as efficient ways of providing patient care to improve outcomes. A fourth characteristic identified was Individualised Consideration. The NUM should recognise the individual contribution and personal needs of staff. NUMs for example should congratulate staff for implementing systems to reduce medication errors (Gabel, 2013).

The study findings of Azaare and Gross (2011) are in contrast with Gabel's (2013). Azaare and Gross (2011) conducted a study in Ghana where 21 staff nurses participated in a tape-recorded interview to explore their perceptions of their nurse managers' leadership styles. Their study revealed four leadership styles: 1) non-consultative leadership, 2) depowered leadership, 3) abusive/hostile leadership and 4) knee-jerk leadership. The nurse managers who practised non-consultative leadership were perceived as autocratic; staff members were not fully informed of changes in the organisation and the nurse managers made changes to suit themselves. Whilst the nurse managers who practised depowered leadership were not constructive when it came to nursing issues, they allowed themselves to be intimidated by other managers, were unable to address staff benefits such as allowances and were considered figureheads. Whereas nurse managers who exhibited the abusive/hostile leadership trait started condemning staff before even listening, insulting staff in front of patients, insulting staff instantly without query and shouted at staff whenever they felt like doing so. Lastly, those nurse managers who exhibited knee-jerk leadership acted spontaneously, took actions before investigating and often later regretted their actions, and took things personally. Depowered leadership was the most dominant style exhibited. From these findings, nurse managers were more transactional than transformational, and were unaware that abusive and hostile behaviours may demoralise followers, and decrease their

commitment and trust in the leader and ultimately decrease job satisfaction. Azaare and Gross' findings support those of Lindholm et al. (2000) where hierarchical authority is practised rather than the career approach. Nurse managers should be sensitive to the feelings of their staff and be able to stay calm, with ease and in a controlled manner in stressful situations (Lorber & Skela Savič, 2011).

Azaare and Gross' (2011) findings also support those of Malloy and Penprase (2010). Malloy and Penprase (2010) conducted a study to examine the relationship between leadership style and psychosocial work environments of 120 registered nurses. They used the MLQ 5 to assess the leadership style of nurse managers and the Copenhagen Psychosocial Questionnaire to measure aspects of aspects of the psychosocial work environment. Their study found that leadership style has a strong influence on the psychosocial work environment. The results support the Full Range Leadership Theory, especially with the implementation of transformational and contingent reward leadership behaviours, which promote positive work environments and increase job satisfaction and motivation, while they found management by exception active and passive, and laissez-faire promoted negative work environments (Malloy & Penprase, 2010).

A descriptive study was conducted by Suliman (2009) in one of the hospitals of the National Guard Health Affairs in Saudi Arabia to explore the leadership styles of nurse managers and to determine the impact of leadership styles in a multi-cultural environment on staff intention to stay in or leave their positions. Suliman used the MLQ to assess the leadership style of nurse managers where 31 nurse managers and 118 staff nurses participated, who came from different nationalities: Middle East (Arab Countries), Far East (Philippines, China, Indonesia, Korea, Malaysia, etc.), and Western (America, Australia, New Zealand, South Africa and Europe). Although the overall results showed that the predominant style of leadership was transformational, nurse managers rated themselves higher than staff

rated them. This result concurs with other studies where it was also found that nurse managers usually rated themselves higher on transformational leadership than staff rated them (Failla & Stichler, 2008; Ghorbanian et al., 2012; McGuire & Kennerly, 2006; Raup, 2008). Suliman (2009) found that participants' nationality and intention to stay or quit affected their perception of transformational leadership. There was a significant relationship between nationality and intention to stay with transformational leadership, which suggests that transformational leadership promotes staff nurses' retention. This finding is consistent with other studies in that transformational leadership contributes to staff retention (Azaare & Gross, 2011; Failla & Stichler, 2008; Gabel, 2013; Ghorbanian et al., 2012; Lindholm et al., 2000; McGuire & Kennerly, 2006; Raup, 2008; Williams et al., 2001). Suliman indicated that reasons to leave employment were categorised as: 1) Setting-based which is related to place of work, culture and country. Participants' comments included cultural reasons and lack of promotion opportunities; 2) Management-based which included nurse managers and job-related issues such as inappropriate behaviours of nurse managers, stress created by nurse managers and lack of motivation from nurse managers to improve; and 3) Personal-based which included waiting for visa approvals from other countries and wanting to be reunited with families back home (Suliman, 2009).

Zampieron, Spanio, Bernardi, Milan and Buja (2013) conducted a study at the Italian National Health Service to compare different leadership styles perceived by nurse managers and their staff. The CPE model questionnaire was used to survey 21 nurse managers, 266 nurses and 87 assistants to determine participants' preferred and perceived leadership styles. Their findings revealed that both nurse managers and staff had the same perception of leadership styles preferred, but there was a difference between leadership styles that nurse managers reported they were adopting and the styles staff reported them adopting. Unlike other studies that found nurse managers rated themselves higher as transformational

compared to the ratings of their staff (Failla & Stichler, 2008; Ghorbanian et al., 2012; McGuire & Kennerly, 2006; Raup, 2008), Zampieron et al. (2013) showed that staff rated their nurse managers more positively than nurse managers rated themselves. They attributed this discrepancy to nurse managers being less confident about their performance and therefore underrating their behaviours.

It is suggested that popularity of transformational leadership style in nursing has limited the exploration of other leadership behaviours that may be more suitable for health care organisations (Hutchinson & Jackson, 2013; Sellgren et al., 2006). NUMs must be able to adopt contemporary theories to be effective leaders (Chase, 2010). Other leadership styles identified as suitable for health care settings include connective leadership, authentic leadership and servant leadership (Kallas, 2011; Scully, 2014)

The emergence of inter-professional practice in health care settings suggests that a more comprehensive and contemporary interpretation of nursing leadership be considered (Hutchinson & Jackson, 2013). Connective leadership or shared leadership may be the way in which nurse leaders of today should lead (Scully, 2014). In connective leadership, NUMs interact with two groups of followers: patients who require care and staff who provide the care. NUMs have a therapeutic relationship with patients, providing them with the necessary care to be able to return to independent life. As well, NUMs have a collaborative relationship with other health care providers to achieve a common goal, which is that health outcome for the patient (Bernhard & Walsh, 1990). Connective leadership is a form of leadership where a task can be shared or distributed among members of a team to enable them to work towards not only their own goals but those of the group in which they are involved (Sahoo & Das, 2012). Connective leadership reflects the modern practice of nurses today as it involves collaboration with other health care professionals with a common goal of achieving the best patient outcome (Scully, 2014).

Authentic leadership style has been regarded as one of the necessary standards in creating a healthy work environment by The American Association of Critical Care Nurses (AACN) (Kallas, 2011). This style is the most recent approach considered in nursing management that heightens the positive effects of transformational leadership (Cross, 2013). Authentic and transformational leadership styles have been effective in empowering and inspiring nursing staff to have a sense of commitment when change is needed, and this can ultimately lead to the success of the nurse manager (Pickerell, 2014). Authentic leadership appeals to the heart, that can therefore have potential for greater relational capacity (Jackson & Parry, 2011). It promotes an open relationship between leaders and followers and thus enhances feelings of trust, engagement and empowerment.

Servant leadership has also gained attention in nursing management (Kallas, 2011). In servant leadership, the nurse manager serves staff who in turn serve the patients (Neill & Saunders, 2008). Neill and Saunders described a set of 10 skills in servant leadership that are particularly applicable to nursing management: listening, empathy, healing, awareness, persuasion, conceptualisation, foresight, stewardship, committed to the growth of people and building community. This skill set promotes professional growth of nurses and the improvement of health care delivery through a combination of interdisciplinary collaboration, shared decision making, and ethical behaviour (Neill & Saunders, 2008). Neill and Saunders described how this skill set of servant leadership was applied in practice at the George E. Wahlen Veterans Affairs Medical Center in Salt Lake City, Utah and earned them a consistently high ranking on quality patient care and increases in professional satisfaction in nursing practice. Neill and Saunders (2008, p 396) described the skill set as follows:

1) Listening: the nurse leader encouraged all ideas from employees and then translated these into meaningful action by identifying opportunities for staff nurses to develop innovations for the improvement of health care services.

2) Empathy: the nurse leader made an effort to consider others' viewpoints and helped them to realise their dreams. The nurse leader worked on the premise that he/she would not ask a nurse to perform a task that he/she would not do.

3) Healing: the nurse leader identified the strengths of each staff member and carefully created opportunities for each individual to use these qualities which resulted in the acceptance of each individual and boosted the confidence of staff members.

4) Awareness: the nurse leader practised holistic care by recognising critical events in the lives of employees and guided other staff to be supportive of each other, resulting in a more positive, familial and caring environment.

5) Persuasion: the nurse leader assumed the position of persuader who provided staff nurses with insights and strategies to rectify concerns.

6) Conceptualisation: the nurse leader thought beyond present time urgencies to incorporate broader based creative thinking and situations were more manageable when shared by the entire team.

7) Foresight: the nurse leader had the ability to anticipate outcomes and had the ability to predict outcomes of a particular decision. Being innovative was a hallmark for such nurse leaders.

8) Stewardship: the nurse leader empowered staff to continuously improve the quality of services and create an environment that was better than yesterday for patients and nurses.

9) Committed to the Growth of People: the nurse leader demonstrated commitment to the growth of people by recognising the talents of each individual and then aligning their strengths for their development. The nurse leader recognises the importance of taking care of staff who take care of patients.

10) Building Community: the nurse leader built a team with the sense of sharing values and common purpose by meeting the needs of all interdisciplinary providers and building a community of members who are helpful, supportive and respectful of each other.

Duffield et al. (2011) conducted a study in 21 hospitals across two Australian states to examine the impact of leadership characteristics of NUMs as perceived by staff nurses on staff satisfaction and retention. They found that NUMs perceived by staff as good leaders were visible, provided praise and recognition, were flexible and available for staff consultation. The authors also found that NUMs who scored highly on a broad range of leadership items contributed to higher job satisfaction among their staff.

Although transformational leadership has gained popularity in nursing management, NUMs must be adaptable and flexible in their leadership styles and consider using contemporary theories to be effective in their roles. With the use of charisma and transactional styles, NUMs can influence staff nurses to meet organisational goals. Through the use of transformational, connective, shared or servant leadership, and authentic leadership styles, NUMs can bring staff together and lead work teams to be productive (Chase, 2010).

2.5. Preparing Nurse Unit Managers for the leadership/management role

Staff nurses are often thrust into managerial positions but they are not adequately prepared in their nursing education, leaving them unprepared to assume the role effectively (Doria, 2015; Gaskin et al., 2012; Heller et al., 2003; McCallin & Frankson, 2010; Titzer et al., 2013; Townsend et al., 2012). Considering the difficulty and importance of the role, many NUMs have no leadership experience or training before assuming the role (DeCampli et al., 2010). Noting that training is not essential, some leadership theories, such as the trait theory, claim that leadership is inborn. However, other leadership theorists disagree. As quoted in Giuliani (2002, p. xii), “Leadership does not simply happen. It can be taught, learned, developed.”

Leaders evolve through a range of experiences and learn from others (Arnold & Nelson, 2004; Scully, 2014). McGuire and Kennerly (2006) asserted that transformational leadership skills, such as establishing clear expectations, creating shared vision and inspiring others for organisational commitment, can be taught. Mathena (2002) stated that nurse managers will have fewer feelings of uncertainty if they have effective leadership preparation.

2.5.1. Succession planning

Certainly, many aspects of good leadership can be learnt; but it is also important, firstly, to identify staff who can be trained to be effective leaders. There is a need to promote succession planning in order to reduce the longstanding problems of preparing NUMs for their role (Griffith, 2012; McCallin & Frankson, 2010; Titzer et al., 2013). Although there is vast literature on the characteristics of good nurse leaders, there is limited information on how to identify nursing staff who may have potential leadership skills, how to cultivate them to become future leaders (Conners, Dunn, Devine, & Osterman, 2007) and exactly how to achieve these goals (Lindholm et al., 2000). Effective succession planning should result in the advancement of capable and efficient leaders (Griffith, 2012). Some people are just not suited for management and so it is important to make sure the right people undertake the role (Kirby, 2010). Furthermore, Kirby (2010) suggested that time should not be wasted in training people who do not possess the necessary attributes of a good leader.

Conners et al. (2007) identified three types of people in an organisation: those on the right side, those on the left side and those sitting on the fence. Those on the right side are individuals who have innate characteristics of good leaders that include drive, energy, determination, vision, self-discipline and flexibility. The more senior nurse leaders must endeavour to identify these individuals and help them to develop so others can learn from them. Those on the left side are individuals who do not demonstrate positive characteristics

of good leadership. These individuals can be loud and tend to have a negative influence on the team and may create their own group of followers. They are often mistaken as unit leaders because of their ability to influence others. However, they frequently do this through poor behaviour. The nurse leader should be aware that the best clinician cannot be the best leader if they do not possess innate leadership traits (Conners et al., 2007). A nurse leader who fails to identify and develop quiet leaders will be left with negative leaders who could be unproductive and will ultimately destroy the cohesiveness of the team. Because these negative leaders often are more vocal and tend to be more influential than quiet, positive leaders, they can easily persuade those individuals who are sitting on the fence to move to the left side or wrong side of the fence. Once the senior nurse leader has identified the right positive leader, then appropriate training can be provided (Conners et al., 2007; Kirby, 2010). Scully (2014) also asserted a need for appropriate identification, support and development for future nurse leaders. Scully (2014) agreed with Conners et al. (2007) about avoiding the incidental development of negative leaders who do not possess evidenced-based leadership qualities, or who display the loud and inappropriate behaviours which have negative effects in the workplace.

Picker-Rotem et al. (2008) suggested there should be a more reliable method for identifying new leaders. They took a different approach to identifying and creating a pool of potential leaders. In their study, they used peer evaluation to identify and select new nurse leaders. Staff were asked to confidentially vote for a nurse who fitted the leadership profile that was presented to them. The results of their study showed a difference between staff and management's choices of potential candidates. Of those potential candidates selected by staff, 31% were not the first choice for their head nurse. They also found that only half of the deputy head nurses were nominated by staff. Traditionally, deputy head nurses were chosen by the head nurses or upper level management. This result indicated that there may be a

perceptual gap between staff and management as to what or who is a leader. The outcomes of their study further cemented their initial assumption that leadership is sometimes more easily recognised by staff rather than senior managers who do not come into direct contact with all staff members but rely on knowledge of existing hierarchical structures.

Brunero, Kerr and Jastrzab (2009) developed a model of succession planning at South Eastern Sydney Illawarra Area Health Service. The model provided an opportunity for participants to act in a senior managerial or clinical nursing position for a planned leave relief. The participants in their study reported that the experience gave them real insight into the different roles and helped them to plan for their next career path. However, Duffield and Franks (2001) noted that in Australia, a lack of ability or desire to identify nurses with potential for the NUM position is evident. They also commented on a lack of responsibility taken by senior nurse managers for succession planning and appropriate educational preparation. The study completed by Lord et al. (2013) in Western Australia revealed a similar finding where the participants stressed the need for current leaders to identify and prepare future leaders. The participants in their study expressed concern regarding succession planning due to the age of existing nurse leaders and the impending retirement of nurse managers. The authors found there was an absence of structured succession planning, education and training for future leaders. Accordingly, this led to a "last person standing" process of succession (Lord et al., 2013, p. 188). Some of their participants also expected the leaders to have leadership attributes and leadership skills, but that leaders did not actually have leadership attributes and skills. Similarly, Brunero et al. (2009) conducted a study in South Eastern Sydney Illawarra Area Health Service and found there was no formal structure or process surrounding succession planning.

Titzer et al. (2013) stated that it takes months for a new NUM to adapt to the expectations of their new role. Health organisations need to integrate nurse manager

succession planning in their strategic plan along with a method for identifying and developing potential leaders. Titzer et al. (2013) found that resource allocation for proactive, deliberate development of current and future leaders was lacking and systematic evaluation of succession planning was limited. Laframboise (2011) stated that succession planning is important in developing and nurturing nurses as future leaders. As an embedded strategy, effective succession planning can provide an avenue for nurse leaders to transfer their knowledge to future leaders. Laframboise (2011) concluded that succession planning may mean a difference between success and failure for nurses and for organisations. Laframboise (2011) and Titzer et al. (2013) shared the same concern that health care organisations and the nursing profession lag behind the corporate sector in succession planning. This was also reflected by Doria (2015) who found that succession planning in health care was designed for executive leadership, but not NUMs. This suggests that the leadership component of the NUM's role is often overlooked or misunderstood.

Griffith (2012) conducted a review of literature to evaluate succession planning initiatives in nursing. Griffith found that succession planning in most health care organisations appeared to be fragmented, uncoordinated and inconsistently implemented. The author also indicated that identifying potential leaders was a pervasive and persistent problem. Griffith proposed that succession planning must exist as a continuum and identify potential leaders as early as high school to join the pipeline for emergent nurse leaders. Such research findings suggest that to date, the need for effective leadership at all stages in that pipeline is not generally accepted and adhered to in nurse education.

2.5.2. Educational preparation

2.5.2.1.Formal graduate management/leadership education for NUMs

There is a call from nursing scholars for NUMs to undertake formal education to enable them to function effectively in their roles (Kirby, 2010; Kleinman, 2003; McCallin & Frankson, 2010; Pickerell, 2014; Zori & Morrison, 2009). Pickerell (2014) notes that when nursing leadership competencies are taught effectively, there is considerable impact on NUMs' skills. Gallo (2007) believes that formal graduate education is necessary for the nurse managers to develop their skills and stated that advanced knowledge is a necessity and no longer a luxury. This concurs with Kleinman (2003) who also advocates the possession or eventual acquisition of a graduate degree for nurse managers. The American Association of Colleges of Nursing (2011) and Kleinman (2003) argued that a Masters degree should be a prerequisite for NUMs. Similarly, Cross (2013) advocates this for nurse graduate programs in Canada. Cross believes that nurse graduate programs should not only enhance knowledge, but also foster a deeper understanding of leadership skills and knowledge about the business of health care so that nurse managers are well equipped to adapt to and function in an ever-changing health care system. According to the American Association of Colleges of Nursing (2011), a Masters degree helps nurses acquire and develop leadership and management skills, and the capacity to be innovative and initiate change.

Whyte, Lugton and Fawcett (2000) undertook a 10-year follow-up study on 109 former nursing students from the University of Edinburgh who graduated with a Masters degree. The purpose of their study was to evaluate the influence of gaining a Masters degree on the subsequent professional development of these students. Their study showed that nurses who had a Masters degree were better at integrating their academic and clinical skills than those who did not possess one. They observed also that those with a Masters degree were more confident in their roles and had higher job satisfaction. The results of their study also found

that having such a degree was instrumental for some of the former students being promoted to a leadership role.

Drennan (2012) conducted a study to determine the leadership and management capabilities of graduates who completed a Masters degree in nursing. The 322 participants completed their Masters in nursing from six universities in Ireland. These universities offered nurses (entering the Masters degree) four strands from which they could choose: 1) clinical, 2) education, 3) management or 3) advanced practice. Their leadership capabilities were measured by their ability to change practice, communication/teamwork and problem solving. The results of the study revealed that the leadership capabilities of the students were related to the strand completed. Drennan (2012) found that those who completed the education strand scored better in their ability to communicate whereas those who completed the management strand scored better in their ability to initiate change. Drennan further stated that, regardless of the strand completed, a Masters degree in nursing has an impact on graduates' general leadership and management capabilities.

However, D'Cruz (2002) argued that graduate education was not appropriate for developing nurse leaders. Instead, graduate education was often seen as a platform for developing researchers and other academics to prepare them for scholarly publications for professional advancement. As such, the graduate education model was considered by D'Cruz as not appropriate in developing health care leaders. Intellectual understanding that was offered by graduate degrees was considered by opponents as only a fragment in leadership development. The qualitative study by Gaskin et al. (2012) explored the challenges NUMs encountered while working in acute care settings, the strategies they used to deal with these challenges, and effectiveness of employed strategies, as perceived by NUMs and by their directors of nursing. There were 22 NUMs and three directors of nursing who participated in the interview. The Gaskin et al. (2012) study was conducted in five acute care settings in

Melbourne, Australia. The authors found that although some NUMs had undertaken management training, the courses did not adequately prepare them for the NUM role. The directors of nursing in the study also expressed concern that the content of postgraduate education may not be relevant to the needs of the health care industry.

This concurs with Scott, Savage and Read's (2005) study in which 123 modern matrons in England participated. Modern matrons are clinical leaders who have authority at ward level. Their results indicated that modern matrons still felt inadequately prepared, even though they had been on leadership courses before or immediately after appointments, and had clinical and managerial experiences. Similarly, Gould et al. (2001) undertook a study involving 197 clinical managers in the United Kingdom to explore the changing training needs of nurse managers for continuing professional development. Their study revealed an absence of relationship between having a first degree or Masters degree, obtaining management qualifications and previous managerial experience before assuming the role of nurse manager.

Duffield (2005) agreed with Scott et al. (2005) and D'Cruz (2002), that holding higher degrees does not guarantee that nurse managers are well-prepared for the NUM position or will be able to exhibit effective leadership skills. Duffield found in her survey of NUMs in New South Wales, Australia, that although less than 20% of the respondents held a Masters degree and over 50% were studying at Masters level, they still felt unprepared for the role. This concurs with Gaskin et al. (2012) who revealed that although many NUMs had undertaken some management training, they still seemed under-equipped for the managerial role and insufficiently trained in operational tasks such as budgeting and human resources (i.e. personnel management). This finding may indicate that the courses undertaken were not broad enough to equip them with the knowledge and skills required for the NUM position. It

may also indicate that the courses were taken at a time when they were not in positions where they could implement what they were learning immediately.

In the study by Kleinman (2003), the results revealed that while nurse executives valued the acquisition of a Masters degree, fewer nurse managers valued the acquisition of a Masters degree. Kleinman explained that differing perceptions could be the result of many nurse managers preferring to acquire their skills through on-the-job training without any formal graduate training. It could also be that nurse executives used formal qualifications as a quantifiable selection device in appointing new staff.

2.5.2.2. Leadership in undergraduate curricula

Nursing scholars have suggested that leadership should be incorporated within the undergraduate nursing curricula (Curtis, de Vries, & Sheerin, 2011; Heller et al., 2003; Hendricks, Cope, & Harris, 2010; Jones & Sackett, 2009; Mrayyan, 2004; Shaffer, 2003). Nurses at all levels must be able to lead, since they need to exercise such qualities when dealing with patients and their families, doctors and other staff (Curtis et al., 2011; Galuska, 2012; Heller et al., 2003; Mrayyan, 2004). Nurses are not only providers of care for their patients but manage the care (Jones & Sackett, 2009). When leadership and management principles are included in the undergraduate curricula, students will have a better understanding of their roles, and the NUM's role and other health providers with whom they interact. Students will be able to incorporate the knowledge gained from general principles of leadership when they transition from students to professional nurses (Jones & Sackett, 2009). Therefore, there is a need to develop leadership skills for all nurses and for opportunities for their development in undergraduate curricula (Curtis et al., 2011; Galuska, 2012; Heller et al., 2003; Mrayyan, 2004).

Nurses are expected to manage their patients at point of care. They usually make decisions for the care of their patients without their NUM's involvement. This is reflected in Johansson et al.'s (2010) study at three Swedish hospitals to describe first-line nurse managers' and subordinate registered nurses' conceptions and experiences of their routine work and how leadership was exercised. The registered nurses in their study described their leadership roles as supporting and leading nursing related tasks with their colleagues and other health professionals, acting as nursing coordinators, informing and motivating other colleagues and nurse assistants, taking initiative to carry out work-related tasks, and solving daily problems and issues. The registered nurses in their study indicated that they performed their leadership roles without involving the NUM.

Curtis, De Vries and Sheerin (2011) examined and compared the content of leadership offered at Trinity College, Dublin in Ireland, the University of Edinburgh in the UK and University of Washington in Seattle, USA. The authors found that although leadership was taught within the curricula in undergraduate degrees in these institutions, much of the content was on how the student could transition to nursing, but did not train them to be future leaders in health care organisations. Shaffer (2003) indicated that nursing students graduating from the associate degree or Bachelor of Science programs have only one or two courses on leadership. The examination by Curtis et al. (2011) revealed that the components of clinical leadership education were unclear. The authors suggested that leadership training should begin at the earliest stages of nursing education and continue throughout each phase of nursing education. Earlier studies (Heller et al., 2003; Mrayyan, 2004) found that new graduates did not always have the leadership and management skills to succeed as nurse managers and were not sufficiently prepared in their nursing undergraduate education. They also recommended that leadership and management skills should be undertaken at undergraduate level.

Edith Cowan University in Western Australia designed a pilot leadership program for undergraduate nursing students, commencing in the fourth semester of their studies and finishing in the fifth semester. The program was offered as an extracurricular activity. Ten students participated in the pilot program. The program was designed to equip students with leadership skills when they entered the workforce. Graduate nurses often act autonomously, make decisions at point of care for their patients and communicate with other teams. Thus, students will be more prepared to enter the workforce when they are equipped with leadership skills during their undergraduate education (Hendricks et al., 2010). However, although the participants reported an increase in their understanding of their potential to lead at the end of the program, there was no follow up when these students entered the workforce. Thus, Hendricks et al. could not determine whether these students were able to put into practice what they had learned from this program and Hendricks et al. stated that "the benefits of the program will only be evident in time" (2010, p. 257).

2.5.2.3. Leadership/Management curricula for nurses

Recognising the important role of NUMs, many hospitals are providing help to enhance leadership skill of NUMs by providing onsite training while others send NUMs to nurses' education programs offered by universities or assign mentors (Thrall, 2006). Duffield (2005) stated that it is important to provide the necessary resources for nurses to be able to successfully transition to the NUM position and to provide ongoing staff development for NUMs.

Leadership training can be accessed through leadership curricula, workshops and other professional conferences, seminars, inservice activities, online programs and the provision of onsite graduate training programs (Kleinman, 2003; Pickerell, 2014). Various health organisations involved with these activities can help nurse managers to pursue and undertake graduate education by partnering with universities, providing tuition fees reimbursement, and

by flexible scheduling of the training activities listed above (Gallo, 2007). In addition, Gallo suggested that NUMs develop their skills through 360° feedback, mentoring, coaching, and action learning which health care organisations can usually deliver.

However, regardless of training method, the leadership training goals should be clear and meaningful for all participants (Arnold & Nelson, 2004). Shaffer (2003), for example, noted that periodic courses to train nurse managers were not specific enough to meet the learning needs of nurse managers and were often taught by non-nurses who lacked insight into the nurse managers' role. Nurse managers searched for training programs through Schools of Business or other programs, resulting in fewer nurses prepared for nursing administration (Shaffer, 2003). According to Pickerell (2014), most methods used in developing leadership training for nurses are derived from the business setting and in need of modification to ensure their applicability to nursing practice.

What exactly needs to be covered in nursing leadership courses remains a question (Pickerell, 2014). Kleinman indicated in 2003 that in the United States, the literature lacked research on how nurse leaders could gain the skills needed to perform their roles. Importantly, nursing leadership curricula should be contemporary, relevant and adaptable to assist graduates to lead effectively in the dynamic environment of health care (Dignam et al., 2012). Pickerell (2014) suggested that since nurse managers are evaluated based on their competencies, then competencies will be a guide in developing nursing graduate training.

A group of nurse leaders from education and practice settings in western New York convened to discuss preparation for future nurse leaders (Crosby & Shields, 2010). They developed an educational workshop referred to as the Nurse Leadership Academy. There were 85 nurses who attended the workshop. The participants were surveyed about their educational needs in becoming effective leaders. They were asked to recommend topics

and/or speakers. Participants were also asked to describe the barriers they experienced that hindered the development of nurse leadership. The nurses' educational needs were assessed and considered in the development of the course content for the workshop (Crosby & Shields, 2010). This innovative process of surveying nurse leaders to identify their educational needs could address the problem of what exactly needed to be covered in leadership courses (Pickerell, 2014).

Galuska (2012) conducted a metasynthesis of qualitative studies on leadership development to explore the experience of nurses with effective leadership development strategies. Galuska found that opportunity structure, supportive relationships, and a positive, healthy organisational culture are important for developing nurse leaders. Furthermore, health care organisations should provide opportunities for nurses to apply leadership knowledge and skills gained from leadership training activities. Such opportunities may include formal and informal leadership roles where nurses can exercise their leadership abilities. Nurse managers and other nurse leaders also play an important role in developing nurses' leadership skills by supporting the nurses, acting as role models and as mentors (Galuska, 2012).

Huston (2008) highlighted eight essential competencies that needed to be included in leadership training to prepare nurse leaders for the year 2020:

1) a global perspective or mindset with regards to health care and nursing issues

2) technology skills

3) expert decision making based on empirical science

4) the ability to create organisation cultures that prioritise patient and worker safety

5) understanding and appropriately intervening in political processes

6) highly developed collaborative and team building skills

7) the ability to balance authenticity and performance expectations, and

8) being able to cope and adapt to the rapid change and chaotic nature of the health care system.

Fennimore and Wolf (2011) indicated that the preparation of nurse managers for the role was often "dependent on didactic education or on-the-job training that falls short of true leadership development" (p. 204). The authors described an approach implemented at the University of Pittsburgh Medical Center for the development of nurse leaders. The leadership development program was not specifically for nurse managers but offered to all leaders throughout the hospital. The leadership program focused on contemporary health care issues, evidence-based content, links to recommendations from professional organisations, and knowledge of self through assessment. The pilot program was attended by 25 nurse managers at a time with more than 100 nurse leaders completing the course in the past two years. The curriculum was developed after the task force committee identified essential leadership and management competencies based on a literature review. The participants viewed finance and budgeting techniques, conflict management skills, application of emotional intelligence, and staff motivation strategies as most valuable in the curriculum. Course content used by the participants one month following the course included financial accountability, managing conflict and confrontation, performance accountability, and interviewing and communicating with staff. The participants also described the benefits they gained from peer collaboration. The nurse turnover rate had decreased after the implementation of the program. The authors attributed this improvement to several factors including improved economics but the authors also indicated that enhanced leadership skills of nurse managers who attended the leadership program may also have contributed to this improvement (Fennimore & Wolf, 2011).

Zori and Morrison (2009) suggested that critical thinking should be included when developing leadership curriculum, while Gallo (2007) proposed that the curriculum should also include human resource management, finance, quality management, leadership behaviours and service excellence among others. Mannion, Small and Thompson (2005) suggested that finance should be included in the curriculum, since efficacy and value for money are regarded as essential for the provision of high quality nursing service. NUMs are accountable for business responsibilities such as purchasing new equipment, repairing old products and replacing them if necessary, negotiating equipment costs and dealing with vendors (Anton, Canfield, & Jio, 2004). Douglas and Normand (2005) maintained that NUMs should know how resources are distributed in a most cost-effective way. Therefore, NUMs should have the knowledge skills in building and meeting a budget and be able to analyse financial reports (Hirst, 2005).

Similarly, the Institute of Medicine (Altman, Butler & Shern, 2016) suggested a list of eight competencies that needed to be incorporated in nursing education: 1) leadership, 2) health policy, 3) system improvement, 4) research evidence-based practice, 5) teamwork and collaboration, 6) competency in specific areas such as public health, 7) proficiency in the use of technology and information systems, and 8) collaboration and coordination. Cross (2013) found that although these competencies were used by the Canadian Nurses Association as a guide to reform and promote graduate nursing leadership education, nurse manager competencies were not standardised and held no accountability to the professional bodies in Canada.

As part of a project by the Center for Health Workforce Development in the United States, Heller et al. (2003) developed a leadership course in partnership with the University of Maryland, offered initially for students in the RN to BSN and the RN to MSN who were already nurses in the workforce. The curriculum included two core competencies: core

knowledge areas and individual leadership skills. They included: economics and financial management of health-care delivery systems and managed care; technology, patient safety, resource management and business or administrative practices; organisational theory and change theory; leadership styles; roles of gender and diversity in nursing leadership; and responsibility to the profession. Individual leadership skills included interpersonal skills, communication skills, organisational navigation, crisis management, time management and adoption of an appropriate leadership style. Lectures, group seminars, self-assessment and 360° feedback, case studies, interactions with nurse leaders, and experiential learning where students had the opportunity to observe their mentors from selected health care organisations were all part of learning activities.

The numerous examples given above indicate ongoing debate about the effectiveness of leadership/management curricula for nurses and about models of delivery of such activities, although there does not appear to be considerable consistency in the content of these programs.

2.5.2.4. Importance of Continuing Professional Development

Mathena (2002) believes that organisations should allocate a reasonable amount of time for professional development. Gould et al. (2001) highlighted the importance of Continuing Professional Development (CPD) being tailored to the needs of nurse managers. Their study showed that CPD needed updating and suggested that those involved in planning CPD should pay particular attention to topics where nurse managers felt unprepared, such as human resources, budgeting and information technology. This finding is supported by Joyce (2005) who conducted a study in Ireland with 117 participants who were already in nursing management posts. The study indicated that the introduction of a personal development plan (PDP) could help nurse managers reflect on their roles, and identify and plan for their next career moves. Wilson (2005), using a pre-program and post-program evaluation with 43

participants in the United States of America, suggested that management development could improve job satisfaction and retention of nurse managers.

However, Foster (2000) stated that some ward managers were reluctant to develop their managerial skills unless it was an organisational requirement. This concurs with Mathena (2002) where, in her study involving nurse managers in Boston, she found that nurse managers who were in their posts for more than five years rated their learning needs higher than those with less than five years in the post. Mathena's explanation was that, it was possible that those in the post for more than five years were more open to expand their knowledge and skills and more willing to admit their learning needs. Those with less than five years in the position might be less willing to participate in professional development, may feel less willing to admit their learning needs due to short tenure or being aware of insufficient preparation in their initial formal education. Foster (2000) found that nurse managers preferred structured self-development for personal development. Foster claimed that nurse managers would be more motivated to enhance their skills if their preferred style of training was used. Such findings highlight ways in which individual characteristics can influence acceptance of and responsiveness to graduate training and ongoing professional development in whatever form is offered.

2.6. Clinical knowledge: A necessity for NUMs

Many authors have argued that clinical skills and expertise are not enough or do not equate to being good leaders (Arnold & Nelson, 2004; Heller et al., 2003; McCallin & Frankson, 2010; Oroviogoicoechea, 1996; Sanders et al., 1996; Tilley & Tilley, 1999). However, clinical experience has also been cited as an important requirement for nurse managers to enhance their leadership behaviour and effectiveness (Ohman, 1997). While Yukl (2010) supports the recruitment of non-medical managers, Llewwellyn (2001) insists that a medical

background is important as medical managers are able to comment on clinical issues. Kleinman (2003) also agrees that since nurse managers provide care and at the same time manage the ward, the nurse manager must be equally prepared in both management and clinical aspects.

Jarnigan White (2015), who also conducted a study to explore the motivations of nurse managers for seeking the role, found that nurse managers sought the role because they had the clinical skills and knew staff or felt they knew what was needed on the ward. The participants in the study commented that having clinical skills helped them to understand staff and gain their respect. They also commented that it was an advantage to have worked in the same unit that they were managing, as they already knew the processes and the staff on the ward.

2.7. Barriers to professional development

In meeting the educational needs of NUMs, it is imperative to know the barriers to meeting their professional needs and how to address them. Nurse leaders may not have the time to develop their leadership and management skills due to many competing priorities (Acree, 2006). Russell and Scoble (2003) suggested that since NUMs are gainfully employed, any training program should be designed to meet the needs of a working person. Previous studies have reported that time, financial cost associated with training, availability of appropriate programs, perceived needs for training, geographical limitations/travel, lack of relieving staff, balancing work and personal lifestyle and lack or organisational support are the most common barriers reported to participation in leadership programs (Courtney et al., 2002; Crosby & Shields, 2010; Kleinman, 2003; Mathena, 2002; O'Neil et al., 2008).

In order to overcome these barriers, organisations can offer scholarship or tuition reimbursement to support graduate education, certificate or diploma programs and

educational conferences. Mentoring can be used as a key factor in transmitting knowledge on a one-to-one basis. Collaboration with universities may offer an alternative to traditional education by providing on-site graduate programs for nurse managers who are interested in pursuing further studies, but are unable to do so, due to geographic or time constraints. Distance learning and online programs or web-based education can also be explored. Study updates combined with short courses have been identified as other ways of providing educational development needed (Courtney et al., 2002; Duffield et al., 2011; Kleinman, 2003; Korhonen & Lammintakanen, 2005; Mathena, 2002).

Korhonen and Lammintakanen (2005) have suggested web-based education as an alternative for professional development. Information technology offers many possibilities for nurse managers including collaboration within and outside of the organisation, research, professional development and management of human resources. In Lammintakanen, Saranto and Kivinen's (2010) study, a wide acceptance of nurse managers for use of information systems and acknowledgment of the increasing use of information technology in the future were evident. Prior to that, Koloroutis (2008) suggested telephone coaching as an alternative to face-to-face mentoring. Telephone coaching offers ease of access and neutrality of distance.

2.8. Chapter summary

Chapter 2 discussed the differences between leadership and management and the inter-relationship between these concepts. Although there are different leadership theories and styles, the literature indicates that transformational leadership is the most preferred in nursing management. Importantly, the use of transformational style has been found to correlate with higher job satisfaction among staff. Different methods of preparing NUMs for their role were also explored in the chapter along with barriers to professional development where the main

barrier identified was time. The next chapter will discuss case and commentary writing as a learning strategy.

Chapter 3: Case Writing as a Learning Strategy

3.1. Introduction

The review of the literature indicated a gap in how NUMs can acquire the skills needed to perform their role. Some nursing scholars advocated formal graduate education for NUMs to acquire the necessary skills (Kirby, 2010; Kleinman, 2003; McCallin & Frankson, 2010; Pickerell, 2014; Zori & Morrison, 2009). However, other nursing scholars found that, although some NUMs had undertaken management and leadership courses, they still felt unprepared for the role (D'Cruz, 2002; Duffield, 2005; Gaskin et al., 2012; Scott et al., 2005). Even in the context of 2003, Shaffer argued that yesterday's way of thinking and training methods might not work in a new dynamic health care setting; therefore, there is a need for new, innovative and effective training methods. Gallo (2007) also agreed that traditional ways of training staff nurses for management positions might not prepare them to be effective leaders.

Griscti and Jacono (2006) stated a need for more research studies that address informal methods of learning. While there is an abundance of strategies and methods to prepare nurse managers for their role, these approaches do not draw upon lived experiences of nurse managers, and do not focus on peer coaching and learning (Mackoff et al., 2013). This is one of the reasons case and commentary writing was trialled in this research project as an alternative means of professional development. There is a paucity of research studies that address how professional development incorporating case writing can help develop and prepare NUMs for their role. Although case narratives have been used in professional development by some leaders (Cathcart & Greenspan, 2013; Duffield, 2005; Frank, 2003; Mackoff et al., 2013), none of these studies examined non-face-to-face peer collaboration. Thus, this study investigated how case writing could be used as an alternative to face-to-face

mentoring, and as a learning strategy to help existing NUMs improve their skills and help aspiring NUMs prepare for the role.

3.2. Case writing and Schon's reflection-on-action

Traditionally, it has been noted that many leaders learn from experience (D'Cruz, 2002). Organisations need to make better use of experience in developing the talent of executives as this occurs through on-the-job experience (McCall Jr, 1992). Kotter (1988) in his study of 15 corporations well known for the quality of their executive team, noted that although formal training may be important, formal training was not the key factor for the success of these corporations. Kotter further stated that people spent about 1-2% of their work time on the job to attend formal training and therefore, a greater percentage of learning must have occurred on the job.

Different kinds of experience provide opportunities for leaders to learn different things. However, experience is not a guarantee for leaders to become experts in their role. The missing components of learning from experience are feedback and reflection (D'Cruz, 2002). NUMs need time to reflect on their experience (McCall Jr, 1992). Experience and reflection are interrelated. If the experience is challenging, so too is the reflection (Miettinen, 2000).

Miraglia and Asselin (2015) conducted an integrative review to explore the use of reflection as an educational strategy for registered nurses. Three themes emerged in which reflection was used as an educational strategy:

1) Nested reflective strategies. In these programs, the participants were presented with information relating to practice and educational goals and were paired with a reflective educational strategy. The participants had a change in behaviour and felt that they were ready to apply the knowledge they had learned.

2) Individual versus group reflection. Participants were asked to write a reflective narrative. Participants who only shared their narratives with the facilitator resulted in learning for the individual who contributed the narrative.
3) Structured versus unstructured reflection. Most articles reviewed described the use of structured questions to guide participants in exploring their clinical experiences.

Miraglia and Asselin (2015) noted that reflection increased knowledge, and changed attitudes, values and beliefs of the participants. Group reflection provides grounding for a meaningful impact at organisational level. Markey and Farvis (2014) developed a pilot project to enable nurses to engage in reflective practice in an acute setting in the UK. The participants indicated the importance of having peers to reflect with during the process.

Writing case narratives enables NUMs to relive the experiences and to appreciate the magnitude and significance of the case scenario (Cathcart, Greenspan, & Quin, 2010). Cases are mostly written narratives as in the current study, but can also be in a video documentary format. A case is a description of a specific situation that involves a problem or a decision (Fossey & Glover, 2006). It is a record of a situation of an actual issue that involves a decision, a challenge, a dilemma, an opportunity, or a problem faced by NUMs (Lundberg, Rainsford, Shay, & Young, 2001) with surrounding facts, opinions and prejudices upon which decisions by the NUM depend (Lundberg et al., 2001). Brendel (2009, p. 30) defined narrative as “a personal account or story that brings meaning to bear on a given situation”. Narratives record past, present or future events and can speak to individuals or groups and offer predictions, or hindsight views. Usually the past, present and future come together in a slightly different way in case and commentary writing. When NUMs engage in case writing, they are writing narratives of a personal account or a story about a past or current event.

When NUMs engage in writing commentaries, they are reflecting on past and present events and anticipating what they may face in the future.

3.2.1. Components of case writing

There are three basic components of case writing (Hammerness, Shulman, & Darling-Hammon, 2000): 1) the case narrative 2) the case analysis and 3) two commentaries written. First, writing the case narrative. This involves writing a short description of a specific event or situation, a dilemma or a challenge that NUMs experienced. The events are concrete facts that occurred in the past (Naumes & Naumes, 2012). This may include a reflection on the different aspects of their roles, the problems encountered, how they resolved them, a description of unresolved problems, and how they may approach and resolve a similar situation differently next time (Hammerness et al., 2000). Second, is the case analysis. The cases are detailed narratives that guide reflection and teaching of others. They contain problems that can be framed and analysed from various viewpoints (Hammerness et al., 2000). The cases will provide NUMs with the basis in their decision-making process in different situations to determine alternative solutions to the case (Naumes & Naumes, 2012). Finally, written commentaries. This involves at least two NUMs writing a commentary on a case narrative written by another NUM to provide additional insights and interpretation of the case, or how the case can add value to new concepts and ideas (Hammerness et al., 2000).

3.2.2. Schon's reflection-on-action

In Schon's (1991) *The reflective practitioner*, a framework is provided for reflective practice. Reflective practice is proposed to be most suited to solving complex problems (Schön, 1991) in health care (Johns, 2009; Mann, Gordon, & MacLeod, 2009) and as an approach to achieving competent practice such as that of the NUM. Schon's (1991) work on reflective practice suggests that reflection can occur after an action and while in the middle of an

activity. Schon referred to reflection after an action as reflection-on-action. Reflection in the middle of an activity is what Schon referred to as reflection-in-action. Reflection-in-action is important when there is a need to respond immediately. There is no time to stop and reflect on the situation and then return afterwards (Wilson, 2008) such as during medical emergencies. Case writing has the capacity to draw both reflection-in-action and reflection-on-action with the case and commentary writers engaged in separate processes, which they are able to share when the case and commentary are combined.

Schon (1991) claimed that in reflection-on-action, the practitioner conducts a post mortem on events. NUMs can reflect on their past experiences through case writing, and in commentary writing on the experiences of others, the NUMs can also reflect on their past experiences on similar situations. Reflection can happen after the experience (reflection-on-action), as in case writing, and can be conducted collectively with others (Hammerness, Darling-Hammond, & Shulman, 2002), and is termed reflection-on-action. An effective framework for reflection-on-action requires the NUMs to think about what they did, the knowledge base they employed, how they went about their actions, why they responded the way they did, and to explore their thoughts and feelings at that particular time. Through reflection-on-action using case writing, NUMs can pass on their experiences to colleagues, explain and teach their skills, and promote multidisciplinary collaboration to develop their skills and knowledge.

Some authors argued that while Schon wrote on the concept of reflection-in-action and reflection-on-action, Schon failed to consider reflecting-on-the-future (Greenwood, 1993; Gustafsson & Fagerberg, 2004; Teekman, 2000; Wilson, 2008). Wilson (2008) in his article "Reflecting-on-the-future: a chronological consideration of reflective practice" argued that Schon failed to consider to how humans reflect on and envision future actions. Failing to consider what might happen in the future defies the possibilities for learning, planning,

understanding events, and improving performance. Wilson (2008) proposed that another important concept is reflection-on-the-future. Wilson suggested three chronological considerations regarding reflection: 1) reflection-on-action. By reflecting on past actions, there is the opportunity to assess and evaluate what has happened and identify what went wrong and what could be done better next time. 2) reflection-in action. Reflection-in-action draws on current knowledge to guide actions and behaviours for the current situation. 3) reflecting-on-the-future. Reflection-on-the-future is defined as "the act or process of reflecting on desirable and possible futures with the purpose of evaluating them as well as considering strategies intended to achieve the objective(s)" (Wilson, 2008, p. 180). This can be achieved by analysing current trends and receiving cues for future trends. Reflection-on-the-action can also be achieved by analysing and reflecting on others' past experiences. By reflecting on current and past experiences, one can envision possible scenarios and examine what might happen in the future. "Through placing ourselves in the shoes of others, we can have a reasonable expectation about what might happen and how we might respond" (Wilson, 2008, p. 179). Wilson acknowledged that the suggested chronological considerations of reflection may tend to merge, especially when people explore options and work their way backwards and forwards, as they juggle options for the best possible option to improve performance (Wilson, 2008, p. 183).

While Wilson suggested three chronological considerations for reflection, Daudelin (1997) suggested four stages of reflection: 1) articulation of the problem. At this stage, it defines the event that the mind will work on during reflection. 2) analysis of the problem. This involves searching for possibilities by asking others for similar situations, or imagining how others resolved the same situation. 3) formulation and testing of a tentative theory to explain the problem. 4) action or deciding whether to act. This is the final test of the

hypothesis and where learning occurs. It is the creation of meaning from past or current experiences that guide future behaviour (p. 41).

Gustafsson and Fagerberg (2004) shared the same view as Wilson. In their study, they found that nurses engaged in reflection before an action. Gustafsson and Fagerberg conducted a study in Sweden to explore registered nurses' experiences of reflection in relation to nursing care and to understand how registered nurses used reflection in their daily work. They interviewed two psychiatric registered nurses and two surgical nurses. The results of their study indicated that the participants described reflection in four sub-categories: 1) to think back, 2) mirroring, 3) to reflect before and after, and 4) to use experiences. To think back, the nurses described this as a process of considering what could have been done better or differently. Gustafsson and Fagerberg noted that nurses focused on situations which they regarded as "poor nursing care" and seemed to ignore and did not reflect on situations they regarded as "good nursing care" (Gustafsson & Fagerberg, 2004, p. 275). The participants also described reflection as "mirroring" where they engaged other colleagues to reflect together at the end of the shift, to exchange ideas of what occurred during the shift and then develop a nursing care plan. In reflection before action, the nurses prereflected on situations they were required to perform. Prereflecting on situations, they were able to reflect and plan on desirable and future outcomes, evaluating possible outcomes, as well as considering strategies in order to achieve the intended outcome (Wilson, 2008). After the task had been performed, nurses then evaluated the results which involved reflection after an action. The nurses also related reflection to experience by reflecting on their individual experiences and then sharing those experiences with colleagues in order to exchange ideas and knowledge (Gustafsson & Fagerberg, 2004).

Teekman's (2000) stance was reflected by Wilson (2008) and Gustafsson's and Fagerberg's (2004) statement that Schon failed to consider anticipatory reflection. Teekman

conducted a study to explore whether nurses engaged in reflective thinking, the focus of that thinking and how these nurses made use of reflective thinking in their work. Teekman interviewed 22 registered nurses who worked on different medical and surgical wards from three hospitals in New Zealand. Sense-making, an in-depth qualitative method, was used as a research method. Teekman identified three hierarchical levels of reflection: 1) reflective-thinking-for-action which centred on what to do here and now. The participants in Teekman's study revealed that they thought back on past experience and then they chose from a range of the most appropriate interventions for the current situation. 2) reflective-thinking-for-evaluation which focused on analysing and integrating multiple ideas and viewpoints from others. Reflective-thinking-for-evaluation occurs after reflection-for-action. The participants indicated they did not have all the answers to a situation and needed others' perceptions and viewpoints to clarify the best action for the situation, and 3) reflective-thinking-for-critical inquiry. Teekman indicated that this was not demonstrated by the participants due to limited involvement by nurses in decision making in the delivery of care. In light of these findings, Teekman (2000) defined reflective thinking as:

> a highly adaptive and individualised response to a gap-producing situation and involves a range of cognitive activities in which the individual deliberately and purposely engages in discourse-with-self in an attempt to make sense of the current situation or phenomenon, in order to act. Reflective thinking contributes to better contextual understandings and as such may influence future behaviour (p. 1133).

Similarly, Greenwood (1993) stated that Schon failed to give importance to reflection-before-action. Greenwood argued: "that much of the suffering in the world, caused through nurses' errors, could have been avoided had practitioners stopped to think about what they intended to do and how they intended to do it before they actually did it" (p. 1186).

Greenwood (1998) further stated that reflection-before-action creates an opportunity for feedback.

However, Moon (2004) suggested that reflection could involve anticipation for planning, but in combination with imagination plan for future actions. By reflecting on past experiences or similar situations, the future is extended with the use of imagination. Moon's view suggests that imagination is not part of reflection but may work as a result of reflection. This argument may justify why Schon did not include reflection-before-an-action or reflection-on-the-future (Wilson, 2008). Wilson also commented that reflecting on past (reflection-on-action) and present actions (reflection-in-action) has an inherent and tacit recognition in order to improve future performances, which are the main purpose of reflection. Wilson stated that this is so obvious that it need not be considered. He referred to this as the "reflective elephant in the room syndrome" (Wilson, 2008, p. 182). The definition of reflection offered by Wald (2015) embraces reflection-before-an-action, reflection-in-action, reflection-on-action and reflection-for-the future. Wald defined reflection as:

> Reflection is a metacognitive process including connecting with feelings that occurs before, during, and after situations with the purpose of developing greater awareness and understanding of self, other, and situation, so that future encounters with the situation including ways of being, relating, and doing are informed from previous encounters (p. 697).

Case writing provides a platform for NUMs to reflect on past experiences (reflection-on-action). By reflecting on past experiences, NUMs will be able to imagine and plan for the future (Moon, 2004) in order to improve future performances (Wilson, 2008). Case writing also enables reflection on the future, especially in the case writing component where writers

can imagine and articulate how they may behave in situations such as those outlined in the case.

3.3. Case writing as a learning strategy

The use of case teaching was first introduced at the Harvard Business School. Case studies provide a bridge between theory and practice. Since the introduction of case teaching at Harvard, it has been embraced by top professional education programs (Fossey & Glover, 2006). The cases were presented to students for analysis, open discussion, for framing alternative solutions and for final action to be taken (Lundberg et al., 2001). Cases provide an opportunity for individuals to be involved in decisions that are actually faced by real people in real organisations, to expose their ideas to others and to prepare them to become professionals in their field of work (Lundberg et al., 2001). Cases are useful in helping NUMs to develop and understand how perceptions and analysis of a situation can differ among NUMs (Morrow, 2015). Case writing is a teaching tool in which NUMs engage in the process of thinking, analysis, problem solving, and evaluation. NUMs can learn these skills from real situations, the cases, which they can apply when they are faced with actual experiences (Naumes & Naumes, 2012). Learning from cases can be more effective in NUMs' cognitive development than traditional lectures (Morrow, 2015). Traditional lectures may not be effective in helping NUMs learn how to lead in ever-changing health care organisations and solve unpredictable problems (Graham-Hannah, Cathcart, Honan-Pellico, & Kunisch, 2017).

Experiences are raw data that can be sources of learning for NUMs. However, NUMs can learn from these experiences after understanding and giving meaning to experiences through reflection. Reflection therefore is what translates management experience into learning (Seibert & Daudelin, 1999). Daudelin (1997) also stated that day-to-day experiences of managers are the rich sources of learning and perhaps more appropriate than traditional

"classrooms" (p. 36). Daudelin defined reflection and learning as: "the process of stepping back from an experience to ponder, carefully and persistently, its meaning to the self through the development of inferences; learning is the creation of meaning from past or current events that serves as a guide for future behaviour" (p. 39). It is in this process of reflection that NUMs take an experience and then make connections to other experiences; filter information and then develop different approaches that may have been different without reflection. Mintzberg (2004) sees management education as primarily being about reflection. Activities that encourage reflection are now being integrated into undergraduate, postgraduate and continuing medical education, and other health professions (Mann et al., 2009). Reflection is thus a teaching and learning strategy frequently used in the education of health care professionals. Fragkos (2016) conducted an umbrella review, which is a systematic review of reviews, to explore how reflection impacts on design, evaluation and assessment. Fragkos found that reflection has a positive impact on various learning outcomes.

Gray (2007) presented different reflective tools such as storytelling and critical analysis which can be used by NUMs. Gray (2007) indicated that management learning can incorporate reflection on managers' own experiences that can be sources of learning and critical reflectivity. Critical reflection on critical incidents that are written up and shared with others allows examination within a broader organisational context (Gray, 2007). Case writing is a type of storytelling (Naumes & Naumes, 2012). Storytelling and critical analysis facilitate reflection that helps managers make sense of problems faced and appreciate other's perspectives (Gold, Holman, & Thorpe, 2002). Humans thrive on stories and these stories become more memorable if attached to real situations and persons as in case writing. Clinicians like reading case reports and find them helpful in their work (Friedman, 2006). Stories are emotionally and symbolically charged narratives that when shared with others, NUMs will be able to gain insight about the perspectives of their colleagues (Gray, 2007).

Stories do not have only one meaning, even when the writer perceives certain meanings clearly and formulates specific questions. Each individual reader may view a story differently from the writer. Bringing stories into the public arena is an adventure in the sense that these stories can be questioned and challenged (Bolton, 2006). Clandinin and Connelly (1996) argued that stories of professional practice are stories for reflection. They are a way of making meaning of experiences, of reflecting on thoughts and actions and sharing with others. Storytelling is a relational act between the story teller and the reader, who is the responder, especially in case and commentary writing. Stories are inquiries in which further exploration and investigation takes place through the respondents. Storytelling is a relational act between the teller and the responder (Clandinin & Connelly, 1996). In the present study, NUMs were able to tell their stories by writing case narratives and reflecting on their experiences. The case narratives were then passed on to other NUMs to write commentaries where further explorations on and investigation about the stories took place.

Daudelin (1997) agreed there was a need for a more adaptable and responsive system to help managers learn and succeed in their role. In the working environment, staff shared challenging events with colleagues and with their manager. When individuals who face similar challenges share their experiences with each other, it can assist them in discovering information from different perspectives. By sharing one's experience, others can relate the information to their own experience of the situation. Daudelin conducted an experiment to determine whether reflecting alone, with a helper or in a small group was the most effective way to help managers learn from experience. For example, 48 participants from different units in a Fortune 500 corporation took part in an experiment conducted in corporate classrooms at two locations used for company retreats and meetings. The participants were divided into four groups. The first group was labelled the "individual group" and reflected as individuals. The second group was labelled the "helper group" where the participants brought

along a coach with them to their reflection session. The third group was labelled the "peer group". The participants in this group joined three or four other participants with whom they had no hierarchal relationship. The fourth group was labelled "the control group" where the managers did not participate in a reflection session. Each group was asked to select a current challenging work experience and to take time to reflect on the situation. The experiment revealed there were statistically significant greater learnings from the individual and helper groups than from the control group. The individual and the helper groups recorded more intrapersonal learning or learning about themselves. The peer group did not return statistically significant results. Daudelin found that the peer group tended to search for similarities among experiences rather than learn from the group. The participants in the peer group discussed several participants' experiences that distracted them from concentrating on the selected experience to be scrutinised. Finally, the peer group did not follow the instruction to take notes or use the reflection questions in their discussion. Daudelin concluded that spending just one hour to reflect on a situation using some general questions and guidelines, either alone or with a helper, could significantly increase learning from that situation. Griffiths (2004) contended that "memory that is unearthed from an experience can provide information that becomes the raw material against which the current problem is compared in the reflective process" (p. 347). Interestingly, Daudelin's study suggests that conventional group sharing conversations which are often part of professional development sessions may be less effective than the more directed case and commentary writing activities. In the latter activity, the focus is on the dilemma within a particular event while in the former the focus is more on conversational sharing.

Case writing is a reflection tool that has been widely used in education since it was introduced primarily by Judith Shulman (1991). Cases are narratives of teacher-written accounts of problems in classroom activities. From the point of view of Pring (1996), case

narratives are systematic reflections of what goes on in one's environment and subsequent attempts to raise these reflections to the level of objectivity and present them to others for critical analysis. Teachers' narratives and commentaries opened the way for reflections on what they have learned from the experience and what they might be do better next time in a similar situation (Shulman, 1991). Hammerness, Darling-Hammond and Shulman (2002) explored how student teachers may learn about theory and practice from case writing. Many preservice teachers found it difficult to integrate theories and concepts into their teaching practice. Over many years, student teachers had been asked to write a case about an incident in their own teaching that might have been successful, unsuccessful, surprising or revealing, that were then presented orally to a small group. The cases were used for learning in examining dilemmas and questions. Hammerness et al. (2002) found in their study that case writing helped the students to relate theory and practice. The students also reported that case writing allowed them to view their experiences from a more professional viewpoint. In sharing and discussing their case with others, it enabled them to gain a better understanding of the problem. More recently, Cathcart et al. (2010) noted that writing case narratives allowed NUMs to relive the experience and gain an appreciation of the magnitude and significance of the case scenario. As stated by Cathcart and Greenspan (2013), narratives can preserve the acquired practical wisdom of experienced and seasoned NUMs that can be useful for future NUMs. Further, reflective narrative may be used by NUMs to analyse selected clinical incidents during staff meetings or unit conferences (Asselin, 2011). The knowledge gained from analysing past experiences can enable NUMs to gain insight into self and practice.

Accordingly, Jantzen (2008) conducted an inductive, narrative inquiry to explore the learning experiences of first-line acute care nurses in Canada. There were eight participants in the study. Each participant was required to provide a written story. After reading the stories,

Jantzen conducted follow-up interviews with participants to obtain more information about the story, the event and their recollections of event. The researcher also asked how their participation in writing the stories impacted their nursing practice. Janstzen noted that the participants' stories provided the listener and the reader with clues about what was important and meaningful to them. The participants commented that they were able to learn from the experiences they had written and interpreted. Participants also commented that they were able to learn from colleagues. Jantzen stated that "through storytelling, questioning, observing and working as a team, nurses are able to access experiences of peers" (Jantzen, 2008, p. 24). Case and commentary writing allows NUMs to learn from experiences they (and others) have written about and interpreted. By reading and written commentaries on other NUMs' case narratives, NUMs are able to access experiences from other NUMs and to learn from them.

Smith, Andrews, Oliver and Chambers-Evans (2018) developed the McGill University Health Centre Reflective Practice (MUHCRP) Program to support nurse leaders experiencing difficulty in interpersonal situations involving staff, patients, families and interdisciplinary teams. The program involved monthly meetings and the participants were required to bring in a case that they tried to solve or planned to try to solve in the future. The meetings were facilitated by a trained reflective practitioner. The authors found that the MUHRCP model created a very effective environment for learning to support nurse leaders.

Similarly, Graham-Hannah, Cathcart, Honan-Pellico and Kunisch (2017) conducted an educational program on reflection through narrative writing for 17 nurse managers at Maimonides Medical Center in New York. This was facilitated by an executive nurse with experience in narrative interpretation. The program was a two-hour seminar. The participants wrote a narrative of their leadership practice. Each participant read their narrative to the group and discussion was held around the narrative presented. The authors found that leadership programs incorporating reflection through narratives had the potential to showcase

the skilled knowledge and judgment embedded in NUMs' practice that had not otherwise been unearthed.

Case writing has been used in administration and leadership development in pastoral care. Frank (2003) referred to cases being used in teaching administration and leadership courses for pastors. The author indicated that cases had enriched his understanding of reflection on pastoral leadership. In Frank's study, 19 pastors were asked to write cases from their current experience. These cases were used in the course for analysis and discussion. Frank was struck by how honoured and eager the pastors were to be asked to participate. They were not given a format or outline on how to write the cases but were given verbal suggestions such as bringing the situation right to the point that continues to raise questions for them as pastors. The authors were present during student discussions and were grateful to hear other people's perspectives on their cases. Frank stated that written cases work because they were deliberate. In writing cases, the author is remembering what they experienced describing events and persons; and then putting into words the relationships between people, actions and outcomes. Frank describes this process as action itself. Cases capture the unfolding dynamic of a situation that would not stand still for analysis. As the cases are actual situations, the reader brings to it their own thoughts based on life experience. Case writing captures NUMs' experiences from actual situations, and by reading and commenting on other NUMs' experiences, they bring in their own thoughts on the situation based on their own life experience.

Mackoff et al. (2013) designed a Leadership Laboratory based on lived experiences and peer best practices among 43 cross-disciplinary nurse managers in New York. Each laboratory session concentrated on one topic. Participants were asked to submit a written narrative several weeks before the training that described their own experience, such as a successful resolution of a conflict or a current challenge with a team member, which were

then distributed to participants in the sessions for discussion. In this pilot project, Mackoff et al. (2013) found participants valued peer collaboration, discussion and support in exploring nurse managers' shared experiences. The participants discovered they had similar issues and this built their confidence. Cross (2013) agreed that no one NUM knows or has all the answers but that each NUM can hold a part of an answer. Through collaboration with other NUMs, a solution can emerge. DeCampli, Kirby and Baldwin (2010) also found that nurse managers considered group sessions beneficial as they were able to share different views on the same issue. This supports the study findings of Paliadelis, Cruickshank and Sheridan (2007) who interviewed 20 NUMs in the public health care system in Australia. They revealed that NUMs learned by trial and error with very little support from the organisation. New NUMs received informal support from other NUMs where they were able to draw on insights and knowledge. The participants valued the support of other NUMs, saying that this helped them cope with their roles. Additionally, Paliadelis et al. (2007) concluded that peer support may offer an educational model for developing formal supportive networks for NUMs.

Cathcart and Greenspan (2013) conducted a study on how a nurse manager's narrative can be used to develop leadership practice and facilitates learning. There were 91 nurse managers who participated. Each nurse manager was asked to write a narrative of their lived experience in their role and these were read to a peer group. Specific guidelines in writing the narratives were avoided in order for nurse managers to describe the situation as they experienced it. A nurse executive and a nurse manager who had experience in narrative interpretation facilitated the sessions. Writing a narrative and then reading it to a peer group provided an opportunity for the nurse manager to reflect and to relive the experience. Nurse managers reported that the method of reflecting on their lived experiences was more effective in coping with their role, and they saw peer collaboration as a source of gaining new

knowledge and perspectives for problem solving. Participants understood there was no single, correct method of solving a particular problem. Telling and reflecting on the story preserves experiential learning (Cathcart et al., 2010). Hill (2004) in her study of new manager development, also found that new managers found it easier to learn from experience when they had developmental relationships with superiors and peers. Hill also stated that humans are social learners and thus need others to provide them with feedback and coaching.

Duffield (2005) designed a Master Class leadership course for 18 NUMs employed at four hospitals in New South Wales, Australia. For this Master Class, Duffield (2005) drew on experiential learning where different activities such as games, trips to the beach, park and art galleries were included, and at least one session was conducted at each site where the participants were employed. The purpose of the other activities was to make sure the NUMs were disengaged from their workplace and a safer environment. Another activity that was included was the writing of narratives by the NUMs. NUMs were asked to write a case scenario that described situations in dealing with a difficult staff member, verbal abuse from medical staff and other situations that presented challenges to them. These real-life scenarios were then discussed during the session. Some scenarios of concern were sent via email to NUMs to allow sufficient time to reflect on the issue. The evaluation of the program indicated that through collaboration and interaction with other NUMs, participants came to recognise they faced similar issues in their role and had different approaches to problem solving. The NUMs were able to understand that a group discussion on issues would have better outcomes than an individual approach.

3.4. Chapter summary

The review of literature indicated a gap in how NUMs can acquire the skills needed for the role. There are concerns that formal graduate education does not adequately prepare NUMs to

assume the role. Some nursing scholars suggested the need for more research that addresses informal methods of learning. Case writing has gained popularity in the field of education as a learning tool for teachers. These studies highlight the efficacy and effectiveness of the use of case and commentary writing in nursing professional development. However, there is a paucity of research studies that address how case writing can help NUMs prepare them for their role.

Schon's *The reflective practitioner* (1991) provides a framework for reflective practice. Schon's work suggests that reflection can occur after an action (reflection-on-action) and while in the middle of an activity (reflection-in-action). Other authors criticised Schon for failing to address reflection-before-an-action and reflection-for-the-future. Case writing has the capacity to draw together reflection-on-action, reflection-before-an-action and reflection-for-the-future. Through case writing and written commentaries, NUMs can reflect on past experiences (reflection-on-action). By reflecting on past experiences, NUMs will be able to plan for the future (reflection-for-the-future). By planning for the future, NUMs will be able to develop a plan before engaging in actual situations (reflection-before-an-action) in order to improve future performances. The next chapter will discuss the methodology employed in this current study.

Chapter 4: Methodology

4.1. Introduction

This chapter outlines the methodology of the study. It describes the setting, the recruitment of participants, forms of data collection, software used to analyse data and ethical considerations. A mixed methods approach was employed in this study. This approach incorporates the collection and analysis of both qualitative and quantitative data in a single study and subsequent integration of the findings (Creswell, 2014; Grove, Burns, & Gray, 2012; Loiselle & Polit, 2011; Pole, 2007; Polit & Beck, 2016). Mixed methods provide stronger inferences because the data are looked at from both qualitative and quantitative perspectives. When both qualitative and quantitative methods are used, together, they confirm or complement each other (Loiselle & Polit, 2011; Pole, 2007). There are different types of mixed methods. The concurrent triangulation approach was used in this study. In this approach, qualitative and quantitative data are collected concurrently. Data collected are then compared in the analysis and discussion sections for similarities and differences (Creswell, 2014; Terrell, 2012). By employing concurrent triangulation in this mixed methods study, NUMs were interviewed to explore their perceptions of their leadership styles. NUMs then completed a survey to rate themselves on their leadership styles, and the ANUMS and RNs completed a survey to rate their NUMs on their leadership styles. The data gathered from both tools were analysed separately and then integrated for discussion. In addition to using these methods, case writing was also employed as another qualitative approach to identifying important learning experiences for NUMs while also investigating the viability of case writing as a learning strategy for NUMs.

Schon (1991) provides a framework for reflective practice. Reflective practice is proposed to be most suited to solving complex problems (Schön, 1991) in health care (Johns,

2009) and as an approach to achieving competent practice such as that of the NUM (Schön, 1991). Schon's epistemology of "reflection-on-action" was employed as a theoretical framework for this study. Through reflection-on-action using case writing, the NUMs remember what they experienced and describe the events and persons, and then putting into writing the relationships between events and people, the actions taken and the outcomes (Frank, 2003). Reflection-on-action can be achieved by analysing and reflecting on others' past experiences by placing oneself in the shoes of others, to envision possible scenarios and examine what might happen in the future.

4.2. Research design

This study utilised both qualitative and quantitative methodologies by employing in-depth interviews and a survey. A mixed methods approach was used to draw richer data, and data gathered from quantitative and qualitative methods were integrated for data analysis and discussion (Creswell, 2014; Loiselle & Polit, 2011; Pole, 2007; Polit & Beck, 2013; Terrell, 2012). According to Patton and Patton (2002), qualitative findings can be presented alone or in combination with quantitative findings. In this study, the two principal methods for data collection were a questionnaire and interviews. Case writing and commentaries for NUMs were also employed. Case writing required NUMs to write case descriptions they had experienced in their work. The other participants wrote commentaries on those descriptions to provide additional insights.

In the interviews, the NUMs described their leadership styles and the ANUMs and RNs were also asked to describe their NUMs' leadership styles. Using a questionnaire, the NUMs rated their leadership style and the ANUMs and RNs also rated their NUM's leadership styles. The results of this qualitative and quantitative inquiry were combined in the data analysis.

The focus of the qualitative method in this study was to explore the challenges NUMs faced, the roles, skills and training needed, and NUMs' leadership styles as described from three perspectives: NUMs, ANUMs and RNs. Additionally, the quantitative study focused on the leadership style of the NUM as perceived by the NUM, the ANUM and staff. The NUM's role encompasses both management and leadership activities which require considerable interpersonal interaction with primarily higher management, peers, ANUMs and RNs as well as with patients. Qualitative and quantitative methods enabled reflection by all participants on complex aspects of leadership and management.

Surveys are used to collect information to describe, compare, or explain knowledge, attitudes or behaviours. Surveys can be administered to a larger group than interviews thereby responses can be obtained from a wider participant group (Creswell, 2014; Loiselle & Polit, 2011; Polit & Beck, 2013). The most widely used instrument of survey design is via the use of questionnaire (Boswell & Cannon, 2014; Gillis & Jackson, 2002). The survey, Multi-factor Leadership Questionnaire (MLQ) developed by Bass and Avolio (2004) was used to collect broadly based data. The use of the MLQ determined the leadership styles of the NUMs, and the ANUMs and staff were able to rate their NUMs on their leadership styles. The results of these surveys were used to compare the NUMs' perceptions of their leadership styles to those of the ANUMs and staff.

As well, the study employed in-depth interviews as a prelude to cross-case analysis (NUMs, ANUMs and RNs). Open-ended questions can yield rich data about people's experiences, perceptions, opinions, feelings and knowledge (Patton & Patton, 2002). The three cases were the NUMs, the ANUMs and the RNs. Cross-case analysis involves multiple cases within a study. Large amounts of data for analysis can be generated from these multiple cases. Each case is treated as a single case and data gathered from each case can be analysed separately (Stake, 2013). Similarities and differences in each case were investigated

and used as information for the whole cross-case analysis. The cross-case analysis method is used by researchers to explain or describe a situation, to produce a new theory or dispute an existing theory, or to provide a basis for improving situations, that is, to improve the preparation of NUMs for their role (Stake, 2013). The cross-case analysis method was adapted in this study to explore how prepared NUMs are for their role, to explore their leadership styles, and to explore the perceptions of ANUMs and staff of the NUMs' roles and leadership styles. The data gathered from the NUMs, ANUMs and RNs were analysed separately for similarities and differences.

This study also employed case writing in its research methodology. Case writing was used for NUMs to write case descriptions to reflect on different situations in their work. According to Hammerness, Shulman and Darling-Hammond (2000), case writing is a collaborative method where there is an exchange of ideas and reflections among participants on a situation described in case. There are two components: a case description written by a participant and at least two commentaries from other participants. The case descriptions are short descriptions of a specific event or situation, a dilemma or a challenge that the writer has experienced. The cases are embedded with many problems that can be analysed.

Commentaries are written by other participants reflecting on the case descriptions and can provide additional insights about the situation described in the case. Commentators are able to add additional views in identifying the issues raised by reflecting on their own experiences. Thus, in examining and commenting on the cases, participants have the opportunity to be exposed to different scenarios and actual problems that they might not have otherwise experienced. Case writing promotes the idea of learning from each other by engaging with each other's ideas (Darling-Hammon, Hammerness, & Moffett, 2000).

In this study, NUMs wrote the case descriptions and then wrote commentaries on other NUMs' case descriptions. By participating in writing case descriptions and writing the commentaries, the NUMs had the opportunity to reflect on their experiences and learn from others (Cathcart et al., 2010; Fossey & Glover, 2006; Markey & Farvis, 2014; Miraglia & Asselin, 2015). As noted by Cathcart et al. (2010), writing case narratives allows NUMs to relive the experience and gain an appreciation of the magnitude and significance of the case scenario. In addition, case writing and written commentaries gives NUMs the opportunity to engage in shared problem solving (Fossey & Glover, 2006). Miraglia and Asselin (2015) also noted that reflection could increase knowledge, and change attitudes, values and beliefs of NUMs. Schon (1991) believed that the traditional classroom style of gaining knowledge does not adequately prepare practitioners to be competent in their practice. Schon (1991) therefore advocated the use of reflection as an important constituent for professional practice and a necessary component of intellectual integrity.

The use of reflective journals as a tool for reflection is widely discussed in nursing and management literature. However, reflective journals are more private in nature and as such, the writer may only share the material with a chosen few. Gray (2007) suggested that journal extracts might be more beneficial if they are exposed to a group for group reflection and analysis for additional insights and strategies about an event or situation. Case writing offers a solution to this dilemma.

The case writing method was used in this study to explore how case writing would assist NUMs in improving their skills as effective leaders.

4.3. Procedure

Ethics approval was obtained from Victoria University (Appendix 2) and the participating hospital prior to initiation of the study. To maintain confidentiality, the ethics approval,

LREP Project Number: HREC/13/WH/140, from the hospital was not included as an appendix. A list of all NUMs was obtained from the office of the Executive Director of Nursing. Potential participants were contacted via email with an attachment to explain the purpose of the study. NUMs responded through email about their intention to participate or not. Those NUMS who took part in the study participated in the structured interview, survey, and case writing and commentary writing. They were also invited to provide feedback on their participation in case and commentary writing.

For a NUM to be included in the study, an ANUM and RN working with this NUM were required to participate in the interview. Another important criterion was to have at least six staff in this NUM's team to participate in the survey, which included the ANUM and RN being interviewed. As suggested by Bass and Avolio (2004), at least six raters are required to minimise bias. Each NUM who agreed to participate spoke to their respective ANUMs and RNs about the study. ANUMs and RNs who agreed to participate in the interview were given written information to explain the purpose of the study and their role as participants. Each NUM also received eight copies of the Multifactor Leadership Questionnaire (MLQ) Rater Form to be distributed to the RNs who were willing to participate in the study to complete. Each NUM was given a Leader Form to complete. Included in the questionnaire was information that explained the purpose of the study and their role as participants. The sealed box where completed surveys were placed was collected by the researcher after one week.

4.4. Research setting

This study was carried out in one of the large teaching hospitals in Melbourne, Australia. For ethical reasons, the name of the hospital for this study is withheld and will be referred to as "the hospital". This hospital has three main campuses across Melbourne. One of its campuses has approximately 600 beds which offers a wide range of services including an emergency unit, maternity services, intensive care unit, cardiac care services, women's and children's

services, surgical, medical, mental health, aged care and rehabilitation services. The second campus has approximately 290 beds that offer emergency services, inpatient and outpatient services including acute general medical and surgical, intensive and coronary care, sub-specialty medicine, surgical services and related clinical support. The third campus consists of 90 beds that provide emergency services, surgical services, renal dialysis services, and community rehabilitation and transition services.

4.5. Sample

Three primary samples: NUMs, ANUMs and RNs participated in this study.

4.5.1. NUMs

Non-probability purposive sampling was used in the selection of NUMs from the three campuses to participate in the study. Non-probability sampling is a technique wherein not all participants in the population have equal chances to be included (Etikan, Musa, & Alkassim, 2016; Onwuegbuzie & Collins, 2007). In purposive sampling participants are chosen deliberately by the researcher, based on their knowledge and experience, and who can provide rich information for the study (Etikan et al., 2016; Grove et al., 2012; Onwuegbuzie & Collins, 2007; Tansey, 2007). Purposive sampling was chosen for this study because the intention was to invite NUMs who were willing to participate in the study to share their knowledge and provide rich data on the preparation of NUMs for their role. In particular, the NUMs were selected in terms of the number of years they were working in their role. The experience of the NUMs varied from 8 months to 14 years. This was important in order to compare the roles and preparation of NUMs for their role at different times. Thus, after obtaining a list of all NUMs from the office of the Executive Director of Nursing, the researcher invited three or four NUMs from each campus to participate. From one of the campuses, no NUM agreed to participate, citing lack of time and lack of interest as reasons

for non-participation. There were six NUMs, four from one of the campuses and two from another campus who agreed to participate in this study. However, one NUM from where the other four NUMs worked and who initially agreed to participate, was not included. After several attempts to arrange an interview with this NUM were unsuccessful, it was decided they would not be included.

In qualitative studies, there is no definite number of participants. The required number is attained when saturation point is reached, that is, when there are no more new emerging themes from succeeding participants (Polit & Beck, 2013). Saturation point was reached after the fifth NUM was interviewed. The same five NUMs were also the participants for the survey and case writing.

4.5.2. ANUMs and RNs

In this study, in order for the NUM to be included as a participant, one ANUM and one RN who were working under these NUMs had to agree to participate in the interview, and at least six staff including the ANUM and RN who participated in the interview had to participate in the survey to rate their NUMs' leadership styles. The NUMs spoke to their ANUMs and RNs about the study and about their willingness to participate in the interview and in the survey. The NUMs provided the researcher with the names of ANUMs and RNs who agreed to participate in the interview. A total of six ANUMs and five RNs participated in the interview and a total of 35 staff participated in the survey. A breakdown of the participants for the survey for each NUM is presented in Table 4.1.

Table 4. 1: Breakdown of participants for the survey

NUM	ANUM	RNs	Total
NUM1	**1**	**6**	**7**
NUM2	1	5	6
NUM3	1	6	7
NUM4	1	6	7
NUM5	2	6	8
Grand total			35

4.6. Measures and data collection

The three principal methods employed to generate data were questionnaire, structured interviews and case writing.

4.6.1. The survey

4.6.1.1 Instrument – The Multifactor Leadership Questionnaire (MLQ Form 5X short)

The Multifactor Leadership Questionnaire (MLQ Form 5X short) was used to measure the leadership behaviours of NUMs (Avolio & Bass, 2004). The purchase of the MLQ (n=100) was required in order to receive permission to use the questionnaire (Appendix 3). Due to copyright issues, the entire instrument could not be reproduced but an amended sample of the questionnaire is attached as Appendix 4.

The MLQ is designed to study three leadership styles: transactional leadership consisting of two subscales, transformational leadership consisting of five subscales, and passive/avoidant behaviour consisting of two subscales. In addition, it also measures three outcomes of leadership: extra effort, satisfaction and effectiveness. The leadership style and outcome factors as measured by the MLQ are presented in Table 4.2.

Table 4. 2: Leadership styles measured by the MLQ version 5X (Avolio & Bass, 2004)

Leadership Style/Factors	**Leadership Behaviour**	**Brief Examples**
Transformational		
	Idealised Influence (Attributed)	Goes beyond self-interest for the good of the group
	Idealised Influence (Behavioural)	Emphasises the importance of having a collective sense of mission
	Inspirational Motivation	Articulates a compelling vision of the future
	Intellectual Stimulation	Seeks differing perspectives when solving problems
	Individual Consideration	Helps me to develop my strengths
Transactional		
	Contingent Reward	Discuss in specific terms who is responsible for achieving performance targets
	Management by-Exception (Active)	Keeps track of all mistakes
Passive/Avoidant Behaviour		
	Laissez-Faire	Avoids making decisions
	Management by-Exception (Passive)	Fails to interfere until problem becomes serious
Outcome Factors		
	Extra effort by followers	Gets me to do more than I expected to do
	Satisfaction with the leader	Uses methods of leadership that are satisfying
	Effectiveness	Leads a group that is effective

The MLQ has been used in several studies and has demonstrated stable psychometric properties: Cronbach's α coefficients ranged from 0.74 to 0.94 (Avolio & Bass, 2004; Kanste, Kääriäinen, & Kyngäs, 2009; Kanste, Miettunen, & Kyngäs, 2007). The MLQ has been used

in over 200 research studies (Avolio & Bass, 2004) and the instrument has also been used in several nursing studies (AbuAlRub & Alghamdi, 2012; Bormann, 2011; Casida & Parker, 2011; Failla & Stichler, 2008; Kanste et al., 2009; Kleinman, 2004; Malloy & Penprase, 2010; McGuire & Kennerly, 2006; Raup, 2008).

Two versions of the MLQ were used: the Leader Form and the Rater Form. The Leader form was completed by the five NUMs as a self-assessment, and the Rater form was completed by the 35 staff working under each NUM to assess their perceptions of their NUMs' leadership style. The MLQ consists of 45 items that describe leadership behaviours or effectiveness. The questionnaire takes approximately 15 minutes to complete (Avolio & Bass, 2004). Each item is rated on a Likert scale (0-4) as follows:

Rating scale for leadership items

0 = not at all displayed;

1 = once in a while

2 = sometimes

3 = fairly often

4 = frequently, if not always.

4.6.1.2. Data analysis

The MLQ scoring key was used to group the 45 items by scale (Avolio & Bass, 2004). The items by scale and the corresponding questions are presented in Table 4.3.

Table 4. 3: Items by scale and corresponding question numbers (Avolio & Bass 2004)

Scales	Leadership Behaviour	Question Numbers
Transformational Leadership		
	Idealised Influence (Attributed)	10,18,21,25
	Idealised Influence (Behavioural)	6,14,23,34
	Inspirational Motivation	9,13,26,36
	Intellectual Stimulation	2,8,30,31
	Individual Consideration	15,19,29,31
Transactional	Contingent Reward	1,11,16,35
	Management by-Exception (Active)	4,22,24,27
Passive/Avoidant Behaviour		
Laissez-Faire		5,7,28,33
	Management by-Exception (Passive)	3,12,17,20
Outcome Factors		
	Extra effort by followers	39,42,44
	Satisfaction	38,41
	Effectiveness	37,40,43,45

The scores were entered using Microsoft Excel 2010 software. All data were entered and cleaned by the researcher. Cleaning of the data included hand checking all entries for entry errors and correcting errors. The average for each NUM was calculated by summing the items in each scale and then dividing the sum by the total number of responses for that item. Possible scores ranged from 0-4. Blank answers were not included in the calculation. Averages were compared to norm tables (Avolio & Bass, 2004). The resulting scores indicate the most frequently used leadership behaviour and the predominant leadership style of the

NUM, but it is not designed to label a leader as Transformational, Transactional or Laissez-Faire (Avolio & Bass, 2004).

Since the major role of NUMs is about leadership and management, it was important in this study to obtain the perception of NUMs about their leadership styles and to compare it with staff's perceptions in order to address leadership training for NUMs. Further, one of the central aims of the interviews was to explore NUMs' perceptions of their leadership styles and compare these to the perceptions of ANUMs and RNs about their NUMs. In this study, the MLQ was used just to explore the perception of NUMs of their leadership styles and to compare these with the perception of staff of their NUMs' leadership styles. Therefore, further analysis of leadership styles of NUMs was considered beyond the scope of this study. However, this could be an avenue for further research on the preferred leadership styles of NUMs, for example, in different types of wards.

4.6.2. The structured interview

A structured interview using the same open-ended questions in each interview, as shown in Appendices 5 and 6, was employed to collect qualitative data. Open-ended questions are commonly used in qualitative interviews to give the participants an opportunity to have an open discussion and provide unprompted feedback in response to the questions. Although the researcher prepared a set of open-ended questions and participants were asked the same questions, the interview was conducted in a conversational manner, giving the participants the opportunity to explore the issues they felt were essential. This approach can produce larger and richer data for analysis (Clifford, Cope, Gillespie, & French, 2016; Polit & Beck, 2013). The participants in this component of the study are presented in Table 4.4.

Table 4. 4. Participants for the structured interview

Participants	Number
NUMS	5
ANUMs	6
RNs	5
Grand Total	16

As mentioned earlier, for the NUM to be included in the study, an ANUM and an RN working under this NUM must have agreed to participate in the interview. For one of the NUMs, two ANUMs participated in the interview. The researcher was not aware beforehand that the next interviewee was an ANUM. This ANUM was very interested in participating, so the researcher decided to include this staff member.

All interviews were audio-recorded. The use of audio recording is common in qualitative research. It is useful in collecting detailed responses of participants and in preventing researcher bias, as may happen inadvertently in note taking. It is an important tool to improve the accuracy of information. This method also allowed me to note non-verbal actions of the participants. The duration of the interviews varied from participant to participant. Prior to the interview, all participants provided written, informed consent to be interviewed and for the interview to be audio-recorded (Appendices 7 and 8). Both the participant and I, as the researcher, signed the informed consent forms. A copy was given to the participant and the original copy was retained by me.

A face-to-face, audio-recorded, open-ended interview was conducted for each NUM, ANUM and RN. All NUMs were interviewed in their respective offices while ANUMs and RNs were interviewed in a separate room at the participants' workplace, where privacy was maintained and where participants were encouraged to speak freely without fear of

victimisation. Each interview lasted between 30 to 50 minutes. Follow-up questions were used when necessary to gather more information or clarify responses. I transcribed all interviews verbatim.

Measures were undertaken to ensure trustworthiness of the research. Trustworthiness is the degree of confidence by the researcher in their data in order to persuade others to draw conclusions on the believability of the research findings (Loiselle & Polit, 2011; Polit & Beck, 2013). To establish trustworthiness of qualitative research, four criteria were used which included credibility, dependability, confirmability and transferability (Creswell, 2014; Loiselle & Polit, 2011; Polit & Beck, 2013).

Credibility refers to the truth of the data and accuracy of interpretation. This included prolonged engagement and member checking (Creswell, 2014; Loiselle & Polit, 2011; Polit & Beck, 2013). Prolonged engagement refers to investment of sufficient time for data collection in order to have in-depth understanding of the phenomenon of interest, and to build trust and rapport with the participants (Creswell, 2014; Loiselle & Polit, 2011). Prolonged engagement was achieved by establishing rapport with the NUMs, ANUMs and RNs during the recruitment process and when seeking permission to participate.

Member checking was achieved through presenting the interview transcript to each participant to check (Creswell, 2014; Polit & Beck, 2013; Pope, Ziebland, & Mays, 2000). This was to ensure that the relevant participant verified the interview transcript for accuracy and completeness before I commenced data analysis. When reporting extracts from the transcribed interviews in this thesis, brackets and ellipses have been used to help elucidate the text. Brackets were used for participants' quotes and ellipses were used to indicate the removal of text that was superfluous to what the participants were saying.

Transferability refers to the potential to which the findings can be applied to other settings which is similar to generalisability (Loiselle & Polit, 2011; Polit & Beck, 2013). In this study, the findings are not transferable as the study was not intended to generalise to other settings. The study provides insight into how NUMs can be assisted in preparing for their role.

Dependability refers to whether the findings could be replicated with similar participants in similar settings (Loiselle & Polit, 2011; Polit & Beck, 2013). Dependability was achieved in this study by clearly describing and adhering to the research methodology, and by comprehensively transcribing the interviews.

Confirmability guarantees that the data represents the information that the participants provided and the findings are supported by the data (Loiselle & Polit, 2011; Polit & Beck, 2013). The transcripts of the verbatim notes were made available to participants in order to confirm the accuracy of the information.

4.6.2.1. Data analysis

In qualitative research, the identification of common categories is used to analyse data. There are several computer software programs that are available for qualitative data analysis. For this study, NVivo 10 was utilised which is a powerful software program that allows researchers to handle large amounts of data, perform complex searches and organise data into categories (Davies & Hughes, 2014).

The researcher transcribed the interviews. This was important to ensure the accuracy and completeness of data provided by the participants and the findings were supported by the data. This was also important to ensure confirmability and dependability of the research. Further, this was beneficial because as the researcher was transcribing and listening carefully to the audio recording for accuracy, the researcher at the same time was able to identify

categories arising from the interviews. A category is a group of similar data that enable the researcher to identify and describe its characteristics (Morse, 2008). A category is imposed after assigning labels or tag words in the data which are referred to as codes (Basit, 2003; Grove et al., 2012). Categories are different from themes. Themes are concepts or patterns that emerge regularly after extensive data analysis (Grove et al., 2012; Polit & Beck, 2013).

According to Lincoln and Guba (1985) research data can be broken down into units and coded into categories. A category is a collection of similar data (Morse, 2008; Pope et al., 2000). In this study, the interview materials were managed using NVivo 10 and analysed using category analysis. Category names may be taken from the exact words of the participants, referred to as in-vivo categories, or from concepts from the researcher's profession or from the literature review (Basit, 2003; Corbin & Strauss, 2008). In this study, the category names were taken from the exact language of the participants and from the pool of concepts from the literature review. The data were broken down into units then compared and conceptualised into specific categories. The constant comparative method of data analysis for naturalistic inquiry was employed to analyse the data (Lincoln & Guba, 1985). Constant comparative method entails the researcher extracting and analysing the participants' responses to develop categories. By constant comparison of units of data, the researcher continued to re-examine the concepts, and identify their properties and how the data related to each other (Burns, 2000). This overall process was repeated until the relationships of the categories were established and integrated into a meaningful description (Shkedi, 2005). In this present study, the researcher adapted the technique used by Naidoo (2017) in coding and identifying categories and ideas. The contents of the interviews were analysed, highlighted and similar meaning units were identified and grouped into sub-categories. The sub-categories were further grouped into broader core categories. The core categories were then

analysed to identify the challenges faced and skill gaps of NUMs. The steps taken were as follows:

- The audio recorded data were carefully listened to and transcribed verbatim.
- Each transcript was read individually and thoughts and topics were entered using NVivo 10 software.
- In a word document, a list of similar ideas were identified and written as meaning units.
- The meaning units were coded as sub-categories with descriptive words.
- The sub-categories were reduced by grouping those that related to each other into broader core categories.

4.6.3. The case writing

For the case writing, Schon's (1991) epistemology of "reflection on action" was again employed as a theoretical framework for this part of the study. Each of the five NUMs who participated in the interviews was invited to participate in the case writing. There were two components of the cases: 1) a case description written by each NUM, and 2) commentaries on original cases written by other participating NUMs.

For the case description, the NUM authors were asked to write a short description of a specific event or situation, a dilemma or a challenge that they had experienced. No specific guidelines were given in order to allow NUMs the freedom to write their stories as they experienced the situation. The researcher specified that names and other details that might reveal their own and other people's identities be omitted or changed. These instructions were all included in the participant's information sheet given to the NUMs. The NUMs sent their case descriptions via email except for one NUM who personally handed it to the researcher. All NUMs were informed that their case descriptions would be sent to other NUM authors for their commentaries. Each NUM was given two months to submit their case description.

However, the timeline was extended to another three months for some NUMs due to their busy schedules and being on annual leave.

Before sending the case descriptions to the other five NUM authors for their commentaries, they were de-identified. Any personal information and identifiable markers that might disclose identity were removed. Codes were used so that, as the researcher involved in data collection, I was able to identify participants. The case descriptions were then sent to the other author NUMs for their commentaries. They provided additional insights on the case by identifying the issues raised and reflecting on their own experiences in the commentaries they wrote.

The NUMs then sent their commentaries via email. They were given one month to submit them. Again, this timeline was extended another two months due to the busy schedules of NUMs and annual leave being taken. One NUM did not participate in commentary writing due to a very busy schedule. After several attempts via email and talking personally to this NUM and after giving additional time, the researcher decided not to wait for the commentary.

The researcher compiled all the commentaries per case description and sent a copy to all five NUMs. The NUMs were requested to provide feedback/recommendations on their experience in participating in the case writing exercise. The researcher provided the following questions for NUMs to address in their feedback:

1. How would case writing help in the personal development of a NUM in collaboration with others?
2. Describe your experience when writing your case scenario and writing the comments.
3. How did you feel after reading the comments on your scenario from other NUMs?

4. Do you think case writing would be a better option to face-to-face mentoring considering the time constraint on NUMs?
5. What are your thoughts about case writing as a tool for preserving the acquired practical knowledge of seasoned NUMs and extending these to new or aspiring NUMs?
6. Do you have any suggestions on how we can improve and implement case writing as a tool to support NUMs?
7. Do you think that this research study could be a basis of further research on using case writing in preparing and supporting NUMs in their role?

The NUM who did not participate in writing the commentary also did not provide feedback, despite several attempts. All feedback was analysed categorially. The NUMs' comments/recommendations about their participation in case writing were analysed to establish how their participation in case writing had helped them to improve their management skills and performance and viability of case writing for management development.

4.7. Ethical considerations

As stated earlier, ethics approval was sought from Victoria University (Appendix 2) and from the hospital where the study was conducted, before commencing the study. As this study involved human participants, it was necessary to gain ethics approval to ensure the protection of participants against harm, anxiety or discomfort (Polit & Beck, 2013).

4.8. Consent

Participants were given information regarding the research and were given an option to accept or decline participation (Appendix 9). For NUMs, ANUMs and RNs who participated in the interview, consent accompanied the information sheet for the participants and the

researcher to sign. The consent form included information that the interview would be audio-recorded. And the consent form for the NUMs included information that the case descriptions and commentaries would be viewed by all participating NUMs. Participants had the option to withdraw from the study at any time. Each participant was given a copy of their signed consent form and I kept a copy. For the survey, the return of the completed questionnaire implied consent.

4.9. Confidentiality

All participants were assured that their identity and their institution's identity would not be revealed at any time during or after the study. Any personal information provided in the conduct of this study and any identifiable markers that may have disclosed the participant's identity were removed from the information. Codes were used so that as the researcher involved in data collection I would be able to identify the participants. The results of the study would include findings from the whole group of participants, not individual results. Information was presented as a series of vignettes and/or tables to protect the identity of participants.

Due to the small sample size and ease of identification for NUMs, ANUMs and RNs, the demographic data was deleted to preserve confidentiality. Participants understood they were not to mention patient names.

All completed questionnaires, audio recordings and results of this study were kept in a locked cupboard in the principal supervisor's office and were only accessed by the researcher and her supervisors. All these items are being stored in a locked filing cabinet for five years in the supervisor's office in the College of Arts and Education, Victoria University. After five years, all audio recordings will be destroyed and questionnaires will be shredded.

4.10. Occupational Health and Safety

During in-depth interviews, the interviewee may share sensitive data and may use the interview to vent any frustrations that can cause emotional distress. This could jeopardise her or his role in the organisation and can cause potential harm. It was therefore important to safeguard the confidentiality of the interviewee, especially from those with conflicts of interests (Polit & Beck, 2013). In particular, in this study, the ANUMs and staff were at the lower end of the hierarchy from that of the NUM. The participants were assured by me that confidentiality would be maintained. Any personal information provided in the conduct of this study and any identifiable markers that may disclose the participant's identity were removed from the information. Codes were used so that, as the researcher involved in data collection, I would be able to identify participants. The results of the study included findings from the whole group of participants, not individual results. Information was presented as a series of vignettes and/or tables to protect the identity of participants. Furthermore, the researcher would not be providing feedback to the NUMs. If counselling was required, the participant would be referred to Victoria University Counselling Services.

The study had a low level of risk and it was anticipated correctly that there would be no Occupational Health and Safety (OH&S) implications. The researcher adhered to the organisations' OH&S and ethical conduct of research policies.

4.11. Chapter summary

The purpose of this study was to explore the preparation of NUMs for their role. Since the role of NUMs revolves around leadership and management, it was important to obtain the NUMs' perspectives about their leadership styles and staff perspectives about their NUMs' leadership styles. Qualitative and quantitative approaches were adopted for this study. The data collection processes employed were structured open-ended interviews and surveys using

the MLQ. The interviews were transcribed and NVivo 10 software was used to manage the data. Constant comparative methodology was used to analyse data in order to develop categories. The study also explored alternatives to better prepare and support NUMs to improve their skills. Case writing was employed as another option to face-to-face mentoring and collaboration. The next chapter presents the results of the study and discussion of the findings.

Chapter 5: Results and Discussion of Findings

5.1. Introduction

This chapter presents the results and discussion of findings obtained from structured interviews, questionnaire completion, case writing and commentaries used in this study. As well, it includes feedback from participants in the case and commentary writing component of the study. In the discussion of findings, the literature that is pertinent to the findings will be highlighted. The chapter consists of several sections representing each aim of the study. In the interests of valuing all participants in this study and ensuring the voices of these NUMs, ANUMs and RNs are the strongest they can be in this thesis; there are many direct quotes throughout. Where appropriate, some adjustments have been made to maintain clarity and confidentiality. Further, comments were included to ensure they were the authentic voices of participants and not sanitised. They were real-world experiences and lived experiences which ensured the richness and authenticity of data. In addition, the quotes provided the immense value of enabling the voices of the participants to be heard in finding categories.

5.2. Aim 1: To identify how well prepared NUMs are for assuming their role

Due to the small sample size and ease of identification of the NUMs, ANUMs and RNs who were interviewed, the demographic data was deleted to preserve confidentiality. However, in terms of number of years they had been working in their role, the experience of the NUMs varied from 8 months to 14 years while the ANUMs varied from 4 years to 16 years and the RNs varied from 13 years to 38 years. Two of the RNs indicated they had worked as ANUMs previously.

In order to address Aim 1, all the NUMs, ANUMs and RNs in this study were asked: **"What do you think are the main reasons for getting promoted to the NUM position?**" The core category, sub-categories and attached meaning units are presented in Table 5.1.

Table 5. 1. Core category for promotion to NUM, sub-categories and meaning units

Core Category	Sub-categories	Meaning Unit
Reasons for promotion to NUM	1. Earmarked	• Pre-chosen by higher management
	2. Skills/experience	• Perceived by higher management to have the right skills • Previous training and experience • Acted as NUMs prior to appointment
	3. Dedication/choice	• Personal choice • Interest in the position
	4. Acting as NUMs	• Temporarily applied for the position • Initially as a secondment • Landed in the position by chance
	5. Right personality	• Possession of qualities to lead

Similarities and differences in responses from NUMs, ANUMs and RNs are presented in Figure 5.1.

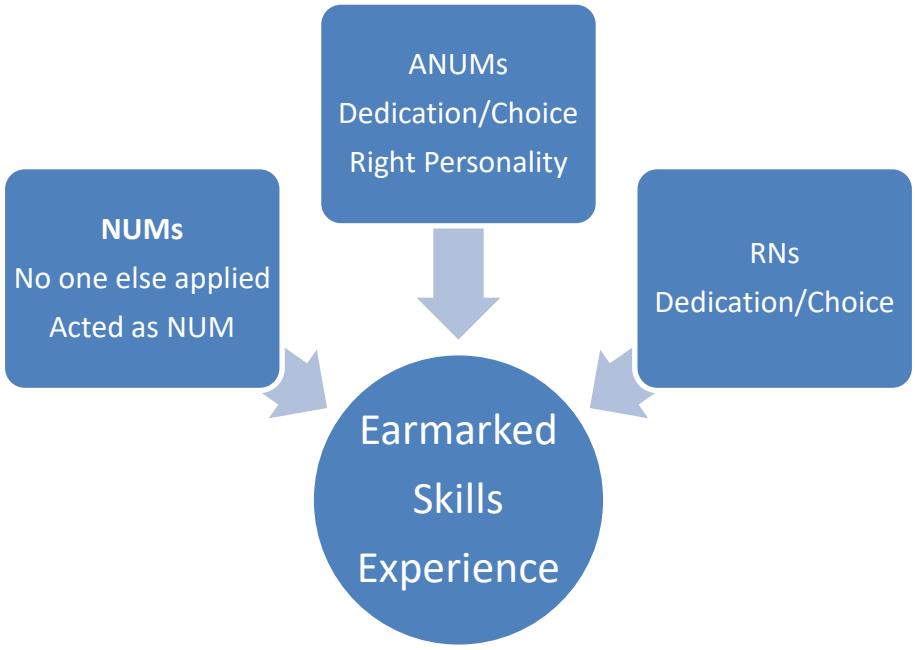

Figure 5. 1. Similarities and differences in responses for promotion to NUM position

As shown in Figure 5.1, NUMs, ANUMs and RNs all agreed that the NUMs were promoted to their positions because they had been earmarked or pre-chosen, and they had the necessary skills and experience to become a NUM. In addition, both ANUMs and RNS perceived that NUMs were promoted because of their dedication or it was their choice. The ANUMs also thought that NUMs were promoted because they had particular personality traits. Some NUMs perceived that they were promoted because they had been acting as NUMs prior to their appointment, or no one else applied for the position.

The findings, as shown in Table 5.1, revealed being earmarked, having skills/experience, demonstrated dedication/choice, acting as NUMs and demonstrating appropriate personality traits in relation to the reasons for promotion to NUM. These were included as sub-categories and they are described in the following sections.

5.2.1.Sub-category 1: Being earmarked

The findings indicated that NUMs were promoted because they had been earmarked or pre-chosen by higher management. NUM5 indicated that he was already earmarked to be a manager earlier during his career. NUM3 indicated having previously known somebody in higher management, so she did not really have to sell herself during the interview. This is reflected by RN1 who believed that NUMs had been pre-chosen even before they were interviewed for the position. ANUM3 also believed that a NUM had already been pre-chosen.

Typical responses from NUMs were:

> "I was earmarked as a young man to be the manager." (NUM 5)

> "Like the divisional director already knew me so when I went to my interview I did not really sell myself at all." (NUM 3)

Typical responses from ANUMs were:

> "I think previously [the] unit manager is already pre-chosen." (ANUM3)

Typical responses from RNs were:

> "I really do not know the process of what they do in getting a unit manager. As far as I am concerned, they are appointed. Apparently they go through like [the] normal process like interviews but I really don't know aside from that. I kind of think that even before any interview, they have chosen already. They have already appointed the unit manager, who they want." (RN1)

> "Getting appointed by higher management." (RN5)

> "Because of their training and experience." (RN3 & RN5)

5.2.2. Sub-category 2: Having skills/experience

Participants indicated that NUMs were promoted because higher management perceived them to have the right skills. NUM1 and NUM2 believed they were promoted because management saw they had the leadership skills. This was echoed by ANUM1 and ANUM2 who believed that NUMs were promoted because management perceived them to have good leadership skills. This was also reflected by RN3 and RN5 who believed that NUMs were promoted because they had the training and experience to lead.

Typical responses from NUMs were:

> "I think it was a combination of my skills." (NUM 1)

> "My NUM saw that I have leadership skills." (NUM 2)

Typical responses from ANUMs were:

"They have perceived that you have a good leadership skill." (ANUM1)

"They have been promoted because I think they are seen to have leadership skills, compassion, [are] flexible, able to manage staff, manage the ward and they need to be visionary." (ANUM2)

"…experience and good leadership and management qualities." (ANUM4)

Typical responses from two RNs were:

"Because of their training and experience." (RN3 & RN5)

5.2.3. Sub-category 3: Demonstrated dedication/choice

In addition, both ANUMs and RNS perceived that NUMs were promoted because of their dedication, or it was the NUM's choice because they were interested in the position, as exemplified in the following quotes:

"NUMs are promoted because they are interested, they are genuine." (ANUM3)

"First of all, choice of the person to become a NUM." (ANUM4)

"Your dedication. If you are not dedicated and you don't love your job, you will not be able to do it." (ANUM5)

"I think it is something you want to do, that you aspire to." (RN1)

5.2.4. Sub-category 4: Acting as NUMs

Some NUMs perceived they were promoted because they had been acting as NUMs prior to their appointment. NUM3 and NUM4 applied for the position temporarily, or as a secondment. Both NUMs believed that they landed the position because they had previously acted as NUMs for these wards. NUM3 commented that she landed the job because no one

else might have applied for the position. NUM2 thought that management perceived her to be the easiest person to put in the job.

Typical responses from NUMs were:

> "So this position became available and so I temporarily applied for it and I was successful because I was previously an acting NUM for this ward for three months. Maybe no one else applied." (NUM3)

> "Initially, it was a secondment. Another manager was moving into a different role so it gave me an opportunity to move across and try it first, which I did for a few months. And I also previously relieved the unit manager as an ANUM and I enjoyed the role in that capacity so I moved across." (NUM4)

> "I did lots of acting roles, about four or five acting roles before I became a NUM." (NUM5)

> "…I also think that I was the easiest person to put in the job compared to other options on the unit." (NUM2)

5.2.5. Sub-category 5: Demonstrating appropriate personality traits

ANUMs also thought that NUMs were promoted because they had particular personality traits. The participants indicated that management might have perceived them to have leadership skills and personality to lead as indicated in the following quotes:

> "…compassion, flexible." (ANUM2)

> "They have confidence, experience, they have good vision as to where their career path is going and [their] working life, and they want to make a positive contribution to the ward and [a] very good personal relations person, good communicator, also committed

to do good for the ward, good organiser, trustworthy person, a passionate person and a builder." (ANUM3)

"Right personality to lead." (ANUM5)

"….you've got good interpersonal relationships with your workmates." (ANUM1)

"They have been promoted because I think they are seen to have leadership skills, compassion, are flexible, able to manage staff, manage the ward and they need to be visionary." (ANUM2)

"Good leadership and management qualities." (ANUM4)

The NUMs were asked: **"On the way to becoming a NUM, are there any NUMs or others who influenced your decision? In what ways particularly?"** This question was asked to gain perceptions of how NUMs were influenced in their decision to apply for the position and their preparation for the role. Only one NUM indicated that there was no particular NUM who influenced their decision, but there were several individuals who did.

"I don't think anyone in particular. I think you take the good out from all other people and you find what works for you. So if there are people who are particularly good in engagement, you might take that on board and if there are people who are particularly good at organisation technique, you take that on board; you take snippets from individuals that are good and things that you believe can build your strengths and embrace [it] from that perspective. Not probably one individual in particular but many individuals throughout the years." (NUM4)

All other NUMs were influenced by other NUMs.

"I think it was fostered through my previous NUM that I worked under and she encouraged me to take up the role and my divisional director, the … divisional director, also encouraged me to do it because she felt that I had the right skills to be the NUM here." (NUM1)

"I admired my NUM at that time at the unit when I first became a NUM and I like her leadership style and management style because she was very involved, very hands on, she knows everything what is happening, she knew where her staff were at. So, she was very influential. I think she was the main one." (NUM2)

"Once [name of mentor withheld] .. came back here I linked up with him and I had a chat with him, because I really respected his managerial side like [he was] a great problem solver. If there is anything that needs sorting out he is quite confident and he is able to do that. So, he has been my mentor …" (NUM3)

"Other senior people were teaching me from a young age because I'm someone who likes to achieve things. Yes, I have three mentors, in particular they were all … NUMs." (NUM5)

These quotes illustrate the influence of other NUMs on the NUM's decision to take up the role. For example, NUM1 highlighted the encouragement from his previous NUM and divisional director to take up the role. NUM5, on the other hand, was being mentored from a young age to prepare him/her for the position. Both NUM2 and NUM3 were motivated by the leadership styles of other NUMs who acted as role models for them. Similarly, although NUM4 did not identify any particular NUM who was influential in her decision making, NUM4 described combining all positive aspects observed in other individuals in shaping future career options.

To further address Aim 1, NUMs were asked **"Did you have any management education or training before assuming the role?"** and this was followed with the question **"How did this education assist you in your performance and the performance of your staff?"** The purpose of these questions was to assess the importance of management education or training in performing the NUM role. Of the five NUMs, two had management training before assuming the role and two NUMs had undertaken management training after assuming the role. One NUM indicated that they had completed several courses over the years but not specifically management courses. The two NUMs who had management training before assuming the role commented that management training was a useful tool in giving them ideas about management:

> "Yes I did my diploma of management and then when I was also an ANUM, there was an ANUM leadership program that I did. I think it helped a lot. I think without those kinds of programs, I would be more lost if I did not have them. So definitely it gave a lot of direction, a lot of tips to be [a] more efficient kind of manager." (NUM1)

> "I got a certificate in management that I undertook through one of my workplaces and it certainly helped but it wasn't to be the end of managers, I believe. It gives you a tool to work from. It's about using it as a tool. I do believe you do learn on the job and improve as a manager as years go down [sic]. And it is about the stuff that you learn in management education that can help you give boundaries to what you can and can't do, rather than get yourself in hot water and making mistakes it can help you." (NUM5)

NUM2 undertook management training after assuming the role and was involved in project roles, commenting that management training would have been helpful before assuming the role:

> "No. So, after I did my original NUM role I did four years then I went into project roles and then I did a certificate in management and health care system, which was really useful and would have been useful before becoming a manager. Yes, I think I took learning from that and brought it into this role as well other experiences that I had looking at different points of view from the project role." (NUM2)

NUM3 who also attended management training after assuming the role commented that formal management training was not helpful:

> "No. I did an ANUM study day at … and I also completed the diploma of management through ... The ANUM study day was a few years ago when I was an ANUM. And that was interesting like gave you a short training on budget, HR and OH&S things. The diploma of management was not great. It was given by … partnering with … and there was no great deal that I learned from it that I brought back to my workplace. But I just enrolled in the advanced diploma in community sector management." (NUM3)

NUM4 described how she sought out resources when needed and how they assisted the role:

> "I have done several courses over the years with varying degrees of assistance and helpfulness. It's one of those jobs that you learn while you are doing it and you watch other people do it and you take on board what they do and take on board what they do well, and what they don't do so well, just sort of store that in your memory for a later date and it evolves you that way. I think it is something that you really have to do to be honest, and then evolve from that and seek out what your resources are because sometimes you don't know what you're learning deficits are until you actually start doing the role. And once you start doing the role, you think, "oh, I should know more about this" and then that actually takes you in that direction and then when you've actually addressed that problem, then there might be something else that arises from

that that you need to know more of as well. It is often good to have a mentor but often mentors are not available." (NUM4)

NUM4 agreed with NUM5 that managers improve with time and experience. NUM4 further described formal training as "very black and white" and mentioned the importance of formal training "in terms of technical stuff like documentation which is standardised".

> "Sometimes the training is very black and white and dealing with routine type of things like performance management is often done with tables and graphs, with information collecting, documentation and informal meetings, these sort of things so that sort of process is you do get training with that and that sort of process is helpful to have in those situations because it keeps everything above board. Everything is to a standard and it is not about a particular person and it does not actually fit that sort of person, it actually addresses the issues of concern. The training, I don't think, for management, as far as people matters go; people are so variable and you need to have agility as a leader because you need to able to respond to people's needs at different times and those needs are different. And I don't think there is any training that you can get that will help you with that, other than time and experience." (NUM4)

The findings of this study showed that NUMs were promoted to their positions by chance and not by conscious choice, or by having been pre-chosen by management, having been seen to have the leadership and management skills for the role. The results of this study concur with Townsend (2012), that the majority of NUMs landed in the role by accident, and with Bondas (2006), asserting that nurse leaders did not make conscious choices to apply for the positions as compared with their conscious choices to become nurses. Similarly, Duffield and Franks (2001) stated that nurses found themselves in the role by chance and not by active

choice, or by having been chosen by others because they were perceived to have management potential.

The results of this study further concur with the findings of Bondas (2006), that nurses entered the role through four different paths which she called the Path of Ideals, the Path of Chance, the Career Path and the Temporary Path. NUM5 was appointed to the role through a combination of the Path of Ideals and Career Path. He described himself as someone who always wanted to lead and liked to achieve things. He continued to seek knowledge, was taught by senior people from a young age and was earmarked as a young man to be the manager. This description is consistent with Bondas' (2006) description of the Path of Ideals where the nurse continues to seek new knowledge and the Career Path where the nurse is motivated by interests and ambitions. According to Bondas (2006), these leaders described themselves as being leaders since childhood and as having an instinct to lead and further described themselves as informal leaders on their ward, even before they were appointed. NUM5's description is also consistent with Jarnigan White's (2015) findings that some nurse managers had planned to take up the nurse manager position. The participants in Jarnigan White's study (2015) commented that the nurse manager's role was a way for them to do more for their community as well as for themselves, that they are destined to be in the leadership role, and also as an opportunity to make a difference. Some commented that they pursued further studies to prepare themselves to move to the next level of their career.

NUM2 obtained her position through a combination of the Path of Ideals and the Path of Chance. She described herself as always driven, which is a characteristic of the Path of Ideals. NUM2 further stated that her NUM saw that she had leadership skills and she was the easiest person for the job compared to other options on the ward. NUM2 also mentioned that she had the clinical experience and was driven to undertake management roles. She admired the leadership style of her previous NUM, whom she thought was very influential in her

decision to take up the role. NUM2's descriptions reflect Bondas' (2006) explanation of the Path of Chance. In the Path of Chance, the leaders moved into the role because somebody made the decision for them. They were basically thrust into the role because somebody has to do it and no one else could. Leaders who took on the role through the Path of Chance also described themselves as having other leaders who mentored them and persuaded them to take up the role. Furthermore, these leaders described themselves as having the necessary clinical expertise and years of experience on the ward (Bondas, 2006).

NUM1 also fitted the description of Path of Chance (Bondas, 2006). NUM1 described his promotion to the role as due to his clinical skills which he developed over the years, his experience as an ANUM, and his knowledge as access manager for the organisation. NUM1 stated that his previous NUM and the divisional director encouraged him to take up the role. NUM1's description is supported by Jarnigan White's findings (2015), that some nurse managers landed in the role because there were some nurse leaders who encouraged them to take up the role.

NUM4 and NUM3 were promoted to the position through the Temporary Path. NUM4 described her promotion as "initially, it was a secondment." NUM4 had the opportunity to try out the role of NUM for a few months when another NUM was moving into another role. NUM4 stated that she enjoyed the role and finally took on the role. NUM3, on the other hand, stated there was no available work when she was due to come back after maternity leave and the NUM position became available. NUM3 applied for a temporary NUM position. Both NUM4 and NUM3 stated they previously acted as NUMs on the ward. NUM3 linked up with another NUM who acted as a mentor while NUM4 did not identify any particular NUM who was influential in her decision, but described combining all positive aspects that she observed from other individuals in shaping future career options. These descriptions fit with Bondas' (2006) Temporary Path. Nurse leaders who entered through the Temporary Path described

their path as a leader substitute or as a trial period where they could withdraw if they did not want the role, and there was the possibility of returning to their former positions (Bondas, 2006). The findings of the present study are consistent with Jarnigan White (2015) where some nurse managers landed in the role because they were already acting as a nurse manager when their previous manager moved to another role.

To further address Aim 1, the NUMs were asked if they had any management education or training before assuming the role. There were two NUMs who had management training before assuming the role, and commented that the management training was a tool in giving them directions to manage. Two other NUMs had undertaken management training after assuming the role and one commented that there was not a great deal she learned from the diploma of management that applied to the workplace. Another NUM described how she sought out resources when needed and commented that formal training is "very black and white" and that these are important in terms of technical knowledge like documentation, such as graphs and tables, which are standard in presentation. Both NUM5 and NUM4 agreed there was no training that could help prepare NUMs for their role, except time and experience. The findings in this study concur with other previous studies. In a survey by Queensland Health (2008), their findings revealed that although the NUMs found leadership workshops and courses very helpful, they found it difficult to put the knowledge gained into practice. The study by Paliadelis et al. (2007) with 20 NUMs in Australia, found that NUMs lacked the proper education and training for the role. Their study showed that the NUMs received very little support from the organisation to help them in the transition from their clinical role to the NUM role and that they were not able to access formal support in the organisation. Instead, the NUMS gained support from their nursing colleagues and learned from experience through trial and error. This supports the study findings of McCallin and Frankson (2010) where they revealed that the charge nurse managers in New Zealand had

minimal training in organisational management. It was often non-existent, premature or too late. Front-line managers learned through trial and error and that resulted in some struggling to adjust and becoming vulnerable. They commented that this was no longer practical and reasonable. This is highlighted in the study by Duffield et al. (2001) in New South Wales, Australia where they found that more than half of the first-line managers had no assistance during the development of their careers. Hill (2004) found in her study that for new managers, it was a process of learning from experience and she found experience was a tough teacher, because these managers faced real-time problems with real-time consequences.

The inadequate preparation of NUMs for the position can be a problem in succession planning. ANUMs and RNs were asked, "**If a position for a NUM becomes available, would you be interested in applying for a NUM's position? Why or why not?"** This question attempted to uncover concerns of staff and it raised the important question about succession planning. The results are shown in Table 5.2.

Table 5. 2. Interest in applying for the NUM position

	ANUMs (N=6)	**RNs (N=5)**
Yes	1	0
No	4	5
Undecided	1	

The categories that emerged about lack of interest in applying for the NUM position are shown in Figure 5.2.

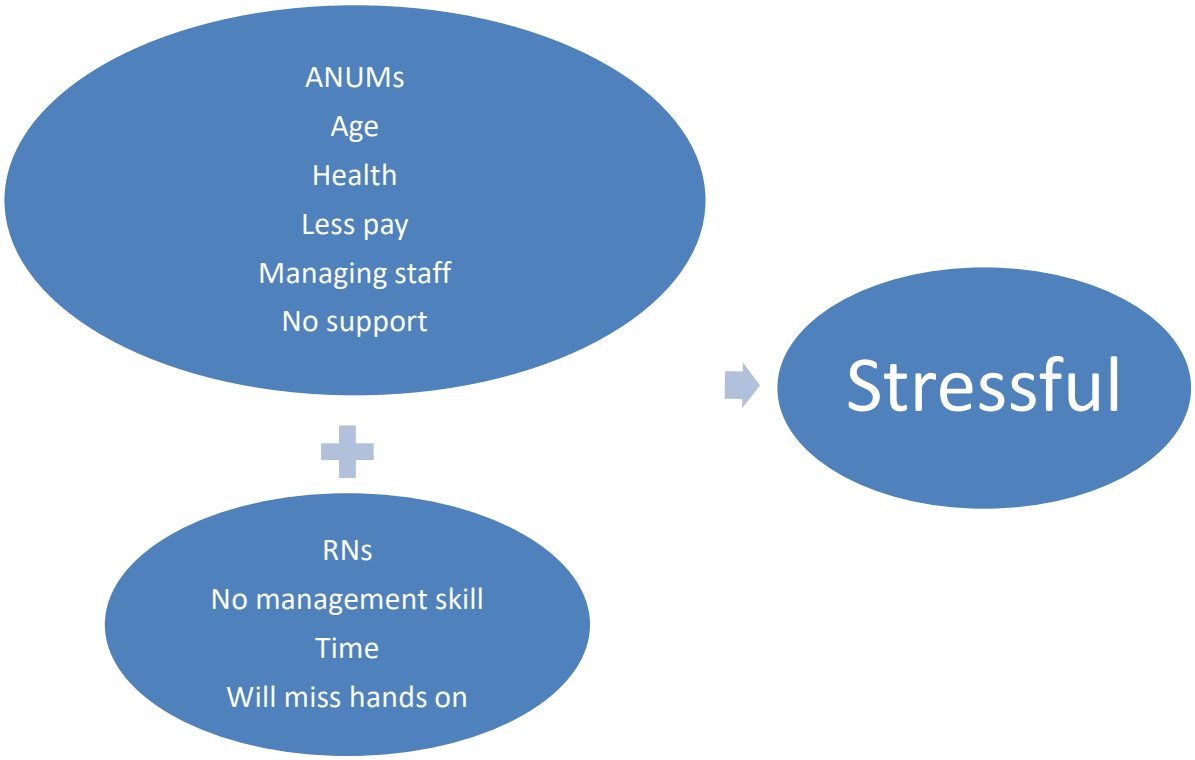

Figure 5. 2. Reason for no interest in applying for the NUM's position

As shown in Table 5.2 all RNs (five) said they were not interested in applying for the position while four ANUMs said they were not interested. Only one ANUM was interested in applying for the position while another ANUM was undecided.

As shown in Figure 5.2, the core category that emerged among all the participants was that the job was very stressful. They found that managing people was stressful. ANUM4 and RN1 and RN4 commented:

> "Myself personally, no. And I couldn't tell you personally 100 percent why, but it's not an aspiration of mine. I think that possibly the first thing that comes to mind is the managing of staff because it is very hard to deal with nursing staff who work below the

line. And I find that very frustrating. That is something that I don't want to deal with regularly." (ANUM4)

"Right now my answer is no. It mainly comes from, when I was in the medical ward, I was an ANUM then and I got the chance to act as a nurse unit manager. A lot of stressful factors were getting to me. I am not even thinking of doing that. It is very difficult like when dealing with different kinds of people. I should have the heart to do it. So I really did have a good experience at that time so I am enjoying where I am now. So it is no." (RN1)

"No. I did an ANUM role and I ended up on stress leave. I am not a manager. It's not in my natural personality. It distresses me and I don't do well at it. I just don't enjoy it." (RN4)

Another ANUM commented on the support NUMs received from management and their pay:

"I am qualified. I might or I might not. I don't know because I am leaving for an ANUM position. I see how I go there. I think it is frightening when you go to a NUM position and then you feel you don't have that support; I think the support from management is so important, you know, from the divisional directors, you know, they all need the support and if you don't have that interaction and emotional support, I think nobody wants to do that because it is a hard job. It is a headache job and the pay, she [NUM] gets paid less than the ANUM working on night duty or a theatre specialist nurse. They are not doing it for the pay; they are doing it because they have a passion to make a change for the ward. To make the ward better and to raise the profile of the ward. To make staff happier. I might go for it on a smaller scale but where I am going I don't know what is happening yet. So I [would] like to do my postgraduate course next year and [then] I will see. It is not an easy job but it is a challenge and it is rewarding as

well. If you see that you can make a difference, that you are making a change like less sick leave; staff are happier and morale is good, you feel you [have] made a difference." (ANUM2)

RN2 made a comment about losing clinical skills in addition to the stress experienced by NUMs:

"No. I think I will miss the hands on too much. I don't know if I [can] deal with the stress. I find that looking after 12 patients and staff that are here, I think I can manage it okay but the whole ward of 53 beds, I don't know. And I know that is sort of out of the ordinary but even 20 or 30, I don't think that I have the management skills to do that. Maybe I just don't have the confidence in myself. I have done an ANUM position on and off, I find that I am better at the bedside working with the patients. And I can still give staff some directions, bedside education, all of these things that could be rolled into a NUM's role but you end up having many more other things post [sic] upon you, and the reason that we became nurses is to be with the patients, and being with the families and the NUM's role take you away from that." (RN2)

Only one ANUM said they would be interested in applying for the role in the future and the preparation they were doing now.

"I think in the future I will be [a NUM]. I don't think, I am not ready yet. As I said I have done the diploma of management and I am working towards developing my leadership skills and in the future I will be interested." (ANUM6)

The ANUM who was undecided made the following comment:

"Yes and no. Yes because it might be good for my career. Money to me is not important any more. If I could create a ward where everybody want come to work,

> everybody could not wait to go to work. No, because dealing with human nature is very hard. Different culture within staff, in patients especially now people can say you're a racist, you're sexist. Moneywise I am not interested because as I have said I am financially secure and happy." (ANUM3)

While another ANUM commented they were happy to be just acting as a NUM:

> "I am not applying but I'm happy to step in for a short time period but to become a full-time NUM, I have no plans because it is a stressful job and I am already old. Maybe if I'm still young but I am now nearly to retirement." (ANUM5)

The results of this study showed that all RNs (N=5) and four ANUMs (N=6) were not interested, while only one ANUM was interested in applying for the NUM position in future and the other ANUM was undecided. The main and overwhelming reason cited was the NUM's role is stressful, especially with regard to managing staff. The RNs also perceived the role as very confronting. The results of this study concur with other studies. In the survey conducted by Queensland Health (2008), some clinical nurses acting as NUMs during the study said they were not interested in applying for permanent NUM positions. They mentioned being inadequately prepared for the role. Sherman (2005), in her study of nurses aged between 22 to 42 in Florida, found that these younger nurses viewed the nurse manager role as unattractive. Shirey et al. (2008) expressed concern that younger nurses perceive the role of nurse manager as undesirable and ask: "Why do you do this? Is it worth it?'(Shirey et al., 2008, p. 128). Recruitment of nurse leaders is further complicated by other career options for nursing advancement other than nursing management such as education, research, publishing and occupational nursing (Doria, 2015).

There is a need to promote succession planning in order to reduce the longstanding problems of preparing nurse managers for their role (Laframboise, 2011; McCallin &

Frankson, 2010; Titzer et al., 2013). Titzer et al. (2013) found that resource allocation for proactive, deliberate development of current and future leaders was lacking and systematic evaluation of succession planning was limited. Laframboise (2011) agreed with Titzer et al. (2013) that health care organisations and the nursing profession lagged behind the corporate sector in succession planning. Griffith (2012) also found that succession planning in most health care organisations appeared to be fragmented, uncoordinated and inconsistently implemented. Griffith also indicated that identifying potential leaders was a pervasive and persistent problem.

Duffield and Franks (2001) noted that in Australia, there was the lack of ability or desire to identify nurses with potential for the NUM position. They also commented on a lack of responsibility taken by senior nurse managers for succession planning and appropriate educational preparation. The study by Lord et al. (2013) in Western Australia revealed a similar finding where the participants stressed the need for current leaders to identify and prepare future leaders. Similarly, Brunero et al. (2009) conducted a study in South Eastern Sydney Illawarra Area Health Service and found there was no formal structure or process surrounding succession planning. There was a need to identify staff who could be trained to be effective leaders (Conners et al., 2007; Griffith, 2012; Kirby, 2010; Picker-Rotem et al., 2008; Titzer et al., 2013; Townsend et al., 2012). The nurse leaders must endeavour to identify individuals who have innate characteristics of good leaders that include drive, energy, determination, vision, self-discipline and flexibility and help them develop as good leaders (Conners et al., 2007). The nurse leader should be aware that the best clinician cannot be the best leader if they do not possess innate leadership traits (Conners et al., 2007). In this present study, one ANUM commented that management should take into consideration the ideas of staff when getting references for NUMs. This is reflected in a study done by Picker-Rotem et al. (2008) who took a different approach to identifying and creating a pool of

potential leaders. In their study, they used peer evaluation to identify and select new nurse leaders. Staff were asked to confidentially vote for a nurse who fitted the leadership profile presented to them. A result of their study cemented their assumption that leadership was more easily recognised by staff rather than by upper managers who do not come in direct contact with all staff members. Brunero et al. (2009) developed a model of succession planning at South Eastern Sydney Illawarra Area Health Service. The participants in their study were given an opportunity to relieve in a senior managerial or clinical nursing position for planned leave relief. In this model, the participants were able to gain insight regarding the different roles which helped them plan their career path. Scully (2014) also asserted a need for appropriate identification, support and development for future nurse leaders. Scully (2014) agreed with Conners et al. (2007) to avoid developing informal negative leaders who do not possess evidenced-based qualities of being a leader or display the loud and negative behaviours which have negative effects in the workplace.

Once the nurse leader has identified the right positive leader, then appropriate training can be provided (Conners et al., 2007; Kirby, 2010). Duffield (2005) also stated that it was important to provide the necessary resources to successfully transition into the NUM position and also the provision of ongoing staff development. Lin et al. (2005) suggested that the job requirements for the NUM should be systematically analysed to prepare a successful training program. In the study by Atsalos and Greenwood (2001) in Western Sydney, Australia, one of the themes was the need for the leaders to have leadership training to boost their confidence and motivation. Brown et al. (2013) also suggested that organisations need to invest in training and support suitable candidates for nurse managers. McCallin and Frankson (2010) recommended that since the nurse manager role is an organisational one, organisations should provide in-house management courses. Griffith (2012) proposed that succession planning must exist as a continuum and identify potential leaders as early as high school to

fill in the pipeline for emergent nurse leaders.

5.2.6. Section summary

This section explored how well prepared NUMs were for their role. The findings indicated that the NUMs were promoted because they have been earmarked by higher management. The findings also revealed that although the NUMs found the management training was helpful in giving them directions to manage, they found it difficult to apply the knowledge gained into their workplace. The inadequate preparation of NUMs for the position poses a problem in succession planning. The findings indicated that no RNs were interested in applying for the NUM position and only one ANUM was interested in applying to for the NUM position.

5.3. Aim 2: To identify the skills required for the role of a NUM

In order to address Aim 2, NUMs, ANUMs and RNs were asked to describe the NUM's role. The NUMs were asked **"How do you describe your role?"** And the ANUMs and RNs were asked **"How do you describe your NUM's role?"**

Similarities and differences in responses from NUMs, ANUMs and RNs are presented in Figure 5.3.

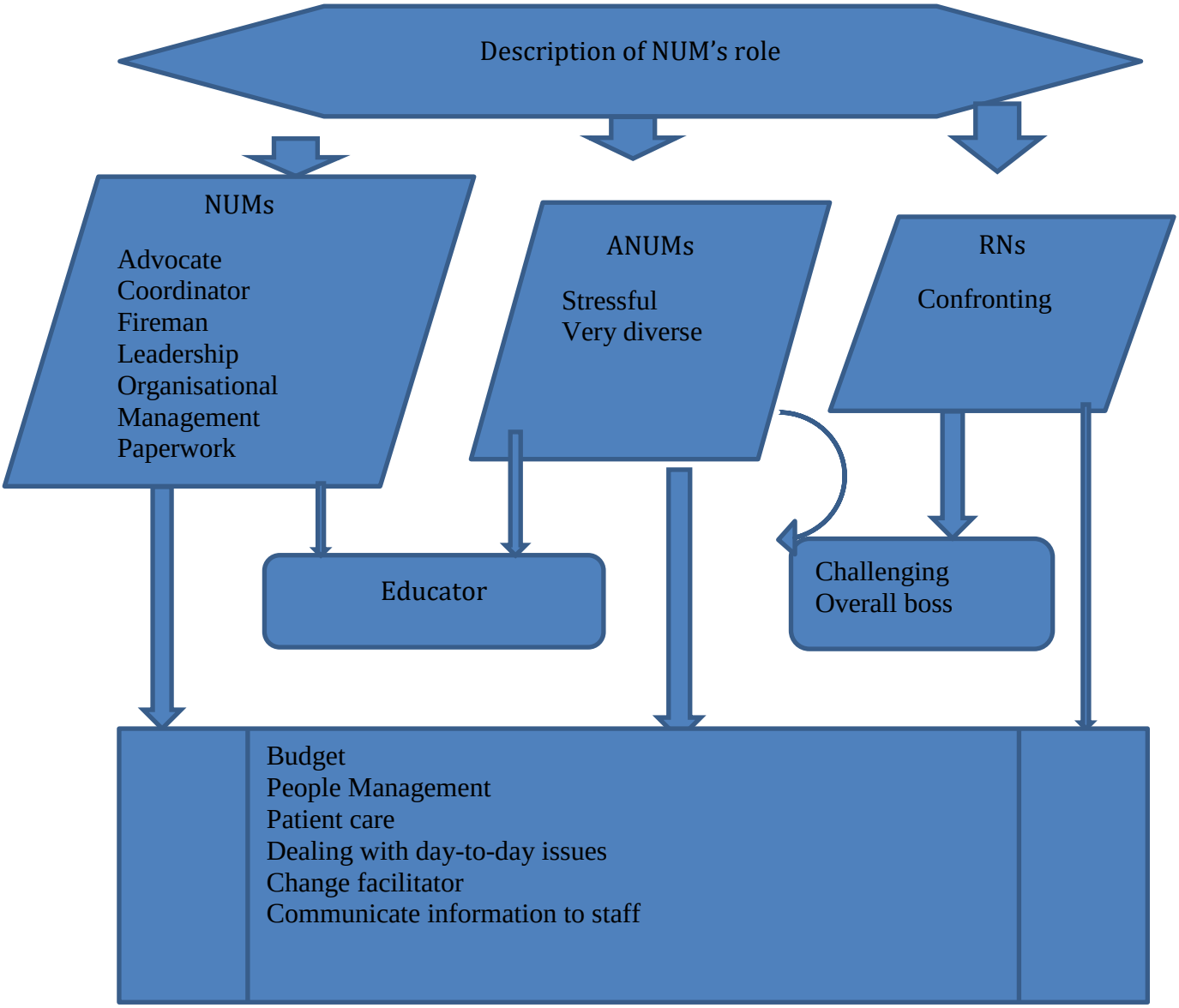

Figure 5. 3. Similarities and differences in response to description of NUM's role

The results in Figure 5.3 show that the description of the NUM's role varied among the groups. NUMs, ANUMs and RNs all agreed that the NUM's role involved budgeting, people management, patient care, dealing with day-to-day issues and change facilitation. NUMs actually in the role were more expansive in their responses than ANUMs and RNs.

The findings revealed three core categories, namely, roles and responsibilities of the NUM, leadership and management. The core categories, sub-categories and attached meaning units are presented in Table 5.3.

Table 5. 3. Core categories for description of NUMs' role, sub-categories and meaning units

Core category	Sub-category	Meaning unit
Roles and responsibilities of the NUM	Diverse	• Too many responsibilities • Stressful • Huge responsibility • Challenging • Confronting
Leadership	Change facilitator	• Resistance to change
	Educator	• Staff education
	Communication manager on the ward	• Conduit between higher management and ward staff
	Team leader	• Conflicts on the ward • Team building • Role model
Management	Human resources and staffing issues	• Supervision of staff • Managing staff sick leave and annual leave • Number of staff and skills mix • Staff rosters
	Finance	• Budget • Procurement of equipment
	Coordinator	• Dealing with day-to-day issues
	Administration	• Paperwork

5.3.1. Core category 1. Roles and responsibilities of the NUM

The findings revealed that the roles and responsibilities of the NUM were quite diverse. This is included as a sub-category and described as follows.

5.3.1.1. Sub-category. Diverse

The findings indicated that NUMs had "too many" responsibilities and a "huge overall" responsibility. NUMs described their roles as advocate, coordinator, fireman, leader, organisational manager, paperwork shuffler, budget manager, people manager, patient carer, day-to-day manager and change facilitator with big responsibilities. ANUMs and RNs

empathised with NUMs and felt that the NUM's role is challenging, confronting and stressful.

Typical responses from NUMs were:

> "Many, many different hats. You're a nurse, you're a manager, paperwork nurse, nurse on the floor. Huge. A big role, big responsibility. Not only are you responsible for 30 patients on the ward, you're also responsible for approximately 38 staff, not including PSAs (Patient Service Assistant) because they're under environmental, food services, allied health, and medical doctors so it is a big role." (NUM3)

> "It's quite dynamic though, the large majority of it is leadership. So you do have to lead a team of nurses but you also, in between higher management and obviously on the floor at the ground level." (NUM1)

Another NUM stated:

> "I joke sometimes to say it's [NUM's role] a bit like a fireman because I am often putting out fires…" (NUM5)

Some comments from ANUMs and RNs were:

> "It is a headache job." (ANUM2)

> "Very stressful job." (ANUM5)

> "Very diverse, particularly in this ward, very busy managing three wards so she needs to go visit the three wards in the morning…." (ANUM2)

> "Very confronting depending on what kind of people you deal with, whether they are staff nurses or patients, or even doctors or relatives." (RN1)

5.3.2. Core category 2. Leadership

The findings revealed NUMs as change facilitators, educators, communication managers on the ward and team leaders in their wards. These were included as sub-categories and they are described in the sections that follow.

5.3.2.1. Sub-category 1. Change facilitator

The findings indicated that NUMs had responsibility as change facilitators. NUMs were seen as responsible for communicating information to staff and allied health staff for any new changes to be released. Some staff might be resistant to change. The NUMs explained how communication enabled their staff to be involved in the change process and provided opportunities for senior management to gather input from staff.

Typical responses from NUMs were:

> "But the role also entails facilitating any changes throughout the network." (NUM 1)

> "Engaging allied health in processes that we are implementing like we are releasing time to care which is currently on the ward, getting them to have some input and so much more." (NUM 3)

> "So you do a lot of planning with all the stakeholders whenever there is a new program that needs to be released so you are really pivotal in that role." (NUM 1)

Some comments from ANUMs and RNs were:

> "If they have to do changes to improve the ward they are responsible for that and again not everybody is open to changes so is a big job for a NUM." (RN1)

> "Open communication with staff so whatever plans there are for the ward from upper management, he has to communicate everything to staff." (ANUM1)

5.3.2.2. Sub-category 2. Educator

The findings indicated that NUMs were responsible in facilitating education for staff. They needed to make sure staff were qualified and up-to-date with all training and competencies.

Typical responses were:

> "Also facilitating education for staff, so for staff I work very closely with the educators … to address any education that my staff particularly need." (NUM1)

> "Make sure that all staff are qualified and are keeping up-to-date with all the competencies and training, she [the NUM] organises meetings and discussions." (RN4)

5.3.2.3. Sub-category 3. Communication manager on the ward

The findings indicated that NUMs were charged with communicating information from top management. NUMs act as a conduit between staff on the ward and higher management. The ANUMs and RNs viewed open communication with staff as very important in enabling them to participate in change processes and for their views to be heard. They felt that staff are more willing to accept and be part of the changes if they are well informed.

Typical responses were:

> "So things like to support us in the changes, and as well they deliver information to us from the top, so they are the conduit to bring the information from up down [sic] to us. And to bring our concerns up [sic] as well." (RN2)

> "Open communication with staff so whatever plans there are for the ward from upper management they have to communicate everything to staff, as well as the patient's development, as well what is the plan for the patient, they have to communicate everything." (ANUM1)

5.3.2.4. Sub-category 4. Team Leader

The findings indicated that leading the team was another role that was important for NUMs as well as staff education and development for the team to provide optimum patient care. NUMs were responsible in developing team work among staff to be able to do an exemplary job. NUMs were seen as responsible in making sure that conflicts and other problems were resolved as soon as possible to ensure smooth running of the ward. As leaders, NUMs were thought to have responsibility to look after the welfare of their staff, patients and their families and to support staff when there were issues. NUMs were expected to be role models to staff. As well, they were seen as needing to motivate staff and to praise staff as appropriate. Further, NUMs also should be approachable and be able to delegate work to other staff.

Typical responses were:

> "[It] is about leading a team and developing the team to be able to do a great job." (NUM1)

> "I think it is a leadership role …you need to be approachable and be able to delegate and manage difficult situations." (NUM2)

> "Maintain the flow of the… [ward name omitted] smoothly facilitate anything if there is trouble and it is resolved at the end of the day and as early as possible." (ANUM5)

> "To work with the surgeons and the other staff members not just the nurses to ensure that you work as a team." (ANUM6)

> "She's definitely a motivator and so as challenges are identified by a particularly challenging family, then she'll be there to help and support us. When issues are identified she deals with them but she's also there to praise staff." (RN2)

"They need to look after their staff, the patients and families." (RN3)

5.3.3. Core category 3. Management

The findings revealed human resources and staffing issues, finance, coordination and administration as components of management. These were included as sub-categories and they are described in the sections that follow.

5.3.3.1. Sub-category 1. Human resources and staffing issues

The findings indicated that respondents considered NUMs were responsible for many aspects of good practice including supervision of staff. As well, NUMs were seen as responsible in overseeing the running of the whole ward and ensuring that everything was done properly. NUMs also, it was stated, had to make sure that staff sick leave and annual leave applications were managed properly to ensure that patient-nurse ratios and skill mixes were maintained. NUMs were also considered responsible for staff roster. The NUM's role in people management was also given emphasis by the ANUMs and RNs. Staffing was seen as very important in ensuring complete teams were in place at all times. The support of the NUM for staff was also cited strongly.

Typical responses were:

"You need to be aware of everything that is happening in the unit." (NUM2)

"Keeping an eye on sick leave and annual leave." (NUM1 and NUM3)

"Ensure we have complete team, we have reliever as much as we can." (ANUM5)

"Staffing issues, sick leave, staff do not turn up for work." (G2, P2, W3, ANUM2, ANUM4, ANUM6)

"Does the rosters, makes sure that all staff are qualified." (RN4)

5.3.3.2. Sub-category 2. Finance

The findings indicated that NUMs were responsible for the ward's budget. They needed to keep an eye on sick leave applications in order not to blow the budget with regards to staffing costs. As well, their responsibility for determining equipment requirements and the procurement of equipment was mentioned.

Typical responses were:

> "Making sure that the equipment is here and that the patients have good outcomes, liaising with the doctors and working out what new equipment needs to be purchased." (NUM 5)

> "To ensure the ward is running and keeping an eye on the budget." (NUM1)

> "Make sure that we all get the equipment and make sure the…. [ward withheld] is running smoothly." (RN5)

5.3.3.3. Sub-category 3. Coordinator

The findings indicated that NUMs were responsible in dealing with day-to-day issues, which encompass roles on the ward such as patient care and family issues, liaising with doctors and allied health staff, determining equipment requirements, admission and discharge planning, paperwork and ward rounds. Many of these matters were identified in other responses from participants in this project. In dealing with day-to-day issues, NUMs described their role in the following ways:

> "You need to be aware of everything that is happening in the unit." (NUM2)

> "Also, apart from dealing with patients we obviously focus on patient care that also incorporates taking care of any other issues that come about, for example, social, family issues, we do a lot of troubleshooting on the floor." (NUM1)

"Being a patient and staff advocate, and just dealing with day-to-day issues on the ward." (NUM3)

"Making sure that the equipment is here and that the patients have a good outcome, liaising with the doctors and working out what new equipment needs to be purchased, but overall it's about people management I believe." (NUM5)

"Obviously patient care being a health service." (NUM4)

Similarly, both ANUMs and RNs placed emphasis on people management and dealing with day-to-day issues as very important in their NUM's role. In dealing with day-to-day issues, both the ANUMs and RNs agreed that the NUM is responsible for the smooth running of the ward. They described their NUM's role as:

"Running of day-to-day things and the entire behind-the-scenes running of the clinic." (ANUM4)

"Maintain the flow of the ward smoothly, facilitate anything if there is trouble and it is resolved at the end of the day and as early as possible." (ANUM5)

"To work with the surgeons and the other staff members not just the nurses to ensure that you work as a team." (ANUM6)

"Liaise with the allied health team as well." (RN3)

"To oversee the smooth running of the ward." (ANUM6)

"They try to pull the ward together." (RN1)

"Overseeing the running of the whole ward." (RN3 & RN4))

"Particularly in this unit, it is very busy managing three wards so she needs to go visit the three wards in the morning, debrief with us to see where we are up to." (ANUM2)

5.3.3.4. Sub-category 4. Administration

The findings indicated that NUMs had to deal with other administrative tasks and NUMs indicated that they dealt with a lot of paperwork. NUM1 commented "There is also all those paperworks [sic] all that behind-the-scenes stuff" while NUM 3 described herself as a "paperwork nurse".

To address Aim 2, NUMs, ANUMs and RNs were asked to describe the NUM's role to gain insight into their role from three different perspectives. The results in Figure 5.3 showed that the perception of the NUM's role varied among the groups. The roles described by the ANUMs and RNs closely matched those of the NUMs. However, the latter identified more roles. NUMs, ANUMs and RNs placed emphasis on people management and dealing with day-to-day issues as very important in the NUM's role. In dealing with day-to-day issues, both the ANUMs and RNs agreed that the NUM was responsible for the smooth running of the ward. A greater emphasis was placed by ANUMs and RNs on the role of the NUM as change facilitator and communicator of information from upper management. NUMS, ANUMs and RNs viewed open communication to staff as very important for participation in change and in gaining input from staff. They felt staff were more willing to accept and be part of change if they were well informed.

The results of this study reflect similar findings to those of Skytt et al. (2008). They explored the front-line manager's role from four perspectives, that is, from the viewpoint of front-line managers, registered nurses, assistant nurses and heads of departments. Their study also found that perceptions of the front-line manager's role differed for each group. As in the current study, Skytt et al. reported that front-line managers and RNs perceived that NUM's

responsibility for staff and day-to-day work were important. Similarly, providing information to keep staff well informed and to give them opportunities to participate was emphasised in both studies.

The expanding roles of the NUMs as perceived by NUMs, ANUMs and RNs in the current study are consistent with other studies. There is clear evidence from the literature that the roles of NUMs have significantly changed with broader responsibilities (Bonner & McLaughlin, 2014; Cipriano, 2011; Clark-Burg, 2013; DeCampli et al., 2010; Hill, 2004; Lee & Cummings, 2008; McCallin & Frankson, 2010; Meyer et al., 2011; Shirey et al., 2008). NUMs are responsible for effective, direct patient care, and for providing management and leadership of staff (Cipriano, 2011; McCallin & Frankson, 2010) in order to improve quality nursing care and patient outcomes (Clark-Burg, 2013; DeCampli et al., 2010; Lee & Cummings, 2008; Stewart, 2013). They are also responsible for more administrative roles such as writing reports, preparing the budget for the ward and allocating rosters (DeCampli et al., 2010; McCallin & Frankson, 2010; Meyer et al., 2011; Stewart, 2013). NUMs have the responsibility for the education of staff to promote professional development and personal advancement (Cipriano, 2011; Lee & Cummings, 2008; Stewart, 2013). They must ensure that the work environment is safe, has adequate facilities and equipment and adheres to quality assurance requirements (DeCampli et al., 2010; Gallo, 2007; Lee & Cummings, 2008; McCallin & Frankson, 2010; Stewart, 2013).

Queensland Health (2008) conducted a survey of the role of NUMs in Queensland and reported their role had increased considerably. The survey revealed that their role involves leadership responsibilities in the areas of patient flow, standards of care, being a driver of a model of care, patient and family advocacy, and discharge planning. NUMs are responsible for general management of staff, budgeting, maintenance of equipment and communicating with other stakeholders (Queensland Government, 2008). They also maintain clinical

governance such as OH&S, risk management and reporting, investigation of complaints and incidents and accreditation (Queensland Government, 2008). Their role also involves leading the team, being a role model, and managing professional development of staff. Huston (2008) and McCallin and Frankson (2010) also found the role of NUMs had become broader, more complex and required multiple skills, and that workloads had increased (DeCampli et al., 2010; Lee & Cummings, 2008; Stewart, 2013) with the breadth of role change (Surakka, 2008). These findings concur with Bonner and McLaughlin (2014). They reported that nurse managers' roles are complex and difficult to define and may vary depending on the type of ward that is managed. They also found that the participants were unclear about their role priority whether managerial or clinical. In the current study conducted in 2017, the story of the complexity of the expectations of the NUM's role repeats stories told in earlier research studies.

The expanding role of NUMs can be a potential problem in their recruitment, retention and succession planning. Although the roles described by ANUMs and RNs closely matched those given by NUMs, the NUMs identified even greater complexity in their roles. The results summarised graphically in Figure 5.3 reveal that ANUMs and RNs identified only about half of the roles of the NUM, as opposed to the number of tasks identified by NUMs. This result may indicate that when NUMs assumed the role, they were not aware of the expanded role required of them. The result of this present study may also indicate the lack of understanding of the NUM's role by the ANUMs and RNS. This study's finding supports that of Feather and Ebright (2013). They found there was a disconnect between what RNs perceived the nurse managers doing in their role and how it related to their daily work. This is reflected in the study by Lord et al. (2013) where there was an extensive discussion by participants about the lack of role clarity in their workplace, and how this in turn impeded effective decision-making and effective leadership. Studies have also shown that NUMs often

assume expanded roles and responsibilities without adequate resources, education or support (Mathena, 2002). Without adequate training and preparation, the task could be overwhelming (Arnold & Nelson, 2004; Bondas, 2006; Douglas, 2008; Heller et al., 2003; McCallin & Frankson, 2010; Queensland Government, 2008; Townsend et al., 2012). Shirey et al.'s study (2008) also found that nurse managers felt overwhelmed by the number of tasks not being done due to the complexities of the nurse manager's role. As noted earlier, the results of this study showed that only one ANUM considered applying for a NUM position.

Further, to address Aim 2**,** the three groups of participants were asked **"What do you think are necessary training and skills before assuming the role?"** The NUMs, ANUMs and RNs were asked this question to gather their perceptions of the training and skills needed to prepare for the position of a NUM. The responses are summarised in Table 5.4.

Table 5. 4. Necessary training and skills before assuming the NUM's role

NUMs	ANUMs	RNs
Budget	Experience	Budget
Certificate of Education	Being in charge regularly	Business qualifications
Clinical training	Communication	Clinical experience
Communication	Financial skills	Difficult conversations
Computer skills	Health and safety	Management
Difficult conversations	Management training or education	Mentoring
Diploma of Management	Nursing degree	Nursing background
Experience	Psychosocial skills	People management
Leadership and management skills	Public relations	
Managing sick leave		
Roster on		
No particular training		

All participants placed emphasis on clinical knowledge and on having a nursing background. NUM1, for example, described the importance of clinical knowledge for positive patient outcomes:

> "Clinically, the training I got was important. So after my grad year I moved to …[ward deleted] so I did learn a lot of things there about clinically taking care of acute patients and [this] really helped with my clinical knowledge and skills. I moved to …ward to become the ANUM. My experience there as an ANUM has helped me develop lots of leadership skills out on the floor because it's a good combination of leading a shift or leading a team of nurses. I have to perform clinically as well as provide education to staff, and mentoring and supervision and preceptoring. [sic]" (NUM1)

ANUMs and RNs also agreed that clinical knowledge and having a nursing background were important before assuming the role of a NUM. RN2, for example, described a scenario and the potential problem of having a NUM without a nursing background. RN2 explained how a

NUM without a nursing background might want to get rid of an alcohol based disinfectant, used for hand hygiene to minimise infection, because of its high cost.

> "Probably something like qualifications along with the nursing. I know that they have spoken before about a NUM being purely [a] business [role] then you would lose the focus. I have heard of wards, you know, they have look[ed] at their budget, for example, and it said debug, and all these things cost too much, so we just get rid of it because they do not understand what debug is. You know, get rid of this stuff, it is not important. You need to have a nursing background first and then some sort of business [background] because it has fallen on the NUMs now. It used to be separate. Budget used stay out [sic] but it is there now…" (RN2)

Similarly, RN3 also thought that a NUM should be a nurse first in order to experience firsthand how it feels to be a nurse:

> "I think you need to be a nurse on the floor as well before you become a nurse manager, because you could lose sight of what the nurses on the floor are doing and you are the boss. You need to do assertive training perhaps, dealing with difficult people and you need to have good clinical skills as well." (RN3)

ANUMs and RNs emphasised the importance of having worked in and developed knowledge about the ward before becoming a NUM on a particular ward:

> "You need to be a nurse; I think you need to have done or worked in a particular area for some time so that you know the area, you have experience like in ICU or theatre. You should have worked in the area first, and planning, management, education in the area would be very beneficial as well and probably an experience as an ANUM for some length of time before working up to be a NUM." (ANUM6)

> "They have to have good experience like scrubs scout so that they will know how to fix a problem in the theatre, and how to deal with people. They should have people skills."(RN5)

By contrast, RN1 thought that training to be a NUM should start and build from the beginning of a NUM's career: the RN.

> "I think you can get the training and skills when you start working in the hospital setting. …So I think your training and skills start from the very beginning and you just have to hold on to the knowledge that you get, that you developed and then just continually improve on it." (RN1)

For NUM5 it was a combination of clinical knowledge and leadership traits:

> "I think it's all about a mix between having a good clinical knowledge and also having the traits to be a leader." (NUM5).

The participants felt that leadership and management skills were necessary before NUMs assumed the role, especially in relation to people skills. For example, NUM2 and NUM3 spoke about the importance of communication. NUM2 also spoke about the importance of developing leadership and management knowledge from the level of RN and build throughout their career:

> "Definitely there was something lacking but there is more support now for the new NUMs but definitely having knowledge of leadership skills and management skills, having difficult conversations, managing sick leave, all of those short courses that are available now I think something that you need to do even as a CNS (Clinical Nurse Specialist) level or RN level so you are building it up into ANUM and NUM level because we do tend to end up with people in the position that they do not necessarily

want to end up in; but I think anyone who, ideally all those leaders on the ward need to have that education about simple things like managing simple conversations, because it is something that does not come naturally to some people, and communication as well." (NUM2)

NUM3 reiterated the importance of people skills and technical training for "roster on" which is a program in managing staff rosters and vacancies.

"More people skills like HR, having conversations with staff. I think a lot of training on roster on, vacancies like establishment vacancies." (NUM3)

NUM3 commented on the need for knowledge about budgeting and effective use of technology to help NUMs perform the role:

"Budget, because I know a lot of different divisions have budget meetings and I do a budget variance which I email each month. But some other areas do not do that within our division so I think budget is the most important." (NUM3)

"And also computer skills like for graphs and things like that, because we are expected to put up all these graphs on our drawing board and I don't have a clue about how to do it." (NUM3)

RN4 and RN2 also stressed the need for NUMs to have management skills before assuming the role:

"As well as being a nurse, you also need to have training in management and possibly even with budgeting because they need to control the budget and order supplies." (RN4)

> "Probably something on budgets, something on dealing with challenging staff behaviours and patient behaviours. Having those difficult conversations so I think some training in that because it is very hard and I think you get stuck a lot with that without the training." (RN2)

As well, three ANUMs commented on the importance of NUMs having the experience of leading a ward before assuming the NUM role:

> "You should at least be involved in being in charge of the ward regularly so you'd be able to feel how it feels to be in charge and lead the ward…. A positive for you to be able to understand how you can cope with your position." (ANUM1)

> "Even if you don't do the role and even if the NUM does not tell you to do it you have to have the initiative to do it as practice. When the time comes that you have to do his job, this is easy." (ANUM5)

> "….. I think there needs to be regular training for NUMs, they need to be able to have training, meet and mingle with other NUMs to share their experiences, to learn from each other and they need to have support from the divisional director of nursing to see how they are going. So there is a lot of pressure so I think they need a lot of support but they also need training to prepare for the role." (ANUM2)

NUM4 and NUM5 stated there was no training that could help prepare the NUM for the complex role. For example, NUM5 commented:

> "I actually believe that leadership is innate. I don't believe it's taught. I believe you teach management but you don't teach leadership." (NUM5)

NUM4 thought that the courses offered were not practical:

> “I don't think a lot of courses help. They are not very practical. I think sometimes you just have to do it.” (NUM4)

In contrast to many other comments ANUM4 agreed with NUM4, that no other training is required except having a nursing degree:

> “You need to have your nursing degree and I personally think that there is no other training required, just experience.” (ANUM4)

ANUM3 felt unsure as to whether the skills gained were from life experience and unclear about the value of training for the role:

> “Management skills but you also needs financial skills, public relations skills, communication skills, health and safety skills, psychosocial skills and to be able to give people support as well and understanding [about] how to change them. I don't know if you get that from life experience first and also work experience but training where you learn everything. And yes, through the years you go through training like management of difficult people. But I think a lot comes from experience and this is where you become successful or unsuccessful. Success in the role and preparing staff is very important.” (ANUM3)

NUM1 commented that while the knowledge gained from doing the Certificate of Education and Diploma of Management had given them a formal process for educating and managing people, NUM1 commented that no training would ever prepare the NUM for the role. As NUM1 commented:

> “I don't think it ever prepares you, no matter what kind of training but I think the training that I had has been useful. But in terms of thinking more as a manager, it really helped when I did the Diploma of Management because they went through a lot of

strategies on how to manage people or a different kind of situation, so that was really helpful. And in doing the Certificate of Education also beneficial because it went through like formal processes of how to educate people." (NUM1)

The results showed that all three groups of participants agreed that clinical knowledge and nursing background were important before assuming the NUM role. In particular and surprisingly, ANUMs and RNs emphasised the importance of having worked in and having knowledge about the particular ward before becoming a NUM on that particular ward. They were speaking primarily from their current ward roles. Clinical experience and knowledge of the ward were further emphasised by RNs when they were asked about what qualities a NUM should have to succeed in the role. NUM1 described the importance of having clinical knowledge in dealing with an issue that led to a positive outcome for the patient and safety for both the patient and staff. While Yukl (2010) supports the recruitment of non-medical managers, Llewwellyn (2001) insists that a medical background is important for managers as they are able then to comment on clinical issues. Kleinman (2003) also agrees that since nurse managers provide care and at the same time manage the ward, the nurse manager must be equally prepared in both management and clinical aspects. Jarnigan White (2015) found in her study that nurse managers sought the nurse manager role because they had the clinical skills and they knew staff, or felt they knew what was needed for the ward. The participants in Jarnigan White's study commented that having the clinical skills helped them to understand staff and gain their respect. These participants also commented that it was an advantage to have worked in the same unit that they were managing, as they already knew the processes on the ward.

However, it should be noted that many authors have argued that clinical skills and expertise are not enough or do not equate with being good leaders (Arnold & Nelson, 2004; Heller et al., 2003; McCallin & Frankson, 2010; Oroviogoicoechea, 1996; Sanders et al.,

1996; Tilley & Tilley, 1999). The results of the present study also found that leadership and management skills, especially managing staff and budgeting, are necessary skills before assuming the role. These skills were further emphasised when the three groups of participants were asked what they think are the greatest challenges in being a NUM. The results of the study showed that NUMs, ANUMs and RNs all agreed on people management as the greatest challenge in being a NUM. These groups were then asked what qualities a NUM should have to succeed in the role. Again the NUMs, ANUMs and RNs placed emphasis on good management, leadership and people skills as the most desired qualities the NUM should have in order to succeed in the role. Interestingly, the leadership/management dichotomy debate was raised with comments about the extent to which training could impact on management but perhaps less so on leadership, which was considered more the product of personal qualities.

These results are consistent with other studies. In order for the NUM to survive and to function efficiently, they should have the skills of both a manager and a leader. The NUM is the head and manager of the ward and is also a leader of the health care staff on the ward (Sellgren et al., 2008), and so being both a leader and a manager, the NUM is involved in establishing direction, aligning resources and motivating people (Kotterman, 2006). As discussed in Chapter 1, the leadership role of the NUM includes effectively delivering direct patient care, managing patient flow and standards of care, and managing and leading staff (Clark-Burg, 2013; Lee & Cummings, 2008; McCallin & Frankson, 2010; Queensland Government, 2008). This includes also being a role model for staff, a driver of a model of care, a patient and family advocate as well as being responsible for the motivation of staff to achieve a common goal (Manfredi, 1996; Queensland Government, 2008). NUMs are responsible in leading the team, ensuring education of staff by promoting professional development and personal advancement and for introducing innovations (Lee & Cummings,

2008; Queensland Government, 2008). In executing the managerial role, the NUM is responsible for more administrative roles such as writing reports, preparing the budget for the ward and formulating rosters (McCallin & Frankson, 2010; Meyer et al., 2011; Queensland Government, 2008). They must ensure they maintain clinical governance such as OH&S, making sure the work environment is safe, has adequate facilities and equipment, that equipment is properly maintained, and they must adhere to quality assurance compliance in risk management and reporting, and investigation of complaints and accreditation (Gallo, 2007; Lee & Cummings, 2008; McCallin & Frankson, 2010; Queensland Government, 2008).

The ANUMs and RNs were asked **"Do you think that management education or training is necessary before assuming the role?**" The results are shown in Table 5.5.

Table 5. 5. Management education or training before assuming the role

	ANUMs (N=6)	**RNs (N=5)**
Yes	3	5
No	3	0

As shown in Table 5.5, all the RNs (N=5) thought that management education or training was necessary before NUMs assumed the role. The ANUMs were divided in their opinions where half of them (N=3) said "yes" and the other half said "no" or "not necessarily". ANUMs who agreed, believed that management education or training would help the NUMs connect theory and practice. Those ANUMs who disagreed thought that experience was enough before assuming the role.

> "Yes, definitely. But how you are going to do that, I do not know." (ANUM3)

> "Yes, it is because theory will help with your experience. With the theory you can apply it with your actual job." (ANUM5)

> "I think it definitely helps. I think if you are an experienced ANUM you may not need it but I think it is very beneficial." (ANUM6)

ANUM4 thought that experience is enough to be able to assume the role:

> "No, I don't. I think that experience is enough to get you through. And that certain things that you would not do as an ANUM, you can learn on the job to being a NUM." (ANUM4)

While ANUM1 and ANUM2 thought that prior education and training was not necessary, they thought it could be an advantage:

> "Not necessarily but a plus factor if you have that one, especially if you are a NUM because you'd be able to do your role, not ideally but realistically, if you are able to do the management and educational training but not necessarily, you don't need to be doing these before you're able to assume the role. But it really helps a lot though." (ANUM1)

> "Not necessarily, some of them. Sometimes they need leadership skills. It is necessary but while in the role they can still be doing that. If you are going for a NUM job and if they say you have not done your management qualification but they have that ability already, so while in that role they can go for that training. They need to be flexible but I think management should support that." (ANUM2)

All the RNs thought that management education or training was necessary as it connects theory and practice. RN1, for example, described how their management education had helped them to perform the role of an in-charge nurse:

> "I think so. When I was back home I did a Masters in Management and Supervision and Administration. And when I came to Australia after a year, I started working as an in-

charge nurse. And I think what I've learned from the Masters back home helped me. It's very important that you know how to manage your people, not only the ward itself, but at the same time you've got to have the confidence managing these people. If you know, you yourself know that I think I know what I'm doing and I know what I am talking about, so it does help. So it is very important that they know how to supervise people and usually what we do now, we've got to look after junior nurses, graduates and from there you know that you can basically tell yourself yes, I can actually say that look I am able to teach people and be able to manage because it's very stressful to be on the floor and at the same time managing the ward. So I think it is very important, they go hand in hand, the knowledge in management and your clinical skills or hands on training." (RN1)

Supporting management education, RN3, RN4 and RN5 all commented on the value of being able to apply theory to practice:

"Yes I do. Because you need to cover a whole spectrum of ideas and you need to apply them. So you need the extra training I believe for the theoretical part." (RN3)

"I think it would be extremely helpful. I think it will teach you how to manage and deal with people, how to deal with problems and cope with them, and I think they give you the skills to do the role."(RN4)

"Yes I think so. It is really necessary so they have a background on about how to fix the problem, how to deal with people." (RN5)

RN2 commented that management education or training should be undertaken as soon as possible after assuming the role, if not taken before assuming the role:

> "If it is not before then it should be soon after they start the role. Because it is putting all those pieces together and perhaps makes you realise that you are the only one, so you have like a mentoring role that you can go to someone else who is doing that and [ask] how did you deal with this or what works for you and then they find their own way of doing things too." (RN2)

The ANUMs and RNs were asked if management education or training is necessary before assuming the NUM's role. The results in Table 5.5 show that all RNs (N=5) thought that management education or training is necessary before assuming the role while ANUMs were divided in their opinion. Half of the ANUMs (N=3) said "yes" and the other half said "no" or "not necessarily". ANUMs and RNs, who agreed that management training was necessary before assuming the role, thought that management training connected theory and practice. On the other hand, ANUMs thought that experience was enough and did not consider management education necessary before assuming the role. NUMs were asked: **"Did you have any management education or training before assuming the role?"** and: **"How did this education assist you in your performance and the performance of your staff?**" The results showed that two NUMs had management training before assuming the role and two NUMs undertook management training after assuming the role. One NUM indicated they had completed several courses over the years but no management courses. As discussed in the previous section, some NUMs indicated that management training was a tool in giving them direction to manage. One NUM who had undertaken management training after assuming the role indicated there was not a great deal she learned from the Diploma of Management to apply to the workplace. The results showed NUMs believed that time and experience helped them improve their skills as managers. This study finding is in agreement with Kleinman (2003), that many managers developed their skills on the job. It is interesting to note that RNs in the current study were mostly in favour of education and training for

NUMs. As noted earlier, in terms of number of years the RNs had been working in their role, the experience of the RNs in the current study varied from 13 years to 38 years and two of the RNs had worked as ANUMs before. Perhaps they were most familiar with the ongoing professionalisation of nursing. Another explanation could be that they had been acting as in-charge nurses, coupled with the fact that the two RNs were formerly ANUMs, and thus they felt the necessity for leadership/management training.

Another interesting comment from the participants is the importance of having leadership training at RN level and building the workforce from a lower level. This finding concurs with earlier suggestions from other nurse leaders that leadership training should be undertaken at undergraduate level (Heller et al., 2003; Mrayyan, 2004; Shaffer, 2003). They asserted that leadership and management skills are necessary for all nurses since they need to exercise leadership when dealing with patients and their families, doctors and other staff. This is reflected in Johansson et al.'s (2010) findings. Registered nurses in their study described how they supported colleagues and other health professionals, acted as nursing coordinators, took initiatives to carry out work-related tasks, and solved daily problems and issues without involving the first-line nurse manager. Curtis, De Vries and Sheerin (2011) agreed with earlier suggestions from nurse leaders and also suggested that leadership training should begin at the earliest stages of nursing education and throughout their education. This is further supported by Galuska (2012) who indicated that since leadership is a fundamental component of nursing practice, nurses at every level are expected to demonstrate leadership skills.

However, Heller et al. (2003) and Mrayyan (2004) found that new graduates did not always have the leadership and management skills to succeed as nurse managers and were not sufficiently prepared in their nursing undergraduate education. Shaffer (2003) also agreed that nursing students graduating from the associate degree or Bachelor of Science programs

have only completed one or two courses on leadership. Also, a more recent study by Curtis, De Vries and Sheerin (2011) found that although leadership is taught within the curricula in the undergraduate degrees in these institutions, much of the content is on how the students transition to nursing rather than training them to be future leaders in health care organisations.

The issue of preparation of nurses for leadership is clearly fraught as the findings of these studies and of the current study indicate. It is not surprising that questions around the value of training and the timing and content of training persist within a profession along with others in related health professions, which continue to carry the taint of hierarchy.

In order to assess the current training needs of existing NUMs, participants in the study were asked: **"Currently, are there any education or training or skill development programs that you need to improve your performance?"** The following needs emerged:

- Coaching
- Computer skills/ Technical training
- Difficult conversations
- Managing absenteeism
- Performance management
- No particular training.

The majority of NUMs said they needed more training on people management which included difficult conversations, managing absenteeism and performance management. They also spoke about being open to improvement:

> "About difficult conversations. I think there are some people that are great at it but there is always room to improve. I've got room to improve". (NUM5)

> “I would like to do a course around managing absenteeism, to be more aware of what our rights are as managers. Just brushing up on that I think and that's probably the main one.” (NUM2)

> “I am always open to learning as I am not perfect.” (NUM1)

NUM3 and NUM1 also wanted more technical training:

> “Computer skills, because I do not have many, difficult conversations may be performance management if ever I have to get there, but staff are very open to me like we have a staff [member] on personal leave and they injured themselves at home and they say "look we can come back but do a six hour shift. Can you do that? And I say ‘yes’, and you can have two hours on personal leave". And some staff might need to decrease the number of hours temporarily because of some reasons and I spoke to the divisional director, so yes, just being flexible.” (NUM3)

> “…probably I could benefit from I guess not so much on leadership, but more on the technical side of things so apart from budgeting more on that detailed kind of stuff I could learn a bit more about. I'm looking outside of the ward now and more from a network perspective....” (NUM1)

NUM4 commented there was no particular training and other courses that were not management courses that could be useful in developing the NUM. NUM4 also commented on the accessibility of technology like YouTube in assisting NUMs to explore and find information:

> “I think we all are constantly improving on our performance. As to what educational training would be useful, I have already done numerous courses in staff development that I thought would be helpful which has proven to be very helpful which did not

necessarily tag with management courses. So things like coaching was one thing I found very useful and learning how to engage people, and to actually help people be their best and to bring out the best in people, and help them to move past what they see as obstacles and help them to realise their dreams, ambitions and true potential. That is not a management course. That has nothing to do with management. And yet there are snippets of that particular course that come through. And they come through in leadership courses, you might do a little bit of resilience building and those sort of things. And some of the leadership courses that I have done, they always feature very strongly because of the stress levels. But I don't think that there is any particular course, and everyday can bring you new challenges that make you reassess the way you do things. And I think the Internet is very good these days to be able to give assistance and my favourite thing is I jump on YouTube because I like the visual side of things. There are quite a few good videos on YouTube that actually help you and if you can pinpoint specifically what you want to explore further, YouTube can give you very good advice." (NUM4)

The results revealed that NUMs needed further training in leadership and management which included coaching, difficult conversations, managing absenteeism and performance management. Computer skills and technical training were also mentioned for further training. NUM4 commented there was no particular training and that other courses were not management focused but could be useful in developing NUMs. This finding may indicate that NUMs assumed the role without adequate preparation for these duties.

NUMs were asked: **"What would your advice be for new or aspiring NUMs?"** The question included perceptions of how aspiring NUMs could be better prepared for the role. Most of the NUMs suggested that aspiring NUMs should do their leadership and

management training before assuming the role and the importance of buddying up with a NUM in order to have a true perspective of what NUMs actually do:

> "To get as much education prior to actually landing the role. So if they know that they want to become a NUM in the future; I think it is important to prepare so to do all the education as much as possible that you need before you actually land the role. When you actually land the role and when you start doing all the necessary courses it gets harder and it will add to your stress. But if you can develop those skills and the knowledge beforehand it will help a lot with the role rather than doing it all at once, because coming on onto the NUM role there are so many things that you have to learn, even if you've done or you think you have done all these kinds of courses in the lead up, it is a different ball game when you actually do the role." (NUM1)

NUM2 was also in agreement about enrolling in management courses beforehand, and also the value of buddying up with a NUM. In addition, NUM2 commented on the importance of having leadership training at RN level:

> "Definitely to do the leadership courses that are now available and to do a management course and also to buddy up or ask early on, or to work with the NUM or buddy up or do a supernumerary day, because I think it is very different when you are covering even as an ANUM for a week, I think it is very different from to actually doing the NUM role…… but I think we can make it a lot more, we could have more support to get RN level staff training in that sort of education so we are building the workforce from a lower level." (NUM2)

NUM3 also made an interesting comment about the importance of buddying up with a NUM:

"To follow a NUM in their day, definitely. So like they can use their study leave day to follow a NUM on a clinical day as well as on office day, to see what meetings they go to, to see how they get, not like get into trouble, but your length of stay may be too long for some reason, but as long as you can justify as to why that is, you've got no problem. So like, buddying up. And to see exactly if that's what you want. People think that it is really glamorous being a NUM, but it is lots of paperwork and meetings to go to. It is a bit difficult because we have two different wards on this ward, so I have double meetings. I've got a stream of meetings here as well as there, then we have a leadership meeting, then I've got NUMs meeting within the different campuses to go to. And so it is like a supernumerary for the aspiring NUMs to see what it really entails. For me, you sort of get a real understanding that it is not just sipping on a coffee, just sitting in front of the computer doing whatever, like you have a patient or a relative just come up and say 'I have complain[t] to make, oh hang on, I have two admissions into the ward, I have to make sure that my two discharges are right', but they are really important, you have to deal with that and you got the delegate as it is. Yeah, I reckon like exposing them to actual, real experience would be good." (NUM3)

Also, NUM3 further described the delegation process for staff to prepare them for the NUM role:

"I know a lot of the areas don't have portfolios. So maybe giving some NUM's stuff to ANUMs as portfolios like I was really doing a lot of stuff here, we have an ANUM here from … when that closed, I have delegated so quality stuff now goes to an ANUM. [It] Falls within a group like we got a ward hierarchy so all those ANUMs will be responsible like doing appraisals and so forth for all the other staff, so I sort of like give them a bit more experience, for the next project, about what is a NUM's role and

also covering when I am on leave, so they can do some of the fun stuff that I do like statistics." (NUM3)

NUM4 emphasised the importance, in addition to having leadership training, of not just sitting in the office:

"Just be open minded, non-judgmental, seek out a good mentor that you could discuss things with. It would be good to complete a leadership program, or facilitator workshop. I think they would be useful things to do assuming that the NUM or aspiring NUM has already completed a Diploma of Management or something like that, give them some basic background but having a mentor would really be good. But I think workshops that deal with communication and engagement would be ultimately the things that I would recommend, given that if they have to prioritise what they are going to do, these would be the things I would suggest they do. And to make sure that they get out there and don't sit in the office, but get out there and find out what's happening with their teams, because sometimes the feedback doesn't always flow freely." (NUM4)

NUM4 further commented on being an ANUM first before assuming the role of a NUM:

"I think it's one of those jobs that you need to do and it is best done after you have been an ANUM, or something like that so you have some mentoring from a NUM as an ANUM and you have worked through it. I think it is something that you need to do; if that is what you aspire to do then just do it and then develop as you are doing it because I don't think there [are] any course[s] that you can do. It is not like a course that you do in nursing that teaches you all about the patient and when you get on the ward you can do some basic things and then add to it. It is not like that because I think there are more tasks and procedures and I don't think you can classify the nurse unit manager into tasks and procedures wholly. There are some procedures like the budget those sort of

things and they are some sort of basic things that can be mentored and taught in a computer room, but they are only small snippets as I said of what the bigger job is." (NUM4)

And NUM5 spoke about the importance of switching off.

"Don't burn out. You've got to set yourself solid structure in your management. One of the things I've done is to make sure I have down time so I don't work seven days a week, often new managers try to and they end up getting tired, burning out, making mistakes. So I think by having your days off you can discharge and recharge." (NUM5)

When NUMs were asked what advice they would give for new or aspiring NUMs, most of the NUMs suggested that aspiring NUMs should do their leadership and management training before assuming the role and as NUM1 commented, "Coming onto the NUM role there are so many things that you have to learn even if you've done or you think you have done all that kind of courses in the lead up it is a different ball game when you actually do the role." This study finding is consistent with other studies. In a recent study conducted by Townsend et al. (2012) in Australia, they found that ward managers landed in the position, accidentally, unprepared and relatively unsupported. They suggested that nurse executives needed to properly select and appropriately develop the skills of staff before appointing them as ward managers. Earlier, Hill (2004) noted that although new nurse managers had anticipated they would have to acquire new knowledge and skills, they had grossly underestimated just how challenging it would be to develop the myriad of technical, human, and conceptual competencies needed. More importantly, they were ill-prepared and unnerved by the unexpected necessity to develop new attitudes, mindsets, and values – the transformation of personal identity demanded by their new positions. Likewise, Heller et al. (2003) agreed that **s**taff nurses were often thrust into managerial positions but they are not

adequately prepared in their nursing education to assume the role effectively. This supports Mathena (2002), who stated that nurse managers would have fewer feelings of uncertainty if they have effective leadership preparation. In the current study, NUMs identified their current needs to improve their performance. The nurse executives have an important role in making sure these needs are incorporated when planning for NUMs' professional development. The earlier suggestion by Gould et al. (2001) that continuing professional development should be tailored to the needs of nurse managers and should pay particular attention to topics where nurse managers felt unprepared, should be taken into consideration. The topics for leadership and management included coaching, difficult conversations, managing absenteeism, performance management, and computer /technical skills development.

A call from nursing scholars suggests that nurse managers need formal education to function effectively in their role (Kirby, 2010; Kleinman, 2003; Pickerell, 2014; Zori & Morrison, 2009). When nursing leadership competencies are taught effectively, it has a great effect on the nurse manager's skills (Pickerell, 2014). However, it must ensure that the curricula are contemporary, relevant and adaptable to assist graduates to lead effectively in a very dynamic health care environment (Dignam et al., 2012). But what exactly needs to be covered in leadership courses and how to do so remains a question (Pickerell, 2014). As early as 2003, Kleinman indicated that in the United States, there was a gap in the literature about how nurse leaders could gain the skills needed to perform their roles.

Some nurse leaders advocate graduate education as a necessary requirement for nurse managers to develop their skills (Cross, 2013; Gallo, 2007; Kleinman, 2003). A study by Whyte et al. (2000) showed that nurses who had a Master degree were better at integrating their academic and clinical skills. They also found they were more confident in their role and had higher job satisfaction. However, there are other nurse leaders who believe that graduate education is not a guarantee to prepare NUMs for their role. D'Cruz (2002) stated that

graduate education was a platform for developing researchers and other academics to prepare them for scholarly publication and professional advancement, but that the graduate education model was inappropriate in developing health care leaders. D'Cruz (2002) further stated that intellectual understanding offered in graduate degrees was only a fragment of what is needed in leadership development. This is reflected in a more recent study by Gaskin et al. (2012) in Australia where the directors of nursing expressed their concern about whether the content of postgraduate education was relevant to the needs of the health care industry. This is consistent with the study by Scott et al. (2005) and Gould et al. (2001) where they found there was an absence of a relationship between having a first degree or Master degree in obtaining management qualifications and managerial experience prior to assuming the role of nurse manager. Duffield (2005) agreed with Scott et al. (2005) and D'Cruz (2002) that holding higher degrees does not guarantee good preparation for the NUM role or effective leadership skills. Duffield found in her survey of NUMs in New South Wales, Australia, that although less than 20% of the respondents held a Master degree and over 50% were studying at masters level, they still felt unprepared for the role. In this present study, none of the NUMs had a Master degree but four NUMs had completed either a Diploma or Certificate in Management while one NUM did not have any formal management training.

Although NUMs indicated that management training provided them with a direction and a tool to work with to be an efficient manager, they still believed that managers learnt on the job and in turn improved as managers. NUM3 found that the formal training was not helpful and indicated there was not a great deal she learned to take back to her workplace. NUM4 also commented that sometimes, the formal training was "very black and white" and "I don't think a lot of courses help. They are not very practical. I think sometimes you just have to do it". These comments from NUMs indicate that formal training might not adequately prepare them for the position. The findings from the present study concur with

previous studies in that obtaining graduate education or obtaining management qualification does not adequately prepare NUMs for their role (D'Cruz, 2002; Duffield, 2005; Gaskin et al., 2012; Gould et al., 2001; Scott et al., 2005). The result of this study also concurs with Gaskin et al. (2012) who found that although many NUMs had undertaken some management training, they still seemed ill equipped for the managerial role and insufficiently trained in operational tasks such as budgeting and human resources tasks such as personnel management. This finding may indicate that the courses they had undertaken were not broad enough to equip them with the knowledge and skills required for the NUM position (Gaskin et al., 2012). In the earlier study conducted by Kleinman (2003), the results revealed that while nurse executives valued the acquisition of a Master degree, fewer nurse managers agreed. Kleinman explained that differing perceptions could be the result of many nurse managers acquiring their skills through on-the-job training without any formal graduate training.

5.3.4. Section summary

Aim 2 was to identify the skills required for the role of a NUM. The findings in this study indicated that the NUM's role is diverse and possibly includes too many responsibilities. The ANUMs and RNs felt that the NUM's role was challenging, confronting and stressful. These factors were some reasons for ANUMs and RNs not being interested in applying for the role. The three groups of participants agreed that clinical knowledge and a nursing background were important before assuming the role. Some authors agreed that clinical experience was important before assuming the role (Jarnigan White, 2015; Kleinman, 2003; Llewellyn, 2001). However, some other authors have noted that clinical skills and expertise are not enough, or do not equate with good leadership (Arnold & Nelson, 2004; Heller et al., 2003; McCallin & Frankson, 2010; Oroviogoicoechea, 1996; Sanders et al., 1996; Tilley & Tilley, 1999). The participants in the current study felt that leadership and management skills were

necessary before assuming the role. Some spoke of the importance of developing leadership and management skills as an RN and building those skills throughout their career. All RNs believed that management education or training were necessary before assuming the NUM role. Some NUMs and ANUMs thought that having management training before assuming the role was an advantage. However, the NUMs felt management training did not adequately prepare them for the role. They felt that experience helped them improve their skills. These findings are consistent with previous studies that found an absence of relationship between having previous management training and assuming the role (D'Cruz, 2002; Duffield, 2005; Gaskin et al., 2012; Gould et al., 2001; Scott et al., 2005). Adequate preparation of NUMs for their role is clearly a matter for continuing discussion and research.

5.4. Aim 3: The management challenges of the NUM's role

In order to address Aim 3, NUMs, ANUMs and RNs were asked **"What do you think are the greatest challenges in being a NUM?"** Similarities and differences in responses from all three groups of participants are presented in Figure 5.4.

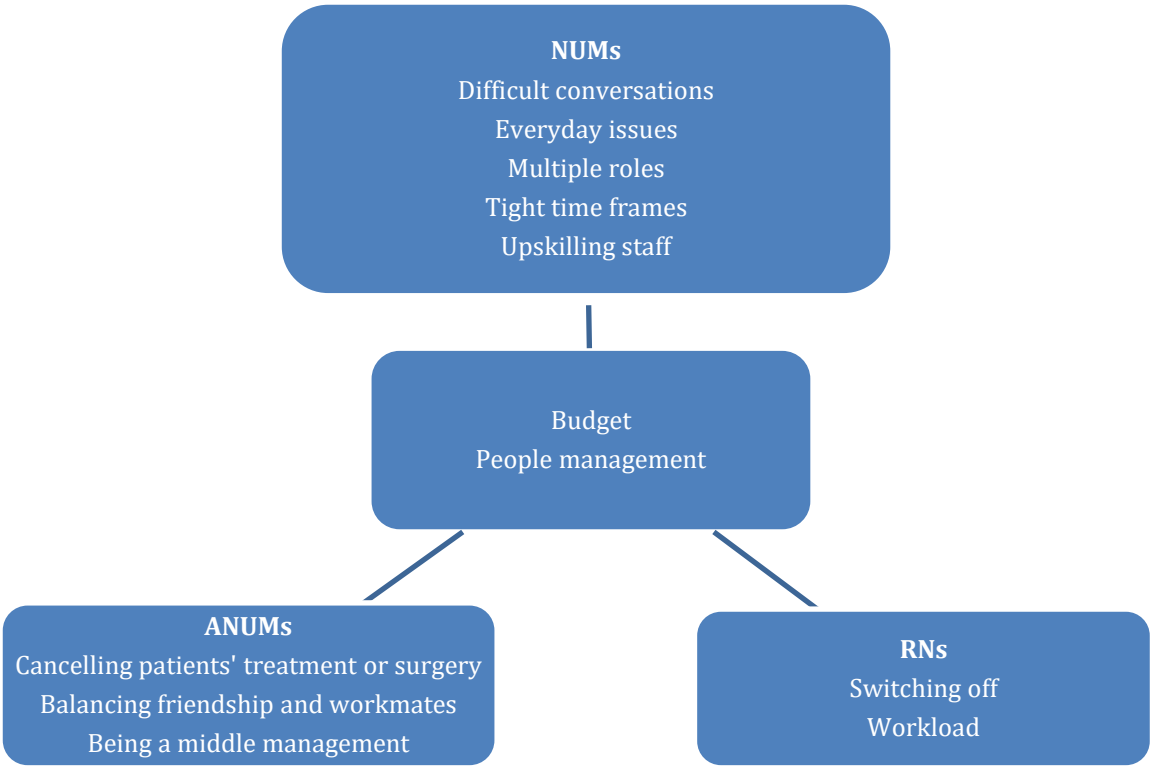

Figure 5. 4. Greatest challenges in being a NUM

As shown in Figure 5.4, NUMs, ANUMs and RNs all agreed on people management and budgeting as challenges in being a NUM.

The findings revealed two core categories, namely, leadership challenges and NUMs' needs. The core categories, sub-categories and attached meaning units are presented in Table 5.6.

Table 5. 6. Core categories for greatest challenges in being a NUM, sub-categories and meaning units

Core categories	Sub-categories	Meaning Unit
Leadership challenges	Underperforming staff	• Non-productive staff • Upskilling staff
	People management	• Difficult conversations • Different personalities • Dealing with internal and external issues • Hierarchical nature of nursing • Balancing friendship and workmates
NUMs' needs	Workload	• Multiple roles • Tight time frames • Switching off

5.4.1. Core category 1. Leadership challenges

The core category of leadership challenges included the sub-categories of underperforming staff and people management, described in the sections that follow.

5.4.1.1. Sub-category 1. Underperforming staff

For NUMs, their greatest challenge was dealing with staff who were non-productive and underperforming. NUM4 described the challenge of dealing with non-productive staff who did not respond to passive and encouraging approaches:

> "It depends if staff member is below the line and behaving in a way that is negative and not productive; it is very difficult to get them to see the opportunities that are available to them. And sometimes the only option is to actually do a formal performance management process with the person because they don't respond to more passive and encouraging approaches. So probably that is a difficult thing to do." (NUM4)

This challenge was echoed by NUM5:

> "It is the ones you have to sit down with, someone is not performing and you have to be able to be upfront but not hurt their feelings to the point where they cannot succeed. You have to come up with ideas about how they can improve." (NUM5)

Part of the NUMs' role is to educate or arrange training to upskill their staff. Preparing staff to be competent in their roles may be challenging. The following comments from the NUMs exemplify this challenge:

> "I think for the moment my greatest challenge is preparing my staff for ICU coming over and the rest of the cardiac and coronary care and ensuring my staff are prepared for more acute and sicker patients." (NUM1)

> "So I try to coach people to see their deficits if they are not performing and encourage them to do that in a positive way to address that and make themselves better at their job and realise their potential because everyone has great potential." (NUM4)

5.4.1.2. Sub-category 2. People management

Difficult conversations with staff were challenging for NUMs, especially with underperforming staff. NUM4 commented:

> "But some people are often a little lost and even though with your best effort you try to bring them around and give them that information that they can work on and build on, it often is difficult for them to embrace the concepts and they often fall back on old habits." (NUM4)

While NUM5 commented:

> "I think sometimes it is the difficult conversations. …You have to come up with ideas about how they can improve. I think sometimes they are hard ones." (NUM5)

ANUMs and RNs spoke about dealing with different personalities and trying to keep everyone happy as challenges for NUMs. ANUM1 described the difficulty a NUM is faced with when implementing changes on the ward due to different personalities among staff:

> "If there are lots of negatives like when staff are very negative about things when you tell them about changes for the ward and when there are lots of conflicts among your staff, it's a very big challenge because they have different personalities. It's really more about conflict and how to resolve it." (ANUM1)

RN2 also made a comment about different personalities:

> "I think because you are dealing with humans. I think if you are dealing with machinery it would be a easier to just press the button and make it happen, but all the different personalities, people who come with a good heart but are so gung-ho that they push people away, making other people see that, you know, this person has a good heart, this is what they are trying to do, but sometimes it does not come across." (RN2)

Keeping everyone happy was considered another challenge by ANUMs and RNs. ANUM2 described the problem of rostering staff:

> "Dealing with people. Dealing with staff. They complain, rostering, it is hard for her because she is doing the rostering as well, it is a headache. It is a very busy role." (ANUM2)

And this was echoed by RN1 who made the following comment:

> "Another challenge is to keep everyone happy as much as they can, starting from simple things like rosters, holidays, so the NUM does not have a narrow mind but a lot of understanding." (RN1)

RN4 found that keeping everything under control was a great challenge:

> "I think keep everything under control and make everybody happy, and the right program, keeping it together working as a team." (RN4)

NUMs have to deal with internal and external issues. Internally, they have to deal with their staff and other issues on the ward such as dealing with patients and their families. NUM2 commented:

> "…ongoing issues that crop up every day, working out how you can best get the best out of the situation that you are in." (NUM2)

RN1 described the challenges faced by NUMs in dealing with internal and external issues:

> "Dealing with issues internally and externally. Staff, every single one [of] us is different, [so this] is a very big challenge already. Internally, he strives for excellence. And how he's going to do that is a major problem for him if staff are not together, are not with him, [this] is a main issue." (RN1)

> "Dealing with difficult situations with patients, difficult people, staff, personality clashes, multi-supernumerary staff." (ANUM3)

One ANUM also suggested that cancelling patients' treatment or surgery could be particularly challenging for a NUM.

> "Sometimes when we cancel patients it is very stressful because you have to explain to the patients the consequences." (ANUM5)

The NUMs have to deal with external issues and deal with the hierarchical nature of nursing:

> "Doctors who are very demanding, staff who [are] very demanding." (ANUM5)

> "I feel they are sandwiched in the middle because they are being pushed down by the divisional director and being pushed up by staff on the ward." (ANUM2)

> "Bridging the communication gap between the top and bottom. She is being sandwiched in the middle, being pushed." (ANUM3)

ANUM2 perceived that balancing friendship and professionalism was also a challenging aspect of being a NUM and commented "You also have to balance friendship with workmates."

5.4.2. Core category 2. NUMs' needs

The findings revealed the workload in relation to NUMs' needs. This was included as a sub-category and described in the following section.

5.4.2.1. Sub-category: Workload

The findings indicated that NUMs had to perform multiple tasks, including non-nursing related tasks, in tight time frames. NUM3's comment exemplifies the multiple tasks of NUMs:

> "And also I am the incident commander here. So not only are you in charge of your ward, you are the incident commander of the whole hospital. So if there is a code, you have to leave your area. Hopefully you have someone who has been trained to be an area warden to step up and then run off and deal with codes. Like we had a code yellow next door, where sewerage was coming out of the toilets and I was off the ward for nearly two hours. But I was not replaced, so that makes it difficult. " (NUM3)

Working under tight time frames could be challenging for NUMs. NUMs need to be able to switch off from their heavy workloads. They indicated that they did not have enough time to

do all of their tasks during their working hours and that they needed to take some of the tasks home.

> "I think finding time to do everything properly." (NUM2)

> "Finding the time to be on the floor when you are on your clinical days, because I do three days on the floor and two days in the office, but I do have a lot of meetings that do not fit in my two days in the office." (NUM3)

> "So leaving the ward short is really difficult like when I have to leave at one o'clock or quarter past one to rush off to a meeting at another campus, that is difficult." (NUM3)

> "Working in tight time frames." (NUM2)

> "Sometimes I take stuff home like to do graphs and things for my quality boards, which I know I should not, but depending on how busy you are on the ward or getting out on time sometimes; but this week has been my first week that 3:30 I just have to let it go so I will not fall to pieces if I don't do it." (NUM3)

RNs empathised with NUMs and had indicated that switching off when the workload was expansive was challenging for a NUM.

> "Switching off at the end of the day I think that would be hard to have it in your mind to be worried on everything. But I don't know how you can be a NUM for 53 beds." (RN2)

> "The workload, because you have a lot of people that want to speak to you all day, phone calls, problems to deal with ranging from agitated patients…" (RN3)

To further address Aim 3, NUMs, ANUMs and RNs were asked: **"What qualities should a NUM have to succeed in the role?"** This question sought to gather perceptions

from three perspectives, to gain insight about the necessary qualities needed to be a NUM and how NUMs could be prepared. The responses are presented in Table 5.7.

Table 5. 7. Qualities to succeed in the Nurse Unit Manager's role

NUMs	**ANUMs**	**RNs**
Able to delegate	Ability to delegate	Approachable
Accountable	Able to deal with issues	Caring
Compassionate	Amicable	Experience
Computer skills	Approachable	Fair
Engaging	Compassionate	Good knowledge of the ward
Good communication	Dynamic	Good leadership
Good listener	Experience	Good people skills
Good time management	Fair	Intelligent
Have the passion and interest to manage	Flexible	Kind
Leader	Generous	Motivated
Ongoing education	Good communication	Patient
Open to change	Good leadership	Personable
Patience	Good listener	Role model
People person	Good organiser	
Protector	Good people skills	
Respectful	High ethics	
Role model	Honest	
Self-sufficient	Kind	
Trustworthy	Motivated	
Understanding	Positive	
	Professional	
	Understanding	
	Versatile	
	Visionary	
	Wise	

As shown in Table 5.7, all three sample groups, NUMs, ANUMs and RNs, placed emphasis on good management, leadership and people skills as the most desirable qualities the NUM should have in order to succeed in the role. Good management skills included having the ability to be able to delegate, the ability to deal with issues, good time management, and being accountable.

The sheer scope of the NUMs' role meant good time management and prioritisation in dealing with issues in a timely manner. ANUM2 felt that NUMs would lose the respect of their staff if they did not deal with issues appropriately.

> "…need to deal with problems in a timely manner because if they come to you with issues and you brush that away and you don't deal with it, they will not have respect for you." (ANUM2)

NUMs felt that delegation of certain jobs was important to ease their workload. One NUM indicated that by having tasks delegated to them, staff felt empowered.

> "So another thing is with engagement comes delegation. So delegating tasks to other team members, so they feel empowered and appreciated and trusted, is very important as well." (NUM4)

NUM4 also indicated the importance of engaging staff:

> "…engaging staff is very important. It does really matter if you spend your time doing tasks, you accomplish an outcome but you won't engage your team. And if you are not a strong leader and you don't seek to engage the team, then you always work a little harder because you won't have anybody giving you a lot of assistance. I think one of the primary things is staff engagement because you can't do it all alone, and it is very

important that you actually have the engagement to lift you and support you and give you the assistance that you need to be able to do the job well." (NUM4)

ANUMs and RNs placed emphasis on fairness as another desirable quality of being a NUM. They wanted NUMs to be fair with everybody, using words like non-biased and balanced.

"To be fair with everybody." (ANUM5)

"Nonbiased" (RN4) and "balanced person." (ANUM3)

One RN discussed the issue of friendship indicating that NUMs should not favour other staff because they are friends, as a consequence, may be destructive for the cohesiveness of the team.

"Even though they are very friendly people, do not just be everybody's friend. There are very difficult decisions to make and you have to be the one to make those decisions and then be able to follow them up so if you make that decision on this day, you have to be able to do it again on that day, so that everyone knows it is fair and an equitable place where we are working, because otherwise you can divide staff if they don't feel that the same things are happening. If they feel the NUM is a "push over", they will just do nothing." (RN2)

In addition, ANUMs placed emphasis on flexibility and communication as other desirable qualities for NUMs and as qualities they should expect in their staff.

"…flexible to staff needs because if you are too strict then staff will not come to you." (ANUM2)

"They want you to be flexible with everything so you have to be multiskilled." (ANUM1)

The ANUMs valued open communication to keep information flowing from upper management to staff.

"Open to communication…Also you have to have an open communication all the time; you communicate whatever is communicated to you so that everyone will know what's happening around the ward so they have an understanding of what's happening." (ANUM1)

"Lots of communication skills are required to be a NUM because you work with lots of different types of people and getting through with different people can be very different. So you need to be able to address people individually rather than just have one style." (ANUM4)

"Communicate well with people on their level, so not to talk down to people, to be able to negotiate as well under different circumstances." (ANUM6)

When there is open communication, staff are more open to change.

"And be open to change like from higher up like the executives, divisional directors and so forth, and adapt to different things and always like sort of moving forward with the ward with current therapies, with wounds, just always like moving forward, improving while you are improving the ward to ultimately have the best care for patients and families." (NUM3)

Leadership styles and behaviours were given importance by all groups in the smooth running of the ward.

> "You must have a good interpersonal relationship with staff and everyone. It helps a lot to smoothly do your job." (ANUM1)

ANUM1 described how a democratic style of leadership could bring about team cohesiveness.

> "He should have a democratic style of leadership because, especially with this multiskilled staff, it is easy to have a cohesive group of staff if you do that style of leadership. And it is not good to be an autocratic leader because staff won't like that." (ANUM1)

This was reaffirmed by ANUM2, who discussed the importance of NUMs having good relationships with staff so the ward did not crumble.

> "…people skills…And also they should have a good relationship with the team leader, ANUMs as well so they have that relationship. But I find that if sometimes they don't have that relationship, because they worked as a team, we don't work alone and some NUMs can be, their personality can be not to have that good relationship with the ANUMs or staff and the ward just crumbles." (ANUM2)

NUM5 agreed, noting that the NUM would not be able to survive without the support of other people.

> "I think you have to be a people person. If you are not a people person you will not survive." (NUM5)

ANUMs and RNs valued approachability and listening to staff especially in difficult times as other positive qualities for NUMs.

"…to listen to everybody, to understand the situations especially in difficult times." (ANUM5)

"Approachability, someone that you know that even if the door is closed she doesn't mind you coming in." (RN2)

"She needs to be very approachable." (RN4)

Trustworthiness was another leadership behaviour that was valued in order for staff to be more engaged with NUMs.

"And I think you should also be honest. I think it is important to be honest and fair." (NUM1)

"…believe you when you say things. If they don't believe you they won't follow." (NUM5)

"to be truthful with everything because if you are hiding something staff will not like it." (ANUM5)

RNs perceived that NUMs should have clinical experience and knowledge of the ward as important qualities.

"I think they need to have an experience on the ward as well. I don't think you could go straight from [a] university course and graduate and then go into a nurse unit manager's role. I think you need experience from the ward and to see other people managing and just have experience working with staff and nursing experience background, because a lot of things that may happen that are not necessarily under the nursing umbrella and if you don't have the skills and training I think that would make it difficult too. …. She should have a good knowledge of the ward staff." (RN4)

> "Very important the experience, the training, the skills like hands on, not just managerial but they have to be clinically with it because a lot of people are very good at managing but clinically they are not as good." (RN1)

One RN described the importance of "switching off" even in demanding circumstances.

> "I think also a good quality of a NUM is to be able to go home at a particular time and switch off. I have NUMs who were here from seven o'clock in the morning till seven at night." (RN2)

NUMs were then asked "**What is your most positive experience of being a NUM?"** Similarly, ANUMs and RNs were asked the question, "**What is your most positive experience with your NUM?"** This was an attempt to gather further insight into NUMs' leadership styles. Effective leadership style is linked to staff retention, job satisfaction, enhanced team performance, productivity and organisational commitment (Casida, 2007; Casida & Parker, 2011; Hirst, 2005; McGuire & Kennerly, 2006; Williams et al., 2001). Overall, NUMs' stories indicated that their leadership behaviours had influenced positive outcomes for patients and for staff.

Interestingly, the positive experiences described by NUMs resonated with the positive experiences of ANUMs and RNs with their NUMs. The NUMs clearly indicated their role in developing staff and the positive effect of this on staff. For example, NUM2 and NUM4 gave examples of how developing staff influenced their careers.

> "I think the most positive experience is getting people to be developed, developing staff and seeing them grow." (NUM4)

> "Getting feedback from staff and saying that they have felt that I have influenced their career and how they do the job and their aspirations." (NUM2)

This was echoed by ANUM4, ANUM5 and ANUM6, for example:

> "Her support in training me to take over when she was on leave." (ANUM4)

> "Every time he goes away he gives me the responsibility as a NUM. In this way he trusted me and he knew that I can do it, even if I was asking myself if I can do it, the first time I did it and he said I can do it and I listened to him." (ANUM5)

> "His interest in my development as an ANUM. His help in encouraging me to further my educational experience and [he] teaches me other components like running the budget and things like that." (ANUM6)

Some NUMs described how they had enhanced team performance, staff retention, job satisfaction and organisational commitment especially in terms of patient outcomes. NUM1, for example, described positive feedback from other people and how it influenced staff:

> "Probably the most positive experience is hearing the compliments. Since I started, a lot of people, not just in my division but other departments, have complimented me on how well the ward is running at the moment and how happy my staff seem to be with my management." (NUM1)

Another ANUM expressed similar sentiments:

> "He is very appreciative of everything staff shares on the ward because whatever success he gets from the ward it all comes down to what staff do. Everyone appreciates him because he's open to everything. He is open to criticism, is open to positive feedback and he has a good relationship with management as well, and to staff and everyone, the doctors and the allied health staff and the PSAs. So if you have a good personality, he has a good personality and he is doing his best as a hard-working NUM.

The ward is really in a good position at the moment. Everybody likes the ward in the whole hospital." (ANUM1)

NUM3 spoke about how the culture of their ward had changed with staff not wanting to leave:

"…getting thank you cards in our tearoom saying they don't want to leave the ward, doctors not wanting to leave the ward because they are so happy with all staff and the culture that we have now." (NUM3)

NUM3 continued the comment with reference to the appreciation of staff:

"I reckon getting present for Christmas that was such a surprise. I did not think staff saw me in that light or in that high regard." (NUM3)

NUM3 further described the positive outcome for patients and families due to staff performance and organisational commitment.

"We got a $2000 donation from a family for caring for two patients that happened to be sisters." (NUM3)

ANUM3 and RN3, RN4 and RN5 expressed their satisfaction and appreciation with their NUMs:

"I would say that she is a person with great integrity, you can trust her, and you know she will have a positive impact on the ward. With staff, it makes my working life much easier for instance and she is promoting a very good environment for people to work with and also a safe environment, because she also has to be a health and safety person on top of everything else. And I think she's trying very hard to change the negative attitude to positive things. And I think that is not an easy thing to do because for

instance we are trying to cut down on sick leave, we are encouraging people to let, say work cover to come back and not lingering around. And I think she's trying very hard to work with the person. She's a person person and hopefully this will help to increase the morale of the person when you show concern and interest. Same thing with patients like sometimes she has happy patients and some are horrible patients and families and you cannot please everybody. But I think she's trying to balance a lot of things and she is good in that way because she has the people skills." (ANUM3)

"I was off work for three months and I found that when I had to ring up and speak to her I found that she was very approachable, and did not rush me and was very understanding." (RN3)

"I have had health issues and so did my daughter and she was very supportive of me throughout those times. She has always helped me by changing my rosters to help me to do what I need to do." (RN4)

"I can rely on him with all the decisions regarding ….. He is approachable. He makes sure that all problems are fixed. He's a good manager." (RN5)

The mere presence of the NUMs was seen as having a positive impact on both ANUMs and RNs. They described how they appreciated the NUM visiting them and checking everything.

"I like that she comes to visit us in the morning, and she visits each of us to see how we are going, I think that it's important, and she needs to know a whole variety of wards as well. I think if you have only one ward it is easier but here she has three wards so she has to go to three of them and to make sure [sic] how they are going." (ANUM2)

"I don't know, there are lots. She's very very supportive and sometimes because there are so many things going on it is amazing that she remembers everything. Like we have a staff member whose dad died and she organised the flowers and she sent them. Those sorts of things that might be just expected of some NUMs, they don't always do it but she does. Checking in with everything and she knows if something has happened she follows up, how people are feeling. In … ward for example, we had a few deaths in a row, so she checked with us if we needed debriefing. Like I said with that particular challenging family, she makes her presence known and lets them know that she was supporting us. And she gets legal involved if that is required but she can also minimise things to, because you do not want everything escalating, otherwise everything is bigger than it should be. She can identify what needs to be changed." (RN2)

Another RN described the positive experience of having a NUM who listened to staff and who would tell staff what they needed to hear.

"I am a kind of person who does not really talk to a NUM. So if I can try and avoid going to their office I will do that, but if I have to say something I would go. With our present NUM, I think what's good about him is that he is open, you can go inside his office without thinking 'here we go again' like you can basically discuss anything with him with confidentiality. So for me it's very important that a NUM is really not just accommodating like, I don't think staff nurses like special treatment from their NUMs, they just want to be treated fairly, and if they want to be heard it would be nice to have a NUM who listens and currently we do have a NUM who is good at that. He listens, he address things if need be. So it's positive because like at the moment I don't really want to talk to the NUMs quite often. So now I think I'm comfortable with the NUM that we have because I know that he will listen and he will tell me if I've done something

wrong; he does not say things that I just want to hear so I think that's one of the positives." (RN1)

NUM5 also made a comment about the development of different teams or specialty wards into a culture of one. This was brought about by the merging of two specialty wards that used to be managed by two different NUMs.

"My last role at [ward withheld]…. to be honest. I was able to develop two different teams and create a culture of one. And I think it was a great outcome for everyone. And [a] much more efficient department works out [of] there now." (NUM5)

To develop a perception of leadership styles, the NUMs were asked to describe their leadership styles. As discussed in the literature review, in order for the NUM to be successful in aligning the organisation's vision and mission to their ward, NUMs must demonstrate effective leadership styles that are appropriate and can positively impact on organisational performance (Casida, 2007; Kanste, Kyngäs, & Nikkila, 2007). The NUMs described their leadership styles along the lines of transformational leadership, that is, leaders who practise transformational leadership; inspire, motivate, act as role models, provide intellectual stimulation and encourage employees to self-manage (Bass, 1985; Marriner-Tomey, 2009). NUMs' responses with sample quotes are shown in Table 5.8.

Table 5. 8. NUMs' descriptions of leadership styles

Approachable	"Making sure that I am out there and still approachable." (NUM2)
Coming up with ideas and utilising staff	"Very open manager. I don't believe in setting anything in concrete, it's about coming up with ideas seeing if they work, utilising staff that have great knowledge and going from there." (NUM5)
Democratic, not dictating	"And sort of not dictate this is what's going to happen but like the network will say you would need introduced bedside handover for example, staff will say we don't like it. Well then I say we need to do it, how do we do it to make it good for our patients and staff. So we make a compromise." (NUM3)
Empowering	"..giving staff back accountability and responsibility so the ward can function. If I am not here, the ANUM is not here and the ward clerk is not here we are not going to fall in the heat. So it is some sort of empowering them." (NUM3)
Encouraging	"So when if try to roll something out or I have an idea I always do think that I do seek the opinions of staff to really make an informed decision. And I try to engage my staff as much as I can to make sure that whatever I am rolling out is successful and I think the only way to do that is to gather all staff and gather their opinions on things and to make them feel that they are part of the decision and I'm not just dictating what to do." (NUM1)
Fair	"I always try to be fair." (NUM1)
Grateful	"But then in saying that, like the AFL grand final day, I ordered pies and sausage rolls from the kitchen for staff who were working on grand final day. Or if I bake something from home I bring it in, not just for any reason, but 'look we really had a very bad week, it has really been very heavy, thank you' and yes I put it out there for all staff." (NUM3)
Open	"I am like an open book. What you see is what you get. I am very open, very encouraging." (NUM3)
Role model	"I like to lead by example and would like to be more hands on here and a lot more on the floor than I am." (NUM2)

The NUMs were then asked "**Can you please give an example of how you approach a difficult situation?"** This was a means of gathering examples of the effectiveness of their leadership styles. The NUMs' stories revealed they used the escalation process in dealing with difficult situations. NUM1, NUM2 and NUM3 gave examples of how they escalated

difficult situations when they thought that the situation could not be resolved at their level:

> "So we had a difficult family, at present he has been at the unit for six weeks, we tried different approaches. We had the nursing staff dealing with the concerns at that time, we had the nurse in charge dealing with concerns and that escalated to me and I tried talking to the family regarding their concerns, assure them that I would investigate and give feedback to them and then refer them to relevant people as well, because unfortunately it was a situation [that] could not be managed at my level. So, I think knowing when to escalate and ask for help as well. So I have to escalate that to a higher level of staff to deal with because it is getting nowhere. Also organising support for staff on the ward through debriefing to make sure that staff got the support they needed. I got the support from my management and the family got their issues dealt with from the independent person." (NUM2)

NUM3 explained how she dealt with an incident:

> "……., an incident occurred where previously to me she was only working nightshift which was fine. And I came on one morning shift and there was an agency slip left on my desk where she worked an agency shift during the day. But she has a medical certificate saying that she cannot work day shift. So I thought what will I do? Is this fraud? So I contacted HR, spoke to the Director of Nursing here, then I have to ring staff member about the incident and what happened and she was very defensive." (NUM3)

NUM1 described the importance of having clinical knowledge that led to a positive outcome for the patient and safety for both the patient and staff:

> "One is an issue that came about with me and a manager from a different department. He was trying to send us a patient that we were not capable of taking care of and she thought we were compromising patient care by not accepting the patient. So that was a difficult one to address and we had the head anaesthetist involved and I was able to troubleshoot by talking to her but explaining the reasons why and obviously escalating it to someone higher up in our department to be the kind of mediator. It was probably the most challenging so far. So first I spoke to her and gave her the reasons why we couldn't take the patient and she disagreed with my opinion, so then when she disagreed we have to speak to someone higher up. So when I spoke to the person higher up I explained it, she agreed because I obviously gave clinical reasoning and she was able to inform the manager of that department that we will not be able to take care of the patient for the particular reasons I said. Also she outlined herself that we are compromising the patient. If we accepted the patient there will be greater clinical risk. So it's important that you have a lot of clinical knowledge to advocate for your staff and patient." (NUM1)

In dealing with difficult situations, NUMs also spoke of making plans to gain a better understanding of the situation and gathering opinions from others as exemplified by the stories of NUM4 and NUM5:

> "Basically I tend to understand the situation so I engage others that are involved so that I can find out more information so I can understand the details, then I will make a bit of a plan of how I am going to address the situation. So I don't necessarily do that all on [the] same day. So I am aware of the situation and I might touch base with whoever it might concern that we need to talk about it or discuss it. I'll do some research with other team members or with the patient, or whatever or whoever might have been involved and do some background investigation. Then I make a plan on how it is going

to move forward and then I involve the people that need to be involved and sit them down and have discussions with them about what needs to happen and involve them with what sort of things they think need to be implemented. As well, we come up with a plan, implement, evaluate, see what is happening, revisit it again and if we are getting good success then [we] will keep it, if not then we reassess it and have another brainstorming session." (NUM4)

"It depends on the situation. I absolutely believe, a context would be someone is having high sick leave is about trying to understanding their sick leave and seeing if there are patterns and then planning the answer, no question. Plan before you go into any meeting so [you] have a good understanding of your information. Don't be afraid to record [the details] and then let people know that you are making notes so that you can come back and check things if you get questioned, but it is about prior planning." (NUM5)

NUM3 also described how she worked out a plan to deal with a difficult situation and talked about the support given to staff:

"….., very difficult personality, and has been a problem on the ward apparently for many years, so I have to meet with her, work out a plan; she was not listening and finally we come to an agreement to rotate off night on to afternoon shifts. She says she suffers from insomnia that is why she prefers to work night shifts. And so far she has been okay and so she has been doing afternoon shifts and I'm like, come and talk to me and feel free to come in and vent. So that has been my most difficult person so far in this role…." (NUM3)

NUM2 also spoke further on the importance of debriefing staff after a difficult situation:

"…Also organising support for staff on the ward through debriefing to make sure staff get the support they need. I got support from my management and the family got their issues dealt with by the independent person." (NUM2)

After the interview, NUMs were given the MLQ Self-Rater Form to rate their management styles. ANUMs and RNs who worked with them were given the MLQ Rater Form to rate their NUMs on their leadership styles. The results were then compared to determine if what the NUMs thought of their leadership styles were the same as staff perceived them to be. The overall average behavioural attributes for each NUM were compared to the research validated benchmark for Australia, as shown in Table 5.9 (Palermo, 2005).

Table 5. 9. Australian MLQ5x norms (as at June 2004) (Palermo, 2005)

Behavioural Attributes (Please refer to legend in Figure 5.5 below)	**Total Mean**	**N (12220)** **Std.Deviation**	**Std.Err.Mean**
IA	2.98	.073	0.01
IB	2.85	0.74	0.01
IM	3.00	0.74	0.01
IC	2.88	0.78	0.01
IS	2.87	0.71	0.01
CR	2.96	0.72	0.01
MBEA	1.90	0.95	0.01
MBEP	1.00	0.76	0.01
LF	0.64	0.67	0.01
EX-EFFORT	2.63	0.89	0.01
SATISFACTION	3.19	0.77	0.01
EFFECT	3.16	0.69	0.01

The results of the survey are shown in Figure 5.5.

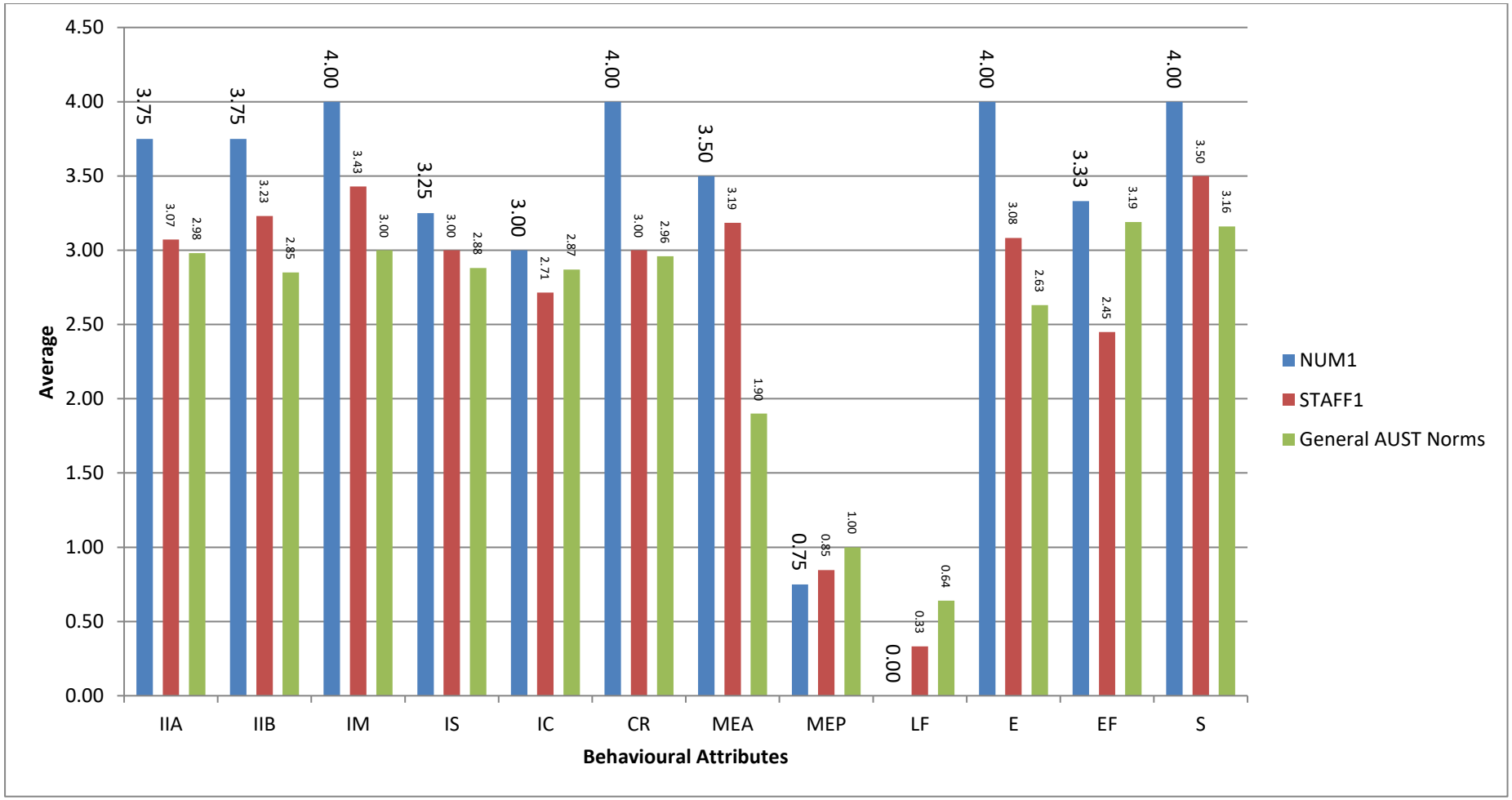

Figure 5. 5. NUM1 average behavioural attributes as compared with general Australian norms

Legend

Transformational Leadership

IIA – Idealised Influence (Attributed)

IIB – Idealised Influence (Behaviour)

IM – Inspirational Motivation

IS – Intellectual Stimulation

IC – Individualised Consideration

Transactional Leadership

CR – Contingent Reward

MEA – Management-by-exception (Active)

Passive/Avoidant Behaviour

MEP – Management-by-exception (Passive)

LF – Laissez faire leadership

Outcomes of Leadership

E – Extra Effort

EF – Effectiveness

S – Satisfaction

Key of Frequency

4.0 = frequently if not always

3.0 = Fairly often

2.0 = Sometimes

1.0 = Once in a while

0.0 = Not at all

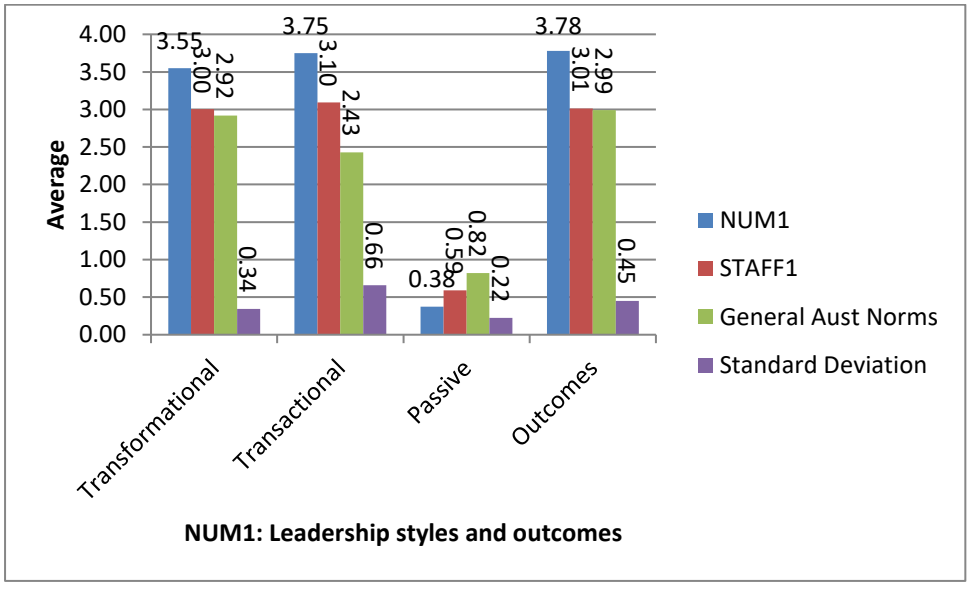

Figure 5. 6. NUM1 leadership styles as compared with general Australian norms

As shown in Figures 5.5 and 5.6, NUM1 rated himself higher than staff in both transformational and transactional styles. Both NUM1 and staff perceived the leadership style as more transactional. Although NUM1 was more transactional in his leadership approach, the level of satisfaction is still high, as compared to the general Australian norms, and the overall outcomes as shown in Figure 5.6 are almost the same as the general Australian norms (Palermo, 2005).

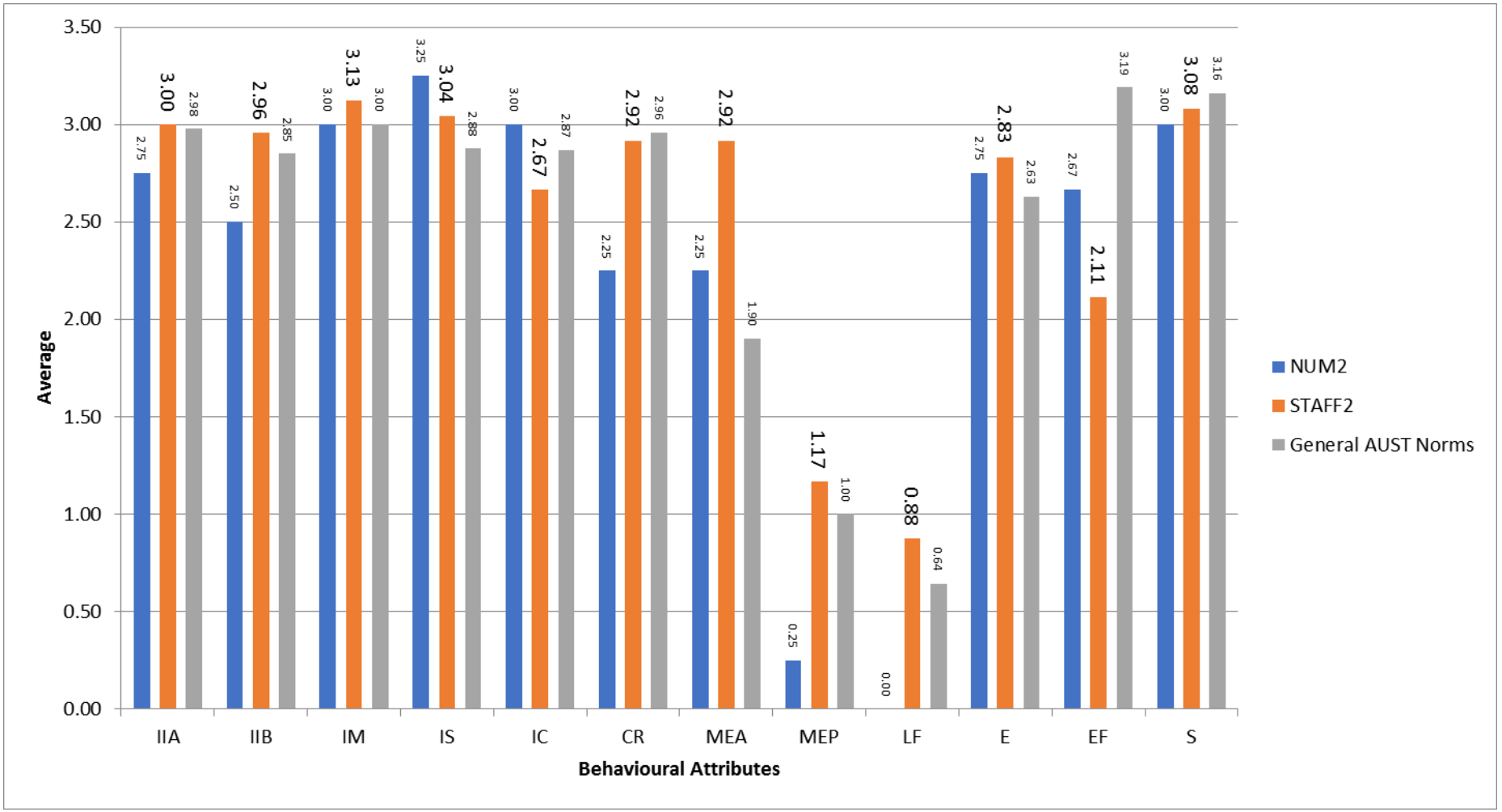

Figure 5. 7. NUM2 average behavioural attributes as compared with general Australian norms

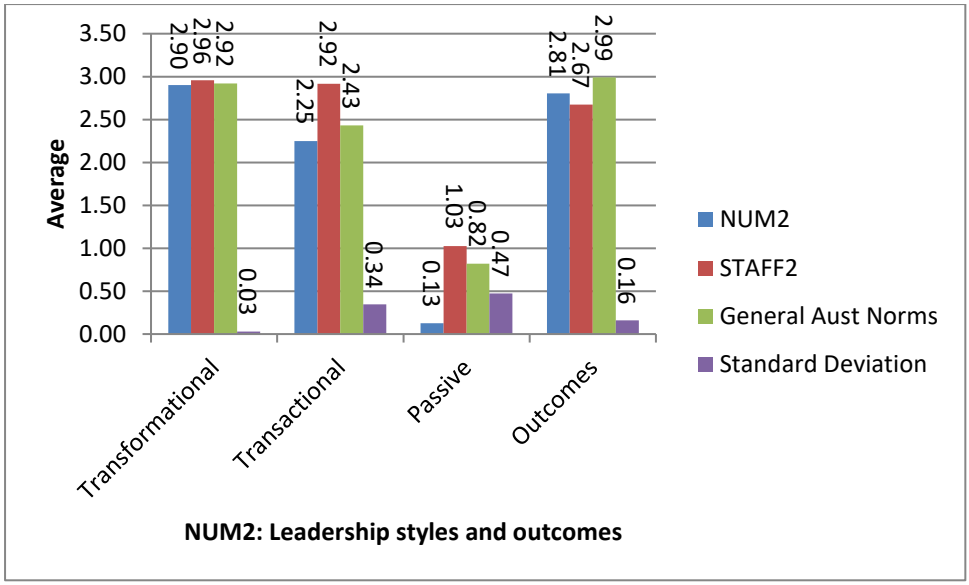

Figure 5. 8. NUM2 leadership styles as compared with general Australian norms

As shown in Figures 5.7 and 5.8, NUM2 perceived herself as more transformational but staff perceived NUM2's leadership approach as a balance of transformational and transactional. Staff rated NUM2 as exhibiting a passive approach higher than the Australian norms as shown in Figure 5.8 and the perceived outcomes staffwere lower as compared to the Australian norms (Palermo, 2005).

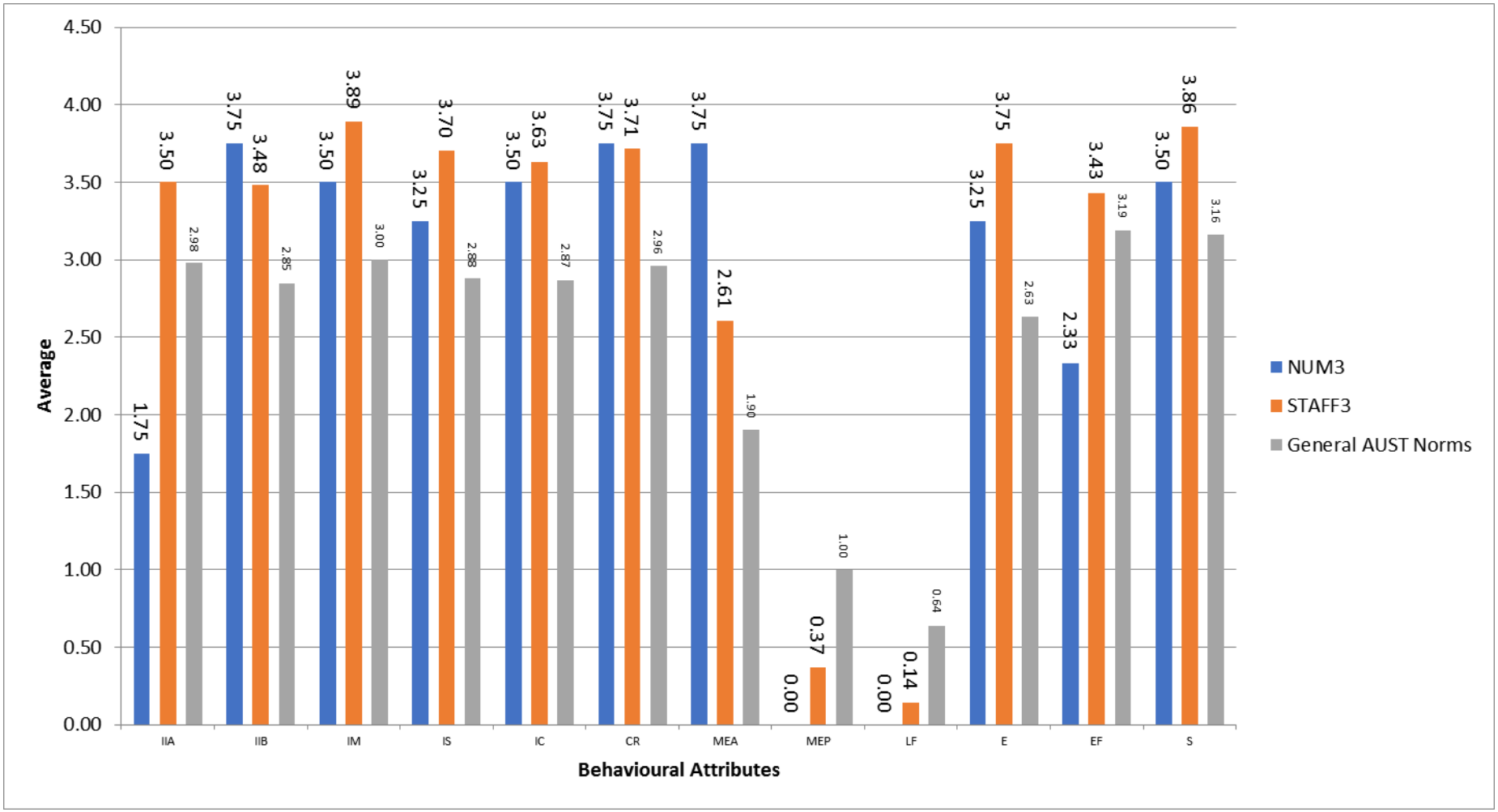

Figure 5. 9. NUM3 average behavioural attributes as compared with general Australian norms

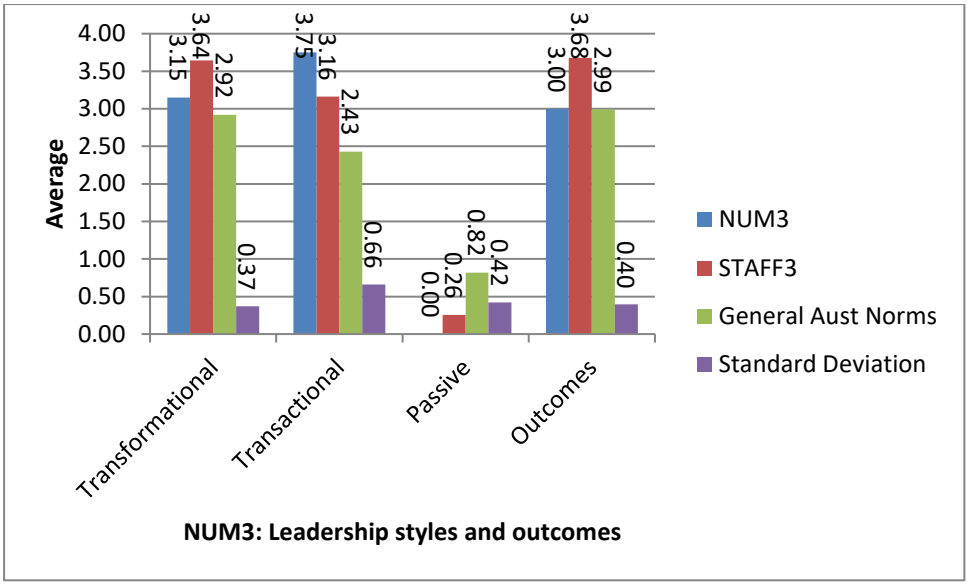

Figure 5. 10. NUM3 leadership styles as compared with general Australian norms

Figures 5.9 and 5.10 showed that NUM3 perceived herself as more transactional but staff perceived that NUM3was more transformational. NUM3 rated herself lower in terms of outcomes but staff gave a higher rating as compared to the Australian norms (Palermo, 2005) as shown in Figure 5.10.

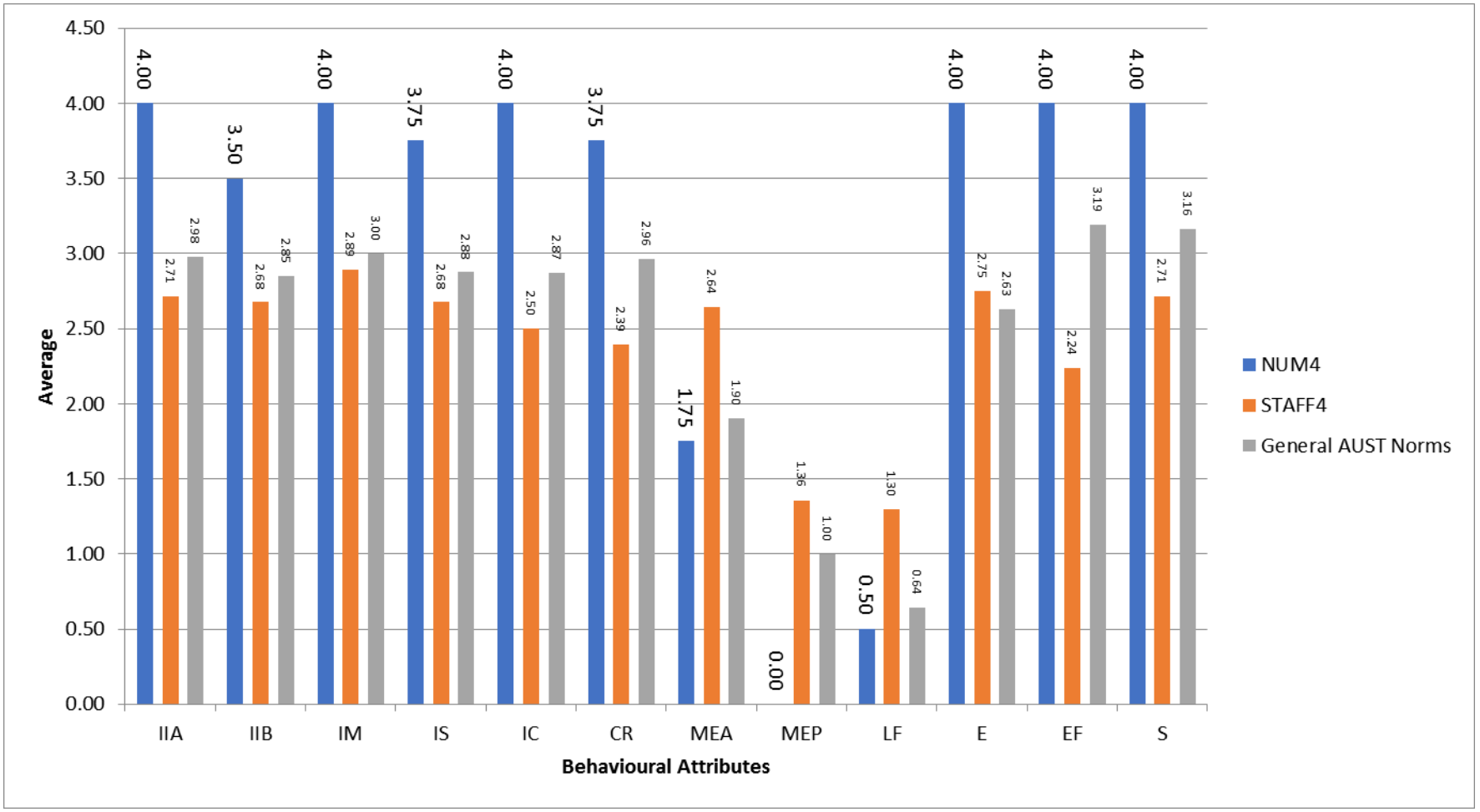

Figure 5. 11. NUM4 average behavioural attributes as compared with general Australian norms

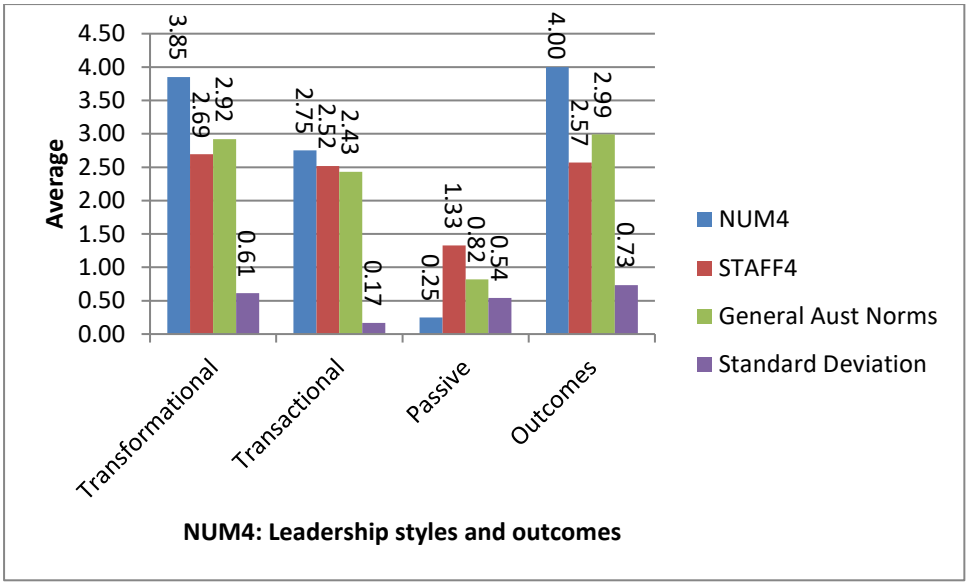

Figure 5. 12. NUM4 leadership styles as compared with general Australian norms

Figures 5.11 and 5.12 showed that NUM4 rated her leadership style as more transformational and less transactional. Staff rated NUM4 as exhibiting more of near equal proportion of both transformational and transactional. Staff also rated NUM4 as exhibiting a higher rate of passive approach than the Australian norm as shown in Figure 5.12. NUM4 rated herself with very high outcomes but staff rated the outcomes lower and also below the Australian general norm (Palermo, 2005).

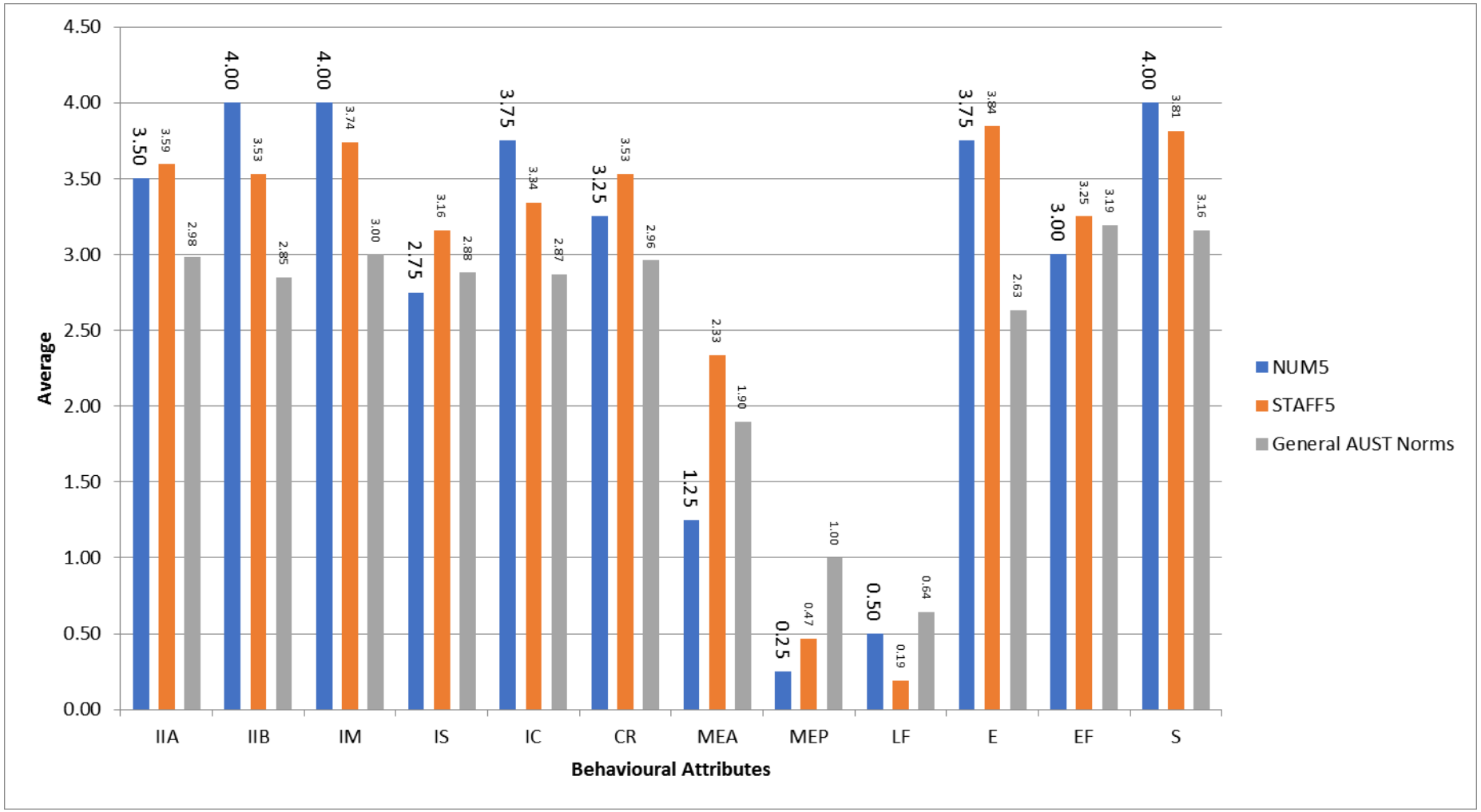

Figure 5. 13. NUM5 average behavioural attributes as compared with general Australian norms

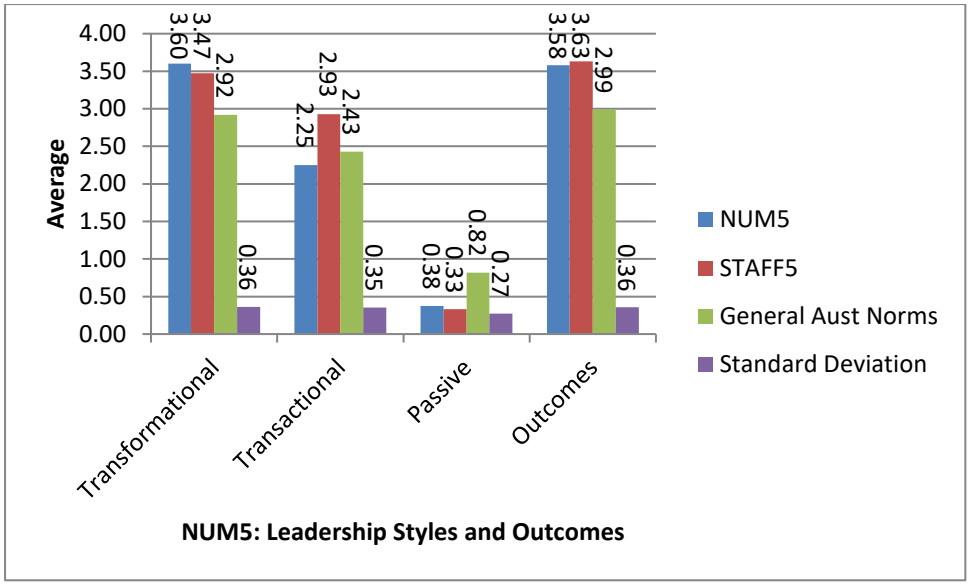

Figure 5. 14. NUM5 leadership styles as compared with general Australian norms

Figures 5.13 and 5.14 showed that NUM5 rated himself as more transformational. NUM5 rated himself lower on transactional but staff rated him higher than the Australian norms. However, in terms of outcomes, as shown in Figure 5.14, staff rated NUM5 higher than what NUM5 rated himself and higher than the Australian norms (Palermo, 2005).

The results of the MLQ showed that the NUMs displayed a combination of transformational and transactional leadership styles, but more transformational, with the exception of NUM1. NUM1, as shown in Figure 5.6, was rated as more transactional but outcomes were still high. Although the results showed that the style of leadership is more transformational style, the respective staff for NUM1, NUM4 and NUM5 rated their NUMs lower than NUMs' perceptions, as displaying transformational leadership style. The results also revealed that staff rated their NUMs higher than the Australian norms in transactional leadership style. The results of the survey are consistent with the results of the interview questions presented in Table 5.8 where the NUMs described their leadership styles as more transformational, that is, NUMs inspire their staff, act as role models, empower their staff, are

approachable and fair. The results also showed that staff rated their NUMs differently from what NUMs rated themselves.

With the exception of NUM5, staff rated their NUMs higher on passive behaviours. NUM2 and NUM4 were rated higher by their staff than the reported Australian norms for the passive style. NUM2 and NUM4 showed a lower rating on outcomes as compared to the other NUMs and the Australian norms.

As noted earlier, in this study, the MLQ was used to explore the perceptions of NUMs on their leadership styles and to compare them with perceptions of staff about their NUMs' leadership styles. Therefore, further analysis of NUM leadership styles was considered beyond the scope of this study. However, this could be an avenue for further research on preferred leadership styles of NUMs on different wards.

5.4.3. Discussion of results

To address Aim 3**, the three groups of participants were asked what they thought were the greatest challenges in being a NUM.** As the results indicated, all participant groups perceived leadership and management skills as the greatest challenges. People management, including difficult conversations, dealing with different and difficult personalities, dealing with everyday issues and doing multiple roles, were some of the challenges mentioned. The NUMs also mentioned working in tight time frames as another great challenge. **The three participant groups were also asked what qualities a NUM should have to succeed in the role.** All three sample groups further emphasised good management and leadership skills including qualities such as having the ability to be able to delegate, being able to deal with issues, having good time management skills and being accountable as the most desired qualities the NUM should have in order to succeed in the role. These participants recognised the importance of having good leadership and management skills. Whitehead et al. (2010)

noted that effective NUMs should possess a combination of qualities in leadership, clinical experience and business knowledge in order to prepare them for the complex NUM role. Accordingly, Sveinsdottir et al. (2018) reiterated that NUMs are required to function simultaneously as leaders and managers. It is important therefore that NUMs must be adequately prepared to face the challenges of the role and to acquire the necessary qualities to be an effective NUM. This relates to education and training needs of NUMs in this study. In the present study, as discussed earlier, NUMs indicated that they needed more training in people management which included difficult conversations, managing absenteeism and performance management as well as technical aspects of the role such as computer skills and budgeting.

In order to gain an understanding of the effectiveness of NUMs' leadership styles, the NUMs were asked: **"What is your most positive experience of being a NUM?"** Similarly, ANUMs and RNs were asked: "**What is your most positive experience with your NUM?"** The NUMs' stories indicated that their leadership behaviours influenced positive outcomes for patients and for staff. Interestingly, the positive experiences as described by the NUMs resonate with those of ANUMs and RNs with their NUMs. Studies have shown that effective leadership style is linked to staff retention, job satisfaction, enhanced team performance, productivity and organisational commitment (Casida, 2007; Casisa & Parker, 2011; Hirst, 2005; McGuire & Kennerly, 2006; Williams et al., 2001). As noted earlier, it is paramount that NUMs recognise their personal philosophies of leadership, because this affects how staff will respond to them, how staff will respond to their work and how staff will perceive them as effective leaders (Northouse, 2009).

Acknowledging the slippage in leadership/management language referred to earlier in this thesis, in order to determine the NUMs' perceptions of their leadership styles, they were asked to describe their leadership styles. NUMs responded along the lines of transformational

leadership, that is, leaders who practise transformational leadership inspire, motivate, act as role models, provide intellectual stimulation and encourage employees to self-manage (Bass, 1985; Marriner-Tomey, 2004). As discussed in the literature review (Chapter 2), in order for the NUM to be successful in aligning the organisation's vision and mission, NUMs must demonstrate effective leadership styles that are appropriate on ward and that can positively impact organisational performance (Casida, 2007; Kanste, Kyngäs, et al., 2007). The leadership styles of NUMs have a profound influence on staff job satisfaction and retention, and the delivery of care and health outcomes of patients (Azaare & Gross, 2011; Kleinman, 2004; McGuire & Kennerly, 2006). NUMs' leadership styles are important factors in staff accepting change and being motivated to achieve high quality care (Azaare & Gross, 2011). Such leadership styles can have an effect on staff perceptions of them as manager or leader (Hill, 2017).

To further assess the NUMs' leadership styles, they were given the MLQ Self-Rater Form to rate their management styles. The ANUMs and RNs who worked under them were given the MLQ Rater Form to rate their NUMs' leadership styles. The results were then compared to determine whether what NUMs thought of their leadership styles were the same as staff perceived them to be. The results in Figures 5.6, 5.8, 5.10, 5.12 and 5.14 showed that staff perceptions differed from what the NUMs thought of their leadership styles. This finding has been highlighted in other studies where it was found that staff rated their managers differently from how managers rated themselves (Edmunds, 2014; Failla & Stichler, 2008; Ghorbanian et al., 2012; McGuire & Kennerly, 2006; Suliman, 2009; Zampieron et al., 2013). The results of the MLQ in this present study revealed that NUMs displayed a combination of transformational and transactional leadership styles but more transformational with the exception of NUM1 who was rated more transactional. The results of this study are consistent with other studies where transformational leadership style is

predominantly used in nursing management (Bowles & Bowles, 2000; Edmunds, 2014; Kallas, 2011; Lindholm et al., 2000; McGuire & Kennerly, 2006; Suliman, 2009). McGuire and Kennerly (2006) found that nurse managers demonstrated both transformational and transactional behaviours and suggested that nurse managers would be more effective if they maintained a combination of transformational and transactional behaviours. Bowles and Bowles (2000) compared the transformational leadership of front-line managers in nursing developmental units and conventional settings in the United Kingdom, with front-line managers being more transformational in their leadership styles. This is also reflected by Suliman (2009) who conducted a study of nurse managers in Saudi Arabia, and found that nurse managers displayed both transformational and transactional leadership styles but predominantly transformational. Lindholm et al. (2000) noted that some nurse managers exhibited a mix of transformational and transactional leadership styles. This is consistent with Edmunds (2014) where nurse managers were rated as exhibiting transformational leadership by higher management, but were rated by staff as exhibiting both transformational and transactional leadership styles.

Another interesting result from this study is that the findings were, unlike other studies which revealed that nurse managers rated themselves higher as transformational than their staff rated them (Failla & Stichler, 2008; Ghorbanian et al., 2012; McGuire & Kennerly, 2006; Raup, 2008), NUM2 (Figure 5.7) and NUM3 (Figure 5.9) were given higher ratings by their staff on transformational behaviours. A possible explanation for this discrepancy could be that these NUMs had fewer years of experience and were less confident of their leadership capacities, thereby underrating themselves. This finding agrees with Zampieron et al. (2013). They also found that staff rated their nurse managers higher. Zampieron et al. (2013) attributed this finding as well to nurse managers being less confident about their leadership and therefore underrating themselves.

Staff rated their NUMs higher on transactional leadership as compared to the reported Australian norms (Palermo, 2005). This result could be attributed to the nature of the NUM's role and their work environment, consistent with McGuire and Kennerly's (2006) study where staff rated their nurse managers as more transactional. The authors stated that the nature of the job of nurse managers is embedded in transactional characteristics, and it could be the effect of the work environment where hospitals and health care organisations are bureaucratic in nature and thus transformational leadership cannot be exercised fully. Failla and Stichler (2008) concur that staff rated their managers as more transactional. They explained that this could be due to the nature of the health care environment, where nurse managers are expected to comply with the organisations' policies, budget and productivity which are transactional in nature. Bormann (2011) found there was a significant correlation between overall job satisfaction of both nurse managers and staff and transactional leadership behaviours. Bormann (2011) suggested that the reasons for this may include role expectations for the nurse manager to exhibit transactional behaviours, such as compliance, to policies and procedures, rules and regulations and requirements about using evidence based practices. This study finding requires further research to explore why staff rated their NUMs higher than the Australian norm and also raises questions about the need for Australian norms to be updated in acknowledgement of the consistently changing health care environment. Other explanations for the discrepancy between study findings and Australian norms could be contextual, including particular characteristics of the hospital or ward.

The study finding also showed that NUM2 (Figure 5.8) and NUM4 (Figure 5.12) were rated higher by their staff than the reported Australian norms for passive style. This concurs with Bormann (2011) who also found that staff perceived their nurse managers as more passive-avoidant than the norm. Bormann (2011) did not offer an explanation for this finding. Hersey and Blanchard's (1993) suggestion that staff require less task orientation as their level

of maturity increases may offer an explanation. Staff require less supervision and direction when they are more experienced (Sellgren et al., 2006). A systematic literature review on the influence of nursing leadership on nurse performance by Brady and Cummings (2010) revealed that nurses viewed autonomy as affecting their motivation and ability to perform. Nurses who had gained the trust of their nurse manager may experience more autonomy in performing the scope of their practice. Explanations by Hersey and Blanchard (1993), Brady and Cummings (2010) and Sellgren et al. (2006) are in agreement with the Path-Goal Theory of leadership, whereby more experienced staff may prefer a leader who is more task-oriented and holding less control over them (House, 1971). Again, this study finding needs further research as to why staff rated their NUMs higher on passive behaviours as compared to NUMs' ratings.

In terms of outcomes, the study results revealed that although NUM1 was rated by staff as more transactional, he still obtained a higher rating on outcomes as compared to Australian norms. This finding agrees with Bass and Avolio (2004) that transactional leadership is a positive form of leadership. However, this contradicts the findings of Bormann (2011), Kleinman (2004) and Azaare and Gross (2011) who showed that transactional leadership was not related to overall job satisfaction. Azaare and Gross (2011) stated that transactional leadership will demoralise followers and in turn decrease their commitment and trust in the leader, which then leads to a decrease in job satisfaction. Kleinman (2004) found that transactional leadership behaviour of active management by exception negatively influences staff retention. Cowden et al. (2011) also found that leadership style that is task-focused, such as management by exception, resulted in lower intention to stay. Bormann (2011) attributed this finding to the nature of the nurse manager's role, whereby they are expected to achieve the goals related to policies and procedures, rules and regulations and work according to evidence based practice. Edmunds (2014) and Failla and Stichler (2008) concur with

Bormann (2011) that nurse managers are expected to meet transactional requirements such as productivity, budgets and quality standards.

Although the results revealed that NUMs were predominantly transformational in their leadership styles, the results also showed that all NUMs displayed a combination of transformational and transactional styles. NUM1, NUM3 and NUM5 were rated higher by their staff than the Australian norms on outcomes. This finding supports the Full Range of Leadership Model where Bass and Avolio (2004) argued that leaders should display both transformational and transactional behaviours but in differing amounts. Bass and Avolio (2004) further argued that transformational leadership augments the effects of transactional leadership on the efforts, effectiveness and satisfaction of subordinates. McGuire and Penprase (2006) also assert that in order to ensure the smooth operation of any nursing unit and to maintain the stability of an uncertain health care environment, the NUM must effectively handle the dual role of transactional and transformational leader. The present study supports the findings of Williams, McGee and Bates (2001) where a nurse manager is more effective when there is a balance between transformational and transactional leadership. Ghorbanian, Bahadori, and Nejati (2012) and Failla and Sticher (2008) agreed there was a strong relationship between transformational and transactional leadership styles and overall job satisfaction. However, the finding of this study is in contrast to the findings of Lindholm et al. (2000) and Sellgren et al. (2006). Lindholm et al. (2000), for example, found that those who exhibited a mix of transformational and transactional characteristics had more management problems than those whose leadership style was distinctly transformational or transactional and Sellgren et al. (2006) found that staff preferred managers with clearer leadership style.

In the case of NUM2 and NUM4, although they displayed a combination of transformational and transactional leadership styles, staff rated them lower than the

Australian norms on outcomes. This finding could be the result of these NUMs being rated higher by their staff than the Australian norms on passive leadership. According to Bass and Avolio (2004), passive leaders avoid specifying agreements, clarifying expectations, and providing goals and standards to be achieved by followers (p. 105). Passive leaders only interfere when problems become more serious. The passive leadership style has negative impacts on followers (Avolio & Bass, 2004). This concurs with Bormann's (2011) finding that staff rated their nurse managers more than the norm on passive leadership and identified negative effects on outcomes. Malloy and Penprase (2010) conducted a study to examine the relationship between leadership style and the psychosocial work environment of registered nurses, which also revealed that nurse leaders who exhibited behaviours consistent with management by passive leadership had negative effects on the work environment.

According to Bass and Avolio (2004), the MLQ is not designed to label a leader as transformational, transactional, or passive-avoidant. The current study calculated averages of leadership behaviours (Avolio & Bass, 2004) and compared them to the Australian norms (Palermo, 2005) to obtain a perception of NUMs as "more transformational than norm", "less transactional than norm", or "less passive-avoidant than norm" and to obtain a perception of the outcomes of their leadership styles as rated by NUMs and staff. The MLQ was used in this study to explore NUMs' perceptions of their leadership styles and to compare them with those of staff on their NUMs' leadership styles. Therefore, as stated earlier, further analysis of NUMs' leadership styles was considered beyond the scope of this study. However, this could be an avenue for further research on preferred leadership styles of NUMs on different wards.

5.4.4. Section summary

This section explored what NUMs thought were the greatest challenges to their role. It also explored NUMs' perceptions about the qualities they should have in order to succeed in the

role. To gain insight into the effectiveness of NUMs' leadership styles, NUMs gave an account of their most positive experience as a NUM. Similarly, ANUMs and RNs described their most positive experience with their NUM. Further, to assess the effectiveness of NUMs' leadership styles, they described how they approached a difficult situation. In order to perceive their leadership styles, NUMs described their leadership. The MLQ Self-Rater Form was used to further assess leadership styles of NUMs. ANUMs and RNs who worked under them were given the MLQ Rater Form to rate their NUMs' leadership styles. The results were compared to determine whether the perceptions of staff and NUMs were the same. The results of the Self-Rater Form were also compared with those of the interview questions for NUMs to describe their leadership styles. The findings of this study showed that NUMs used transformational leadership styles consistent with other studies.

5.5. Aim 4: To identify the barriers in acquiring the skills required for the role

To assess the potential barriers in furthering their education, all participants were asked: "What could be the barriers to furthering your training or education?" Their responses are presented in Figure 5.15.

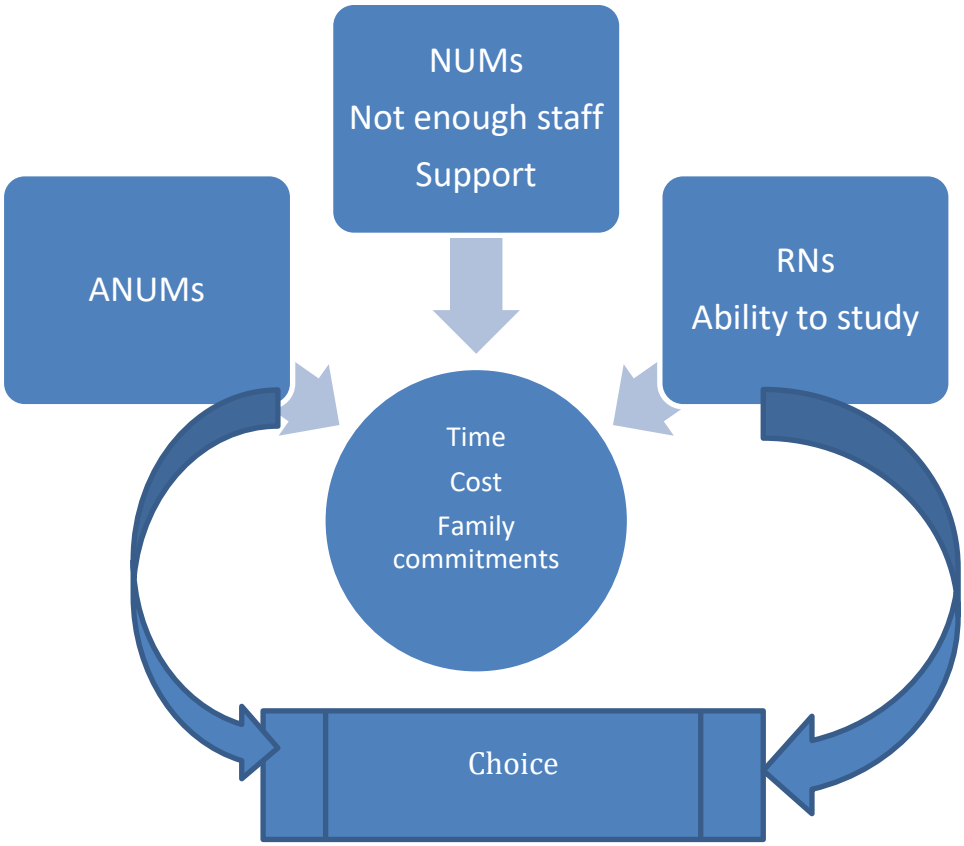

Figure 5. 15. Barriers to further training and education

For all participants, time, cost and family commitments overrode barriers. Some examples of NUMs' responses were:

> "Time. The NUM role can get quite busy with projects, meetings to attend, a lot of roll outs and obviously the day-to-day issues that come up are probably the big barriers to undertaking further education." (NUM1)

> "I think one of the biggest barriers is cost because a lot of people don't prioritise that cost in education and training and time. There are two barriers that I see. Having time to do extra courses, having time to complete the courses and do those sorts of things in your own time when you work full time is difficult, especially if they have family and other commitments." (NUM4)

> "Time. The catchcry of all nurses is time but it's really a management issue. You do not sit down for long. You do not have a lot of spare time. The spare time you do have you usually are investigating something or changing something or developing something. It's very rare that a manager has time." (NUM5)

Typical responses from ANUMs were:

> "Cost and time. A lot of further education is very expensive and I think people have already graduated as a nurse, they are working and I think furthering their education is another burden for the family if they have children. At the same as time, working full time and then fitting in further education can be a challenge and having it [further education] on site is really helpful." (ANUM6)

> "As I have said, you have to balance your work life, family life, social life, balance everything being a woman. With men it might be a bit easier, because they can let the partner do the work. Money and the cost of the study because they are not cheap. Yes, we get compensated somehow but is the monetary reward worth it? Also the stress that comes with studying. I don't know, there are just so many things to do. So basically it is the time and the cost." (ANUM3)

Typical responses from RNs were:

> "I think it's time and making it a priority. The days are already so busy too, if it is something uni [university] based and then there are assessments to follow, they have to fit that in their own time. Another barrier is the cost; if it is at uni then it is expensive, to and from, depending on where your uni is based." (RN2)

> "The timing of the training like what time of the day it is offered, whether you have children and other responsibilities outside of work and how many hours you would be able to work." (RN3)

ANUM1 and ANUM4 thought that furthering training depended on the person's choice and motivation:

> "If you are not motivated to do it, it would be a barrier, if you are negative about doing it, you're not interested in doing it. It would be a big barrier." (ANUM1)

> "I think the barrier is just choice. My choice personally is not to become a NUM. It's never been an aspiration or a goal of mine. I don't think there are any barriers though. Within … health there is not a high turnaround of NUMs so obviously there are good positions, but there are always opportunities for things if you want them and if you think or feel that you need training there are always opportunities there that you can enroll in." (ANUM4)

NUM2 and NUM3 thought that management should cover the cost of training for NUMs in order for them to do their job appropriately:

> "Time and support. I am very supported in my role now to do further education or attend things during work hours; but previously I was in a different area and I wasn't, you know, the talk was there but we were not supported in that role to do this kind of stuff. It was expected that you do that in your own time. Which is okay, but it would be good if you have the support from your manager." (NUM2)

> "Money probably, I reckon. I don't know how … health can't fund more for computer courses. I think computer courses at the moment are like $300 for two days which means, if I am expected to produce graphs, I think that they have to pay for that. Like

the Diploma of Management course, I paid for myself. It was subsidised and with the community sector one I am paying nearly $1100. But that is also subsidised. If I have to do it externally, I would be paying more than that. And probably, yeah money I'd say and maybe staffing, because you don't have many full-time employees at the moment, so if I'm off training there might not be enough senior staff like to cover me as well." (NUM3)

In order to address Aim 4, the three groups of participants were asked: **"What could be the barriers to furthering your training or education?"** As summarised in Figure 5.15, responses for all participants indicated that time, cost and family commitments were overriding barriers. Other reasons included lack of management support, too few staff, and inability to study. The results of this study are consistent with other studies (Acree, 2006; Courtney et al., 2002; Kleinman, 2003; Mathena, 2002). Nurse leaders do not have the time to develop their leadership and management skills due to many competing priorities (Acree, 2006). Previous studies have found that time, financial costs associated with the training, availability of appropriate programs, perceived training needs, geographical limitations relating to travel, lack of relieving staff, balancing work and personal lifestyle and lack of organisational support were the most common barriers reported (Courtney et al., 2002; Kleinman, 2003; Mathena, 2002). Looking at the present study and earlier ones completed more than 10 years ago, nurses interviewed and surveyed continue to face the same constraints in relation to further study opportunities.

In order for NUMs and aspiring NUMs to better prepare for the role and acquire the necessary skills, it is important to determine how to overcome these barriers. Russell and Scobe (2003) suggested that since NUMs are gainfully employed, the training program should be designed to meet the needs of the working person. Foster (2000) found that nurse managers preferred structured self-development for personal development. Foster claimed

that nurse managers would be more motivated to enhance their skills if their preferred style of training was used. In order to address these issues and to further address Aim 4, the three groups of participants were asked: **"Do you have any suggestions about the most appropriate training methods?"** The responses from each group are summarised in Figure 5.16.

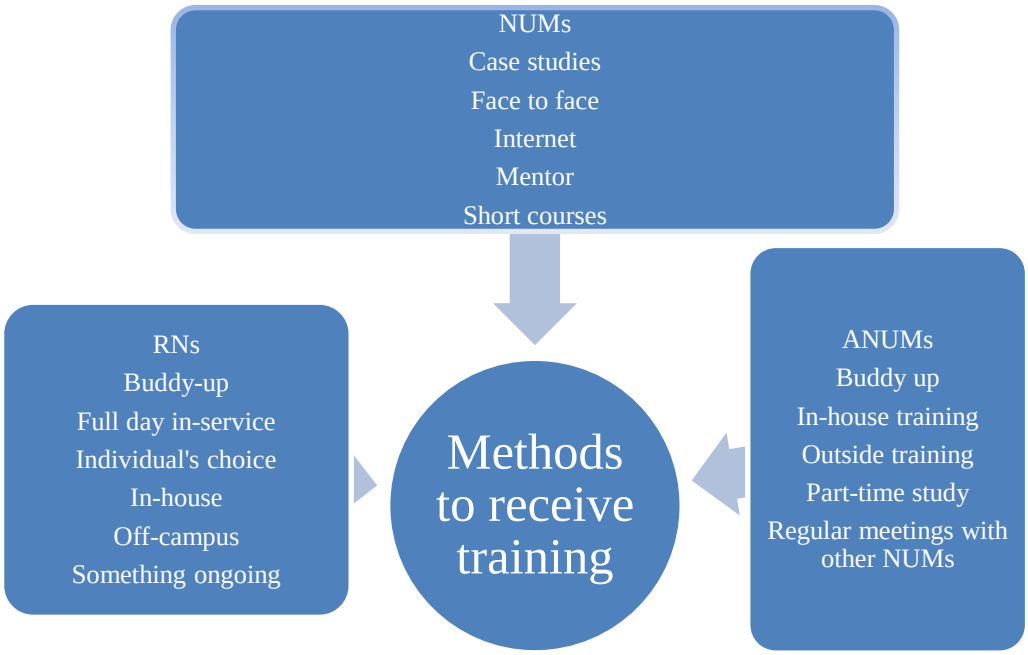

Figure 5. 16. Preferred training methods

The common category that emerged was that all participants wanted face-to-face training through short courses and preferred onsite training. NUM2 and NUM3 made interesting comments in regard to face-to-face training:

> "I think face-to-face like the short sessions or a course, but not an online course, because nurses are very practical people like our job is practical and I find that even with e-learning, staff are more likely to go to an in-service [session] and learn more from that like hands on Basic Life Support (BLS) than doing e-learning because they

are more practical learners, but some people prefer online so that should be an option, but for me it would be face to face." (NUM2)

"For computers, it should be a sit down, taught session but I suppose it depends though on people and the way they learn. I am very much a "monkey see, monkey do" kind of person whereas if you gave me a manual, 'okay this is how do it, go do it, I will be like oh okay'. So, for computer stuff, I would like face to face…." (NUM3)

In-house training tailored to the needs of the organisation was also a preferred method.

ANUM2 commented:

"In-house training is better because it is applicable to what they are doing. I think once a fortnight or once a month and there should be NUM meetings to debrief and I don't know if they have that, maybe they do, to debrief and to learn from each other from people outside or inside coming to teach them a topic that they have surveyed or what topic they want to learn, what sort of management style, what sort of budget they are looking at, or roster or whatever topic, they should go for this training ongoing to help them for preparation because we are always learning. And the same thing for ANUMs, I find that regular meetings or trainings are good for them to prepare." (ANUM2)

NUM3 stated a preference for case studies based on real-life scenarios that occur in the work setting:

"….and I think with having difficult conversation, having case studies, this is really good, relating to actual cases within the network, because that is what I'm finding with staff like if we talk about real patients that have crashed, talk about clinical deterioration of the patients, saying like this is what happened on the ward, vital signs

were not monitored, bla-bla-bla, pressure coded and so forth, so I think real-life scenarios are the best." (NUM3)

NUM4 suggested the use of Internet resources such as "YouTube" to access information that can offer life experiences:

"YouTube because it is easy to access. There are many powerful videos. So it is a fantastic resource that people can upload. Of course there are lots of courses around that people can seek but they don't equate to life experiences. So it is a bit hard to suggest that there is one course that is better than another course…." (NUM4)

ANUM6 was pleased that management courses were offered on-site in partnership with other institutions:

"…Health offers a Diploma of Management and that was very useful and having it onsite helps people to attain and achieve further education as well as working full time." (ANUM6)

Staff can also attend in-service training. These training sessions are short in duration, with training usually lasting two hours and staff work for the other hours on their shift. RN2 thought this was not conducive to learning:

"I don't know what options there are but maybe something that builds on, like building blocks sort of thing but you have a foundation, then you have some experience on the ward, and you come and do some more. I think if it is in-service, it becomes not a priority whereas if it is something off campus, I know with my postgraduate studies, because I was not at work on that day, I could focus on it but if I started on the ward and then just went out for an hour, your mind does not think about it as a priority. You just can't focus on that thing. Even if it is in-service but a full day rather than coming to

the ward and then going to spend two hours that is hard to fit in a NUM's day…" (RN2)

NUM4 and NUM5 suggested the use of mentors so that NUMs may learn from each other:

"….I think that one of the important things for nurse unit managers is having a strong mentor person, someone who they can discuss daily concerns with or come and meet with them once a week and say 'This was a situation I was confronted with this week'. Because people are individuals and they have individual problems and you spend a lot of your time problem solving and assisting individuals from that perspective and I don't believe that there is any course that covers that. And I think that the most valuable thing would be to have a mentor for those people to actually go to, discuss that with and get their perspective on how they would manage it, or they would handle it or the advice that they would give and then that person can actually take from that what they think is appropriate and then find out what works." (NUM4)

"Sometimes courses help. They can give you the tools to be able to do them and also for me I have a mentor in the organisation and I often go to that person and actually ask "What would you do? This is what I've done. Would you have done that?" and sometimes the answer is "No". And it is how you would achieve it and that's how I manage." (NUM5)

This was echoed by RN3:

"Probably buddying up with another nurse unit manager on a ward similar to what you will be working on, attending management courses, may be getting some feedback from your staff about what they would like in a nurse unit manager." (RN3)

For staff to be able to further their training, they need their manager's approval.

> "We usually do it through the education area and they give you all the information that you need to know and then you have to ask your manager if you are able to attend, because it's a whole year course and you have to pay for it out of [your] pocket. I prefer in-house training because it is more formal this way." (ANUM1)

ANUM4 highlighted the support staff needed from their managers:

> "I think …[name of hospital withheld] offers a lot of courses that, I don't think are necessary, but I think ……[name of hospital withheld] health offers quite a few, even just a short day one that you can go to as a NUM, or as an ANUM to get ready to be a NUM, but it also depends on the environment that you are working in with your current NUM, whether they are supportive and encouraging of you to develop as an ANUM, the NUM qualities that are required. I think that is more beneficial if you are working with a NUM that supports and encourages you to take on NUM roles. And I think that is more beneficial than the courses that you do." (ANUM4)

The common category that emerged among all participants was that they wanted face-to-face training through short courses and preferred onsite training. Other methods suggested were: management courses to be offered on-site in partnership with other institutions, in-service, use of mentors and buddying up with NUMs, and Internet resources such as "YouTube". These suggestions concur with those of other nurse leaders who also support the idea of mentoring, collaboration between universities, distance learning and online programs or web-based education (Courtney et al., 2002; Duffield et al., 2011; Kleinman, 2003; Korhonen & Lammintakanen, 2005; Mathena, 2002). Information technology offers many possibilities for nurse managers such as collaboration within and outside of the organisation (Korhonen & Lammintakanen, 2005). In the study by Lammintakanen et al. (2010), there was a wide acceptance of nurse managers' use of information systems and acknowledgment of the

increasing use of information technology in the future. Koloroutis (2008) suggested telephone coaching as an alternative to face-to-face mentoring. Telephone coaching offers ease of access and neutrality of distance. Beyond these suggestions, Foster (2000) found that some ward managers are reluctant to develop their managerial skills unless it is an organisational requirement.

The participants considered cost as one of the biggest barriers to furthering their training and education. In order to overcome this barrier, organisations can offer scholarships or tuition reimbursement to support graduate education, certificate or diploma programs and educational conferences (Courtney et al., 2002; Duffield et al., 2011; Kleinman, 2003; Korhonen & Lammintakanen, 2005; Mathena, 2002).

5.5.1. Section summary

This section addressed Aim 4 which sought to determine the barriers for NUMs to furthering their training or education. The overriding barriers identified by the three groups of participants (NUMs, ANUMs and RNs) were time, cost and family commitments. These barriers indicated that they face the same constraints as those nurses interviewed and surveyed more than 10 years ago. In order to overcome these barriers in furthering the NUMs' training or education, the three groups of participants were asked what they considered the most appropriate method to receiving training, which was face-to-face and preferred onsite training.

5.6. Aim 5: To explore how reflection through case writing can improve the NUM's skill

In 2003 Shaffer wrote that yesterday's way of thinking and training may not work in the current very dynamic health care setting; therefore there was a need for new, innovative and effective training methods. Gallo (2007) also agreed that traditional ways of training staff

nurses for management positions did not prepare them to be effective leaders. More recently, others have noted that traditional lectures may not be effective in helping NUMs learn how to lead in ever-changing health care organisations and to solve unpredictable problems (Graham-Hannah et al., 2017). While there is an abundance of strategies and methods to prepare nurse managers for their role, these approaches do not draw upon lived experiences of nurse managers, and nor do they focus on peer coaching and learning (Mackoff et al., 2013).

Griscti and Jacono (2006) identified a need for more research that addresses informal methods of learning. So for this study, the researcher explored how reflection through case writing could improve NUMs' skills and drew on previous research around the value of experience and reflection on experience. D'Cruz (2002) stated that many managers learn from experience. However, experience is not a guarantee that leaders will become experts in their role. The missing component of learning from experience is feedback and reflection (D'Cruz, 2002). Experience and reflection are interrelated. Leaders reflect on experience. If the experience is challenging, so too is the reflection (Miettinen, 2000).

The participating NUMs were asked to write a case narrative of one of their experiences as a NUM and then write a commentary on the other NUMs' case narratives. One NUM did not participate in written commentaries and did not provide any feedback due to work commitments. The main purpose of this activity was not to analyse the case scenarios but to gather NUMs' the perceptions on the use of case writing to help new and aspiring NUMs prepare for their role and further, how case writing may be used as an alternative to face-to-face mentoring.

The following case narratives are written by individual NUMs while the commentaries were written by other NUMs. They exemplified how case writing and written commentaries

can be used by NUMs to collaborate with each other, and to experience and reflect on other NUMs' lived experiences. The approach taken draws on seminal work in case writing devised by Shulman (1991) with practising teachers. The energy and detail in these cases and commentaries replicates that revealed in the interview responses included earlier in the thesis. This draws attention to the immense capacity and openness of nurses to articulate and learn from their experiences and those of others.

Case scenario NUM1

One issue came about with me and a manager from a different department. She was trying to send us a patient that we were not capable of taking care of safely and she thought we were compromising patient care by not accepting the patient. That was a difficult one to address and we had the head anaesthetist involved and I was able to troubleshoot by talking to her, but explaining the reasons why, and obviously escalating it to someone higher up in our department to be the kind of mediator. It probably was the most challenging so far. So first I spoke to her and gave her the reasons why we couldn't take the patient and she disagreed with my opinion, so then when she disagreed, we had to speak to someone higher up. So when I spoke to the person higher up I explained it, she agreed because I obviously gave clinical reasoning to it and she was able to inform the manager of that department that we would not be able to take care of the patient for the particular reasons that I said. She outlined herself that we were compromising the patient if we accepted the patient, and this would be a greater clinical risk. It's important to utilise your extensive clinical knowledge to advocate for your staff and patient.

In this case, they wanted to send us a patient with a tracheostomy and I was worried that we were not capable of accepting patient with this tracheostomy because staff do not know how to take care of tracheostomy, although I am capable myself to take care of these type of patients, but I am not there 24/7 to provide support and this was a clear patient safety risk. In addition the patient could take care of the tracheostomy themselves pre-surgery, but we were not sure postoperatively if they would be able to do this. If there was an emergency, particularly overnight, no one knew how to take care of a tracheostomy so they would be putting this patient at risk. This risk is not only for nursing staff but also for medical staff as not all medical staff are trained to take care of a tracheostomy.

This scenario raises a number of issues. Firstly in a hospital clinical setting, patients' safety should always be the first priority. In this situation, although the patient may be self-caring with their tracheostomy it is important to consider situations outside the norm. In the event of an emergency all the nursing staff and medical staff working on the ward would need to be competent with the skills and knowledge to take care of a tracheostomy. This level of expertise would need to be ensured for all shifts (AM, PM, nightshift), which in this case was not present. Awareness of this knowledge deficit needs to be followed up with further action, as not accepting this patient is only a temporary measure and should not be an excuse. In this case, education for the ward nursing staff would need to be organised in consultation with the Education Department to ensure future patients with this condition are safely taken care of and staff are deemed competent.

Secondly, although the patient could not be accepted to the current ward an alternative would need to be decided for this patient so that they still received their medical treatment. Therefore no compromise to their health would occur. In this case, there was an appropriate ward at the…. [campus withheld] campus where the patient could be taken care of safely post surgery. Timing and logistics for this alternative could be sorted out by the relevant managers of that department. In this case, the patient was able to be rebooked at the ….[campus withtheld] campus and received their treatment accordingly.

Thirdly, within any organisation there is likely to be many situations where managers from different departments can have differences of opinion. If a compromise cannot be reached with these differences it is important to escalate the matter to the next level of management if appropriate. In this case it was important to escalate the issue to the next level of management so that a decision could be made in the best interests of the patient. When escalating situations to higher levels of authority, it is important to present to them the facts and rationale for proposed decisions and to remain objective about the scenario so that best care for the patient is considered and is not based on personal opinions.

Lastly, it is always a challenge for new members of staff to establish assertiveness in the workplace particularly when someone of authority is trying to influence a decision-making process. In this case, as a new NUM to the hospital, it is important to establish respect, assertiveness and act as the patient's advocate at all times.

Case scenario NUM1 – Commentaries

Commentary NUM3

I cannot agree about patient safety being paramount. It is difficult when there are these isolated instances where a patient's needs are requiring a higher/different level of care and you are not able to provide this over a constant period. I also do not hesitate to escalate any concerns that I have, as my main priority are the patients and staff. It seems that when a patient is in hospital on a ward, then all types of treatment are expected to be carried out by the medical staff. Working in a smaller campus in the network can be very challenging to send patients back to acute when they deteriorate, as there have been times whereby treatment has been ordered and staff are not familiar with how to carry this out, let alone ensure it is safely monitored, etc.

Commentary NUM 4

In the workplace, there are often situations that evoke a conflict or differences of opinion. It is important that we respect our colleagues and their knowledge of their team's ability to perform certain tasks. Trying to force a situation will lead to unsatisfactory outcomes and an unacceptable risk to the patient who we are meant to be caring for.

The limiting factors to providing care should be clearly stated, and if not accepted then I would have sent through an email to the person concerned detailing the factors limiting the ability to care for the patient concerned, cc. the up line. I would also have detailed a plan to educate and train staff so that in future, the ward would be in a position to accept and care for this patient safely. Safety at work is a priority for our patients and staff caring for them. Working outside one's scope of practice and knowledge is negligent and would not be supported in a court of law.

Well done to the NUM for holding firm in their resolve to not accept this complex patient on this occasion.

Commentary NUM 5

This issue can be broken down to the following:

- NUM followed escalation policy
- Patient was sourced an appropriate ward
- Assertiveness is appropriate to protect patient safety
- NUM followed what she/he believed to be the safe option for the patient.

Case scenario NUM2

When I first started as NUM I was originally filling in for four weeks while the NUM was on leave. While she was away I attempted to address issues with the ANUM group about appropriate behaviour on the unit which led to some unhappiness amongst the team. When the NUM was due to return from leave, she came to see me to tell me that she was moving into another position and I was asked to continue in the role as NUM on the unit. The ward staff and ANUM group were all informed at the same time of this change which led to unhappiness amongst the ANUM group as they felt that they had not been informed and that I had known that this would be occurring from the beginning. I had only been an ANUM for six months and was quite young when I moved into the NUM role. I received no support from any senior management, no mentorship. I attempted to make changes on the unit to improve patient care and staff satisfaction but as I had no experience or support I probably went about these in the wrong way. I felt overwhelmed by the position and resigned on three occasions. Each time I was talked into staying in the role but still didn't receive much support.

Looking back now, having experience in roles other than the NUM, I can see where I went wrong with some of the changes I tried to make. I didn't consult stakeholders or plan effectively. I believe now, having worked in other roles, that I make more informed decisions, I take the time to plan and ensure that I communicate with all relevant stakeholders and staff. I think that I am a better manager having had further education and worked in different roles such as project management and independent roles such as CNC.

Case scenario NUM2 – Commentaries

Commentary NUM 1

Filling in for the NUM role and taking it on permanently is a significant task and can be extremely stressful and difficult. The NUM role encompasses a variety of responsibilities and requires mentorship and support particularly in the early stages. In this situation, I would speak to the Divisional Director if I was feeling unsupported as it is their responsibility to support NUMs. The Divisional Director should also appoint another NUM from the same division to provide support and mentorship to the new NUM. Furthermore, seeking the advice of stakeholders is extremely important in making decisions and ensuring implementation takes place. Without support of key stakeholders, change processes will not be effective.

Commentary NUM 3

I too, can relate to the lack of support in the NUM role and all the good intentions you have for both staff and patients will not work if key stakeholders are not engaged. There is a great YouTube clip of a man on a hill at a festival, I think it is called leader on a hill and shows how key people are the second and third followers.

Commentary NUM 4

Stepping up into a senior leadership role, such as NUM, is a challenge for everyone. There is no course you can complete which will provide you with the skills to manage all that confront you on a day-to-day basis. Different situations present a suite of factors for consideration that differ for each occasion. It is important to ease into the role, to get settled into a routine and comfortable with the role requirements, to become familiar with staff and get to know who they are and what they bring to their respective role, and how they can assist you, as a manager, change and develop the team and working environment, so it is a different perspective from the manager's position. All too often we step up and want to change things in a short space of time, that will meet with opposition unless you share your vision and get staff on board to walk and work alongside you, as the manager, to achieve defined goals and objectives.

Commentary NUM 5

- This was an unfair situation to this ANUM/NUM
- It appears that the process was not transparent and the backfill did not follow procedure. This caused her issues.
- Very disrupting that she was not supported.

Case scenario NUM3

When I commenced here on the ward in May 2013, there was no system/process of tracking staff's competencies which are required to be completed each year as per our position descriptions. On a ward that I previously worked on we had an Excel template which listed them all, and staff and the dates that they were due. I asked for permission from the owners of the e-learning packages to gain access to ward reports so we had information to start entering into the template. Staff were notified all during this process, if there were any discrepancies, to come and see me which was good. I then worked through and entered the data and saved this to a shared folder for other ANUM's/CNS to access who could then update staffs competencies as needed. At the end of the month I now run a report for all competencies that are related to us via e-learning and update the template. We also have a ward hierarchy, whereby senior staff complete appraisals and remind staff of when these are next due. A copy of this is printed out each month, once updated, outlining how we are tracking as a ward on our knowing how we are doing board.

Case scenario NUM3 – Commentaries

Commentary NUM 1

Establishing a system/process in tracking ward competencies is extremely important as NUMs have a multitude of tasks to complete. Having a reliable system in place to check when competencies are due ensures that ward staff are compliant with organisational requirements.

Commentary NUM 4

It is important, as a member of a wider group, that we can share knowledge and processes that make our working lives easier. We all have similar challenges and there is bound to be someone who has resolved the problem before us and we should share these innovations.

This is an example of drawing on our experience, reviewing a process that is not working well, seeking a solution from other resources, educating the users, working smarter and creating capacity.

Commentary NUM 5

- Excellent work
- All wards need to keep clear records for staff themselves and management
- Appear to have followed a plan and then followed it up.

Case scenario NUM4

A nurse has been working on the same ward for some time; she has some good relationships with some staff and some not-so-good relationships with other staff.

Now changes to her family situation take this nurse onto another path, she is looking for something that she can balance with the other demands in her life. She becomes a little less engaged in activities at work, not talking as much to staff she gets along with, and talking even less to the ones she doesn't relate to, work becomes a chore and not a thing she enjoys anymore so she starts looking for another job.

Now she finds some jobs that she thinks she would like to try, so she applies for these, interviews well, all seems to be going well until the reference checks are sought and the story told is not too enticing so she doesn't get the new job. She is clinically competent, very knowledgeable, but something is missing and her performance at work begins to slip, sick leave rises, going to work becomes more difficult each day. She doesn't help or support the other staff; she keeps to herself and only does the basics.

Other staff find her rude, not engaging and often defensive. Do you know someone like this? How do you help them? Or do you try to performance manage them, but hang on, she isn't that bad, she is safe at work and doesn't do anything that is that wrong or even dangerous.

How do you manage this situation? Advice is sought from the mentor, who flags this staff member with a workplace coach for advice. The coach accepts the referral, contact is established with staff member, initially that does not seem that promising as staff member is somewhat aloof, and at times rude over the phone.

A meeting time is arranged and the coach talks to staff member about what they are seeking in life and how she plans to achieve her goals and dreams.

Staff member breaks down and cries, it all seems too impossible, she needs a job, needs to pay the bills as the primary earner, is stuck in a job she doesn't like and can't see a way forward, because every job she goes for, she doesn't get, but doesn't understand why.

The coach creates a plan to address the needs of staff member, which starts with a 360 profile. Staff member must nominate people, friends and foes that can be interviewed by the coach to gauge a better understanding of the issues.

The 360 is completed, the strengths and weakness are identified and mapped into themes for an improvement plan that will be created and explored by staff member to improve her situation. The 360 process outcomes are revealed and discussed in a meeting with the coach and staff member, the many strengths identified are acknowledged and highlighted. As these will be used to overcome and address the issues of concern raised in the 360 by other staff, staff member will be fully informed and in complete control of the whole journey forward.

So how did it turn out? Extremely well at this stage, staff member is making concerted efforts to have more pleasant conversations with all staff on the ward, the interactions are pleasant, as staff member is aware of how she can be perceived and how she has been perceived in the past.

She continues to be coached, but is making good progress, she is happier at work and is waiting for another job opportunity to arise, would you employ her now? Would you be prepared to give her a chance, an opportunity?

Case scenario NUM4 – Commentaries

Commentary NUM 1

Changes in one's family/personal life can affect people's performance and relationships in the workplace regardless of the position/role they hold. With any major change/problem, it is important to have an action plan in order to manage this process. The 360 profile is an effective strategy to gain a better understanding of a problem/issue. Feedback is taken from a variety of sources and not just the staff manager. This allows staff member to gain a greater insight on how they are perceived in a variety of areas.

With any intervention/strategy, it is important that they are carried through and effective. I would employ this staff member again, if I can see that she has addressed the issues raised with her and has performed to expectations post intervention. This would demonstrate that she can adapt to change with appropriate support.

Commentary NUM 3

Would you hire her back on your ward? This is one of the last questions on our reference checking template. Depending on the area she was genuinely interested in I would give her a go. Getting the entire story of her previous issues would also help. We had a number of staff arrive on the ward and I was not privy to all the behaviours of one in particular who was going to be a senior staff member, which did cause a few issues on the ward amongst staff working with her. I felt that if I had known earlier I could have put in strategies and made my expectations clearer, especially to her. I see this as a risk to the great morale we already had and think it is always better the devil you know.

Commentary NUM 5

Overall, sounds like I would manage it the same. However, EAP (Employee Assistance Program) would have been good for her. May have progressed a different way. Staff psychologist can aid a staff member get back on track quicker. It's not all about 360 degree reviews.

Case scenario NUM5

The issue was poor bookkeeping of the S8 register and subsequent errors.

A department I was running accumulated 15 riskmans over a 12 month period around S8 errors. After reviewing the riskmans I decided that I needed to understand if there were links with the errors. I mapped out the issues and placed them into sub-categories. These were:

Drug errors = 1, register error =s 8, unexplained dropped drugs = 3, broken ampules found = 2.

As the manager my role is to ensure that staff are trained in how to maintain the register and ensure that staff are aware of the policy around S8 and S11 management.

When incidents occur I review each incident, make changes where necessary and educate staff, which can lead to discipline.

The errors at first glance did not seem to have a connection. However, after mapping the incidents I was able to find a pattern. Two of the dropped drugs and both broken ampules were on night shift. All four cases involved the restocking of the safes. The register errors also appeared to be separate at first. However, again night shift and evenings we found the errors. Most of the errors related to clarity of signatures.

My ANUM and myself made multiple changes.

1: All staff and ANUM nurses were issued with a stamp with had their name and designation. This replaced the writing of the name, not the signature.

2: Monthly audits were started and staff had a report given at the monthly meeting regarding the data results.

3: Three checks were installed throughout the day: 0700, 1200 and 2100. Each ANUM on the incoming and outgoing shifts only were allowed to count the safes. Previously only two checks were undertaken, any RN was being asked to count the drugs. By only allowing the senior ANUM's to count, it meant that action could be taken before errors could escalate. It also isolated the incident into a smaller time frame.

4: Staff were no longer allowed to leave until the error had been found, resolved and reported.

5: Safes were to be restocked one at a time. Staff had made short cuts by taking enough S8 and S11 drugs to restock all the safes. This was managed and monitored. The ANUM's on night shift were reminded of their responsibility and accountability.

With the high volume of S8 and S11, there will be an acceptable amount of dropped drugs that are witnessed. It is important to note that these numbers were not included in this review.

Key learning for me was that links can occur that are not always visible at first. Mapping issues is helpful. Education and repetitive conversations need to occur to ensure staff are aware of …… [hospital name withheld] policies. Audits need to occur. Data helps people understand that there is an issue. I would not wait as long in the future. I may have been able to find the issues that lead to errors earlier.

Case scenario NUM 5 – Commentaries

Commentary NUM 1

Mapping issues is a great method in understanding the connection between the details of a particular issue/problem which often leads to an effective solution.

In this scenario, I agree that the implemented action/solution is effective. On my ward, we also conduct the drug check between shifts with the ANUMs or nurse in charge of each shift only. This ensures a greater level of accountability if an action is required post results of the drug count.

Continued education on policies and procedures or new processes is vital for any department to ensure staff are informed and aware of issues or changes.

Conducting audits is also important as this provides the evidence that processes are being followed or not.

Commentary NUM 3

Mapping is very useful to "see" what the exact issue is and be able to pinpoint this. I also agree with audits as long as there is an action plan as such with all the data collected. Even in my short time here as a NUM, there have been lots of data collected with not much done with it.

Commentary NUM 4

Errors are integral to humans and human error. It is important to thoroughly investigate all variances and look for patterns, whether they be drug errors, falls, sick leave, patterns are often not obvious from the start but as we become more skilled as managers, we notice the regular occurrences that may reveal patterns on further investigation.

The solution needs to address the incident pattern to be effective, the outcomes need to be reviewed to ensure the problem is being adequately addressed. This is what we do every day as managers at work. I tend to consult with my team and in doing so, teach the ANUMs to be critical thinkers and solution focused. Ultimately that prepares them for transition to the NUM role and helps me create capacity in my daily work routine, and reassurance in my absence from work, that things won't fall down and the ANUM team are skilled and prepared to deal with most situations that may develop. All part of developing a high performance team.

The case narratives written by the NUMs varied. NUM1 wrote about his experience of dealing with a scenario where a patient was being moved to his ward, where staff did not have the skills to look after this type of patient. This NUM wrote about how he used his clinical knowledge to resolve the problem. NUM2 wrote about how she assumed the role without any experience and no support from senior management and attempted to resign on

three occasions. NUM3 wrote about an innovative idea that was implemented to track down the completion of competencies among staff. NUM4 wrote about how she managed a difficult staff member. Finally, NUM5 wrote about implementing a process to reduce medication errors. NUM5 wrote about the high volume of Riskmans around S8 medications. (Riskmans is the hospital's process of reporting errors. S8 medications are drugs of addiction and are labelled as controlled drugs. S8 medications are stored in a locked cupboard and there are special policies and procedures in accessing these drugs.)

The case narratives demonstrated how the NUM authors had the opportunity to reflect on their situations, actions taken and outcomes of actions taken. NUM5, for example, wrote about what he would do better in the future to resolve issues.

> "Key learning for me was that links can occur that are not always visible at first. Mapping issues is helpful. Education and repetitive conversations need to occur to ensure staff are aware of …[hospital name withheld] policies. Audits need to occur. Data helps people understand that there is an issue. I would not wait as long in the future. I may have been able to find the issues that lead to errors earlier." (NUM5)

This was echoed by NUM2 where she recognised the errors she made and how to resolve them in the future.

> "Looking back now, having experience in roles other than the NUM, I can see where I went wrong with some of the changes I tried to make. I didn't consult stakeholders or plan effectively. I believe now that having worked in other roles that I make more informed decisions, I take the time to plan and ensure that I communicate with all relevant stakeholders and staff. I think that I am a better manager having had further education and worked in different roles such as project management and independent roles such as CNC." (NUM2)

The NUMs also had the opportunity to put to other NUMs an unresolved query, for example in her case narrative NUM4, she pondered whether she was prepared to employ this staff member and give her a chance.

On the other hand, by reading the case narrative and written commentaries, the other NUMs were able to experience the lived experience of other NUM authors that might otherwise have been lost and to reflect on the situations. By reading the case narratives, the NUMs were able to reflect on similar experiences. For example, case writing gave an opportunity for NUM3 to relate to a similar lived experience to that of NUM2.

> "I too can relate to the lack of support in the NUM role and all the good intentions you have for both staff and patients will not work if key stakeholders are not engaged." (NUM3)

NUM3 also reflected on a similar lived experience of NUM5.

> "We had a number of staff arrive on the ward and I was not privy to all the behaviours of one in particular who was going to be a senior staff member, which did cause a few issues on the ward amongst staff working with her. I felt that if I had known earlier I could have put in strategies and made my expectations clearer, especially to her. I see this as a risk to the great morale we already had and think it is always better the devil you know." (NUM3)

Without face-to-face collaboration, the other NUMs were able to give additional insights into the scenarios. NUM1, for example, offered additional insight into the scenario written by NUM4:

> "Changes in one's family/personal life can affect people's performance and relationships in the workplace regardless of the position/role they hold. With any major

change/problem, it is important to have an action plan in order to manage this process." (NUM1)

NUM1 and NUM3 both agreed that they would employ the staff member described by NUM4.

"I would employ this staff member again, if I can see that she has addressed the issues raised with her and has performed to expectations post intervention. This would demonstrate that she can adapt to change with appropriate support." (NUM1)

"Would you hire her back on your ward? This is one of the last questions on our reference checking template. Depending on the area she was genuinely interested in I would give her a go. Getting the entire story of her previous issues would also help." (NUM3)

NUM5 offered an alternative action to the 360 profile and thought that engaging the services of the Employee Assistance Program (EAP) and a staff psychologist may have a different result and could get staff member on track quicker. EAP is a program provided by the organisation to provide care and support to any employee who requires assistance as a result of stress where their work performance and/or wellness are being affected.

By reading case narratives, the NUMS were able to learn from each other. For example, NUM4 appreciated the new knowledge she learned from reading the case narrative of NUM3.

"It is important as a member of a wider group, that we can share knowledge and processes that make our working lives easier. We all have similar challenges and there is bound to be someone who has resolved the problem before us and we should share these innovations. This is an example of drawing on our experience, reviewing a

process that is not working well, seeking a solution from other resources, educating the users, working smarter and creating capacity." (NUM4)

Further, through written commentaries, NUMs were able to offer advice to NUM2.

"In this situation, I would speak to the Divisional Director if I was feeling unsupported as it is their responsibility to support NUMs. The Divisional Director should also appoint another NUM from the same division to provide support and mentorship to the new NUM. Furthermore, seeking the advice of stakeholders is extremely important in making decisions and ensuring implementation takes place. Without the support of key stakeholders, change processes will not be effective." (NUM1)

"There is a great YouTube clip of a man on a hill at a festival. I think it is called leader on a hill and shows how key people are the second and third followers." (NUM3)

"Stepping up into a senior leadership role such as NUM is a challenge for everyone. There is no course you can complete that will provide you with the skills to manage all that confronts you on a day-to-day basis. Different situations present a suite of factors for consideration that differ for each occasion. It is important to ease into the role, to get settled into a routine and comfortable with the role requirements, to become familiar with staff, and get to know who they are and what they bring to their respective role, and how they can assist you as a manager to change and develop the team and working environment. It is a different perspective from the manager's position. All too often we step up and want to change things in a short space of time. That will meet with opposition unless you share your vision and get staff on board to walk and work alongside you, as the manager, to achieve defined goals and objectives." (NUM4)

5.6.1. NUMs' feedback of their experience in case writing and written commentaries

NUMs were given a copy of all the scenarios with written commentaries and were then requested to give feedback on their experience in participating in case writing and commentaries. The NUMs were requested to consider the following in their feedback:

1. How would case writing help in the personal development of a NUM in collaboration with others?
2. Describe your experience when writing your case scenario and writing the comments.
3. How did you feel after reading the comments on your scenario from other NUMs?
4. Do you think case writing would be a better option to face-to-face mentoring considering the time constraint on NUMs?
5. What are your thoughts about case writing as a tool for preserving the acquired practical knowledge of seasoned NUMs and extending these to new or aspiring NUMs?
6. Any suggestions on how we can improve and implement case writing as a tool to support NUMs?
7. Do you think that this research study could be a basis for further research on using case writing in preparing and supporting NUMs for their role?

NUMs' feedback is presented in Table 5.10.

Table 5. 10. Feedback for case writing and written commentaries

Guide to feedback	NUM	Feedback
1. How would case writing help in the personal development of a NUM in collaboration with others?	NUM1	I would like to thank the researcher (Josefina) for giving me the opportunity to participate in this study. It has been an invaluable experience and has opened my eyes to the shared experiences that NUMs face on a daily basis.
	NUM3	It was good to put pen to paper so to speak and reading others experiences within the same role.
	NUM4	Case writing is an arduous task. I personally prefer to discuss in conference than write responses to case studies.
	NUM5	Case writing can help you see different perspectives on situations. It might make me change the way I would approach the issue.
2. Describe your experience when writing your case scenario and writing the comments	NUM1	The case scenario writing was a useful tool as a form of reflection regarding a difficult situation I have encountered.
	NUM3	It was almost therapeutic to a degree to get a scenario off my chest and then read others reviews, as it is not too often that you have the opportunity to discuss issues on the wards with other NUMs.
	NUM4	I do acknowledge that there are some individuals that benefit from case studies and similar writings because they can refer and reflect. Case studies are a recognised learning methodology that may be suitable for some, but not all.
	NUM5	It was reflective practice. I would not have changed the way I approached the issues.
3. How did you feel after reading the comments on your scenario from other NUM?	NUM1	Reading and commenting on the other case scenarios has allowed me to utilise my current and acquired knowledge in developing an appropriate response or solution to a problem that other NUMs have encountered. It was interesting to see the comments of the other NUMs in regards to the case scenario I submitted as it was reassuring that the responses were similar and supportive of the actions that I undertook.
	NUM3	Good to see that I was on the right track with my scenario from a number of other NUM's; it boosted my own confidence to a degree.
	NUM4	One NUM did not respond at all. The others were of a similar view point, which identifies the commonalities in our roles as managers. Even though we come from very different areas of clinical practice, we all contend with similar problems.
	NUM5	Supported my approach
4. Do you think case writing would be a better option to face-to-face mentoring considering the time constraint on NUMs?	NUM1	I think case writing would be a good supplement to face-to-face mentoring but should not replace this method of mentoring.

Table 5.10 (continued)

Guide to feedback	NUM	Feedback
	NUM3	I think it could be an added benefit to mentoring newly appointed NUM's, as the face to face is really important. Text can be taken in many different ways as there is nil emotion associated with that.
	NUM4	Personally I prefer face-to-face mentoring, because the written word can be harsh in isolation from body language and voice tone, the meanings can become poles apart. However, we need to consider that we all have different learning needs and learning styles.
	NUM5	50/50 face to face is always better, but if we had no time this could be a good option. Lots of time needed by the NUM who is writing it up.
5. What are your thoughts about case writing as a tool for preserving the acquired practical knowledge of seasoned NUMs and extending these to new or aspiring NUMs?	NUM1	Sharing these case scenarios and the commentaries particularly to new NUMs would be extremely beneficial in developing their confidence and knowledge base in regards to the NUM role.
	NUM3	It all depends on the experience of the NUM as you would not want to have bad practices or questionable actions of seasoned NUMs to affect new NUMs.
	NUM4	Quite simply you can't write case studies for every perceivable event; the option of talking through problems needs to be available.
	NUM5	I think it is a great tool for new NUMs. We all make mistakes and it is great to learn from others.
6. Any suggestions on how we can improve and implement case writing as a tool to support NUMs?	NUM1	
	NUM3	No as I have not really thought about it.
	NUM4	Not my area of interest I am afraid. Prefer to discuss and have that personal contact. Every situation is different, with multiple variables that change, case writing is not appropriate for all situations.
	NUM5	Short course. Would not be my first option to introduce this to our area.
7. Do you think that this research study could be a basis of further research on using case writing in preparing and supporting NUMs for their role?	NUM1	
	NUM3	Possibly, again, I have not put much thought into this question to answer.
	NUM4	Limited due to the volume of variables that would need to be considered. Might work ok for task improvements such as DD checks in scenario 5.
	NUM5	Case writing takes too much time. OK for the person reading it.

The categories that emerged from feedback were:

- Case and commentary writing provided opportunities to see different perspectives on situations within the same role
- Support for individual management approaches
- Supplement to face-to-face mentoring
- Another form of reflection
- A good resource of knowledge for new NUMs
- Another demand on NUMs' time

All four participating NUMs commented that case writing and written commentaries had given them an opportunity to read about others' lived experiences and the commonality of the problems they face. The following are examples of their feedback:

> "I would like to thank the researcher (Josefina) for giving me the opportunity to participate in this study. It has been an invaluable experience and has opened my eyes to the shared experiences that NUMs face on a daily basis…." (NUM1)

> "It was good to put pen to paper so to speak and reading others experiences within the same role. It was almost therapeutic to a degree to get a scenario off my chest and then read others reviews, as it is not too often that you have the opportunity to discuss issues on the wards with other NUMs." (NUM3)

> "… the others had a similar viewpoint, which identifies the commonalities in our roles as managers, even though we come from very different areas of clinical practice we all contend with similar problems." (NUM4)

> "Case writing can help see different perspectives on situations. It might make me change the way I would approach the issue." (NUM5)

Three NUMs agreed that the commentaries supported their management approach:

> "The case scenario writing was a useful tool as a form of reflection regarding a difficult situation I have encountered. Reading and commenting on the other case scenarios has allowed me to utilise my current and acquired knowledge in developing an appropriate response or solution to a problem that other NUMs have encountered. It was interesting to see the comments of the other NUMs in regard to the case scenario I submitted, as it was reassuring that the responses were similar and supportive of the actions that I undertook." (NUM1)

> "Good to see that I was on the right track with my scenario from a number of other NUMs, it boosted my own confidence to a degree." (NUM3)

> "Supported my approach." (NUM5)

All the NUMs agreed that case writing was a good supplement to face-to-face mentoring.

> "I think case writing would be a good supplement to face-to-face mentoring but should not replace this method of mentoring." (NUM1)

> "50/50 face to face is always better, but if we had no time this could be a good option." (NUM5)

This is echoed by NUM3 and NUM4. However, they commented that there were no emotions in text:

> "I think it could be an added benefit to mentoring newly appointed NUMs, as the face to face is really important. Text can be taken in many different ways as there is nil emotion associated with that." (NUM3)

> "Personally I prefer face-to-face mentoring, because the written word can be harsh in isolation from body language and voice tone, the meanings can become poles apart. However, we need to consider that we all have different learning needs and learning styles." (NUM4)

Three NUMs commented that case writing was a form of reflection:

> "The case scenario writing was a useful tool as a form of reflection regarding a difficult situation I have encountered." (NUM1)

> "It was reflective practice. I would not have changed the way I approached the issues." (NUM5)

> "I do acknowledge that there are some individuals that benefit from case studies and similar writings, because they can refer and reflect. Case studies are a recognised learning methodology that may be suitable for some, but not all." (NUM4)

Another category that emerged was the amount of time needed to write case narratives. The following are examples of feedback on this:

> "Lots of time needed by the NUM who is writing it up. Case writing takes too much time. OK for the person reading it." (NUM5)

This is echoed by NUM4 who also commented:

> "Case writing is an arduous task. I personally prefer to discuss in conference than write responses to case studies." (NUM4)

The NUMs commented that case narratives and commentaries were beneficial, especially to new NUMs:

> "Sharing these case scenarios and the commentaries particularly for new NUMs would be extremely beneficial in developing their confidence and knowledge base in regards to the NUM role." (NUM1)

> "I think it is a great tool for new NUMs. We all make mistakes and it is great to learn from others." (NUM5)

NUM3 also commented that it depended on the experience of the NUM and that they would not like new NUMs to adopt the bad practices of seasoned NUMs.

> "It all depends on the experience of the NUM as you would not want bad practices or questionable actions of seasoned NUMs to affect new NUMs." (NUM3)

5.6.2. Discussion of findings

In this study, each participating NUM (N=5) was invited to write a case narrative about one of their experiences as a NUM and then write a commentary on the other NUMs' case narratives. However, due to work commitments, one NUM did not participate in written commentaries. As stated earlier, the main purpose of this activity was not to analyse the case scenarios but to gain the perceptions of NUMs about using case writing to help new and aspiring NUMs in their role and of how case writing could be used as a learning strategy for NUMs and aspiring NUMs and as an alternative to face-to-face mentoring. Therefore, the researcher was more interested in the NUMs' feedback on their participation in case writing and commentaries.

The NUMs agreed that case writing was a form of reflection. This finding concurs with other studies. Reflection is what translates management experience into learning (Seibert & Daudelin, 1999). An effective framework on Schon's (1991) reflection on action requires NUMs to conduct a post mortem on what they did, the knowledge base they employed, how

they went about their actions, why they responded the way they did, and to explore their thoughts and feelings at that particular time. Through case writing, NUMs were able to reflect on past actions and experiences. Gray (2007) indicated that management learning can incorporate reflection on managers' own experiences, and be sources of learning and critical reflectivity. Critical reflection on critical incidents that are written up and shared with others allows for examination within a broader organisational context (Gray, 2007). Experience and reflection are interrelated. If the experience is challenging, so too is the reflection (Miettinen, 2000). As Gold et al. (2002) stated, storytelling and critical analysis facilitates reflection that helps NUMs make sense of problems faced and appreciation of other's perspectives. Case writing is a type of storytelling (Naumes & Naumes, 2012). In the present study, case writing enabled NUMs to tell their stories as they reflected on and analysed them. The case narratives were then passed on to other NUMs to write commentaries where further exploration and reflection took place.

Writing case narratives enabled NUMs to relive the experience and provided an appreciation of the magnitude and significance of the case scenario (Cathcart et al., 2010). This finding is mirrored in Cathcart and Greenspan's (2013) study where it was noted a nurse manager's narrative could be used to develop leadership practice and facilitate learning. Cathcart and Greenspan (2013) found that writing a narrative and then reading it to a peer group provided an opportunity for the nurse manager to reflect on and relive the experience. The nurse managers in their study reported that the method of reflecting on their lived experiences was effective in helping them cope with their role and they saw peer collaboration as a source of gaining new knowledge and perspectives for problem solving. Cases are useful in helping NUMs to develop and understand how perceptions about and analysis of a situation can differ among NUMs (Morrow, 2015). When individuals who face similar challenges share their experiences with each other, it can assist them in discovering

information from different perspectives. By sharing one's experience, others can relate the information to their own experience of the situation (Daudelin, 1997) In the present study, by writing a narrative and then giving it to other NUMs for commentaries, participants had the opportunity to reflect and relive their experiences. By reading the case narratives written by other NUMs, they were able to gain new knowledge, in for example, NUM3's case narrative where she wrote about an innovative idea to track down the completion of competencies among staff. The commentaries written by NUMs on a case narrative provided new perspectives for solving a problem, for example, the commentaries for NUM4's case narrative. NUM5 also commented "Case writing can help see different perspectives on situations. It might make me change the way I would approach the issue". Case writing is a teaching tool in which NUMs engage in the process of thinking, of analysis, of problem solving, and evaluation. NUMs can learn these skills from real situations, in the case of the present study, case narratives they can apply when faced with actual experiences (Naumes & Naumes, 2012). This is echoed by Miraglia and Asselin (2015) who conducted an integrative review to explore the use of reflection as an educational strategy for registered nurses. The authors found reflection increased knowledge, and changed attitudes, values and beliefs of the participants. Morrow (2015) contended that learning from cases can be more effective in NUMs' cognitive development than is the pattern with traditional lectures.

The participating NUMs commented that case writing and written commentaries had given them an opportunity to read about others' lived experiences and the commonality of problems they faced. The NUMs further commented that the process supported their management approach and boosted their confidence. One NUM commented that it might change the way he would approach an issue. Another NUM commented that case writing and then reading the comments from other NUMs had a therapeutic effect, stating: "It was almost therapeutic to a degree to get a scenario off my chest and then read others' reviews, as it is

not too often that you have the opportunity to discuss issues on the wards with other NUMs". These findings support other studies. Mackoff et al.'s (2013) pilot project found that the participants valued the peer collaboration, discussion and support in discussing the nurse managers' shared experiences. The participants discovered they had similar issues and this built their confidence. Cross (2013) agreed that no one nurse manager knows or has all the answers but that each nurse manager can hold a piece or type of an answer. Through collaboration with other nurse managers, a solution will emerge. DeCampli et al. (2010) also found in their study that nurse managers considered group sessions beneficial, as they were able to share different views on the same issue. Cathcart and Greenspan (2013) reported that the participants in their study commented that nurse managers' narratives were a source of gaining new knowledge and the participants understood there was no single correct method of solving a particular problem. This echoed the findings of Duffield (2005) who reported that through collaboration and interaction with other NUMs, the NUMs came to recognise they faced similar issues in their role and had different approaches to problem solving. NUMs were able to understand that a group discussion on issues had better outcomes than an individual approach. Hill (2004) in her study of new manager development, also found that new managers found it easier to learn from experience when they had developmental relationships with superiors and peers. Hill also stated that humans are social learners and so they need others to provide feedback and coaching.

NUMs in the present study also commented that case narratives and commentaries were a good source of knowledge, especially for new NUMs. Cathcart and Greenspan (2013) noted that narratives can preserve the acquired practical wisdom of experienced and seasoned NUMs and can be useful for future NUMs. Friedman (2006) stated that clinicians like reading case reports and find them helpful in their work. In the present study, through reflection-on-action using case writing, the acquired practical wisdom of the experienced

NUMs can be preserved and they can pass on their experiences to colleagues, explain and teach their skills and promote multidisciplinary collaboration to develop their skills and knowledge. This finding concurs with Graham-Hannah et al. (2017) who conducted an educational program on reflection through narrative writing for 17 nurse managers at Maimonides Medical Center in New York. The authors found that leadership programs incorporating reflection through narratives had the potential to showcase skilled knowledge and judgment embedded in NUMs' practice that had not been unearthed otherwise.

Some authors criticised Schon for failing to recognise the importance of reflecting-before-an-action or reflecting-for-the-future (Greenwood, 1993; Gustafsson & Fagerberg, 2004; Teekman, 2000; Wilson, 2008). However, Moon (2004) gave justification on why Schon did not include reflection-on-the-future or reflection-before-an-action by suggesting that reflection could involve anticipation in planning, and in combination with imagination, enable planning for future actions. With the use of imagination, reflecting on past experiences or similar situations can be extended into reflection on the future. Moon's view suggests that imagination is not part of reflection but may work as a result of reflection. Wilson (2008) further commented that because reflection on past actions has an inherent and tacit recognition in order to improve future performances, the main purpose of reflection is future oriented. Wilson (2008) suggested three forms of reflection. Wilson identified reflection-on-action as the first of these three considerations which is clearly the basis of the third consideration which is reflection-on-the-future. Wilson also stated that reflection-on-action could be achieved by analysing and reflecting on others' past experiences by putting oneself in their shoes in order to examine what might be relevant in the future. Gustafsson and Fagerberg (2004) who were also critical of Schon's failing to recognise reflection-on-the-future, found in their study that participants think back on past actions to consider what could have been done better or differently. Similarly, Teekman (2000) identified three hierarchical

levels of reflection, the first being “reflective thinking-for-action” which centred on what to do here and now. The participants in Teekman’s study revealed that they thought about past experiences and chose from a range of the most appropriate interventions for the current situation, which to Schon is reflection-on-action. In the present study, case writing provided a platform for NUMs to reflect on past experiences (reflection-on-action) (Schön, 1991). By reflecting on past experiences, NUMs are able to imagine and plan for the future (Moon, 2004). Case writing also enables reflection on the future, especially in the commentary writing component, where writers can imagine and articulate how they may behave in situations in order to improve future performances (Wilson, 2008).

NUMs agreed that case writing could be used as a supplement to face-to-face mentoring, but they preferred face-to-face mentoring, citing “words can be interpreted in many ways and that there are no emotions associated with words”. This finding contradicts the statement of Gabriel (2000) that narratives are stories that are emotionally charged. In this present study, NUMs indicated that they preferred face-to-face mentoring. However, one of the barriers mentioned in furthering their training and education was time. For example, as NUM5 commented, “The catchcry of all nurses is time …. You do not sit down for long. You do not have a lot of spare time. The spare time you do have, you usually are investigating something or changing something or developing something. It's very rare that a manager has time”. NUM4 commented, “It is often good to have a mentor but often mentors are not available”. In this study, one NUM was not able to participate in written commentaries and did not provide any feedback due to work commitments. Some NUMs did not agree to participate in this study citing no time as one of the reasons. Another NUM who initially agreed to participate in this study was not included due to the researcher being unsuccessful in booking an interview with them, observing that this NUM was very busy. Several phone calls were made to NUM5 for their feedback and NUM5 always commented on the difficulty

to “finding time to write the feedback”. NUM5’s feedback was in dot point which is also proof of how busy NUMs are in their role. NUM3 commented: “It was good to put pen to paper so to speak and reading others experiences within the same role. ….. as it is not too often that you have the opportunity to discuss issues on the wards with other NUMs.” These comments and circumstances are reflected in other studies. Although mentoring can provide feedback upon which the leader can reflect, mentoring in health care organisations can be difficult and costly, impeded by the lack of willingness from other staff to act as mentors (D'Cruz, 2002), and by the many competing priorities and other demands on the time of potential mentors.

Another category that emerged was the amount of time to write case narratives. One NUM commented that case writing takes too much time and another NUM commented that case writing is an arduous task and that they preferred to discuss in conference rather than write responses. Again, these comments reflect the busy schedule of NUMs and their lack of free time. Acree (2006) agrees that nurse leaders do not have the time to develop their leadership and management skills due to many competing priorities. D’Cruz (2002) stated that the health care environment and nature of managerial work may not be conducive to reflection. However, D’Cruz (2002) asserts that reflection is essential for leadership development.

In this present study, case scenarios were distributed to participating NUMs to read and then write commentaries. Case scenarios with commentaries were then compiled and distributed to participating NUMs to read. There was no face-to-face collaboration among the participants. Case narratives have been used in professional development by some leaders (Cathcart & Greenspan, 2013; Duffield, 2005; Frank, 2003; Mackoff et al., 2013). However, none of these studies examined non-face-to-face peer collaboration. In these previous studies, case narratives were distributed to participants for discussion during group sessions. In this

present study, NUMs commented that they valued the knowledge they gained from reading and commenting on the other NUMs' case scenarios and as one NUM commented, it allowed him to utilise his current and acquired knowledge in developing an appropriate response to solve a problem that other NUMs had encountered. In previous studies (Cathcart & Greenspan, 2013; Duffield, 2005; Frank, 2003; Mackoff et al., 2013), the authors found participants valued peer collaboration and acknowledged there is no single approach to problem solving. Markey and Farvis (2014), who developed a pilot project to enable nurses to engage in reflective practice in an acute setting in the UK, also indicated participants valued having peers to reflect with during the process.

The findings from this present study suggest that without face-to-face interaction, NUMs can still collaborate with each other to gain and share knowledge. The findings also suggest, and as NUMs have commented, new and aspiring NUMs can benefit from reading these case narratives to help them develop their leadership skills. The results of this study confirmed the importance of developing and addressing informal methods of learning (Griscti & Jacono, 2006). Case writing could be used as a new approach to develop and support new and aspiring NUMs and as a new paradigm for professional development. From the feedback gathered from participating NUMs, case writing can be used to supplement face-to-face mentoring or as an alternative to face-to-face mentoring when mentors are not available.

5.6.3. Section summary

This section presented case narratives and commentaries prepared by participating NUMs. Their feedback relating to their experience in participating in writing narratives and written commentaries on other NUMs' narratives was also presented. Case writing has the capacity to draw both reflection-on-action and reflection-for-future in order to improve performances.

Case writing and written commentaries may be used by NUMs as an alternative to face-to-face collaboration.

5.7. Chapter summary

In this chapter, the findings of the present study were presented and compared with previous studies. The results showed that over the past 10 years, NUMs have continued to be promoted without adequate preparation. NUMs are promoted to their positions by chance or pre-chosen by management, having been perceived to have the leadership and management skills. Although some NUMs perceived that management training gave them direction to manage, they commented that they did not learn a great deal to bring back to the work place. The NUMs believed that no training could help them prepare for their role except time and experience. A need was noted to promote succession planning and to properly identify staff who can be trained to be effective leaders. The results of the present study are also consistent with previous studies, that is, a combination of transformational and transactional leadership styles are practised by NUMs. The greatest barriers for NUMs, ANUMs and RNs in furthering their training are time and cost. Case writing provided an avenue for NUMs to reflect on past experiences and to share these lived experiences with other NUMs. Without face-to-face collaboration, NUMs were able to provide additional insights into other NUMs' experiences through written commentaries on the case-narratives. The next chapter presents the conclusions, limitations of the study and recommendations for the future.

Chapter 6: Conclusions and Recommendations

Chapter 6 summarises the theoretical framework of the study, its conclusions, and accordingly recommendations regarding: areas for further research, implications for nursing management and implications for undergraduate education.

The main limitation of this study which may affect the ability to generalise findings relates to the small sample size. If the study is to be repeated, case writing should involve more NUMs in order to gather more feedback. The small sample size may not reflect the current education/training needs of the majority of current NUMs. Additionally, the study was conducted inside only one hospital network and may not apply to other health care organisations. Finally, the reported data that related to NUMs' leadership styles was based only on the calculated averages of different leadership behaviours and no correlations were done to ascertain the effect of NUMs' leadership styles on staff job performance and satisfaction. An advantage of the small sample size however, was that the study enabled the eloquence of all participants' voices to be presented within this thesis as a counterpoint to figures and charts.

6.1. Theoretical framework

Schon's (1991) epistemology of "reflection on action" was employed as a theoretical framework for this study. NUMs were able to reflect on action using case writing. Through case writing, they remembered and described what they experienced, and then put into writing the relationships between events and people, actions taken and the outcomes. By this process, the NUMs employed Schon's (1991) epistemology of "reflection-on-action". Similarly, in the interviews and in the questionnaire, the aim was to encourage "reflection-on-action" in the participating NUMS, ANUMs and RNs.

6.2. Conclusion and recommendations

The findings of this study show that NUMs continued to assume the role without adequate preparation for the role. The findings of this present study suggest that there has been little change in NUMs' preparation for their role over the past 10 years. The findings of this present study were consistent with earlier and more recent studies that NUMs were promoted to their positions without adequate training and preparation, and were promoted by chance and not by conscious choice, or by having been pre-chosen by management having been perceived to have the leadership and management skills for the role (Bondas, 2006; Brown et al., 2013; Duffield et al., 2001; Hill, 2004; McCallin & Frankson, 2010; Paliadelis et al., 2007; Queensland Government, 2008; Townsend et al., 2012). The NUM's role is multifaceted and without adequate training and preparation, it may be overwhelming (Bondas, 2006; Duffield & Franks, 2001; Hill, 2004; McCallin & Frankson, 2010; Paliadelis et al., 2007; Queensland Government, 2008). This is clear in the reluctance that ANUMs and RNs in the present study indicated about assuming the NUM role.

There is a need to promote succession planning and identify staff who can be trained to be effective leaders (Conners et al., 2007; Kirby, 2010; Lord et al., 2013; McCallin & Frankson, 2010; Picker-Rotem et al., 2008). Picker-Rotem et al. (2008) proposed peer evaluation in identifying and selecting new nurse leaders and Conners et al. (2007) suggested that nurse leaders must endeavour to identify individuals who display the characteristics of good leaders that include drive, energy, determination, vision, self-discipline and flexibility. Griffith (2012) proposed that succession planning must exist as a continuum and identify potential leaders as early as high school to establish a pool for emergent nurse leaders. Although there is a vast literature on the characteristics of good nurse leaders, there is limited information on how to identify nursing staff who may have potential leadership skills and cultivate them to become future leaders (Conners et al., 2007) and exactly on how to achieve

these goals (Lindholm et al., 2000). Succession planning in most health care organisations appears to be fragmented, uncoordinated and inconsistently implemented, and identifying potential leaders is a pervasive and persistent problem (Griffith, 2012). A review of the literature indicated limited information still exists on reliable methods to identify nursing staff who may have potential leadership skills.

Some nurse leaders indicated a gap in the literature about how NUMs could better prepare for the role, what needs to be included in leadership courses, and more importantly, how NUMs can acquire the necessary skills (Gaskin et al., 2012; Kleinman, 2003; Pickerell, 2014). Some nurse leaders advocate the possession of graduate education as a necessary requirement for nurse managers to develop their skills (Cross, 2013; Gallo, 2007; Kleinman, 2003). However, there are still controversies regarding what needs to be included in leadership courses (Pickerell, 2014) and concerns from nurse executives about whether the content of postgraduate education courses are relevant to the needs of the health care industry (Gaskin et al., 2012)

Although NUMs in the current study value formal training as a tool to give them direction, they commented that sometimes formal training was not practical. NUMs believed there was no better training that could prepare them for the role than experience. NUMs' indicated that time was one of the greatest barriers in furthering their education and training. Some nurse leaders suggest a need for new, innovative and effective training methods (Gallo, 2007; Shaffer, 2003) and a need for more research studies that address informal methods of learning (Griscti & Jacono, 2006). More recent studies by Graham-Hannah et al. (2017) and Morrow (2015) note that traditional lectures may not be effective in helping NUMs learn how to lead in ever-changing health care organisations. Although mentoring has been suggested by nurse leaders to help and support other NUMs, mentoring in health care organisations can be difficult and costly, there is lack of willingness from other staff to act as mentors (D'Cruz,

2002), and NUMs have many competing priorities and other demands in addition to acting as mentors (Acree, 2006; DeCampli et al., 2010). In the present study, one NUM commented especially on the availability of other NUMs as mentors, as quoted: “It is often good to have a mentor but often mentors are not available.” (NUM4).

NUMs in the present study identified current needs to develop their skills which included coaching, difficult conversations, managing absenteeism, performance management, and computer /technical skills. The results could be used by nurse executives in developing leadership programs and in identifying how they could prepare aspiring leaders and support current NUMs. The nurse executives have an important role in making sure these needs are incorporated into professional development offered to NUMs.

Considering time constraints among NUMs, the use of case writing was explored in this study as an alternative to face-to-face mentoring. Although case narratives have been used in professional development by some leaders (Cathcart & Greenspan, 2013; Duffield, 2005; Frank, 2003; Mackoff et al., 2013), none of these studies examined non-face-to-face peer collaboration. The findings from this present study suggest that without face-to-face interaction, NUMs can collaborate to gain and share knowledge. The collection of case descriptions and commentaries written by NUMs provide a platform, or an electronic classroom where NUMs can share experiences and collaborate. New and aspiring NUMs can benefit from reading these case narratives and commentaries to help them develop their leadership skills. However, it is not just in reading commentaries that NUMs can benefit. It is in writing the commentaries as well. NUMs reflect in several ways: on their own stories as they write them, on reading others’ cases, on writing commentaries and on reading other commentaries.

From the feedback gathered from participating NUMs, case writing may be used to supplement face-to-face mentoring or as an alternative to face-to-face mentoring when

mentors are not available. The results of this study confirm the importance of developing and addressing informal methods of learning (Griscti & Jacono, 2006; Markey & Farvis, 2014; Miraglia & Asselin, 2015). Case writing can be used as a new approach to develop and support new and aspiring NUMs and as a new paradigm for ongoing professional development. From the NUMs' perspective, the drawback of case writing is the amount of time needed to write case-scenarios and commentaries. Nurse executives have an important role in fostering for the shape and form of professional development. Case and commentary writing may prove to be more active than sitting in a PD session or completing an online course questionnaire. A suggestion would be that case writing be included in NUMs' portfolios with the suggestion that each NUM write one case-scenario every year and participate in writing commentaries on other NUMs' case-scenarios. All case-scenarios and commentaries would need to be moderated and all unethical comments deleted. The case-scenarios could be compiled and kept in a data file in the organisation's intranet for current and aspiring NUMs to access and the health organisation could have the option of providing a link to other health care organisations for greater collaboration.

Since the NUM's role centres on leadership and leadership styles have a profound influence on staff job satisfaction and retention, and the delivery of care and health outcomes of patients (Azaare & Gross, 2011; Kleinman, 2004; McGuire & Kennerly, 2006), NUMs' management styles were explored in this study. Some scholars argue that leadership and management are synonymous, while others believe there is a distinction between management and leadership (Ellis & Abbott, 2013; Hersey & Blanchard, 1993; Kotter, 1990; Ofori & Toor, 2008; Rost & Amarant, 2005; Zaleznik, 1977). Jennings et al. (2007) found that the concepts of leadership and management were not well delineated in nursing administration and leadership courses. The authors stated that their findings may indicate that the distinction between management and leadership had narrowed. In the present study, since

leadership and management are interwoven in the NUM's role and they overlap, it makes it difficult to delineate the concept of leadership and management. Therefore, leadership and management were used interchangeably or were considered synonymous. The leadership styles of NUMs in this study were a combination of transformational and transactional, but more transformational. The MLQ was used in this study to explore the perception of NUMs' leadership styles and to compare them with the perceptions of staff. Further research is recommended to determine which leadership styles are preferred in different specialty wards to explore the correlations between NUMs' leadership styles, and their staff job performance and job satisfaction.

6.3. Suggested areas for further research

This present study investigated the preparation of NUMs for their role from the perspective of NUMs, ANUMs and RNs in one of the hospitals in Melbourne, Australia and explored the use of case writing for supporting existing NUMs and preparing aspiring NUMs.

1. This study found there is a gap in the literature on an effective way of identifying and selecting staff with appropriate characteristics to become NUMs. Peer evaluation was suggested by Picker-Rotem et al. (2008) and one ANUM in this study suggested seeking the opinions of staff when selecting NUMs for the position. These methods and others require further exploration for their effectiveness.
2. As discussed earlier, NUMs benefitted from collaborating with other NUMs without face-to-face mentoring. It is recommended that nurse executives consider the use of case writing for professional development. A suggestion would be that case writing can be included in NUMs' portfolios with the suggestion that each NUM write one case-scenario every year and participate in written commentaries on other NUMs' case-scenarios. The case-scenarios could be compiled and kept in a data file in the

organisation's intranet for current and aspiring NUMs' access. It is recommended a formative evaluation of this practice be undertaken concurrently with its implementation

3. Due to the confusion between the terms, ongoing research into the distinctive way in which management and leadership combine in the NUM role is recommended..

6.4. Implications for nursing management

Several implications arise from the results of the present study. Effective succession planning needs to be implemented along with reliable ways of identifying staff who have the appropriate characteristics to become leaders. As well, the importance of ongoing reviews of the type, nature and effectiveness of professional development programs is important.

The results highlight the importance of developing and addressing informal methods of learning and the need to re-frame professional development for existing and aspiring nurse managers. In this way, both the learners' needs and time constraints can be acknowledged. Case writing may be used as a new approach to develop and support new and aspiring NUMs, and as a new paradigm to professional development. Nurse executives can utilise and capitalise on the lived experiences of NUMs through case writing.

The results of the present study also indicate the importance of exploring further the preferred leadership styles of NUMs in different specialty wards with a view to designing leadership programs to address these differing leadership styles.

6.5. Implications for undergraduate nursing education

Nurses are self-managing. They are responsible for managing their allocated patients. They are the first contact to deal with patients' problems and issues. They are the first to deal with patients' family issues. Nurses are responsible for liaising with doctors and allied health professionals. Nurses are responsible for advocating for their patients. They are expected to

deal with and resolve everyday issues that concern their allocated patients. Therefore, it is important for all nurses to develop their leadership and management skills. The results of this study agree with earlier suggestions (Curtis et al., 2011; Galuska, 2012; Heller et al., 2003; Hendricks et al., 2010; Johansson et al., 2010; Jones & Sackett, 2009; Mrayyan, 2004; Shaffer, 2003) which highlight the importance of developing these skills in nurses at the earliest stages of their nursing education, that is, undergraduate level. It is important to prepare nurses to be clinicians who can manage and lead at the same time. Universities should collaborate with health care organisations and with practising NUMs, ANUMs and RNs about the content and delivery of undergraduate curricula. Universities could also consider integrating the concepts of leadership and management starting from first year of the undergraduate courses where the focus could be on communication. This could include specific activities relating to handover, admitting and taking patient histories, acknowledging cultural and religious diversity and responding compassionately and respectfully. Activities in later years could include the more complex leadership and management issues: difficult conversations, teamwork, dealing with conflict, working in interdisciplinary groups, negotiation skills and handling challenging situations with staff, patients and relatives professionally.

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Appendices

Appendix 1: Position Statement

The Role of the Nurse/Midwife Unit Manager

(Australian Nursing and Midwifery Federation (Vic Branch), 2013)

Each ward/unit, service or team must have a Nurse/Midwife Unit Manager appointed.

The Nurse/Midwife Unit Manager position combines leadership, management, clinical and teaching roles and is integral to the ability of the health care system to achieve quality patient care outcomes.

The Nurse/Midwife Unit Manager is a registered nurse/midwife with responsibility for award, unit, service or team. The ward or unit should not exceed 30 beds and critical care units should not exceed 12 beds.

It is central to the quality of nursing and midwifery care and patient outcomes, job satisfaction and retention of nurses and midwives – not only within individual agencies but within the health care system as a whole.

To achieve quality patient outcomes, the Nurse/Midwife Unit Manager must have sufficient resources that take into account the level of patient acuity and patient throughput.

• The Nurse/Midwife Unit Manager as manager/leader

The Nurse/Midwife Unit Manager has a strong leadership role. As a leader, the Nurse/

Midwife Unit Manager exhibits communication and problem solving skills, a keen understanding of the dynamic nature of the health sector and of clinical governance, an ability to instigate change, delegate responsibilities, encourage professional development and enhance the quality of nursing and midwifery practice.

The responsibilities of the Nurse/Midwife Unit Manager are pivotal to an intra-disciplinary management approach based on an understanding of the processes and systems involved in the provision of patient care. In this context, admission and discharge (bed management), for example, are co-ordinated by the Nurse/Midwife Unit Manager but are the shared management responsibilities of the Nurse/Midwife Unit Manager and the medical practitioner. This approach enhances the quality of patient care and increases staff satisfaction and participation.

The Nurse/Midwife Unit Manager management responsibilities also include recruitment, retention, professional development of staff, financial management, occupational health and safety and return to work programs.

• The Nurse/Midwife Unit Manager gives staff the opportunity to engage in education and research on an individual basis and in collaboration with others. As it is critical to attaining quality patient outcome, this role should be properly funded and supported by the organisation.

• Financial management by the Nurse/Midwife Unit Manager is optimised through the cooperation of all health professionals involved in the provision of patient care. Financial data, education, information technology and financial expertise must be available to support the role.

• The Nurse/Midwife Unit Manager ensures that occupational health and safety policies and practices are designed to minimise/eliminate risks to the health and safety of staff and patients and that staff and patients adhere to these policies and practices. The Nurse/Midwife Unit Manager also facilitates the provision of appropriate rehabilitation and return to work programs for staff who have been injured at work.

• The Nurse/Midwife Unit Manager as clinician

The Nurse/Midwife Unit Manager as clinician has an extensive teaching/mentoring/enhancing role, which encompasses all health professionals involved in a patient's health care as well as the patient and their family.

As an expert clinician, the Nurse/Midwife Unit Manager establishes the standards of nursing or midwifery practice and ensures optimal patient care. The Nurse/Midwife Unit Manager has expert clinical knowledge that is central to the management of the particular clinical specialty. This professional nursing/midwife knowledge is required to make judgements and decisions about the quality and resources required for clinical services and the clinical insight to understand the environmental support and resources required for optimal care and service provision. The Nurse/ Midwife Unit Manager has a lead role in ensuring that the working environment is one in which all nursing staff or midwifery staff, including students and new graduates, are encouraged to strive towards and achieve excellence in nursing or midwifery care.

• The Nurse/Midwife Unit Manager as educator

A Nurse/Midwife Unit Manager requires an excellent understanding of current trends, research and policies in their area of nursing or midwifery practice and utilises this knowledge to promote and encourage professional development and to develop effective networks across the multi-disciplinary team.

The Nurse/Midwife Unit Manager must have access to contemporary teaching techniques and principles to ensure the clinical role is supported. He/she also needs to develop professional formal and informal links, both internally and externally, for the purposes of accessing quality nursing or midwifery resources and education.

• Optimising the Nurse/Midwife Unit Manager role

• The Nurse/Midwife Unit Manager should have no direct patient care allocation in order to focus attention on optimising patient outcomes through:

- the adherence to and promotion of clinical governance
- excellence in nursing/midwifery practice and clinical research
- professional development for nursing and/or midwifery staff
- quality and safety programs

- human resources management
- involvement in relevant internal committees
- benchmarking activities
- risk management activities
- financial planning
- unit and organisation strategic planning
- unit and organisation protocol and policy development.

• The Nurse/Midwife Unit Manager requires the authority for decision making in the areas for which he/she is both responsible and accountable.

• The Nurse/Midwife Unit Manager needs to have access to professional development that enhances management skills, including those required for financial planning.

• The Nurse/Midwife Unit Manager needs access to research funds and/or the ability to instigate or become involved in nursing or midwifery research. Access to study leave which is of benefit to the organisation must be available to the Nurse/Midwife Unit Manager.

• The Nurse/Midwife Unit Manager is involved in quality and safety programs in order to be involved in the evaluation of clinical standards and quality of care at both the unit and organisational level.

• The Nurse/Midwife Unit Manager has relevant professional postgraduate qualifications, or will be supported in the acquisition of such. Where necessary, they will have support in their role as Human Resources Manager.

• The Nurse/Midwife Unit Manager is supported by Associate Nurse/Midwife Unit Managers whose role optimises the functioning of the ward/unit and to whom nursing or midwifery management is delegated in in his/her absence.

• The Nurse/Midwife Unit Manager reports to senior nursing/midwifery management and has access to other nursing/midwifery resources through the organisational executive management structure.

Conclusion

The Nurse/Midwife Unit Manager is at the forefront of the health care system and its everchanging and evolving organisational and management systems. The Nurse/Midwife Unit Manager is pivotal in management and leadership in order to ensure the primary objective of the organisation – the achievement of quality patient outcomes in nursing and midwifery services - is met. In order to achieve this, it is essential that the organisation provides sufficient resources, including appropriate clinical and management nurse/midwife staffing levels, with adherence to ratios where relevant and skill mix.

Position Statement

Reviewed June 2003

Reviewed October 2010

Reviewed July 2013

The Australian Nursing and Midwifery Federation (Victorian Branch) acknowledges the Nurse/Midwife Unit Managers who contributed to the development of the original ANF Position Statement in 1998

Additional copies of this Position Statement are available from:

Australian Nursing and Midwifery Federation (Vic Branch)

540 Elizabeth Street, Melbourne 3000

Ph: 9275 9333

Or from the ANF (Vic Branch) website at www.anmfvic.asn.au

Appendix 2: Victoria University Ethics Approval

Ethics Application - Approved

Quest.Noreply@vu.edu.au

Tue 7/9/2013 1:11 PM

To: maureen.ryan@vu.edu.au <maureen.ryan@vu.edu.au>;

Cc: trish.burton@vu.edu.au <trish.burton@vu.edu.au>; josefina.talavera@live.vu.edu.au <josefina.talavera@live.vu.edu.au>;

Dear PROF MAUREEN RYAN,

Your ethics application has been formally reviewed.

Application ID: HRE13-113
Application Title: The Preparation Of Nurse Unit Managers For Their Role

The application has been accepted and deemed to meet the requirements of the National Health and Medical Research Council (NHMRC) 'National Statement on Ethical Conduct in Human Research (2007)' by the Victoria University Human Research Ethics Committee. Approval has been granted for two (2) years from the approval date; 10/07/2013.

Continued approval of this research project by the Victoria University Human Research Ethics Committee (VUHREC) is conditional upon the provision of a report within 12 months of the above approval date or upon the completion of the project (if earlier). A report proforma may be downloaded from the Office for Research website at: http://research.vu.edu.au/hrec.php.

Please note that the Human Research Ethics Committee must be informed of the following: any changes to the approved research protocol, project timelines, any serious events or adverse and/or unforeseen events that may affect continued ethical acceptability of the project. In these unlikely events, researchers must immediately cease all data collection until the Committee has approved the changes. Researchers are also reminded of the need to notify the approving HREC of changes to personnel in research projects via a request for a minor amendment. It should also be noted that it is the Chief Investigators' responsibility to ensure the research project is conducted in line with the recommendations outlined in the National Health and Medical Research Council (NHMRC) 'National Statement on Ethical Conduct in Human Research (2007).'

On behalf of the Committee, I wish you all the best for the conduct of the project.

Secretary, Human Research Ethics Committee
Office for Research
Email: researchethics@vu.edu.au

This is an automated email from an unattended email address. Do not reply to this address.

Appendix 3: Permission to reproduce MLQ Questionnaire

For use by Josefina Talavera only. Received from Mind Garden, Inc. on July 22, 2014
Permission for Josefina Talavera to reproduce 100 copies within one year of July 22, 2014

Multifactor Leadership Questionnaire

Instrument (Leader and Rater Form)

and Scoring Guide
(Form 5X-Short)

by Bruce Avolio and Bernard Bass

Published by Mind Garden, Inc.

info@mindgarden.com
www.mindgarden.com

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Appendix 4: Modified Sample of The MLQ Questionnaire

(Modified for Thesis)

This questionnaire is to describe your leadership style as you perceive it. Please answer all items on this answer sheet. **If an item is irrelevant, or if you are unsure or do not know the answer, leave the answer blank.**

Forty-five descriptive statements are listed on the following pages. Judge how frequently each statement fits you. The word " others" may mean your peers, clients, direct reports, supervisors, and/or all of these individuals.

Use the following rating scale:

KEY: 0 = Not at all

1 = Once in a while

2 = Sometimes

3 = Fairly often

4 = Frequently, if not always

1.	I provide others with assistance in exchange for their efforts	1	2	3	4
2.		1	2	3	4
3.		1	2	3	4
4.		1	2	3	4
5.	I avoid getting involved when important issues arise	1	2	3	4
6.		1	2	3	4
7.	I am absent when needed	1	2	3	4
8.		1	2	3	4
9.	I talk optimistically about the future	1	2	3	4
10.		1	2	3	4
11.		1	2	3	4
12.	I wait for things to go wrong before taking action	1	2	3	4
13.		1	2	3	4

Appendix 5: Structured Interview for NUMs

1. Demographics
    - How many years have you worked as a registered nurse prior to your appointment as a NUM?
    - How many years have you been a NUM?
    - What is your educational qualification that led to your nursing registration?
    - Were you an ANUM or in a management position before becoming a NUM?
2. What do you think were the main reasons for getting promoted to this position?
3. On the way to becoming a NUM, are there any NUMs or others who influenced your decision? In what ways particularly.
4. How do you describe your role?
5. How do you describe your management style?
6. What is your most positive experience of being a NUM?
7. What are your greatest challenges in being a NUM?
8. Can you please give an example of how you approached a difficult situation?
9. What do you think are the necessary training and skills before assuming the role? Did you had any management education or training before assuming the role?
10. How did these education assist you in your performance and the performance of your staff?
11. What qualities should a NUM have to succeed in the role?
12. Currently, are there any education/training or skills that you need to improve your performance? Do you have any suggestions about the most appropriate method to receive these?
13. What could be the barriers to furthering your training/education?
14. What would be your advice for new or aspiring NUMs?
15. Any additional comments?

Appendix 6: Structured Interview for Associate Nurse Unit Managers (ANUM) and Registered Nurses (RN)

Structured Interview for ANUMs and Staff

16. Demographics
    - How many years have you worked as a registered nurse?
    - How many years have you been an ANUM?
    - What is your educational qualification that led to your nursing registration?
17. What do you think are the main reasons for getting promoted to a NUM's position?
18. How do you describe your NUM's role?
19. What is your most positive experience with your NUM?
20. What do you think are the greatest challenges in being a NUM?
21. What qualities should a NUM have to succeed in the role?
22. What do you think are the necessary training and skills before assuming the role?
23. Do you think that management education or training is necessary before assuming the role?
24. Do you have any suggestions about the most appropriate method to receive these?
25. What could be the barriers to furthering your training/education?
26. If a position for a NUM becomes available, would you be interested in applying for a NUM's position? Why or why not?
27. Any other comments?

Appendix 7: Consent Form For NUMs To Complete the MLQ and to Participate in the Interview and Case writing

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

Study Title - The Preparation Of Nurse Unit Managers For Their Role

Student Investigator – Josefina Talavera

Principal Supervisor – Prof. Maureen Ryan

Associate Supervisor – Dr. Trish Burton

Josefina Talavera is a doctoral student from Victoria University conducting a research study titled "The Preparation of Nurse Unit Managers for Their Role". Studies have shown that Nurse Unit Managers feel unprepared for the challenges within the role. Studies have also shown that an effective leadership style can have a positive impact on organizational outcomes including staff performance and high-quality patient care. The study will explore how prepared the Nurse Unit Managers are for their role. It will also explore and compare the perceptions that ANUMs and staff have of the NUMs' role and leadership styles. The results of the survey will help determine the preferred leadership style for NUMs and aspiring NUMs. The results of the interview will be an avenue for nurse executives to address succession planning for NUMs and to develop educational programmes and support for existing and aspiring NUMs to acquire the necessary skills/competencies to perform the role. In addition, this study can potentially be a basis for future studies in redefining and taking professional development to the next level in preparing Nurse Unit Managers for their role and in improving their leadership and management skills by collaborating with each other through case writing. Your participation in this study is invaluable.

The research study and its procedures have been approved by Victoria University and by the hospital's ethics committees. The procedures involve no foreseeable risks or harm to participants. The procedures include:

1. Completing a questionnaire within 4 weeks upon receipt and this will take approximately 20 minutes in total to complete. The researcher will personally collect the completed questionnaires. The questionnaire is:
    - The Multifactor Leadership Questionnaire-Form 5X. This questionnaire will ask your perception your leadership style.
2. An audio-taped recorded interview of your perception of the NUM's role that will take approximately 30 min- 1 hour.

3. The NUMs to write case descriptions and commentaries. This will involve:
    - Case writing. This involves writing a short description of a specific event or situation, a dilemma or a challenge that you have experienced. This will include a reflection on the different aspects of your roles, the problems you have encountered, how you resolved the problems, a description of unresolved problems and how you may approach and resolve a similar situation differently next time.
    - Written commentaries. This involves writing a commentary on a case description written by another NUM to provide additional insights into that case.
    - Providing feedback on how case writing and written commentaries had helped you to improve your management skills and performance.
    - In this research, each NUM is invited to write one case and a commentary on a case written by another NUM. Case writing and written commentaries cases will be open for one hundred (100) days.

Your participation in this study is voluntary. You have the right to withdraw at any time. The data will be kept in confidence and coded so that your responses will not be linked to your name. Your identity will not be revealed at any time during or after the study. All completed questionnaires and results of this study will be kept in a locked cupboard in the chief supervisor's office and will only be accessed by the researcher and her supervisors. Following completion of the thesis, these items will be stored in a secure place for five years in the supervisor's office and then will be destroyed.

If you have any queries regarding this research, please phone me on 0412 321 834 or e-mail me at josefina.talavera@live.vu.edu.au or you can email Prof. Maureen Ryan at Maureen.Ryan@vu.edu.au or Dr. Trish Burton at Trish.Burton@vu.edu.au. If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001 or phone (03) 9919 4781.

_____

_____

Participant's Name Signature Date

Student Investigator’s signature Date

Appendix 8: Consent Form For Staff Nurses and ANUMs To Complete the MLQ And To Participate In The Interview

CONSENT FORM FOR PARTICIPANTS INVOLVED IN RESEARCH

Study Title - The Preparation Of Nurse Unit Managers For Their Role

Student Investigator – Josefina Talavera

Principal Supervisor – Prof. Maureen Ryan

Associate Supervisor – Dr. Trish Burton

Josefina Talavera is a doctoral student from Victoria University conducting a research study titled "The Preparation of Nurse Unit Managers for Their Role". Studies have shown that Nurse Unit Managers feel unprepared for the challenges within the role. Studies have also shown that an effective leadership style can have a positive impact on organizational outcomes including staff performance and high-quality patient care. The study will explore how prepared the Nurse Unit Managers are for their role and also explore the perception of ANUMs and staff about the NUM's roles and leadership styles. The results of the survey will help determine the preferred leadership style for NUMs and aspiring NUMs. The results of the interview will be an avenue for nurse executives to address succession planning for NUMs and to develop educational programmes and support for aspiring NUMs to acquire the necessary skills/competencies to perform the role. Your participation in this study is invaluable.

The research study and its procedures have been approved by Victoria University and by the hospital's ethics committees. The procedures involve no foreseeable risks or harm to participants. The procedures include:

1. Completing a questionnaire that will take approximately 20 minutes in total to complete. The questionnaire is:

    - The Multifactor Leadership Questionnaire-Form 5X. This questionnaire will ask your perception of the leadership style of your NUM.
2. An audio-taped recorded interview of your perception of the NUM's role that will take approximately 30 min- 1 hour.

Your participation in this study is voluntary. You have the right to withdraw at any time. The data will be kept in confidence and coded so that your responses will not be linked to your name. Your identity will not be revealed at any time during or after the study. All completed questionnaires and results of this study will be kept in a locked cupboard in the principal supervisor's office and will only be accessed by the researcher and her supervisors.

Following completion of the thesis, these items will be stored in a secure place for five years in the supervisor's office and then will be destroyed.

If you have any queries regarding this research, please phone me on 0412 321 834 or e-mail me at josefina.talavera@live.vu.edu.au or you can email Prof. Maureen Ryan at Maureen.Ryan@vu.edu.au or Dr. Trish Burton at Trish.Burton@vu.edu.au. If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001 or phone (03) 9919 4781.

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Participant's Name Signature Date

_____

Student Investigator's signature Date

Appendix 9: Cover Letter For Staff Nurses and ANUMs To Complete the MLQ

INFORMATION TO PARTICIPANTS INVOLVED IN RESEARCH

You are invited to participate

You are invited to participate in a research project entitled **The Preparation Of Nurse Unit Managers For Their Role**.

This project is being conducted by a student researcher Josefina Talavera as part of a PhD study at Victoria University under the supervision of Prof. Maureen Ryan from College of Education and Dr. Trish Burton from College of Health and Biomedicine.

Project explanation

One of the purposes of my research is to compare the NUM's perception of his/her leadership style to that of his/her staff. Studies have shown that an effective leadership style can have a positive impact on organizational outcomes including staff performance and high-quality patient care. The results of this survey will help determine the preferred leadership style for NUMs and aspiring NUMs.

What will I be asked to do?

Your participation in this study will include completing a questionnaire that will take approximately 20 minutes in total to complete. The questionnaire is:

- The Multifactor Leadership Questionnaire-Form 5X. This questionnaire will ask your perception of the leadership style of your NUM.

What will I gain from participating?

The results of this survey will help determine the preferred leadership style for NUMs and aspiring NUMs that will potentially have a positive impact on organizational outcomes including staff performance and high-quality patient care.

How will the information I give be used?

The results of this survey will help determine the preferred leadership style for NUMs and aspiring NUMs.

What are the potential risks of participating in this project?

The research study and its procedures have been approved by Victoria University and by the hospital's ethics committees. The procedures involve no foreseeable risks or harm to participants.

Your participation in this study is voluntary. The return of the completed questionnaires will imply consent to participate. You have the right to withdraw at any time.

The data will be kept in confidence and coded so that your responses will not be linked to your name. Your identity will not be revealed at any time during or after the study. All completed questionnaires and results of this study will be kept in a locked cupboard in the principal supervisor's office and will only be accessed by the researcher and her supervisors. Following completion of the thesis, these items will be stored in a secure place for five years in the supervisor's office and then will be destroyed.

How will this project be conducted?

A questionnaire package will be sent out to participants. Included in the questionnaire package that will be distributed will be a participant information sheet that will briefly explained the purpose of the study, the time required to complete the questionnaire and the mechanisms to maintain confidentiality and anonymity. A self-addressed envelope will also be included with the questionnaire and a drop box will be provided for the return of completed MLQs.

Who is conducting the study?

Principal Supervisor – Prof. Maureen Ryan, Maureen.Ryan@vu.edu.au

Associate Supervisor – Dr. Trish Burton, Trish.Burton@vu.edu.au

Student Investigator – Josefina Talavera, josefina.talavera@live.vu.edu.au, Mobile No. 0412 321 834.

Any queries about your participation in this project may be directed to the Chief Investigator listed above.

If you have any queries or complaints about the way you have been treated, you may contact the Ethics Secretary, Victoria University Human Research Ethics Committee, Office for Research, Victoria University, PO Box 14428, Melbourne, VIC, 8001 or phone (03) 9919 4781.