Lost In Transition: A Study of the Leadership Practices of Nursing Unit Managers

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STATEMENT OF AUTHENTICATION

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

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ABSTRACT

LOST IN TRANSITION: A STUDY OF THE LEADERSHIP PRACTICES OF NURSING UNIT MANAGERS

Leadership has become an important aspect of management practice in the changing health care environment. As health care organisations restructure to meet the demands for accessible, efficient, safe and affordable health care, nurses in management roles are under constant pressure to develop new skills and strategies to meet the challenges that accompany system change. The role of Nursing Unit Manager (NUM), being a frontline management position, is well placed to effect the changes now being asked of health care organisations. Nursing Unit Managers are expected to have management and leadership skills in order to function effectively in their roles and in responding to the challenges that emerge as a consequence of health care systems reform. This study explores the self-reported leadership practices of Nursing Unit Managers (NUMs), examines their leadership strengths from the perspectives of their staff and the impact of their leadership practices on workplace outcomes such as sense of empowerment and job satisfaction of staff. In addition, the study examines the leadership development needs of Nursing Unit Managers. Leadership and employee’s job satisfaction and empowerment are important elements in organisational performance. The relationship of these constructs is still not well understood. Moreover little is known about the influence of NUMs leadership practices on employee outcomes in Australia. Thus, this descriptive, exploratory study was used to explore the self-reported leadership practices of NUMs and describe the relationship of leadership practices to workplace outcomes in a tertiary referral hospital. The study sought to build knowledge and understanding of the leadership practices of NUMs including their impact on the work environment and staff. The study also investigated the barriers and facilitators for NUM leadership role enactment. Role theory was utilised as the theoretical framework for this study. Data generated from the Leadership Practices Inventory, Job in General Scale, and Conditions of Workplace Effectiveness- II Instrument were utilised in this study. Data analyses included the use of Statistical Package for Social Sciences (SPSS). The findings showed that the use of leadership behaviours and employee
outcomes were positively correlated. The findings from this study support the importance of NUM leadership and its potential influence in staff job satisfaction and empowerment. The findings reaffirm the need for organisation to provide a mechanism to help nursing unit managers become effective nursing leaders. Commitment should be made to design and implement management training and leadership development programs that focus on effective and facilitative leadership styles such as a transformational style of leadership.

Nursing Unit Managers continue to struggle with their role because to date the role of the NUM is not clearly defined. Recommendations from the findings can contribute to clarifying the role of NUM and the development of a professional leadership development model, which could foster development of leadership practices within the Australian context.
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<td>CEC</td>
<td>Clinical Excellence Commission</td>
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<td>Conditions of workplace Effectiveness Questionnaire</td>
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<td>JIG Scale</td>
<td>Job in General Scale</td>
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<td>IOM</td>
<td>Institute of Medicine</td>
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<td>LPI</td>
<td>Leadership Practices Inventory</td>
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<td>NaMO</td>
<td>Nursing and Midwifery Office</td>
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<td>NSW</td>
<td>New South Wales</td>
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<td>NSWNA</td>
<td>New South Wales Nurses Association</td>
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<td>NUM</td>
<td>Nursing Unit Manager</td>
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<td>N3ET</td>
<td>National Nursing Education Taskforce</td>
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<td>RN</td>
<td>Registered Nurse</td>
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<td>RCN</td>
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CHAPTER ONE

INTRODUCTION

This study explores the self-reported leadership practices of Nursing Unit Managers (NUMs), examines their leadership strengths and impact from the perspectives of their staff on workplace outcomes such as empowerment and job satisfaction of staff. Furthermore, the study examines the leadership development needs of Nursing Unit Managers (NUM). The study sought to build knowledge and understanding of the current roles and leadership practices of NUMs. Since this study commenced there has been an increased emphasis on the role of the NUM and the role has come under scrutiny from a number of perspectives in order to bring clarity to the role expectations of NUMs in the public health system. The Nursing and Midwifery Office (NaMO-NSW Health) has initiated a project called “Take the lead” which focuses on the development of new knowledge and competencies for NUMs to strengthen performance in the role (Hawes, 2008) and Queensland Health has recently reported on a Review of the Nurse Unit Manager Role (Queensland Health, 2008). The Garling Report (2008) into the acute hospital system in New South Wales (NSW) has also made a number of recommendations regarding the nursing unit managers’ role.

1.1 BACKGROUND TO THE STUDY

Health care systems worldwide are under strain due to economic constraints, ageing populations, growing burden of chronic disease, increasing consumer demand for ready access to quality care and a comprehensive range of services and issues related to recruitment and retention of a skilled health workforce that can meet the needs of their communities. As health care systems continue to change and adapt in order to meet the demands and impact of the consumers, the quality and safety of the care has become
more pressing issue. Numerous reports on the quality and safety of health care (for example Wilson, Runciman, Gibberd, & Harrison, 1995 and Institute of Medicine (IOM) 1999), recommend a focus on leadership along with improved research, quality tools, performance measures, legislation and the raising of expectations amongst health care providers of improved performance standards and quality of care (Ferguson, Calvert, Davie, Fallon, Fred, Gersbach & Sinclair, 2007). Shortages in the health workforce, particularly the nursing workforce, have contributed to ongoing difficulties in improving quality and raising the standards of care provided to an increasingly well-informed health care consumer.

In 1999 the IOM published a report recognising the critical role that nurses have in patient safety, the impact of the working environment and the need for ‘leadership and management practices that are transformational and evidence-based’ (De Groot 2005, p.37). Wong and Cummings (2007) conducted a systematic review of studies that examine the relationship between leadership and patient outcomes. The findings of this review suggested that emphasis on developing nursing leadership is an important organisational strategy to improve patient outcomes. Their review highlighted the important relationship between leadership and reduction of adverse outcomes, perhaps because the leaders play an important role in managing the context and standards of care, staffing and financial resources required to deliver effective care. Leadership is seen as a vital ingredient in short supply in contemporary health care.

According to Porter O’Grady the importance of an effective leader in an organisation is becoming more evident (Porter O’Grady, 2003) and from the Australian perspective NUMs are in a position to provide clinical leadership which can have an impact on patient outcomes. The NUM is under constant pressure to keep up with organisational reform and changes within the healthcare system, to provide leadership, develop innovative strategies to meet organisational objectives and equip themselves with skills necessary to meet the challenges of the changing and restructured health care system. The current role of the NUM requires them to deal with a complex environment, uncertainty and competing demands as they prioritise, organise and explore new ways of
meeting departmental and organisational goals. With growing complexity in health care, the role of nursing unit manager has received renewed interest (Connelly, Nabarette & Smith, 2003, Garling, 2008). Effective nursing unit managers need administrative, educational and clinical expertise along with an understanding of leadership principles (Connelly, Nabarette & Smith, 2003). Often a registered nurse is put into the management position because he or she is the most clinically competent nurse in the unit, however clinical competency does not always ensure leadership competency. Furthermore there may be little if any orientation to the role or development of the NUM once in the role (Connelly, Nabarette & Smith, 2003) and often there is poor professional support. As the NUM is the link between the organisational hierarchy and the clinicians, therefore it is particularly important that the NUM’s role is clarified and that they take an active leadership role within the organisation.

The importance of the concept of leadership in the clinical environment is supported by the findings of the Australian Federal Government Inquiry into nursing (Our Duty of Care, 2000) and a recent Australian Senate Inquiry (Heath, 2002) into nursing provided a number of recommendations regarding the future of nursing in Australia, with two recommendations that were specific to nursing leadership. Those recommendations are:

Recommendation 57 which stated that the commonwealth and state providers of health care services need to support nursing leadership by integrating nurses into the organisational hierarchy, and

Recommendation 67 which specifically addressed the importance of managers receiving training in management styles that promote leadership and consultation.

Since the inquiry, nursing leadership has been addressed at a national and state level through consultations with the profession and in conferences. The National Nursing and Education Taskforce (N3ET) has included nursing leadership and management education as important for nurses (N3ET) with its chair Belinda Moyes (2004) agreeing with The National Health Workforce Strategic Framework (2004, p.9) which states that “the nature of health care provision is likely to change markedly over the next two to three decades...”. Moyes believes that this is a challenge and a call for nursing
leadership at all levels. The NSW Health Nursing and Midwifery Office (NaMO) has taken up this challenge and invested in developing nursing leadership through the implementation of the Clinical Leadership Programme (NaMO Action Plan, 2004) and the “Take the Lead” project. Furthermore, NSW Health has continued to sponsor leadership development for nurses, doctors and allied health clinical leaders through the Clinical Excellence Commission, Clinical Leadership Program (www.cec.health.nsw.gov.au).

International studies have demonstrated that nursing leadership has an impact on staff job satisfaction and nurse retention (Hayes, O’Brien-Pallas, Duffield et al 2006, McNesse Smith, 1997; Taunton et al. 1997; Severinsson & Kamaker, 1999. Taunton (1997) identified managers’ leadership behaviours as one of the interventions most likely to improve retention of staff because of the leader’s ability to improve staff satisfaction. However, because of continuing role expansion, this in turn potentially limits the opportunities for NUMs to concentrate on nursing retention (Kimball & O’Neill, 2000). Leadership behaviours of nurse managers have also been demonstrated to have an effect on staff satisfaction (McNeese-Smith, 1997; Pedersen, 1993), staff empowerment (Morrison, Jones, & Fuller, 1997) and patient satisfaction (Morana, 1987). McNeese-Smith (2001) found that health care employees reported that they were more satisfied in their work, more productive and more committed to the organisation when managers used effective leadership behaviours. Loke (2001) suggested that leadership practices might be an important indirect contributor to better outcomes of care delivery and job satisfaction of staff nurses. In an early study of nursing leadership Dean (1995) argued that although leadership may have visible benefits it may also have potential disadvantages for nurse leaders such as committing to more work and responsibility than they can reasonably cope with.

Bolman and Deal (1991, cited by Cook, 2001, p. 33) suggested that it is usual for “leadership to be offered as a solution for most of the problems of organisations everywhere”. Despite this, leadership continues to be an elusive concept and there have been numerous authors who have provided definitions of leadership. Although no one
best definition exists, most definitions are about power, authority and leader and follower relationships (Huber, Maas, McCloskey, Scherb, Goode & Watson 2002). While leadership is a highly studied concept, Bowles and Bowles (2000) contend that it remains poorly understood. Early leadership research failed to link organisational characteristics to outcomes; for example failing to show a relationship between factors such as leadership and the quality care delivered to patients (Flood, 1994). More recent work by Aitken (West, 2001) on magnet hospitals has been able to identify a relationship between organisational characteristics such as strong leadership and improved outcomes for patients and staff. Many studies demonstrate that effective leadership is associated with better performance (Kreitner, 1995). In a study carried out by Cummings, Hayduk & Estabrooks (2005) the provision of leadership by nurse managers was associated with less emotional exhaustion and better job satisfaction among staff.

Many authors have addressed leadership and management and the relationship between the two concepts. Zaleznik (1992) believes that not all managers are necessarily leaders. He explored the differences in leaders and managers and says that managers tend to be more reactive and have a more impersonal or passive attitude towards goals whereas leaders are more proactive in shaping ideas instead of responding to them. Peters (1987 cited in Bennis & Nanus1985) predicted that successful organizations have leaders not managers. Huber in 1996 described leadership and management as separate entities that overlap. French (2004) argues that leadership and management are interdependent and cannot be separated. She is of the view that leadership without management is chaotic and wasteful and management without leadership is dangerous and destructive. More recently Marquis and Huston (2009) state that although the debate continues about the relationship between leadership and management there does appear to be agreement in the literature about the need for both leadership and management. Marquis and Huston (2009) summarise some of the arguments stating that “leadership is viewed by some as one of management’s many functions; others maintain that leadership requires more complex skills than management and that management is only one role of leadership” (2009, p.31).
Wong and Cummings (2007) in a recent review of studies looking at the relationship of leadership and staff and patient outcomes reveal that nursing leadership influences staff performance. Scott, Sochalski, Aitken (1999) in their study found that the staff identified that their leader stimulates them into looking at innovative ways in problem solving, challenging their goals and motivating them to do more than they were originally expected to do. Anderson, Issel and McDaniel (2003) using a relationship orientated leadership instrument, found that relationship orientated leaders utilised behaviours that ensure open communication and interpersonal connections among staff which then translates to a more positive patient outcomes. This type of leadership is grounded in a theory of emotionally intelligent leadership (Cummings, et al., 2005) and is essential in supporting the development of nurses (Cummings et al. 2008).

The purpose of this study is to explore the role of Nursing Unit Managers and their self-reported leadership practices, to examine their leadership strengths from the perspectives of their staff and the impact on workplace outcomes such as empowerment and job satisfaction of staff. This study is important in today’s climate, due to renewed emphasis on the role of nursing unit manager and lack of leadership education for nursing unit managers.

1. 2 MEASURING LEADERSHIP PRACTICES

Nursing unit managers play a critical role in today’s evolving health care environments that are characterised by increased patient acuity, financial constraints and a shortage of the nursing resources required to meet increased patient demands. If leadership is defined as ’an influence relationship amongst leaders and followers who intend real changes that reflect their mutual purposes’ (Rost 1991, p.102), then one of the most important concepts of leadership is the nature of the relationships between the leader and the ‘followers’. Through their research Kouzes and Posner (1995) identified human relations as the means by which leaders promote success in their organisation. For this
study, leadership will be measured through self-assessment and observer assessment of leadership behaviours of NUMs using the Leadership Practices Inventory (LPI) developed by Kouzes and Posner (2002). This inventory measures five types of leadership practices that are congruent with transformational leadership style (Tourangeau & McGilton, 2004). These included behaviours that are associated with modelling the way, challenging the process, inspiring a shared vision, enabling others to act, and encouraging the heart. These five practices were found to be common among leaders who were able to get things done in an organisation Kouzes & Posner, 2002). A number of studies have demonstrated the importance of these five leadership practices in improving organisational outcomes. McNeese-Smith (1996) conducted a study on leadership behaviours of hospital managers. The result of her study indicated that hospital managers when demonstrating these leadership behaviours could increase employee’s productivity, job satisfaction and commitment to organisational goals. This study was replicated by Loke (2001) with similar results. She found that there was a positive correlation between managers that displayed the five leadership practices and staff job satisfaction, productivity and organisational commitment. These five leadership practices have potential implications for nursing unit managers, as they identify the leadership practices and skills required to successfully lead a department and have an impact on recruitment, retention and quality of care. In an evaluation of instruments said to measure leadership, the Leadership Practices Inventory was the only instrument that rated highly in both psychometric properties and ease of use when compared against 17 other leadership instruments (Huber et al. 2000).

1.3 EMPLOYEE OUTCOMES

Leadership has been positively linked to many different nursing outcomes (Maunz & Steyrer, 2001, Loke, 2001, Stordeur, Vanderberghe & D’Hoore. 2000, McNesse-Smith, 1999). Of interest to this study is the relationship of nursing leadership to staff empowerment and job satisfaction.
1.3.1 Empowerment

Kanter’s (1977, 1993) work on organisational empowerment describes six empowerment structures in the work environment that enable employees to accomplish their work in meaningful ways. These six structures are access to opportunity, information, support, resources, formal and informal power. When these structures are missing, staff feel that the organisation does not value their contribution to the organisational goals. According to Patrick & Laschinger (2006) work environments where staff have access to information, support, resources and opportunities to learn and grow in their work setting are empowered and are able to accomplish goals.

Although there have been numerous studies of staff empowerment, there have been fewer studies focusing on NUMs ability to empower staff. In a study of nurse managers and staff nurses, Laschinger and Shamian (1994) found that nurse managers’ perceptions of empowerment were related to their self-efficacy for various leadership competencies. Furthermore staff nurses feelings of empowerment were related to their perceptions of their managers’ abilities to get things done which supports Kanter’s (1977, 1993) notion that powerful managers empower their employee by association.

1.3.2 Job Satisfaction

Job satisfaction is widely researched and, like leadership, researchers vary in their definitions of the concept. Smith (1996) defined it as the feelings of individuals about their job. Locke (1976, p.1300) describes is as “a pleasurable or emotional state resulting from the appraisal of one’s job or job experience”. Vroom (1964) defined job satisfaction as "affective orientations on the part of individuals toward work roles which they are presently occupying” (p.99). Even though the definitions vary, a commonality among the definitions seems to be that job satisfaction is a job related emotional
reaction. Research has shown that job satisfaction or dissatisfaction leads to a number of consequences. A number of studies have shown that job satisfaction leads to more productivity, high quality of care and organisational commitment from staff (Smith, 1996, Knoop, 1995). On the other hand job dissatisfaction has been found to increase turnover, absenteeism and occurrence of high stress among staff (Tonges, Rothstein & Carter, 1998). Factors affecting job satisfaction are recognition of achievement, the work itself and opportunities for advancement (McNeese-Smith, 1997). Taunton, in 1997 identified managers’ leadership behaviours as a contributing factor to staff satisfaction and more recently Duffield, Roche, O’Brien-Pallas, Catling-Paull and King (2009) have reported that nursing leadership at ward level is extremely important to clinical nurses in relation to job satisfaction, satisfaction with nursing and intention to leave (p.11). One of the aims of this study is to explore the relationship of the leadership practices of NUMs to staff job satisfaction.

Casterle, Willemse, Verschueren, & Milisen (2008) suggest that nurse leaders are the key agents of change and play a pivotal role in organisational effectiveness. However, the literature also highlights the lack of effective leadership in nursing. Given the complexity of concept of leadership, McCoppin and Gardner (1994) argue that leadership behaviour should be understood in the context of the social system. In recent years the demand for effective ways to improve employee outcomes and productivity has resulted in research on leadership styles and outcomes of effective leadership within organisations. This underlying interest has led to this study, which aims at understanding the leadership practices of NUMs (including the barriers and enablers to effective leadership) and the relationship between leadership and employee outcomes. Organisational factors that can influence leadership effectiveness and the influence of NUMs leadership practices on staff job satisfaction and empowerment have not been examined together in the Australian nursing context.
1.4 THEORETICAL FRAMEWORK

1.4.1 Role Theory

The theoretical framework for this study is based on the concept of role theory. Role theory specifies a set of behaviours, norms and values associated with a given role (Hardy & Conway, 1987). Role theory is a collection of concepts, definitions and hypotheses that predict how actors will perform in certain roles and under certain circumstances (Williams, 1996). This is an appropriate theoretical framework because the focus of this study is on the role of Nursing Unit Managers in a specific occupational context. There are two distinct approaches in role theory, namely the structural-functional approach and the symbolic interactionist approach (Hardy & Conway 1987; Barter, McLaughlin & Thomas, 1997). The structuralist approach views the role as set of behavioural expectations associated with a position (Murray, 1998) and the interactionist approach allows the person occupying the role to bring his or her personal values, goals and meanings to discover and enact a new role (Schmitt, 2005). Nursing unit managers’ foundational education and clinical experience no doubt influences their experience particularly during the transition from a clinician to a manager.

Hardy and Conway (1987) argue that neither of the two approaches could be utilized alone, and recommended the use of both perspectives in examining theoretical assumptions. In examining the functions and behaviours of the NUM, the structural–functional perspective and symbolic interactionist perspectives will be applied. Role theory illustrates how individuals react and behave in social situations (Biddle & Thomas, 1966) and recognises the influence of others on individuals through the behaviours, rules and sanction of others and their own understanding of the roles they assume in an organisation. Montgomery (2001) supported the use of role theory as a framework that can be used in contemporary research that deals with exploring identity and culture. There have been many facets of individual behaviour that have been investigated in studies of role including self-appraisal, role performance and how role
performance affects others (Clifford, 1998). Others explore and clarify the meaning of role conflict (Shead, 1991) and role strain (Olsen and Gullberg, 1987).

The word “role” is sometimes used to describe a given status or position. For example in the nursing context a role may be a clinical role, nurse practitioner role, a specialist role or a managerial role. Biddle and Thomas (1966) suggest that it is the amount of time spent and types of behaviour that are the distinguishing factors in different roles. Hence, a nursing unit manager will spend a large amount of time in undertaking the traditional management roles, but will also require well developed leadership behaviours to function effectively in this front line role in a changing health care system. There have been several studies addressing the issue of role in specific occupational contexts such as perioperative nursing (McGarvey, Chambers & Boore, 2004) and clinical nurse specialist (Glover, Newkirk, Cole, Walker and Nader, 2006). It was found that to perform their roles effectively these clinicians needed clarity regarding the role expected of them and support to perform that role in a stressful environment. Rheiner (1982) identified three factors needed to define a specific role: expectations, conceptions and performance. According to Rheiner (1982) role expectations are attributes that different layers of staff in an organisation believe an individual displays in his or her position. Role conception is how an individual defines the role and role performance is how an individual fully understand the expectations of other staff and the organisation regarding their role. Therefore the role of the NUM is dependent on the relationships between expectations, conception and performance. When the role of NUM is not clearly defined role conflict may ensue. Nurse Unit Managers also experience role confusion and role ambiguity as a result of different expectations from staff and the organisation. Ernst (1995) identified that head nurses in a rural hospital perceived role conflict and role ambiguity in their job. Currently, NaMO is undertaking project called “Take the Lead” the aim of which is to understand and clarify the current role of the Nursing Unit Manager within the NSW Health system (Hawes, 2008).

The notion of leadership is complex; however it is the individual taking the leadership role that defines the experience in the context of his or her environment. How the leader
behaves is a product of the role itself and the personality of the person concerned (Williams, 1996). The underlying assertions of role theory relevant to this study are:

- a person’s values, attitudes and beliefs are linked to the roles he or she plays within the social environment (Merton, 1968)
- role performance is influenced by organizational context (Katz and Kahn, 1978) and the individual who performs in that context (Hurley, 1978), and role behaviours are recurring patterns of actions that are considered important for functioning in the particular role in the particular organisation (Biddle and Thomas, 1966).

With the role of NUM becoming more complex in the constantly changing health care environment, those in the role cannot rely solely on traditional management skills. In order to survive the changes in healthcare organisations, they must lead people by working alongside and building effective relationships with them. Kanter (1993) believes that managers are ideally positioned to create structural conditions for work effectiveness. As the pace of change confronting NUMs increases, leadership skills will be vital for this important role. Upenicks (2002) states that nurses in leadership roles produce positive gains and have the potential to influence the nurses they manage. The Nursing Unit Manager leadership role is an important factor in influencing staff perceptions of change and staff productivity.

### 1.5 THE AIMS OF THE STUDY

As the NUM’s role continues to evolve in today’s health care setting, nursing leadership has become a focal point in healthcare literature. There is evidence to suggest that nursing leadership is associated with health care organisational success (Perra, 2000; Stordeur, Vanderberghe & D’hoore, 2000). If nursing leadership is seen as an important factor in improving health care organisations, it is important to understand the impact of such leadership on staff recruitment, retention and staff satisfaction, the barriers and
facilitators to effective leadership in health care organisations and the type of development needed by nurse leaders in order to improve their leadership practices. While there is a growing amount of research into nursing leadership and increasing evidence of the impact of leadership development on leader effectiveness (Bowles & Bowles, 2000; Krugman & Smith 2003) there is significant interest in the actual relationship between nursing leadership and staff and patient outcomes (Vance & Larson 2002; Wong & Cummins 2007). Hence the aim of this research project is to explore the self-reported leadership practices of Nursing Unit Managers examine their leadership practices from the perspectives of their staff and how these practices impact on workplace outcomes such as empowerment and job satisfaction of staff. Furthermore, the study aims to examine the leadership development needs of Nursing Unit Managers to use that information to inform the development of a model for professional leadership development for NUMs within the Australian context.

The purpose of this study is to develop an in-depth knowledge and understanding of the leadership practices of NUM and the impact of these practices on staff empowerment and job satisfaction.

The study aims of the research will be addressed by answering the following research questions:

1. What are the reported leadership practices of Nurse Unit Managers? Is there a difference between the self-reported leadership practices of NUM and their leadership practices as rated by their staff?
2. What are the leadership attributes and resources that are needed in the changing health care system?
3. What are the barriers and facilitators to the NUM’s leadership role?
4. Are there demographic characteristic of a NUM (age, gender, educational qualification) that are related to self-reported leadership practices?
5. Does the provision of leadership by the Nurse Unit Manager impact on staff’s job satisfaction and workplace empowerment?
6. What is the role of Nursing Unit Manager and what are the development needs of the NUMs?

**1.6 SIGNIFICANCE OF THE STUDY**

Most research on nursing leadership to date has focused on the leadership practices of nurse executives and senior nurse managers and its effect on job satisfaction of nursing staff, however there are few studies that examined the relations among leadership practices, workplace empowerment and job satisfaction, particularly within the Australian context. With increasing emphasis on providing leadership in the clinical setting and its perceived benefits, it is imperative to examine and gain information pertaining to the effective leadership practices of NUMs. The literature review provides evidence that leadership is essential to success in an organisation. Work of this nature has not previously been published in Australia and therefore the findings will be of enormous benefit as it explores the NUMs leadership practices, common strengths and weaknesses and the context for improvement in leadership practices and development. It explores the relationships between the five leadership practices identified by Kouzes and Posner (2002) and the outcomes of these practices such as levels of job satisfaction and employee empowerment. The study also identifies organisational factors that support leadership development amongst Nursing Unit Managers and it provides information on barriers and facilitators for the leadership role of the NUM by articulating the relationship of leadership practices to workplace outcomes.
1.7 SUMMARY

The purpose of this study is to develop an in-depth knowledge and understanding of the leadership practices of NUM and the impact of these practices on staff empowerment and job satisfaction. Chapter 1 included the research questions, introduction and background information and a rationale for the study and study aims. Role theory as the theoretical framework for this study was briefly analysed and discussed. The significance of the study for advancing knowledge and understanding of leadership practice was also discussed. Chapter 2 contains a review of relevant literature and research on the relationship of nursing leadership and employee outcomes, the role of nursing unit manager and the instruments to be used in this study.
CHAPTER 2

LITERATURE REVIEW

INTRODUCTION

This chapter presents review of relevant literature for the study. The purpose of the literature review is to access, analyse, critique and discuss relevant information on the role of nursing unit managers, nursing leadership and the relationship of leadership practices to employee outcomes.

The review of literature from Australia, United Kingdom (UK), United States of America (USA) and Canada revealed an abundance of information generally on the evolving health care organisation, the importance of leadership in health care, particularly its influence on employee outcomes and the expanding role of nursing unit managers. Electronic databases searched included CINAHL and Medline. Manual searches of specific journals such as Journal of Nursing Management, Journal of Nursing Administration, Journal for Nurses in Staff Development, Canadian Journal of Nursing Leadership, Journal of Advance Nursing and Nursing Management were also completed to ensure that the search was exhaustive and complete. The online and manual searches yielded a total of 100 titles and abstracts. There are quite a number of studies in U.S.A and Canada on nursing leadership and its influence on employee outcomes particularly empowerment. However, there is a paucity of information regarding NUMs’ leadership practices and influence on job satisfaction and empowerment of staff particularly in the Australian context. Throughout the literature a number of themes emerged that proved crucial to this study: (a) changing health care organisations, (b) changes in the role of the NUM, (c) leadership in nursing and (d) leadership practices and its influence on employee outcomes. These themes will now be reviewed in greater depth.
2.1 THE CHANGING HEALTH CARE ORGANISATION

Health care is an industry that affects the community at large; particularly the employees in the system and the recipients of health care services. Health care experts agree that the health care systems in Australia have undergone significant change and continue to be faced with new challenges. Health care in Australia is becoming more complex and like other similar countries will continue to be presented with changes and challenges (Heath, 2002). Over the last decade health care systems have faced an increased pressure from the government for improved efficiency and effectiveness (Hancock, 1999). With around 9.0 per cent of Gross Domestic Product in Australia consumed in health expenditure in Australian in 2005-06 (Australian Institute of Health and Welfare, 2008) the continued implementation of health care reforms is inevitable.

According to Duckett (2000) the primary focus of the health care reforms has been about control or cost reduction. Health care reforms signalled the adoption of business systems thinking in health care. Health care has become market driven. The continuing shifts in resource funding and restructuring of health services are just some examples of the changes in the current health care system as a result of health care reforms. The assumption for these changes was that, with limited resources, health care organisations should still be able to provide quality care to the consumer (Borthwick & Galbally, 2001). Health care organisations have had to make drastic changes to meet the demand. Degeling & Carr (2004) suggest that health care reforms in England and in Australia have had little impact in terms of improving performance and they suggest that leadership at departmental level is important in the success of implementing any health care reforms. In New South Wales (NSW), restructuring of 17 area health services into eight larger areas was implemented in 2004. The overall aim of the restructuring was to deliver more resources to frontline clinical services resulting in significant improvements in patient care, and an opportunity for clinicians to have a voice in the planning and delivery of health services (NSW Health, 2004). One of the consequences
of this restructure and reorganisation of the health care system is a recognition that strong leadership is required to achieve these new organisational objectives.

The quest for better performance in public organisations such as hospital has seen the use of business terms such as efficiency, accountability and strategic planning and the introduction of different forms of performance indicators, and quality management systems. According to Duckett (2000) these developments are occurring as a result of economic rationalist philosophy utilised in health care organisations. The doctrine of economic rationalism is that market systems provide an efficient method for allocating and distributing resources to achieve the best possible economic and social outcomes (Hancock, 1999). Despite the fact that this philosophy has been roundly criticised in relation to the validity of its application to health care and the view that health is different to other commodities it continues to be a driving force in health care reform.

Some of the significant changes that demonstrate an economic rationalist approach in the current health care system are derestructure of health care organisations and shifting management methods of resource allocation, demand for quality care and quality improvement initiatives, increasing emphasis on information technology, increase consumer participation and funding allocation such as the use of episode based funding. These reforms are changing the way in which health care organisations operate. The current directions of health care have been influenced by a business type approach to the provision and management of health service. Currie (1997) is concerned that economic rationalist principles may have an impact on health service managers with a clinical background. He suggested that these managers might have difficulty in understanding the principles behind corporate management.

The continuing changes in the health care system and the new trends emerging as a result can lead to increased organisational complexity and instability (Anthony et al. 2005). As health care has become more complex organisations have been undergoing restructure, redesign and reorganisation (Beyers, 1999) in an attempt to meet the health care needs of the population. In order for these reforms to succeed there is recognition
that new approaches to management will be required. Health care organisations are moving away from the traditional multi-layer hierarchy to more horizontal and matrix organisational structures (Alexander, 1997). Chapman (2001) argues that managerial work is changing and that the role of the manager and the expectations of others will evolve as a result of reorganisation. Despite all of this, Lutz, Grossman, & Biglake (1998) contend that success in reorganisation of health care can only be achieved if variables such as lack of resources, workforce issues and complexity of patient populations can be overcome.

The types of health care reforms described above have brought considerable change in the practice of the professional involved in the delivery of health care. With a strong emphasis on the business management thinking, on efficiency and effectiveness in health care organisations, the need for strong leadership is evident. As health care organisation strive to improve organisational performance, much of the responsibility for achieving these outcomes has fallen on the nurse (Brooks 1999), in particular the Nursing Unit Manager. Furthermore, the changes associated with this evolving health care system will have a bearing on the current and future role of managers and will drive the need for management and leadership development, particularly for frontline managers such as the NUM.

### 2.2 ROLE OF NURSING UNIT MANAGER

Parallel to the changes in the health care system, the Nursing Unit Manager’s role has changed considerably over time. From the traditional role of attending to staff rostering, ensuring patient safety and monitoring stores supply, the role of the NUM has expanded and become more complex (White & Bray, 2003). Many different responsibilities have now been included in the domain of a the Nursing Unit Manager, including accountability and responsibility for the type and quality of care delivered to patients and for ensuring that their respective services and / or departments are responsive to the
needs of the patient and the organisation. In meeting these needs, NUMs needs to balance the demands of government policy, professional interests and patient needs.

In Australia the role of the NUM has been studied by a number of authors as it has shifted from clinical expert to departmental manager (Duffield, 1991; Duffield, 1992; Duffield, Franks, Wood & Brisley, 2001). This paradigm shift from clinical expert to departmental manager has directly impacted on the roles and responsibilities of the NUM. The expanded role requires such skills as effective leadership, in addition to basic management skill. NUMs are expected to manage their departments efficiently, which involves activities such as strategic planning, financial and human resource management, overseeing nursing clinical practice, ensuring patient and staff safety and providing leadership in the workplace. The multifaceted role of the NUM also requires the acquisition of skills such as coaching, motivation, the ability to empower others and the ability to lead (Duffield, Bunt, Thornton, Cahill, Franks, Moran & Beutel, 2001). There is general agreement that the main responsibility of the nurse manager is to organise and control human and fiscal resources and achieve the most efficient outcomes for the organisation (Duffield, 1992; Sofarelli & Brown, 1998). The difficulty is now that the occupation of a management position and good management skills are no longer sufficient – strong leadership and interpersonal skills are also required.

In 1986, as part of the review of the main nursing award, the Public Hospital Nurses’ (State) Award, the position of nursing unit manager was created in NSW (White & Bray, 2003). From then on the role of the NUM and the tasks they performed grew in response to organisational changes in health care (Duffield & Franks, 2001). Evidence of the growing NUMs’ role came when the NSW Nurses Association (NSWNA) campaigned successfully in 1997 to increase the award range because of the increase in work value. The NSWNA also argued that the devolution of responsibilities from senior management to the NUM level had resulted in significant change in the role and responsibility of NUM. Historically, the NUM had excellent clinical skills and was the most experienced member of staff, and understood how the organization functioned (Duffield, 1992; Duffield & Franks. 2001). Nurses that are committed to the nursing
role are usually promoted on the basis of their clinical competency to be a manager, (Brewer and Lok, 1995, Wilmott 1998). Hence, without sufficient educational preparation or training for the role, NUMs often failed to manage their departments efficiently as they often invest more time in a more familiar clinical role, and neglected managerial responsibilities (Paliadelis, Cruikshank and Sheridan, 2007). While this may be appropriate at times, changes occurring in the health care system have resulted in different expectations of the role of NUM (Duffield et al. 2001). Watters, Clark, Ingall and Dean-Jones (2003) report that recently appointed NUMs needed to learn on the job from more experienced managers. They reported that mentorship and support provided by senior nurse managers were vital to new or less experienced NUMs.

Outside of Australia, the changing role of nurses in management position in a changing health care environment has been described by a number of authors (Knox, 1995; Davidson, 1996). Existing studies commonly deal with issues related to role expansion. Johnson (1995) identified the advantages and disadvantages of an expanded managerial role. One advantage was that the nursing unit management position was a step on a management career pathway. One disadvantage, according to Johnson (1995) was that the managerial tasks were taking valuable time from managers and reducing the focus on patient care. The NUMs perception of their roles has been described in a number of earlier studies. Baxter (1993) interviewed 20 NUMs about their roles, with results showing that NUMs were most familiar with elements of the role such as monitor, resource allocator, leader and liaison person. Katz’s model of three domains of management skills - human, technical and conceptual skills was used by Duffield (1994) to classify 156 competencies identified by nursing unit managers in NSW. Managers identified human skills such as communication, decision making and team building as important to the managers’ effectiveness. Persson and Thlyfors (1999) showed that the role of NUM is associated with seven managerial tasks: planning, supervision, consideration, administration, organisational development, patient care and research. Findings from Sullivan, Baumgardner, Henninger & Jones (1994) study affirmed the increasing managerial content of the NUMs role. Only 25% of the NUMs time was
spent in direct patient care activities with the remaining 75% spent on managerial functions.

Collectively, the major focus of the studies reviewed was on tasks and roles being required of NUMs. The varying roles identified and the lack of agreement on what the role of NUMs should be was evident in the literature. Furthermore, studies concerning the roles of nursing unit manager are mostly descriptive and data was usually gathered through interviews. Inductive data analysis makes it difficult to construct an overview of the described roles of the nursing unit manager.

It is no surprise that NUMs have indicated confusion about the expectations in their role (Lifkin, Herrick, Newman, Hass, & Berninger, 1992). Role conflict and role ambiguity among head nurses has been studied by Ernst (1995) who found that head nurses were experiencing role conflict and ambiguity in their current role, and that the major source of role conflict was caused by lack of time to perform administrative functions. The study concluded that management training would clarify roles and reduce role ambiguity. Thorpe and Loo (2003) identified that the nature and number of recent changes in health care system have resulted in role ambiguity and this ambiguity hinders manager from developing competence in their role. Furthermore, as a consequence of all the changes in a nursing unit manager’s role, nursing unit managers, particularly new NUMs were often unable to fulfil the demanding but important elements of the role of the nursing unit manager such as teamwork and supporting their staff. Similar findings have emerged from recent reviews by NSW Health (2009) and Queensland Health (2008) following reviews of the role of the NUMs in those state hospital systems.

In summary the literature continues to indicate that the NUMs’ role continues to expand and remains unclear. There is evidence that NUMs are poorly prepared for their role and experience lack of support from their organisations. Most of the studies in relation to describing the role of nursing unit managers involved only the NUMs. No study has been found in Australia that describes the perceptions concerning the role of NUMs held
by the NUMs themselves as well as by their staff, and its impact on employee outcomes. This study aims to explore these areas in some depth.

### 2.3 WHAT IS LEADERSHIP?

The most powerful concept of leadership in a learning organisation, according to Senge, is not the traditional role of ‘leaders at the top driving change’ but rather leadership which provides the capacity for a human community to shape its future, specifically by sustaining the processes of change required (Senge, 1999, p. no.356). In this context, leadership comes from the ability to hold ‘creative tension’ while vision is developed, reality identified and energy created to draw reality closer to the vision. This view of leadership suggests that an organisation needs to have leaders in all levels of the hierarchy including the front line managers, the ‘network leaders’, who work within the informal network of an organisation to foster and support change at all levels and executive leaders who have grasped the learning-oriented culture (Senge, 1999).

Huber (2000) defines leadership as the process of influencing people to accomplish goals. Everson-Bates and Forsbinder (1994, p.36) define leadership as “the desire and ability to influence the beliefs, values and behaviours of others”. A nurse leader is also perceived as supportive, knowledgeable, visible and responsive to the needs of staff (Upenieks, 2003). The nurse as a leader is in an influential position as they are close to the delivery point of care and have both clinical and management experience. According to Cook (2001) developing clinical leaders should be a major priority in health services as they influence and motivate staff through their leadership behaviour and interaction with them. Such leader behaviours include actions that facilitate goal achievement, supporting staff effort and being involved in goal accomplishment (House, 1971). The leadership literature presents many different perspectives and ways of examining leader behaviours (Bass, 1990). A prominent conceptualisation of leader behaviour distinguishes transactional and transformational behaviour. Lloyd (1998)
describes a transformational leader as the leadership style most sought after in the public health domain. The attributes of a transformational leader include subtlety to inspire group ownership of strategic vision, capacity for enthusiasm, ability to recognise individual contribution and celebrate accomplishments and ability to motivate and foster belief in self-efficacy (Lloyd, 1998). Leadership issues not only concern the leaders but those being led as well. This study explores nursing unit managers’ leadership as viewed by NUMs’ themselves and as viewed by the staff they lead. As suggested by Rosengren, Athlin & Segesten (2007) understanding staff perceptions may contribute to more active and conscious decisions about leadership practice.

2.4 LEADERSHIP IN NURSING

 Whilst empirical research in nursing leadership is relatively new, much can be learnt from other organisations. A survey of the 27 most admired companies revealed that effective leadership separates the most admired organisations from the rest (Snow, 2001). These companies invest in not only developing their leaders and but also their potential leaders. Although these companies were non-health organisations, the findings from the research in these admired companies can be transferred to the health care environment. The American Association of Colleges of Nursing recommended that graduate programs for nursing administration should include curriculum content that prepare nurses in managerial roles to assume both leadership and management roles (Purnell, 1999). Two major reports about nursing shortages also address leadership as an important key to improving staffing (Kimball & O’Neill, 2002) and building a thriving workforce (Ritter-Teitel, 2003). The reports also included competencies of a good leader such as being good communicators, change agents and analytical thinkers. In 2000, Clarke (2007) went as far as to suggest that in nursing at that time there was a shortage of leaders and of leadership. While today there is an increased emphasis to invest in nursing leadership and the importance of leadership development for nursing leaders (Bowles and Bowles 2000; Krugman & Smith 2003) there is still a knowledge gap between the actual relationship of nursing leadership and nursing and patient
outcomes (Vance and Larson 2002; Wong and Cummings 2007). One of the issues in interpreting the current research is that ward managers are the only respondents in most studies on leadership in health care organisations (Rosengren, Athlin & Segesten 2007). Several researchers claim that because ward managers emerged from nursing practice and are trained to care for patients (Mallik, 1998; Gould, Kelly, Goldstone & Maidwell, 2001; Thorpe & Loo 2003), they have a tendency to care for patients instead of supporting and coaching staff members. This can create a problem, as nursing staff need support from their managers in order to provide high quality care. Drach-Zahavy and Dragan (2002) reported that ward managers spent most of their time being occupied by “doing” and the “here” and “now” rather than leading, planning and being proactive in addressing issues. Drach-Zahavy (2004) argues that ward managers should be released from the burden of administration duties and suggests that they should coach and build teams instead.

Leadership in nursing has been associated with certain personality characteristics or traits (Harvath et al. 2008). McBride et al. (2006) recognised that being a nursing leader is not just a matter of becoming skilled or knowledgeable, but using that skill and knowledge in order to make a difference. Hence it is important for nursing leaders to be visionary and creative and they also need to develop the skills necessary to motivate individuals and organisations to change. Furthermore, several authors have reinforced that nurses in leadership position needs to have good business acumen to direct resources toward desired change (Jennings, Scalzi, Rodgers & Keane, 2007; Upenieks, 2002).

Research in social sciences indicates that leadership can have significant influence on performance and outcomes, however, minimal transfer of these findings are evident in health care according to Vance & Larson (2002). Only 5.2% of the research articles reviewed from 1970-1999 by Vance and Larson (2002) include correlations between leadership and patient and organisational outcomes. They reported that the difficulty was due to lack of precise definitions and specific measurement tools. According to the studies Vance and Larson (2002) reviewed, evidence showing direct effect of
leadership on patient and organisational outcome is still limited. Clearly, further insight into the relationship of leadership and employee outcomes is essential. With the pressures of constant reform, increasing consumer demand and workforce shortages, there is a need to understand nursing leadership.

2.5 LEADERSHIP OR MANAGEMENT

According to Malby (1997, p.15) “Leadership is an interpersonal characteristics of influence, the product of personal characteristics rather than mere occupation of managerial positions”. Bennis and Nannus (1985) stated that although management and leadership are both necessary in managing individuals, they identified a difference between a manager and a leader. They believe that managers do things right and leaders are individuals who do the right things. Doh (2003) believes that the literature has created a false dichotomy between leadership and management. Although some authors argue that leadership and management are different many others argue that these two distinctive concepts are complimentary or indeed, interdependent (French, 2004). Other authors go as far as saying that leadership attributes are synonymous to those of management (Duffield, 1992; Sofarelli & Brown, 1998), however, what is clear in the literature is that being a good manager does not necessarily equate to being a good leader. Gokenbach (2003) stated that being skilled as a manager is a framework for developing leadership skills. Chapman (2001) believes that managers are slowly shifting away from previous roles such as those related to administrative functions to supportive coaches and visionary leaders.

The Institute of Medicine reports recommended that the issue of patient safety can be addressed by the creation of a more favourable work environment for nurses. To create this type of environment for both nurses and patients, strong nursing leadership is required (Baker et al. 2004; IOM, 2004). Some authors see transformational leadership as a leadership style that fits today’s nursing environment (De Geest, Claessens,
Longerich, & Schubert, 2003; Thyer, 2003). In managing health care organisations, Dixon (1999) suggests that transformational leadership behaviours are needed. A transformational leader is one who challenges the process and seeks opportunities (Al-Kandari 1993) and motivates others to achieve the best possible outcomes (Bass & Avolio, 1994). Laschinger (1996) found that leadership behaviours impact on nurses’ perceptions of empowerment. McKay (1995) found a relationship between managerial leadership style and staff nurse empowerment. In his study, staff nurses who perceived their manager to be transformational tended to have higher levels of empowerment than those that perceived their managers as transactional. Managing human resources requires more than transactional leadership (Bass, 1985). It requires skills to motivate, transform, empower and enabling staff to perform to a higher level than they may otherwise do. There have been several studies examining how transformational leadership affects workplace outcomes. They have reported positive correlations between transformational leadership practices and job satisfaction, employee commitment, productivity and organisational effectiveness (Durnham-Taylor, 2000; McNeese-Smith, 1997). Bass (1985) suggested that transformational leadership has the potential to make a difference in organisational outcomes.

2.6 LEADERSHIP AND ORGANISATIONAL OUTCOMES

Leadership in nursing may be defined as the “process whereby a person, who is a nurse, facilitates the actions of others in goal determination and achievement” (Yura et al. 1986, p.77). French asserts “leadership should not be left to chance but be recognised as an area of study” (2004, p.38). In U.K, The Royal College of Nursing (RCN) Clinical Leadership Programme was established in 1995 to identify how nurses in leadership positions could improve patient care. To date, positive outcomes have emerged from the programme (Cunningham & Kitson, 2000), which included improved performance from ward and senior nurses and evidence showing patient care had also improved. The
programme has also been adapted in several European countries and implemented in Australia in South Australia and New South Wales.

The concept of leadership has become an interesting focus in today’s management practice. Morrison (2000) suggested that the lack of leadership was the largest issue facing health care organisations. Cook noted in 1999 that there are few empirical studies into leadership and nursing and most of the articles were only opinion based, a view supported by Hurst (1997) and Girvan (1996). Cook (1999) suggested that there is a need for focused research into leadership in nursing. Kleinman (2003) supported this notion. There have been numerous studies which demonstrate the positive benefit of effective leadership including one by Kleinman (2003) which demonstrated positive relationship between leadership and workplace outcomes such as reasonable standards of performance from staff and an emphasis on teamwork relationships. Leadership behaviours of nurse managers have also been demonstrated to have an effect on staff satisfaction (McNeese-Smith 1997; Pedersen 1993), staff empowerment (Morrison, Jones & Fuller, 1997) and patient satisfaction (Morana, 1987). Strong associations were also found between Nurse Unit Managers’ leadership styles and employees productivity, job performance and employee empowerment (Baker, 1993; Morrison et al. 1997; Klakovich, 1996). Leadership behaviours have also been found to positively impact on nurses’ perception of empowerment (Laschinger, 1999). Thyer (2003) found that staff nurses who perceived their managers to have a transformational leadership style tended to display higher level of empowerment.

One of the difficulties in interpreting studies on leadership is that many of them lack an empirical basis (Laschinger-Spence, Wong, McMahon & Kaufman, 1999). Flood (1994) stated that some health care organisation research failed to link organisational characteristics to outcomes; for example failing to show a relationship between factors such as leadership and the quality care delivered to patients. More recent work by Aitken (West, 2001) on magnet hospital studies was able to identify a relationship between organisational characteristics such as strong leadership and improved outcomes for patients and staff. Casterle, Willemse, Verschueren & Milisen (2008) review of
literature (1999-2006) revealed that leadership development positively affects nursing outcomes. The outcomes studied were mainly limited to job satisfaction, autonomy, burn out, stress, productivity and commitment. Comparison of these studies was limited due to differences in the methodologies used.

The complexity of health care has increased dramatically over the last decade as a result of increased technology and restructures in response to external pressures. It is evident that traditional management practices are no longer sufficient to meet organisational needs. The challenge is to create a future for nursing leadership in managing services that is consistent with workplace demand. Lindholm & Uden (1999) believed that there is a higher expectation for nursing unit manager to attain further skills required for the management role. As health care organisations continue to embrace, implement and challenge health care reforms, the role of the nursing unit manager is and will continue to evolve to adapt to this changing environment. Bowles and Bowles (1999) emphasised the need for strong leadership skills in nursing. Advocates for nursing leadership believe that it is more vital in today’s health care because of the recruitment and retention crisis in the nursing workforce. Porter O’Grady (2003) suggested that leadership requires different skills from those that were predominant in the past. Changes in technology, the health care delivery system and nursing practice require an increasingly skilled NUM. Nurse leaders required different leadership characteristics than their predecessors (Jobes & Steinbinder, 1996). Today’s nurse leader needs to inspire and encourage, be proactive and innovative. The Nursing Unit Manager leadership skills and abilities have become important as they perform management roles such as financial and human resource management and as well as providing leadership by motivating staff, sharing a vision and achieving operational efficiency. The provision of leadership has become an important ingredient in managing a department (Loke, 2001).
2.6.1 Measuring Leadership Practices

The Leadership Practices Inventory by Kouzes and Posner (2002) measures five types of leadership practices that are congruent with transformational leadership style (Torangeau & McGilton, 2004). These included behaviours that are associated with modelling the way, challenging the process, inspiring a shared vision, enabling others to act, and encouraging the heart. These five practices were found to be common among leaders that were able to get things done in an organisation (Kouzes & Posner, 2002). In testing, The Leadership Practices Inventory was the only instrument that rated highly in both psychometric properties and ease of use when evaluated with 17 other leadership instruments (Huber et al. 2000). McNeese-Smith (1996) conducted a study on leadership behaviours of hospital managers. The result of her study indicated that hospital managers when demonstrating leadership behaviours could increase employee’s productivity, job satisfaction and employee commitment to organisational goals. This study was replicated by Loke (2001) who concluded that positive leadership made a difference in employee outcomes, especially job satisfaction. Both studies demonstrated the importance of these five leadership practices. These five leadership practices have potential implications for nursing unit manager, as they identify the best leadership practices and skills to successfully lead a department. Torangeu and McGilton (2004) recommended that further research is needed to gather evidence of LPI psychometric properties within the nursing context. The LPI has been used for educational and research purposes across employment sectors, but there exists little information about its use in health care setting, specifically with and about nurses. Scores obtained using the LPI in research have been relatively consistent and have been found to be unrelated to various demographic characteristics such as age, marital status, educational experience and work tenure. For this study LPI will be used to measure the leadership practices of nursing unit managers.
2.6.2 Empowerment

Empowerment has been conceptualised as “creating and sustaining a work environment that speaks the values that facilitate the employees’ choice to invest in own personal actions and behaviours resulting in positive contributions to organisational mission” (Tebbit 1993, p.19). In nursing the concept of empowerment has been used in relation to improving patient care, training and management (Gautier & Matterson, 1995; Ryles 1999; Lashinger et. al. 1999). Empowerment is associated with growth and development. Kanter developed the “Theory of Organisational Empowerment” in the 1970s. The premise of her theory is that when opportunities for empowerment are provided, employee attitude improves and in turn the organisation becomes more effective in achieving its vision (Laschinger et al. 2000). Kanter (1993) believes that work environments that empower are those in which access to information, resources, and support that is necessary to accomplish work, is available. The level of empowerment is directly related to the circumstances experienced by staff in the work setting (Kanter 1977; Laschinger et al., 1997). Access to these empowering structures comes from formal and informal power sources. Power that is represented as formal power is derived from the position held (Laschinger et al., 1997) and the job characteristics. Informal power is a type of power derived from relationships with people within the organization. Both formal and informal power influences staff access to information, support and resources (Lucas, Laschinger & Wong, 2008; Patrick & Laschinger, 2006) required to do their job as well opportunity to learn and grow which can result in greater commitment and motivation. Staff must have access to resources, both fiscal and human to be able to accomplish their goals. Access to information refers to being informed and participating in organisational decision-making. Lastly access to support refers being able to received feedback and guidance from line managers, peers and colleagues. Patrick and Laschinger (2006) contend that when all these are in place, staff feel empowered, the organization benefits because of improved employee attitudes, which in turn contributes to organisational effectiveness.
And although there have been numerous studies of staff empowerment there have been fewer studies involving nursing unit managers. One study reported difference in nurse managers’ perception of power and opportunity based on their position within the organisational hierarchy (Goddard & Laschinger, 1997). In this study middle level managers reported having greater access to power and opportunity compared to first line managers. Upenieks (2003) qualitative research supports Kanter’s contention, that when leaders have access to empowering structures, it translates into an empowering environment. Several studies have provided empirical support for Kanter’s seminal work on structural empowerment (Laschinger, 1996). In those studies nurses rating of workplace empowerment were moderate suggesting the need for additional access to opportunity, information, resources and support in workplace setting. A number of studies have linked empowerment to organisational outcomes such as job satisfaction (Laschiner, 1996; Laschinger et al. 2000 & Laschinger et al. 2001) while others found empowerment to have a direct positive effect in management (Laschinger et al. 2000; Finnegan & Laschinger, 2001). Nurse leaders play a key role in creating an empowering environment (Finnegan & Laschinger, 2001). Empowered managers also have the ability to empower others. When nurses perceived their managers to be confident and have influence in the organisation they are more likely to feel empowered themselves (Whyte, 1995; Laschinger & Shamian, 1994).

2.6.3 Job Satisfaction

Job satisfaction is defined as the feelings an employee has about their job in general (Smith, Ironson, Brannick, Gibson, & Paul, 1989). Job satisfaction is generally recognised as a multifaceted construct that includes staff feelings about a variety of intrinsic and extrinsic factors (Misener, Haddock, Gleaton, & Ajamieh, 1996). Concerns about staff job satisfaction are just as critical in health care setting as they are in other business sectors. There are numerous factors that influence staff job satisfaction including salary, working conditions, organisational culture, work flexibility and
interpersonal relationships. Irvine and Evans (1995) emphasised the importance of work characteristics (autonomy and feedback), characteristics of how work is defined (role conflict and role ambiguity) and characteristics of work environment (leadership, opportunities and participation) in relation to job satisfaction.

The literature indicates that low levels of job satisfaction are prevalent amongst nurses (Randall Andrews & Dziegielewski, 2005). Sochalski (2002) reports that one out of three staff nurses expressed job dissatisfaction with his or her current job. Similar findings were reported by Aitken, Clarke and Sloan (2001) in their multinational study of staffing and organisational outcomes in five countries. Sources of job satisfaction are associated with factors related to patient care, increasing workload, staff relationships, personal and organisational factors (McNeese-Smith, 1997). Lack of job satisfaction has been associated with other variables such as increases in absenteeism (Cortese, 2007), motivation (Khowaja, Merchand and Hirani, 2005), quality of service and health care (Aiken et al. 2001) and these are just some factors that if all summed together, may compromise an organisation’s overall effectiveness (Tzeng, 2002 & Cortese 2007).

The effect of empowerment on job satisfaction has been studied by a number of researchers (Manojlovich & Laschinger, 2002; Shaver & Lacet, 2003 & Ingerssol et al. 2002), but only few studies have addressed the relationship of job satisfaction and leadership practices of nursing unit managers (Loke, 2001). Laschinger (2002) explained that 38% of the variance of nurse job satisfaction was explained by structural and psychological empowerment. Studies on job satisfaction among nurses have focused primarily on autonomy and organisational variables and less on other factors such as provision of nursing leadership. Further study of job satisfaction in nurses is needed in particular looking beyond previous factors and exploring the remaining unexplained variance in job satisfaction. A portion of this variance may reside in the characteristics of NUMs and these factors may add substantial information to the current knowledge about job satisfaction of nurses.
2.7 SUMMARY

To continue to meet organisational outcomes and deal with the constant changes within the healthcare system, the NUMs’ are under constant pressure to develop strategies and to equip themselves with the skills necessary to deal with the challenges of the changing and restructured health care system. The ever expanding role of the NUM means that they have to deal with competing demands and prioritise their work according to current trends while being challenged to look for innovative ways to meet departmental and organisational goals. At the same time, the restructuring of health care organisations provides an opportunity for NUM to examine the influence of their leadership practices in the workplace as they struggle with issues related to recruitment and retention of staff. As the NUM is the link between the organisation and the clinicians, it is particularly important that they take an active leadership role. The challenge for the NUM is to make the necessary transition from a controlling and directive manager to a transparent, visible and motivational leader.

The purpose of this research is to develop an in-depth knowledge and understanding of the leadership practices of NUM and their impact on staff empowerment and job satisfaction. The literature review included an overview of the literature related to the changing health care environment, the relationship between leadership and management, leadership in nursing and the changing role of the NUM. Issues related to the definition of leadership, the relationship between effective leadership and organisational outcomes and the measurement of leadership practices was also discussed.
CHAPTER 3

METHODOLOGY

INTRODUCTION

This chapter presents the research methodology used in the study. It includes the design and methods used in this study. The rationale for participant’s selection, the distribution of questionnaires, and the storage and retrieval of data are documented. Limitations of the chosen methods are acknowledged and are included with the relevant sections within this chapter.

3.1 RESEARCH DESIGN

This exploratory descriptive study identifies the self-reported (NUMs’) and observer reported (RNs’) leadership practices of Nursing Unit Managers in one of the tertiary hospitals in NSW, and the effect of these behaviours on workplace outcomes. It will also explore the NUM’s leadership strengths, barriers and facilitators to the NUMs leadership role, and investigate the NUM’s professional development needs.

A survey using a number of questionnaires with self-rated scales was chosen for this study because it can provide suitable information on the leadership practices, job satisfaction and workplace empowerment of NUMs and the perceptions of registered nurses who worked within each NUM’s unit. This method was chosen because of the anonymity that is afforded to the respondents and because it allows questions to be completed that may not have been responded to in an interview setting (Lo-Biondo-Wood and Haber, 1994). Surveys are widely used to collect data related to a specific set of questions, especially in education and behavioural sciences (Isaac & Michael, 1990). According to Spector (1997) job satisfaction research is mostly done with
questionnaires. One issue in survey research is the low response rate. A response rate of 15% to 30% is common in survey research according to Gerrish and Lacey (2006). The administration of a survey in the form of a questionnaire and self-rated scales for this study had benefits that outweighed other data collection methods such as a telephone survey or interviews. A telephone survey was not considered for this study due to possible inconvenience of participants being absent from work or house when the researcher telephoned for information (Lo-Biondo Wood and Haber, 1994), the need to have people complete a number of self-rated questionnaires and, according to Polit & Beck (2006) telephone surveys are often a less effective method of gathering this type of information. Interviews were not considered for this study because of the time and cost involved, and were deemed unnecessary as the measurement instruments used in this research require a self-completion survey.

Thus a questionnaire survey was used, which aside from being economical (Polit & Beck, 2006), also provides anonymity and does not introduce interviewer bias (Lo-Biondo Wood & Haber, 2002). The instruments chosen for this study are designed to be administered using a survey design.

3.2 SETTING

One tertiary referral hospital in Sydney South West Area Health Service (SSWAHS-Western Zone) was selected for this study. SSWAHS has the largest population of any Area Health Service in New South Wales. It caters for an estimated 796,846 residents and over 6,237 square kilometres (SWSAHS, 2004).

The acute care tertiary hospital is a trauma referral centre with comprehensive specialty health care services. The hospital has approximately 500 beds, including specialty units such as intensive care, paediatric and a neonatal intensive care unit.
3.3 PARTICIPANTS

Participants were NUMs and RNs employed at the tertiary referral hospital in NSW. Forty-one NUMs worked at this hospital at the time of the study. Inclusion criteria were that the NUMs (1) had been in a NUM position for more than one year, to ensure continuity in the management role (Brewer & Loke, 1995); and (2) were responsible for more than 10 staff.

The NUMs survey packages were coded to identify their ward or department. They were requested not to put their names on any survey forms. As each NUM agreed to participate in the study and returned their survey package to the investigator, ward rosters were accessed and five RNs were randomly selected from each NUMs ward and invited to participate in the study.

3.4 INSTRUMENTATION

The survey (Appendix C) consisted of two parts. Part A was the demographic data sheet used to gather information about the participants including number of years in management, educational level, age and gender. Part A also collected information about the current role of NUM, the organisational support they received, the facilitators and barriers in fulfilling the role of nursing unit managers and the developmental needs of NUMs.

Part B consisted of the three validated instruments namely: the Leadership Practices Inventory (LPI), Job in General Satisfaction Scale and the Conditions of Work Effectiveness Questionnaire (CWEQ-II). Permission to use the instruments was obtained.
3.4.1 Leadership Practices Inventory

The LPI is a leadership practices or behaviour measurement instrument that has been frequently used in organisational surveys (Kouzes & Posner, 1995). It has often been used extensively in nursing research related to leadership (Torangeau & McGilton, 2004). The LPI measures five types of leadership practices which are congruent with the transformational leadership style (Torangeau & McGilton, 2004) and are common among effective leaders in an organisation (Kouzes & Posner, 2002). These practices are: **modelling the way**, **challenging the process**, **inspiring a shared vision**, **enabling others to act**, and **encouraging the heart**. The LPI was created by developing a set of statements describing each of the various leadership behaviours. Each statement in this 30-statement instrument is rated on a 10-point Likert scale (1 = almost never; 10 = almost always). The LPI was the only instrument that rated highly in psychometric properties and ease of use when evaluated with 17 other leadership instruments (Huber et al., 2000).

3.4.2 Conditions of Workplace Effectiveness II

Workplace empowerment was measured using the Conditions of Work Effectiveness Questionnaire-II (CWQEQ-II) which measures nurses’ perceptions of access to the six elements of structural empowerment described by Kanter (1977, cited by Laschinger, Finnegan, Shamian, & Wilk, 2001). The CWQEQ-II is a 20-item instrument with four subscales. Six questions are related to access to opportunities to learn and grow, three are related to access to information, three to access to support, three inquire about resources available to do the job, three questions are about informal and formal power and two are about global empowerment. The CWQEQ-II uses a 5-point Likert scale. The items for each subscale (information, opportunity, support, resources, formal power, informal power and global empowerment) are averaged to give subscale scores ranging from 1 to 5. An overall empowerment score is obtained by adding the mean score of the
four subscales. The higher the score, the higher the perceived levels of personal empowerment (Laschinger et al.; 2001).

3.4.3 Job in General Scale

The Job-in-General (JIG) scale is said to be a direct measure of overall job satisfaction. The JIG is regarded as an excellent measure of job satisfaction (Leong & Vaux, 1992; Spector, 1997) and has been used in a variety of settings (Loke, 2001). The JIG scale consists of 18 evaluative adjectives in response to the initial question, “Think of your job in general. All in all what is it most of the time?” For each adjective, respondents choose one of three answers yes, no, or ‘?’ if uncertain. A yes response is scored 3, No is scored 1 and ‘?’ scores zero. The JIG measures respondents’ overall job satisfaction and scores can range between 0 (no satisfaction) to 54 (maximum satisfaction), with higher scores reflecting greater overall long term satisfaction with the job. Convergent validity in regard to the JIG was demonstrated through correlations with other job satisfaction scales ($r = .66-.80$) (Balzar et al., 1997; Smith et al., 1989).

3.4.4 Instrument Reliability

Reliability can be defined as the extent to which the instrument yields the same results on repeated measures (Li-Biondo-Wood & Haber, 1994). One attribute of reliability is homogeneity, or internal consistency, which means that all items in the instrument measure the same characteristic. Scale reliabilities for LPI, CWEQ-II and JIG scales were measured using Cronbach’s alpha.

For the LPI reliability for the items related to leadership practices as measured by the Cronbach alpha were: challenging the process .80, inspiring a shared vision .87, enabling others to act .75, modelling the way .77, and encouraging from the heart .87
(Kouzes & Posner, 2002). For the LPI observer, the internal reliabilities ranged between .81-.91. For this study, the LPI-Student version is used.

Reliability for the JIG scale has been established, with a reported Cronbach’s alpha of .92 (Balzer et al. 1997).

Recent studies examining the internal consistency of the four subscales of the Conditions of Work Effectiveness – II Questionnaire yielded the following range of Cronbach alpha reliability: .80 to .87 for information, .79 to .84 for opportunity, .73 to .89 for support and .73 to .84 for resources (Laschinger, Finnegan, Shamian, & Wilk, 2001, & Laschinger, Almost, Tuer-Hodes, 2003)

3.4.5 Limitations

Limitations taken into consideration during the analysis include:

- There is a potential that nurses may underrate their rating on CWEQ II and JIG scale. This could be due to low morale in workplace setting, because when the questionnaire was distributed the Area Health Service was undergoing amalgamation.
- There is a possibility of Nursing Unit Manager rating themselves higher in LPI than the observers rate them, which has been previously observed in the literature (Plowman, 1991; McTavish, 2001).

3.5 ETHICS APPROVAL AND SAFEGUARDS

Ethics approval was received through the SSWAHS Human Research Ethics Committee (HREC) and University of Western Sydney HREC. All research data remained locked in a filing cabinet accessible only by the chief investigator and all electronic files were password protected. All files will be destroyed according to National Health and Medical Research Council (NHMRC) guidelines. Respondents were asked not to
include their name on their questionnaires. No individuals are identified in reports or publications.

Participants were assured that their confidentiality will be protected. All coded data forms will be securely stored for at least 5 years after completion of the analysis and not used for any purpose other than that stated on the information sheet (Appendix F). The voluntary nature of participation was explained to participants in the information sheet, and they were assured that if they do not wish to participate, that decision would not affect their employment. They were assured that they could withdraw from the study at any time.

### 3.6 PROCEDURES

Data were collected using a questionnaire distributed to NUMs and RNs of a tertiary referral hospital. The Area Director of Nursing and Midwifery Services was provided with the research proposal and survey instruments, and her support was sought for the study. Support from the facility Director of Nursing and Midwifery was also sought and received.

**Covering letter**

A covering letter is a worthwhile strategy for engaging potential participants and maximising response rates (Weirsma, 1991; Lo-Biondo Wood & Haber 1994). The covering letter clearly communicated the aim and benefits of the study and assured participants that their responses were important to the research outcomes. The letter also explained what was required of each participant and introduced the Participant Information Statement and Consent Form.
Distribution of the questionnaires

Following the initial letter, the questionnaire survey packet was sent to all NUMs. Subsequently, the questionnaire was sent to the five randomly selected RNs under the management of each NUM. The survey packet consisted of a letter of participant information statement, demographic information sheet and the three survey instruments. Participants were asked to complete the surveys and to return them in the self-addressed, stamped envelope to the researcher within 14 days.

A master list of potential participants was established and the survey packets were coded prior to participants receiving the packets to ensure confidentiality. Participants were instructed not to put their name or any identifying information on the instruments.

The literature recommends strategies to increase response rates for surveys including:

- A reply paid envelope in each packet (Gillis & Jackson, 2002)
- A covering letter to communicate the aims, importance and benefits of the study (Lo-Biondo Wood, 2002)
- The redistribution of the questionnaire survey packets thanking those who had responded and a reminder to the non-responders to return the questionnaire (Weirsma, 1991, as cited in Gillis & Jackson 2002).

Gratz (1985) showed in his research that follow up procedures increased his response rate by another 5%, confirming the value of the follow up letter.
Follow-up procedures

A follow-up letter was sent to participants who did not respond to the questionnaire after the initial 14-day period. After 14 days, non-respondents were sent another follow-up letter and given 7 more days to submit their survey.

At the project’s conclusion, a letter of appreciation was sent to participants who completed a survey and an abstract of the study report was made available.

3.7 DATA ANALYSIS

Data were analysed using Statistical Package for the Social Sciences (SPSS) version 16. Data are summarised descriptively using means, standard deviations and then t-tests, which were employed when comparing NUMs’ and RNs’ results. Correlation and regression analysis was used to analyse relationships between leadership practices and employee outcomes.

Content analysis was used for analysing responses for the qualitative section of the questionnaire. Content analysis can be used in analysing open-ended questions and focus group discussions (Downe-Wambolt, 1992). Qualitative responses from the open-ended questionnaire items were analysed and categories established.

The analysis was performed in the following steps:

a. The responses were read and re-read in order to give an understanding and familiarity of the text.

b. Themes and categories were identified and frequencies noted
Members of the research team reviewed the data and confirmed the categories and the placement of the responses in the categories, to increase the reliability of the subjective analysis (Brink & Wood, 2001)

3.8 SUMMARY

This chapter described the research design, instrumentation, data collection procedures and methods of data analysis. It is a quantitative design to explore the leadership practices of NUM and their influence on staff satisfaction and workplace empowerment. The results of this study are presented in chapter 4 with a discussion found in Chapter 5.
CHAPTER 4

RESULTS

INTRODUCTION

This chapter presents the survey results, commencing with a sample description, then the results for NUMs’ leadership practices, and responses to open-ended questions. Correlation and regression results relating NUMs’ leadership practices to employee outcomes follow.

4.1 SAMPLE DESCRIPTION

The study population consisted of NUMs and RNs employed in a tertiary referral hospital in Sydney South West Area Health Service. A convenience sample of 42 Nursing Unit Managers and 200 Registered Nurses were invited to participate in this study with a total of 242 survey packets being distributed. Eighty-one completed surveys were returned. Two questionnaires were returned unanswered. Twenty-three surveys with usable data were received from NUMs (response rate = 58%) and 58 were received from RNs (response rate = 29%). One question in the NUM survey which was, “Have you had any leadership and or management training courses, workshop, seminars? If yes please indicate the title and if the training was valuable or not valuable was not completed by 60% of the respondents, and those who attempted it either did not address the question and or provided incomplete responses. Data from this question were excluded in this study.
4.1.1 Gender and Age

Of the 81 respondents, 91% were female. The preponderance of females applied to both classifications (93% of RNs, and 87% of NUMs). Ages ranged from 23 to 60 years ($M = 39.16$, $SD = 9.47$). NUM ages ranged from 30 to 55 years ($M = 42.50$, $SD = 8.23$). RNs’ ages ranged from 23 years to 60 years ($M = 37.62$, $SD = 9.68$).

4.1.2 Work Experience

Table 1 lists the participant’s work experience. The total number of years working as NUMs or RNs ranged from 1 to more than 10 years (see Table 1), whilst the NUMs had worked as RNs for at least 5 years before taking up the role of the NUM. Almost half of the NUMs (44% $n = 10$) had worked as a NUM for more than 5 years. Half of the RN participants (57%, $n = 33$) had worked as RNs for more than 10 years. The NUMs tend to have almost all worked as RNs for more than 10 years, and they have been NUMs for varying times, some short and others quite long.
<table>
<thead>
<tr>
<th>Class interval</th>
<th>RNs</th>
<th></th>
<th>NUMs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Years as RN</td>
<td>Years as RN</td>
<td>Years as NUM</td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1 to &lt; 2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2 to &lt; 3</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3 to &lt; 5</td>
<td>5</td>
<td>9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5 to &lt; 7</td>
<td>8</td>
<td>13</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>7 to 10</td>
<td>8</td>
<td>13</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>&gt; 10</td>
<td>33</td>
<td>57</td>
<td>21</td>
<td>92</td>
</tr>
<tr>
<td>Total</td>
<td>58</td>
<td>100</td>
<td>23</td>
<td>100</td>
</tr>
</tbody>
</table>

4.1.3 Educational Qualifications

Respondents’ highest educational qualifications are shown in Table 2. The most common highest nursing qualification was either a Bachelor of Nursing degree or a graduate certificate. More than a quarter (39%, n = 9) of the NUMs had obtained a masters degree. Very few NUMs (17%, N = 4) had a hospital certificate as their highest qualification, whilst 47% of the RNs reported a post basic qualification. Overall, both NUMs and RNs appear to be highly educated, with 56% holding a post basic qualification.
4.2 NURSING UNIT MANAGERS LEADERSHIP PRACTICES

This section shows results for the LPI self and observed leadership practices inventory. The first research question addressed the leadership practices of the NUMs and whether there was a difference between the self reported leadership practices of NUMs and their observed leadership practices as rated by their staff (i.e. the RNs working on their wards).

The LPI self and observer descriptive statistics are shown in Table 3. On average, the NUMs reported displaying behaviours associated with the five leadership practices fairly often, but by no means always, while the RNs’ reported observing the leadership behaviours slightly less often than that reported by the NUMs.

Means were compared using a separate-variance independent $t$ tests comparing NUM and RN ratings. NUMS consistently rated themselves significantly higher in all five
leadership practices compared to RNs score, indicating that they reportedly used each of the leadership practices more often than the RN raters thought they did. The differences between the NUM and RN ratings are typically in order of 1.5 rating scale values.

The first leadership practice, challenging the process, encourages the leader to be a risk taker. Approximately 48% of NUMs reported that they engaged in this practice usually. Inspiring a shared vision had the lowest mean score for both NUM ($M = 7.72$) and RN ($M = 6.42$). Registered Nurses reported observing behaviours related to inspiring a shared vision sometimes to fairly often.

### Table 3 Frequency of leadership practices: NUMs and RN descriptive statistics

<table>
<thead>
<tr>
<th>Leadership Practices</th>
<th>Self (NUM) N = 23</th>
<th>Observer (RN) N = 58</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenging process</td>
<td>8.16</td>
<td>7.00</td>
</tr>
<tr>
<td>Inspiring shared vision</td>
<td>7.72</td>
<td>6.42</td>
</tr>
<tr>
<td>Enabling others to act</td>
<td>7.72</td>
<td>6.49</td>
</tr>
<tr>
<td>Modelling the way</td>
<td>8.03</td>
<td>6.62</td>
</tr>
<tr>
<td>Encouraging the heart</td>
<td>7.99</td>
<td>6.61</td>
</tr>
</tbody>
</table>

All $p < .001$, $df = 78.1$ to 78.9.

4.2.1 Relationship between NUM characteristics and self-reported leadership practices.

Demographic variables were examined for their relationship with the five leadership practices. Age, work tenure and educational qualifications were examined. Gender was not analysed for relationship because 96% of sample were female.
There was no statistically significant relationship between self reported leadership practices and age at .05 of level of significance. This result is attributed to the small sample size (N = 22). To examine the relationship between tenure and leadership, a Spearman rank order correlation was performed. Although the correlation was positive on the leadership practices ‘Modelling the way’ and ‘Encouraging from the heart’, it was not significant (Table 4).

The same test was used to determine relationship with educational qualifications; there were positive correlations on all five leadership practices. There are significant relationships between educational qualification and three leadership practices challenging the process, inspiring a shared vision and encouraging from the heart (Table 4).

Table 4 Educational qualification and NUM experience and Leadership Practices

<table>
<thead>
<tr>
<th>Leadership practices</th>
<th>Educational Qualification</th>
<th>Work Tenure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Correlation coefficient</td>
<td>Sig</td>
</tr>
<tr>
<td>Challenging the process</td>
<td>.547**</td>
<td>.007</td>
</tr>
<tr>
<td>Inspiring a shared vision</td>
<td>.536**</td>
<td>.008</td>
</tr>
<tr>
<td>Enabling others to act</td>
<td>.052</td>
<td>.815</td>
</tr>
<tr>
<td>Modelling the way</td>
<td>.336</td>
<td>.117</td>
</tr>
<tr>
<td>Encouraging from the heart</td>
<td>.433*</td>
<td>.039</td>
</tr>
</tbody>
</table>
4.3. LEADERSHIP ATTRIBUTES and RESOURCES NEEDED IN THE
CHANGING HEALTH CARE SYSTEM

The questionnaire captured qualitative information about essential leadership skills of
NUMs, and the current role of NUMs as described by NUMs and RNs. The study also
identified facilitators and barriers to fulfilling the role of NUM, and the most important
leadership and management needs that are not being addressed in today’s health care
environment. Responses to these questions were analysed using content analysis.

4.3.1 Essential Leadership skills of NUMs

The responses to the question, What do you believe to be the essential leadership skills
of a nursing unit manager? revealed a large number of leadership skills that are seen to
be essential for the role of NUM. In the raw data, participants identified 185 separate
essential leadership skills. The leadership skills were classified into 13 frequently
identified categories. The frequency and percentage by classification is illustrated in
Table 5. Although a large number of skills were listed, overall there was a strong
agreement by the NUMs and RNs on the essential leadership skills. Communication
skills, leading by example, personal characteristics, strategic skills and relationships with
staff were the frequently mentioned essential leadership skills. Both types of participant
identified the skills of being creative and innovative least frequently.
Table 5. Essential leadership skills as identified by NUMs and RNs

<table>
<thead>
<tr>
<th>Essential Leadership Skills</th>
<th>NUM</th>
<th></th>
<th>RN</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Communication skills</td>
<td>17</td>
<td>74</td>
<td>22</td>
<td>38</td>
<td>56</td>
</tr>
<tr>
<td>Personal Characteristics</td>
<td>9</td>
<td>39</td>
<td>27</td>
<td>47</td>
<td>43</td>
</tr>
<tr>
<td>Strategic/Forward Thinking</td>
<td>13</td>
<td>57</td>
<td>14</td>
<td>24</td>
<td>41</td>
</tr>
<tr>
<td>Good informal personal relationship with staff</td>
<td>10</td>
<td>44</td>
<td>17</td>
<td>29</td>
<td>37</td>
</tr>
<tr>
<td>Lead by Example</td>
<td>9</td>
<td>39</td>
<td>17</td>
<td>29</td>
<td>34</td>
</tr>
<tr>
<td>Leadership in general</td>
<td>8</td>
<td>35</td>
<td>10</td>
<td>17</td>
<td>26</td>
</tr>
<tr>
<td>Managing ward/staff</td>
<td>6</td>
<td>26</td>
<td>14</td>
<td>24</td>
<td>25</td>
</tr>
<tr>
<td>Planning/Organising skills</td>
<td>7</td>
<td>30</td>
<td>7</td>
<td>12</td>
<td>21</td>
</tr>
<tr>
<td>Supporting staff</td>
<td>4</td>
<td>17</td>
<td>9</td>
<td>16</td>
<td>21</td>
</tr>
<tr>
<td>Knowledge of Service</td>
<td>4</td>
<td>17</td>
<td>14</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>Formal role (effectiveness)</td>
<td>6</td>
<td>26</td>
<td>7</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>Providing feedback</td>
<td>3</td>
<td>10</td>
<td>6</td>
<td>10.</td>
<td>10</td>
</tr>
<tr>
<td>Creative and Innovative</td>
<td>2</td>
<td>9</td>
<td>3</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>

The essential leadership skills leadership skill for NUMs that participants identified ranged from technical skills (i.e., planning, organising, ward knowledge) to human skills (i.e. providing support to staff, being a role model, good communication skills). Some of the categories are illustrated below with participant comments and responses corresponding to the identified skills.
Communication skills

Communication skills were the theme most commonly raised. Both groups believed that communication skills are essential leadership skills for a NUM.

RNs’ comments included:

- NUM should have effective communication skills, being assertive and can articulate verbally.
- They have to have an ability to communicate in an open, honest and positive way.
- Good communication with staff and hierarchy.
- NUM should have good listening skills.

NUMs’ comments included:

- NUMs should be an effective listener and communicator.
- Good communications skills- effective workplace relationships so staff have confidence and trust.

Strategic and forward thinking

Strategic and forward thinking was identified as an essential leadership skill for NUMs. They apply skills in developing vision for their teams and ensuring systems are in place to foster effectiveness in a health care environment characterised by change. Comments included:

- NUM should have good planning skills
- To be able to adapt to change
- Ability to develop visions for the team
- NUM should have good strategic thinking and decision making skills
- Ensuring processes are in place to ensure quality service and facilitate change
**Good informal personal relationship with staff**

Having a good informal and formal relationship with staff was identified as an essential leadership skill for NUMs.

NUMs’ comments included:
- Ability to develop meaningful relationships with staff and colleague
- Organising social events to encourage bonding
- Working through with staff to learn where they may have improve

RNs’ comments included:
- Has good camaraderie with staff
- Being able to be part of the team and guides the team in reaching set goals
- Has good rapport with staff

**Lead by Example**

The fourth most prevalent category was lead by example (32 %). RNs in particular stated that they would emulate their leader’s values if their leader were leading by example. Some of the RNs’ responses were:
- NUMs demonstrating leadership; walk the walk, not just talk the talk.
- Acts as role model to staff.
- Good role model, resource person, sets good example and credible.

NUMs illustrated lead by example by comments such as:
- NUM should set personal example.
- NUM should be a role model for staff
- NUM lead by example
Knowledge of job and specialty

Participants believed that an effective nursing leader must have knowledge of management and the ward clinical specialty. RNs believed that for NUMs to be an effective leader they must understand the ward (specialty), have knowledge of functions such as planning, directing, and have the ability to manage staff. The following comments from RNs denote this:

- NUM should have expertise and skills in area of specialty.
- Has the knowledge and skills in managing the unit and firm to all subordinates.
- Understanding the clinical functions of ward [or] department.

Other essential leadership skills identified by participants are in Table 5.

4.3.2 Critical Elements of Nursing Unit Management role

Participants were asked to identify the critical elements of NUM role. Amongst the responses were: management skills, supporting staff, motivating staff, keeping the ward together and communication skills. Both groups identified technical skills such as budgeting and rostering, among others, as elements of NUM role (Table 6). Management skill was identified by NUMs as the most important element in a NUM’s role. The majority of respondents made reference to performance and managing staff, good management practices, conflict resolution skills, managing the ward and staff retention. Registered nurses identified management skill, budgeting and leadership skill as the most important critical element in a NUM’s role. The responsibility for supporting and motivating staff and keeping the ward together were also identified as critical to a NUM’s role. Both groups saw patient safety and quality initiatives as part of the NUMs role.
Table 6 Critical elements in a NUM role as identified by NUMs and RNs

<table>
<thead>
<tr>
<th>Identified critical elements</th>
<th>NUM</th>
<th></th>
<th></th>
<th>RN</th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>%</td>
<td>Frequency</td>
<td>%</td>
<td>%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management skills</td>
<td>14</td>
<td>61</td>
<td>21</td>
<td>36</td>
<td>49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supporting staff</td>
<td>13</td>
<td>57</td>
<td>14</td>
<td>24</td>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budgeting</td>
<td>9</td>
<td>39</td>
<td>21</td>
<td>36</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership</td>
<td>8</td>
<td>35</td>
<td>21</td>
<td>36</td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development of self and others</td>
<td>6</td>
<td>26</td>
<td>9</td>
<td>16</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promoting quality patient care</td>
<td>6</td>
<td>26</td>
<td>9</td>
<td>16</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal characteristics</td>
<td>5</td>
<td>22</td>
<td>10</td>
<td>17</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>3</td>
<td>13</td>
<td>12</td>
<td>21</td>
<td>17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to influence others and produce changes</td>
<td>3</td>
<td>13</td>
<td>8</td>
<td>14</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to deal with complex situations</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.3.3 Role of Nursing Unit Manager

NUMs were asked to describe the role of NUM in today’s health care environment. The responses were not associated with conceptual or technical skill of the NUM role. They were associated more with the psychological aspects of the role such as: work overload, the role being challenging, diverse, difficult and demanding, and the need for role clarification (Table 7).
Table 7: Role of Nursing Unit Manager

<table>
<thead>
<tr>
<th>NUM (N= 23)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenging</td>
<td>50%</td>
</tr>
<tr>
<td>Difficult and demanding</td>
<td>50%</td>
</tr>
<tr>
<td>Restrictive autonomy; (micromanaged, baby sitting)</td>
<td>41%</td>
</tr>
<tr>
<td>Diverse; jack of all trades</td>
<td>32%</td>
</tr>
<tr>
<td>Holding ward together</td>
<td>27%</td>
</tr>
</tbody>
</table>

Some comments from NUMs were:

- It’s a demanding, busy role with changing emphasis on patient flow.
- The role changes to meet current political climate.
- There is a high expectation to be multi skilled from clinical resources to business management.
- NUMs’ role is being micromanaged by upper management.
- NUMs are caught between two opposing sides.
- Leaders with ability to multitask and [be] resourceful given current climate of amalgamation, micromanaging, financial constraints and staff shortages.
- Negotiator, problem solver, listen to staffs problems; fixer, magician, obtain equipments that is not available.

One of the NUMs described the role as that of a “baby sitter.”

- There is not much management – some days I feel as though I am baby sitting my department. Need approval for almost everything… yet we NUMs are responsible.

Others viewed the NUM’s role with a leadership perspective.

- NUM is a leader who is willing to step out of his or her comfort zone to increase and capture benefits for patient and staff in an ever changing environment.
• NUM stabilises staff, shows commitment and is willing to be innovative.

The expanding role of Nursing Unit Manager was felt by one NUM, who commented:
• I’m the negotiator, the problem solver, the person who listens to all staff’s problem, fixer, obtain equipment that’s not available, magician and probably more...

4.3.4 Positive Aspects of the NUM role

Behind the challenges in a NUMs’ role is some kind of motivation. The question “What do you see as the positive aspects of the role of the NUM in today’s health care environment?” was to capture some of the attraction of being a manager. Table 8 summarises the NUM responses. The most frequently mentioned positive aspect was “provision of good outcomes”. Typical responses were as follows:

• To be able to achieve what you set out to do today or this week.
• Seeing good outcomes for staff-succession planning and good outcomes for clients.

Table 8 Positive aspects of the role of the NUM

<table>
<thead>
<tr>
<th>NUM (N=23)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of good outcomes</td>
<td>69%</td>
</tr>
<tr>
<td>Ability to influence others and be innovative</td>
<td>55%</td>
</tr>
<tr>
<td>Challenging but rewarding</td>
<td>18%</td>
</tr>
<tr>
<td>Opportunity for career development</td>
<td>14%</td>
</tr>
<tr>
<td>Recognition of job (staff/line manager)</td>
<td>9%</td>
</tr>
</tbody>
</table>
Some of the comments were:

- Ability to make a difference.
- Watching new staff develop and mature with support and education and take on new avenues and job prospects.

Some NUMs saw career opportunity and recognition of job as positive aspects of the role of NUM.
- There is an opportunity for career development.
- The expanding role of NUM is a stepping stone to future management roles.
- Being appreciated by senior management and recognising the contribution made to the organisation.
- Positive feedback from peers and own staff.

4.3.5 Organisational Support for NUM

NUMs were asked to identify sources of support in their organisation for the development of NUMs. Five categories emerged, as shown in Table 9. Overall there are two themes emerging with some NUMs believing that they received organisational support through formal training, while other NUMs indicated that they received minimal support from the organisation and that they seek support from either their line manager or through their colleagues.
Table 9 Organisational support for NUMs as nursing leaders

<table>
<thead>
<tr>
<th>Organisational support</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>53%</td>
</tr>
<tr>
<td>Formal training</td>
<td>47%</td>
</tr>
<tr>
<td>Line manager support</td>
<td>16%</td>
</tr>
<tr>
<td>“Sink or swim”</td>
<td>16%</td>
</tr>
<tr>
<td>Colleague based</td>
<td>11%</td>
</tr>
</tbody>
</table>

Some NUMs (47 %) reported that training is provided in their organisation.

- NUMs’ educational program is available. There is also an opportunity to undertake frontline management.

- Mentorship and management development program is available

Participants clearly identified the minimal support from the organisation with one participant feeling that she either “sinks or swims” in her role due to the lack of support. NUMs gave examples of the minimal support they receive:

- Support is available but is only offered if and when the NUM raises concerns.
- Minimal, new NUMs are told to seek mentors.
- No formal education and training. Sink or swim.
- In my first few years the support was good and there was ample and fair opportunity. In recent years nursing appears to have taken a step backwards and support is definitely lacking.
- Nil. I have initiated all my attendance to courses, conferences and education myself as well as paid for my own education.
Some NUMs stated they received support from line managers and colleagues. The support from line manager and informal support received from peers are valued by the participants.

- Colleague based excellent, not much support from upper management.
- Peer support is great.
- I have a supportive line manager, so my experience is different from other NUMs.

4.3.6 Facilitators and barriers to fulfilling the role of NUM

NUM participants were asked to identify facilitators and barriers to fulfilling the NUMs role. NUMS identified seven barriers, such as fiscal and human resources, increased workload, reduced autonomy, balancing competing demands, role identity and evolving health care as the major challenges affecting their roles. Table 10 shows percentage of frequently identified barriers to NUMs’ role.
Table 10 Barriers to fulfilling the role of NUM

<table>
<thead>
<tr>
<th>Barriers to fulfilling the role of NUM</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fiscal and human resources</td>
<td>52</td>
</tr>
<tr>
<td>Role identity</td>
<td>43</td>
</tr>
<tr>
<td>Reduce Autonomy</td>
<td>43</td>
</tr>
<tr>
<td>Balancing/Competing demands</td>
<td>43</td>
</tr>
<tr>
<td>Increase workload</td>
<td>33</td>
</tr>
<tr>
<td>Evolving health care</td>
<td>14</td>
</tr>
</tbody>
</table>

**Fiscal and human resources**

NUMs reported having to achieve more than what's possible with a restricted budget and staffing. Some of the NUMs comments were:

- The demand has increased. However resources and support has decreased.
- There is [sic] inadequate staffing and finances to allow provision of better care.
- Request to do more work in the same amount of time.

**Reduced autonomy**

NUMs considered that power is an important aspect of their job. however, the NUM’s role is perceived as becoming less autonomous. NUMs illustrated this by the following comments:

- The lack of authority to order or in some instances make a decisions due to micromanagement from area level.
- Lack of autonomy, lack of trust in ability to manage ward.
- Centralised management-disempowerment of middle managers.
Role identity
Because the role of NUM is expanding, role identity was perceived as a significant challenge.

- The role is expanding. More and more and are delegated to the NUMs.
- There are different expectations of the role from staff and public.
- Who is managing the ward?

Increasing workload was identified by seven NUMs as another barrier to fulfilling their role. Related to this factor were issues about increases in administrative work, and more roles being delegated to NUMs. Some illuminating responses follow:

- Increased office work and endless report to be submitted
- Role is expanding more and more delegated to the NUMs
- Expected to cover staff deficiencies- NUM to act as clinician resource person and ward clerk

4.3.7 Facilitators of the NUM role

Varying responses were provided by NUMs when asked, “What do you see as the facilitators in fulfilling the role of NUM?” The categorised responses that facilitate or enable NUMs to fulfil their role are listed in Table 11. Relationship orientated facilitators were frequently mentioned (staff support, relationship with line manager and peer support). When describing staff support, participants identified support from their staff, line manager and medical staff as important enablers in fulfilling the NUM,s role. The specific “knowledge and education” included responses such as having qualification in management, having good clinical skills and education and experience- based knowledge.
<table>
<thead>
<tr>
<th>Facilitators to fulfilling the role of NUM</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff support</td>
<td>41%</td>
</tr>
<tr>
<td>Peer support</td>
<td>35%</td>
</tr>
<tr>
<td>Access</td>
<td>29%</td>
</tr>
<tr>
<td>Knowledge and education</td>
<td>24%</td>
</tr>
<tr>
<td>Relationship with line manager</td>
<td>24%</td>
</tr>
<tr>
<td>Positive outcomes</td>
<td>18%</td>
</tr>
</tbody>
</table>

Comments included:
- The staff and support of other staff are important.
- Expanded roles of staff to take some aspects of NUM’s role.
- Good colleagues and staff to work with.
- Having support from senior management.
- Good patient care, personal satisfaction to improve systems.
- Having qualifications in management.

4.3.8 NUM leadership and management developmental needs

NUM participants identified important leadership and management skills that are currently not being addressed by the health service or professional organisations. There were four leadership and management needs that were identified by NUMs. Response categories are shown in Table 12. Some of the results are presented in sub headings, with illustrative quotations.
Table 12: NUM leadership and management developmental needs

<table>
<thead>
<tr>
<th>Leadership and management needs of NUM</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role clarification</td>
<td>63%</td>
</tr>
<tr>
<td>Leadership skills</td>
<td>42%</td>
</tr>
<tr>
<td>Management program</td>
<td>37%</td>
</tr>
<tr>
<td>Executive feedback</td>
<td>21%</td>
</tr>
</tbody>
</table>

Role Clarification

NUMs are often uncertain of the expectations of their role, implying that their role needs clarifying, although some NUMs perceived the changing role as a positive aspect of the role of NUMs. Role clarification was variously described as:

- There needs to be clarification of the NUM’s role.
- The role changes to suit the current political climate.
- For new NUMs there is a lack of information about how to do the job.
- Centralised management is disempowering NUMs.
- Lack of autonomy, lack of trust in ability to manage ward.
- NUMs are not given the flexibility or feeling of trust it appears to be autocratic.

Executive feedback

Some NUMs regarded feedback from line manager as an important leadership issue that was not being addressed in their organisation.

- Feedback of how you’re performing – some acting NUMs who do not perform well are not told and therefore [are] not offered the acting role again.
- Recognition for doing well in challenging situations.
- Lack of positive reinforcement from upper management.
- Recognition and thanks for helping out in other roles at short notice rather than just being an expectation.
NUMs valued feedback from their line manager. Fifteen participants identified that their line manager was not providing adequate feedback.

Management and Leadership Program
According to NUMs, preparation of clinicians for a manager’s role should include operational management skills, planning and financial skills. NUMs also identified the lack of leadership training for NUMs. Reference was made to leadership using words such as: change management, empowerment, role modelling, mentoring and succession planning.

4.4 EMPLOYEE OUTCOMES

Employee outcomes such as empowerment and job satisfaction were measured using validated instruments: CWEQ-II and JIG Scale. This section presents results for empowerment and job satisfaction, and relationship between these outcomes and leadership practices.

4.4.1 Empowerment

Descriptive statistics for CWEQ-II, measuring workplace empowerment, are presented in Table 13. The full range of scores for each CWEQ-II scale is 1-5, and the total score is 6-30. The mean scores for the CWEQ-II subscales show similarities in ratings among RNs and NUMs. All CWEQ-II subscale scores are above midpoints of the scales, with both groups reporting opportunity as the most empowering work structure. NUMs perceived access to support as the least empowering condition. RNs perceived that they have minimal access to resources and information; however RNs perceived their job to have moderate informal power. NUMs perceived that they have greater access to
information about the hospital’s goals than RNs, but felt they have least access to resources.

Cronbach alpha reliabilities for CWEQ-II ranges from .57 to .95 (Laschinger et al.; 2000; Laschinger et al.; 2003; Laschinger et al.; 2004; Armstrong & Laschinger 2006). For this study, the Cronbach alpha reliabilities for the 6 subscales and the total empowerment reliability coefficient were satisfactorily high (Table 13). The total empowerment score, as measured by CWEQ-II, suggested that both NUMs and RNs both perceived their work setting as moderately structurally empowered. The corresponding global empowerment was also moderate for both groups. Mean ratings on workplace empowerment were not significantly different for NUMs and RNs, $t = -0.57$, $df = 79$, $p > .05$.

Table 13 Descriptive statistics for CWEQ-II

<table>
<thead>
<tr>
<th>CWEQ-II scales</th>
<th>(NUM) n = 23</th>
<th></th>
<th>(RN) n = 58</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>Opportunity</td>
<td>4.12</td>
<td>0.65</td>
<td>4.13</td>
<td>0.73</td>
</tr>
<tr>
<td>Information</td>
<td>3.30</td>
<td>0.71</td>
<td>2.84</td>
<td>0.98</td>
</tr>
<tr>
<td>Support</td>
<td>2.77</td>
<td>0.90</td>
<td>3.01</td>
<td>1.06</td>
</tr>
<tr>
<td>Resources</td>
<td>2.83</td>
<td>0.72</td>
<td>2.72</td>
<td>0.92</td>
</tr>
<tr>
<td>Formal power</td>
<td>3.09</td>
<td>0.71</td>
<td>3.08</td>
<td>0.92</td>
</tr>
<tr>
<td>Informal power</td>
<td>3.72</td>
<td>0.58</td>
<td>3.89</td>
<td>0.77</td>
</tr>
<tr>
<td>Total empowerment</td>
<td>19.99</td>
<td>2.86</td>
<td>19.67</td>
<td>4.15</td>
</tr>
<tr>
<td>Global empowerment</td>
<td>3.20</td>
<td>0.95</td>
<td>3.34</td>
<td>1.01</td>
</tr>
</tbody>
</table>

Regression analysis tested whether formal and informal power were predictors of global empowerment. The overall model was significant, $p < .00$, with multiple $R = .65$, $R^2 =$
.42 and adjusted $R^2 = .40$ and $SE$ of the estimate = .77. Both formal ($B = 0.51, \beta = 0.44 \ t = 4.29, p = .001$) and informal power ($B = 0.41 \ \beta = 0.29 \ t = 2.87, p = .005$) were significant predictors of empowerment, which means that NUMs perceived that greater access to formal and informal power at work increases access to workplace empowerment structures.

A correlation analysis between the CWEQ-II subscales and global empowerment revealed that all subscales were significantly correlated with nurses’ overall sense of their workplace as an empowering environment. When these subscales were entered in a multiple regression analysis, they explained 63% of the variance in global empowerment ($R= .79, R^2 = .63$, adjusted $R^2 = .60$ and $SE$ of the estimate = .63. The strongest significant predictors were access to support ($B = 0.58, \beta = 0.59 \ t = 5.80, p = .001$) and informal power ($B = 0.32, \beta = 0.23 \ t = 2.61, p = .011$).

Table 14: Correlation analysis CWEQ-II subscales and Global Empowerment

<table>
<thead>
<tr>
<th>Scale</th>
<th>Global Empowerment (N = 81)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$r$</td>
</tr>
<tr>
<td>Opportunity</td>
<td>.49</td>
</tr>
<tr>
<td>Information</td>
<td>.38</td>
</tr>
<tr>
<td>Support</td>
<td>.74</td>
</tr>
<tr>
<td>Resources</td>
<td>.34</td>
</tr>
<tr>
<td>Formal power</td>
<td>.59</td>
</tr>
<tr>
<td>Informal power</td>
<td>.52</td>
</tr>
</tbody>
</table>
4.4.2 Job Satisfaction

Descriptive statistics for the Job in General Scale, measuring job satisfaction, are presented in Table 15. All participant scores were in the positive half of the range. The mean scores for Job in General Scale are descriptively similar for NUM and RNs, and not significantly different $t = -.32$, $df = 79$, $p > .05$. On average NUMs and RNs perceived they are moderately satisfied with their current job.

Table 15 Job in General Scale descriptive statistics by classification

<table>
<thead>
<tr>
<th></th>
<th>NUM $n = 21$</th>
<th>RN $n = 57$</th>
<th>RN &amp; NUM $N = 78$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
</tr>
<tr>
<td>JIG Scale</td>
<td>27.85</td>
<td>5.31</td>
<td>29.22</td>
</tr>
</tbody>
</table>

A Spearman correlation was used to test association between educational qualifications and work tenure. Mean ratings on job satisfaction were not significantly different for NUMs and RNs, $t = -.85$ $df = 76$ $p > .05$.

Most of the correlations between CWEQ-II and Job satisfaction were low and not significant. There was a significant correlation between information subscale of CWEQ-II and job satisfaction among NUMs (Table 16). Job satisfaction tends to increase with increased scores on information. NUMs in this study felt that access to information influenced their job satisfaction.
Table 16 Correlation (r) between CWEQ-II scales and Job Satisfaction

<table>
<thead>
<tr>
<th>Scale</th>
<th>Job Satisfaction</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RNs N = 58</td>
<td>NUMs N = 23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>r</td>
<td>p</td>
<td>r</td>
<td>p</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opportunity</td>
<td>.02</td>
<td>.868</td>
<td>.20</td>
<td>.378</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td>.01</td>
<td>.915</td>
<td>.71**</td>
<td>&lt; .001</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support</td>
<td>-.04</td>
<td>.773</td>
<td>.22</td>
<td>.334</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td>.10</td>
<td>.439</td>
<td>.26</td>
<td>.254</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal power</td>
<td>.16</td>
<td>.251</td>
<td>.39</td>
<td>.081</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal power</td>
<td>.11</td>
<td>.418</td>
<td>.43</td>
<td>.053</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empowerment</td>
<td>.19</td>
<td>.577</td>
<td>.53*</td>
<td>.013</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.4.3 Leadership Practices and Employee Outcomes

RNs’ and NUMs’ mean ratings for empowerment and job satisfaction were similar (refer to Table 13 and Table 15). There is no significant difference between the NUMs’ and RNs’ employee outcomes rating, with $p > .05$ on both job satisfaction and empowerment.

The mean scores for employee outcomes were also determined by demographic characteristics (Table 17). Participants who had been working in the hospital longer or with higher qualifications, tended to score half a point higher in both employee outcomes. Nurses less than 30 years of age were slightly more satisfied with their job compared to the older than 30 years age group.
Table 17 Employee outcomes as rated by nurses according to demographic characteristics

<table>
<thead>
<tr>
<th>Employee outcomes</th>
<th>Job Satisfaction</th>
<th></th>
<th>Empowerment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( M )</td>
<td>( SD )</td>
<td>( M )</td>
<td>( SD )</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>28.87</td>
<td>6.58</td>
<td>19.87</td>
<td>3.79</td>
</tr>
<tr>
<td>Male</td>
<td>28.71</td>
<td>2.87</td>
<td>18.55</td>
<td>4.26</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; 30 years</td>
<td>30.88</td>
<td>3.85</td>
<td>20.06</td>
<td>3.59</td>
</tr>
<tr>
<td>&gt; 30 years</td>
<td>28.27</td>
<td>6.97</td>
<td>20.10</td>
<td>3.69</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; Bachelor’s Degree</td>
<td>28.57</td>
<td>7.15</td>
<td>19.57</td>
<td>3.32</td>
</tr>
<tr>
<td>&gt; Bachelor’s Degree</td>
<td>29.09</td>
<td>5.64</td>
<td>20.00</td>
<td>4.44</td>
</tr>
<tr>
<td>Work Experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>( \leq 5 ) years</td>
<td>28.55</td>
<td>.576</td>
<td>19.66</td>
<td>.177</td>
</tr>
<tr>
<td>&gt; 5 years</td>
<td>28.89</td>
<td>.643</td>
<td>19.78</td>
<td>4.02</td>
</tr>
</tbody>
</table>

Pearson correlations analysed the association between leadership practices of NUMs, and the job satisfaction and total empowerment of RNs. There were strong correlations between all five leadership practices and total empowerment (Table 18).

There was significant correlation with leadership practices associated with encouraging from the heart and job satisfaction \( (r = .65, df = 20, p < .05) \) and enabling other to act and empowerment \( (r = .67, df = 21 p < .05) \) from NUM participants (Table 19).
Table 18 Correlations between NUMs’ use of leadership practices, and Job Satisfaction and Total Empowerment as rated by RNs.

<table>
<thead>
<tr>
<th>Leadership practices</th>
<th>Employee outcomes (N = 57)</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Job Satisfaction</td>
<td>Empowerment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>r</td>
<td>p</td>
<td>r</td>
</tr>
<tr>
<td>Challenging the process</td>
<td>.17</td>
<td>.206</td>
<td>.58**</td>
</tr>
<tr>
<td>Inspiring a shared vision</td>
<td>.10</td>
<td>.458</td>
<td>.61**</td>
</tr>
<tr>
<td>Enabling others to act</td>
<td>.10</td>
<td>.453</td>
<td>.66**</td>
</tr>
<tr>
<td>Modelling the way</td>
<td>.10</td>
<td>.440</td>
<td>.63**</td>
</tr>
<tr>
<td>Encouraging from the heart</td>
<td>.17</td>
<td>.202</td>
<td>.647**</td>
</tr>
</tbody>
</table>

Table 19 Correlations (r) between NUMs’ self reported leadership practices and job satisfaction and total empowerment as rated by NUMs

<table>
<thead>
<tr>
<th>Leadership practices</th>
<th>Job Satisfaction</th>
<th>Empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>r</td>
<td>Sig.</td>
</tr>
<tr>
<td>Challenging the Process</td>
<td>.18</td>
<td>.443</td>
</tr>
<tr>
<td>Inspiring a shared vision</td>
<td>.05</td>
<td>.844</td>
</tr>
<tr>
<td>Enabling others to act</td>
<td>.33</td>
<td>.137</td>
</tr>
<tr>
<td>Modelling the way</td>
<td>.22</td>
<td>.336</td>
</tr>
<tr>
<td>Encouraging from the heart</td>
<td>.51*</td>
<td>.018</td>
</tr>
</tbody>
</table>

The data were analysed separately for both employee outcomes: job satisfaction and empowerment. When all five leadership practices were entered in a multiple regression analysis, they explained 9% (Table 20) of the variance in job satisfaction of registered
nurses ($F = .98, df = 5.00, p > .001$) and 46% of the variance in RNs’ empowerment in their workplace environment ($F = 9.00, df = 51, p = < .001$). There is a strong relationship (refer to Table 20) between leadership practices and empowerment ($R^2 = .48$).

Nearly half of the variation in RNs’ empowerment ratings is explained by leadership practices. The higher the nurses rated their manager as displaying leadership behaviours, the higher the nurses’ job satisfaction and workplace empowerment.

Table 20 Leadership behaviours predicting job satisfaction and empowerment for RN

<table>
<thead>
<tr>
<th></th>
<th>Job Satisfaction</th>
<th>Empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>N= 57</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>R2</td>
<td>t</td>
</tr>
<tr>
<td>.09</td>
<td>7.27</td>
<td>.442</td>
</tr>
<tr>
<td>Challenging the process</td>
<td>1.65</td>
<td>1.05</td>
</tr>
<tr>
<td>Inspiring a shared vision</td>
<td>-1.10</td>
<td>-.70</td>
</tr>
<tr>
<td>Enabling others to act</td>
<td>-.48</td>
<td>-.33</td>
</tr>
<tr>
<td>Modelling the way</td>
<td>-1.08</td>
<td>-.37</td>
</tr>
<tr>
<td>Encouraging from the heart</td>
<td>1.45</td>
<td>.53</td>
</tr>
<tr>
<td>N= 58</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>R2</td>
<td>t</td>
</tr>
<tr>
<td>.464</td>
<td>4.06</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Challenging the process</td>
<td>.085</td>
<td>.47</td>
</tr>
<tr>
<td>Inspiring a shared vision</td>
<td>-.375</td>
<td>-2.05</td>
</tr>
<tr>
<td>Enabling others to act</td>
<td>.468</td>
<td>2.78</td>
</tr>
<tr>
<td>Modelling the way</td>
<td>-.297</td>
<td>-1.79</td>
</tr>
<tr>
<td>Encouraging from the heart</td>
<td>.366</td>
<td>2.33</td>
</tr>
</tbody>
</table>
4.4 SUMMARY

This chapter has reported the results of the questionnaire measuring the self and observed leadership practices of NUMs, and their relationship with employee outcomes. It provided insight into the barriers and facilitators for NUM leadership role enactment. Results of the study provided information on some of the leadership development needs that should be addressed, as identified by NUMs. The key findings were:

- NUMs and RNs rated each of the five leadership practices as occurring fairly often.
- NUMs rated themselves significantly higher (indicating greater frequency of usage) on all five leadership practices compared to RNs.
- Communication skills are one of the essential leadership skills identified by participants.
- NUMs describe their current role as being diverse, difficult, demanding and challenging.
- There is a conflicting notion amongst NUM regarding provision of organisational support, to support NUMs as nursing leaders. Some NUMs feel that they are not supported by the organisation however others feel that they receive adequate support.
- A lack of role autonomy and role identity is examples of barriers in fulfilling the role of NUM.
- Sixty three percent of the NUMs identified that role clarity is important for them to function effectively.
- Forty two percent of NUMs identified leadership training for NUMs is reportedly important, and needs to be addressed by the employing organization.
- There is positive and significant correlation between NUM leadership practices and empowerment.
CHAPTER 5

DISCUSSION

The purpose of this study was to develop in-depth knowledge and understanding of the leadership practices of the Nursing Unit Manager (NUM). The aims of this study were to: (a) identify the leadership practices of NUM; (b) examine the effects of NUM leadership behaviours on employee outcomes such as job satisfaction and empowerment; (c) identify barriers and enablers in facilitating NUM’s leadership role; (d) to identify the NUM’s perception of their current role and identify the NUMs leadership development needs. This study found that there is a correlation between the NUM’s leadership behaviours and employee outcomes such as job satisfaction and empowerment. Limitations of the study are identified and discussed.

5.1 ESSENTIAL LEADERSHIP SKILL OF NURSING UNIT MANAGERS

Effective leadership is fundamental to the success of the organisation. The study participants (NUMs and RNs) were asked to identify essential leadership skills for NUMs. The participants identified an array of skills they considered essential to the leadership role. Both NUMs and RNs frequently mentioned leadership skills such as communication skills, good working relationships with staff, leading by example (being a role model), having strategic and forward thinking skills and possessing certain personal characteristics such as being honest, transparent, approachable and fair. Utilising Katz’s (1974) and Chase (1994) approach to skills of an effective manager, the authors classified the skill into five essential skills namely, technical skills, human skills, conceptual, leadership and financial. The most frequently mentioned skills were associated with human (communications skills and personal characteristics) and leadership skills (lead by example, strategic thinking and leadership in general).
Human skills, especially communication skills were frequently identified (56%) as an essential leadership skill for NUMs. Effective communication has been seen as crucial in a manager’s role by many authors (Everson Bates, 1992; Everson Bates & Forsbinder, 1994; Duffield 1993). Because the NUM is the link between the organisation and the nursing staff, effective communication is vital in making the values and objectives of both the department and the hospital understandable to all staff. Chase (1994) in her study involving nurse managers, identified communication and decision-making as the most important skills for nurse managers as they promote improved interactions and relationships among staff members. Open and honest communication and the manager’s ability to listen is said to be an important part of both the NUM and staff members roles. These findings were similar to previous studies, where communication skill was identified as an important part of a ward manager’s daily role (Lindholm, Sivberg and Uden, 2000; Cook, 2001; Thyer, 2003). Relationship orientated personal characteristics such as being transparent, fair, honest, approachable and supportive are also frequently identified as essential leadership skills for NUMs by both RNs and NUMs. This skill is particularly vital in today’s context, where staff are seen to be the most important resource in an organisation.

The results highlighted the importance of good formal and informal relationships between NUMs and their staff (see Table 5). Relationships are progressively built through positive experiences, which can result in loyalty, mutual respect and high performance from staff. However, the development of positive relationships can be a challenge for NUMs with many competing priorities and where a large span of control and constant restructuring serve as barriers to the development of quality relationships between staff and managers.

The majority of the essential leadership skills identified in this study can also be classified as transformational leadership characteristics which include good communication and interpersonal skills and possessing personal characteristics such as being honest, fair and transparent. The leadership skills participants identified in this
study were similar to the leadership skills depicted in the magnet hospital research carried out by Upenieks (2003).

There were definite similarities between the NUM and RN participants’ descriptions of the essential skills necessary for a leader. Many participants noted that there was just not one particular characteristic that defines a leader. To be effective, nurse leaders must have strategic, organising and planning skills for effective management of the ward or department. They need to developed strong informal and formal relationships with staff. Finally, for NUM to be an effective leader, they should be able to provide ward leadership that includes functions such as operational management of the ward, patient flow management and clinical leadership. These skills set was identified both by the NUM and RN participants in this study as the essential leadership skills needed by NUMs in the current health care environment.

While transformational leadership skills are seen to be important in a clinical leader role, the more transactional, day-to-day operational management skills are also required if care delivery is to be effective (Marquis & Huston, 2009). Management, budgeting and supporting staff are the top three frequently identified critical elements in a NUMs role as identified by both NUMs and RNs. NUMs, because of their contact with staff and patients in the delivery of care, also require good operational management skills to ensure adequate standards of care are being delivered by staff. Effective operational management involves a wide range of activities such as resource allocation (human and financial), setting goals and providing direction, monitoring and evaluating care, and continuous quality improvement. Management skills included functions such as ensuring effective staffing, staff recruitment and retention strategies and performance management of staff. In today’s health care environment, NUMs will not survive in their roles unless they understand financial management. There is constant pressure to monitor and justify nursing budgets as they are a critical part of an organisation’s operating budget. Despite the increasing emphasis in the literature about transformational nursing leadership, financial management was ranked highly by participants as a critical element of a NUM’s role. Previous studies have ranked
financial skills highly along with leadership and management skills (Oroviogoicoechea, 1996; Chase, 1994). Study participants, in identifying the essential leadership skills of the NUM, emphasised the need both for transactional and transformation leadership qualities for effective day-to-day management within the health care environment.

Participants in this study ranked ‘leading by example’ (or being a role model) as the fourth critical element in the role of NUM. Pedersen (1993) in her study showed how the perception of staff nurses with regard to leadership skill of the clinical manager potentiated the outcomes of respect, pride and job satisfaction on the part of the nurses. In this study participants often mentioned the “soft” leadership behaviours such as building, guiding and being visible and nurturing to staff. Leading by example was emphasised by participants in relation to organisation of the ward. NUMs displaying behaviours such as being a good motivator, engaging and empowering nursing staff, being supportive and visionary contribute to the organisation and effective day-to-day running of the ward. Several studies have identified these leadership qualities as an important characteristic for managers because of their potential relationship with organisational outcomes (Morrison et al., 1997; Upenieks, 2003; Wong & Cummins, 2008). The health care literature has identified leadership attributes such as the ability to listen and communicate, as well as being collaborative and receptive, as producing a supportive inpatient environment (Upenieks, 2003). The attitudes, values and behaviours of the staff on any ward develop as a result of the leadership that is in place. To be effective, NUMs need well-developed transformational and transactional skills and qualities.

Evaluation of this skill set should be a starting point for development of professional training program for nursing unit managers. Based on the skills set identified by the participants in this study, professional development for NUMs should include transformational leadership skills, strategic and organisational skills and personnel management skills.
5.2 ROLE OF NURSING UNIT MANAGER

NUM participants were asked to describe the current role of nursing unit managers. NUMs described their current role as difficult and demanding, challenging, diverse, needing to hold the ward together and having restricted autonomy. These descriptors used by NUMs in describing their role were different from those identified in previous studies. In a study of the role of the nursing unit manager by Duffield (1994) NUMs identified activities associated with the technical, conceptual and human skills that are essential for managers. In this study, the NUM participant described the psychological aspects of their role and the changes they have experienced over time instead of describing the activities associated with the role, as in the Duffield (1994) study. These different responses may be linked to the substantial and disruptive organisational change taking place when the study was conducted. In such times, NUMs often become involved in events outside of their control, and can be required to assume different or expanded roles and responsibilities associated with the restructured organisation. Because NUMs connect staff and the organisation, they are exposed to numerous and often differing expectations from the ward staff and from senior management.

NUMs perceived that they had lost most of the autonomy that they had previously enjoyed in their roles as leader and manager of a ward or department. It was felt that this is due to increased control (micro management) and direction from senior administration because of financial pressures and the need to meet performance targets. This finding is supported by previous studies reporting that NUMs were experiencing decreases in authority and control over their wards, and as a consequence they were experiencing role conflict and role ambiguity (McGillis Hall & Donner, 1997; Ernst, 1995). This perceived loss of autonomy has implications for NUMs in relation to their job satisfaction and the likelihood that they will stay in the role. NUMs described the dilemma of not having the autonomy to be effective in their roles while being subject to high expectations regarding their role performance. One NUM commented “not much of management, some days I feel like babysitting”. This example demonstrates that nurses continue to lack control over the content and context of their work. Hart (2001) reported
that 53% of nurses leave their organisations because they were dissatisfied with the lack of input to decision-making that affected them.

NUMs described their role as challenging and demanding. Some of the NUMs describe their role as that of a “magician”, a negotiator and problem solver. Because of the difficult environment, NUMs were trying to meet the needs of staff and balance those with the needs of the consumer and the organisation at a time of an increased emphasis on efficiency in relation to both fiscal and human resource management. According to respondents there was an expectation that the NUM was a specialist clinician and resource for clinical staff as well as having good business management skills. As one NUM commented, “the role changes to meet the current political climate, high expectation to be multi-skilled from clinical resource to business management”. As a consequence, some NUMs reported that they were experiencing work overload and role ambiguity.

Despite these findings, one of the conclusions from this study is that there is still a knowledge gap in relation to the purpose and critical elements of the role of nursing unit manager. After nearly two decades in existence, the role of NUM is still unclear, and continues to change and expand as a result of the turbulent health care environment. This finding should be of interest to health care organisations and to the nursing profession, as the role of NUM is critical to improving both patient and staff outcomes. Unclear and ambiguous role expectations as well as the differing perceptions of the nursing unit managers’ role by different stakeholders is likely to affect the managers’ role performance, job satisfaction and retention in the positions.

5.3 ORGANISATIONAL SUPPORT FOR NUMs

The multidimensional role of the NUM requires sound educational preparation and organisational support if they are to be successful. NUMs provided conflicting
responses when asked about organisational support being provided for their development as nursing leaders. Some voiced concern that there is lack of, or minimal support from their organisation. They subsequently felt unsupported in their roles. Other NUMs commented that support is available when there is concern expressed. Although support is available, it is not encouraged. Others who identified that the organisation is providing them support described the support as provision of management workshops such as the NUM educational programs. One NUM reported that she has a supportive line manager. This difference in perceptions about organisational support can lead to either a loyal or obstructive culture for staff and for NUMs.

The lack of support has a profound effect on nursing unit managers. NUMs are left to learn by trial and error rather than developing as a manager by undertaking a course or through learning from a mentor or role model. This finding was similar to the study by Paliadelis, Cruickshank, and Sheridan (2007), where 20 NUMs were interviewed about their roles. That study revealed that NUMs received little support from their organisation. In contrast, Magnet Hospital research has identified that one of the most crucial element of a successful organisation is having a supportive culture (Upenieks, 2003). Laschinger et al. (2006) found that managers either had or perceived that they have had organisational support from their supervisors had higher levels of job satisfaction. Thomas & Dunkerly (1999) found that the managers’ attitudes towards the job and the organisation became increasingly cynical and bitter when they felt that their physical and emotional efforts for the organisation went unrewarded and these feelings ultimately led to withdrawal or alienation. Nursing unit managers in this study felt only somewhat supported by their organisations. This is concerning in light of the consistent finding of Eisenberger, Fasolo, & Davis-La Mastro (1990) that linked perceived organisational support to employees’ attendance and job performance.

Paliadelis et al. (2007) found that NUMs also valued the support they gained from their colleagues. NUMs in this study reported they are able to grow and develop into their role because of the support received from colleagues. Coulson and Cragg (1995) in their
study of nurse managers observed that the greatest personal support (emotional, political and practical) came from their peer group of nurse managers.

While attempts are being made by the organisation to support NUMs in their development as a leader by offering management courses and workshops, there are a number of paradoxes in health care that hinder their development. Complicating the quest for support and developing leadership skills are the competing demands for meeting key performance indicators, managing consumer and staffing issues and the lack of support from the organisation for professional development. The most difficult barrier in developing NUMs as leaders is the traditionally bureaucratic management of hospitals. On the one hand, the NUM is expected to develop and acquire leadership skills and effectively manage clinical service; yet they lack autonomy to make the necessary decisions (refer to Table 10).

Organisational support has been evident in the literature as a key factor in the development of leadership skills (Mathena, 2002). Magnet hospital research found similar results (Manojlovich, 2005). It is evident from this study that there are still inconsistencies of organisational support and inadequate support for NUMs. It is alarming that this is still the case two decades after it was first identified within the Australian context. Duffield et al. (2001) compared NUMs in NSW in 1999 to their counterparts in 1989 and found that NUMs in 1999 consistently reported that they have less access to support, when compared to their counterparts in 1989. Organisations need to be aware that for NUMS to develop as effective leaders, consistent organisational support and leadership development is required.

5.4 CHALLENGES AND BARRIERS TO THE NUMS ROLE

Similar to the responses they gave in describing their current role, a lack of autonomy in their roles was frequently mentioned as a barrier to effective role performance. NUMs
felt they could no longer manage their wards as they saw fit, as they had to ask for approval for everything from their line manager. One NUM describe her role as that of a “baby sitter”, as she felt she was being micromanaged by senior management and had no autonomy in decision-making about the running of the ward. It is ironic that nurses are trained and expected to act autonomously within their scope of practice (Sabiton & Laschinger, 1995) but reported that they receive little or no support. The Lindholm et al. (1999) study on nursing managers illustrated the importance for nurse managers being able to make decisions related to patient care. They relate to this as “intuitively knowing what to do” because they are in close contact with staff and patients. Autonomy has been described in magnet hospital research as one of most significant features explaining job satisfaction (Upenieks, 2003). Upenieks (2003) reported that magnet nursing leaders support the concept of an autonomous work climate with the need for nurses to have control over their practice and be accountable for their actions. The challenge for the NUMs in this study was how to regain the autonomy required to be effective in their role as leader and manager.

This study highlighted that one of the most important challenges for NUMs is the issue of role clarity and role autonomy. Role autonomy in this context is understood as being able to make or participate in the decision-making that will influence the ward, their staff and/or the organisation. Having too much power or role autonomy, can however sometimes be detrimental (Manojlovich, 2005). Manojlovich (2005) stated that although power is a great motivator for successful leadership the importance of maturity in relation to the use of power should be considered. It is still evident in today’s health care environment where NUMs feel that the requirements are changing. They perceive that the bureaucratic management demonstrates a micro managerial ethos. These issues have recently been highlighted in the Garling Report (Garling, 2008) of an inquiry into acute care services in NSW. As a result of recommendations from that report there will be significant changes to the role of the NUM. The recommendations included the review and redesign of the role of nursing unit manager (Garling, 2008). As managers experience less autonomy and freedom in decision making as a result of health care changes, the concept of autonomy may require further study.
NUMs also identified diminishing fiscal and human resources and the lack of time to meet the job demands as challenges to their role. The diminishing fiscal and human resources challenge NUMs as these issues consume their time and energy and are unlikely to be easily resolved in the current climate. NUMs believe that they are expected to achieve certain organisational outcomes but are limited by decreasing budgets and staffing constraints. The role of resource allocator (fiscal and human) was reported to occupy the NUMs time and engagement to a large extent. As a consequence, this is affecting their ability to perform the other roles required for nursing unit managers and leaders.

Balancing the workload demands was perceived by NUMs as another challenge in fulfilling their role. They believe that they did not have adequate time to meet the demands from the organisation, the staff and patients. The findings from this study were similar to Bolton’s (2005) study where ward managers identified that the managerial and clinical roles expected of them were irreconcilable. Similarly in a study by Persson and Thyfors (1999), in which they surveyed 33 managers, they noted that ‘survival’ was an issue for NUMs as they coped with lack of time and resources to perform their roles as managers. In a study by Wise (2007) balancing workload demands of the ward manager’s multiple roles was perceived not only by ward managers themselves as stressful but by the nurses and midwives as well. In the current situation, the nature and volume of the workload of NUMs might not only affect the NUMs themselves, but this situation negatively affects RNs who are aspiring to become the next generation of NUMs.

Increases in patient acuity and the lack of staff complicates the situation and puts a greater demand on the role of the NUM. There appears to be an expectation that, when there is a lack of staff, the NUM can carry out the managerial responsibilities of running a ward and perform a clinical role to replace the shortage of clinical staff. This work intensification is a significant barrier to fulfilling the role of NUM. Comments by participants in relation to the expanding role of NUM were similar to findings from
previous studies by McGillis Hall and Donner (1997), Wilmot (1998) and Fletcher (2001). NUMs continue to report complex issues such as role expansion, increasing responsibilities, decreases in staff and resources and a lack of time to achieve the requirements of the role.

Despite these findings, NUMs survive the challenges of the health care system because of facilitating factors and the positive aspects of the role. Facilitators to the NUMs role identified in this study were: having support from staff and peers, relationships with their line manager, access to resources, knowledge and education and positive outcomes for staff and patients.

Receiving support from staff and peers, including medical staff was identified as the main facilitator for a NUM’s role (Table 15). NUMs appreciated the support they receive from all levels of staff. According to McNeese-Smith (1997) support decreases the nurse’s sense of being vulnerable and overwhelmed by the job. Relationships with their line managers were also identified as an enabler in a NUMs role. Good working relationship with line managers is not only an enabler in a NUMs role but has also been mentioned in many studies as an important factor related to job satisfaction (McNeese-Smith 1997, 1999; Tovey and Adams, 1999).

Knowledge and education are important facilitators for the NUM’s role. Participants believed that the NUM should have both formal and experiential knowledge of the role (see Table 15). Responses such as extensive knowledge and education of the clinical specialty and qualifications in management were mentioned as facilitators in fulfilling a NUM’s role. The response related to ‘knowledge and education’ appeared to be related to the clinical knowledge needed to manage and lead the ward.

NUMs were articulate in describing the positive aspects of their job. Current professional satisfaction for NUMs is associated with achieving good outcomes for patients, staff and themselves. NUMs identified that achieving good quality outcomes for patients and staff directly or indirectly, exemplified that they made a difference
through their actions as managers. Their ability to influence others and to guide staff members to develop and grow provided considerable satisfaction to the NUMs in this study. Another positive aspect of the job was an interest in personal growth and development for themselves and the staff. NUMs identified that a positive aspect of the role was that there is opportunity for career development for example progressing into after hours nurse manager or patient flow manager positions.

5.5 LEADERSHIP AND MANAGEMENT DEVELOPMENT NEEDS OF NUMs

Although NUMs in this study articulated numerous essential skills for a NUM to have to be an effective leader, they were less explicit in their responses to the question *what are the most important leadership and management development needs of NUMs that are not currently being addressed by health services or professional organisation?* The NUMs voiced concerns about their development needs in their responses, such as the need for appropriate management and leadership programs and the importance of feedback from their line managers. Furthermore, from a research and practice perspective, health care organisations would benefit by clarifying the role of the NUM. NUMs recommended that attention be given to adequate management and leadership training. It seems that the lack of leadership preparation for NUMs is affecting NUMs leadership effectiveness. NUMs have not had an opportunity to develop in their role, either because of lack of training, lack of support or because there are too many competing priorities with minimal resources. Mathena (2002) reported that NUMs frequently assume expanded responsibilities and roles without adequate support, resources or education. There is evidence regarding the lack of support for training for nurse managers throughout the literature and in this study, but there are no clear plans to address the issue. Henninger (1994) demonstrated that nurse manager performance improved after participating in a leadership program. This is only one of the numerous studies that support the necessity and benefits of a leadership development program. Effective leadership and management preparation, along with clarification of the
purpose and core functions of the NUM, will lessen the feelings of uncertainty, role overload and role ambiguity, and assist NUMs to recognise the critical role they play in the health care organisation.

Investing resources into the ongoing development of the leadership and management skills of the NUM will improve their leadership effectiveness and can provide significant contribution to staff and health care organisations. Knowledge and skills that were adequate in previous health care structures and environments are no longer sufficient. NUMs needed to develop new skills, knowledge and support if patient safety and staff satisfaction are the benchmark of an effective health care organisation. Leadership development, executive feedback and role clarification are crucial to increasing effectiveness at this level.

The need for clarification of NUM role was frequently identified by NUMs as an issue that was not being addressed by health care organisations or professional organisations. The findings of this study substantiate the views of role theorists who state that the execution of the role is linked to the individuals who perform in that role and the overall context within which the actual role occurs (Biddle, 1979). With the new organisational structure implemented during this study, changes in the context of care and the expectations of line managers, the NUM role had become unclear and ambiguous. This in turn, hindered the NUMs in their ability to develop competence in their role. Role theory acknowledges a distinction between the expectations and behaviours of role senders, and that the perceptions or expectations of the role (what the NUM interprets to be role expectations) and the sent role messages (what staff and organisation as whole is trying to convey to the NUM) may all contribute to the clarity of a NUM’s role (Katz & Kahn, 1978). NUMs consequently interpret others sent expectation (the received role) either accurately or inaccurately, and use them in combination with self role expectation to decide how to act. Gaps between sent and received role messages can create different expectations, which may result in role ambiguity (Katz & Kahn, 1978).
Role is defined as “behaviours characteristic of one or more persons in a context” (Biddle 1979, p58). NUMs display different behaviours depending on the various influences they are exposed to. Some NUMs learn their role on the job; others think that their role changes because of the challenges brought about by their organisation. In this study, the NUMs described their current roles and expressed the need for role clarification. This substantiates the views of role theorists who state that the performance of role is inextricably linked to the individuals who perform in that role and the overall context within which the actual role behaviours occur (Hardy & Conway, 1987). The impact of organisational support and having a position description that clearly describes the role of the NUM should not be underestimated. An accurate description of a NUM’s role is possibly the most important factor in influencing the ways in which NUM performed their role.

The findings of this study are similar to that of Loo and Thorpe (2003) and Carnivale (1997), who found that in a constantly changing health care environment the role of NUM remains unclear. As the role of NUM continues to shift and change to meet the pressure of the health care system, clarity in relation to the role will be difficult, and as a consequence, NUMs will struggle to provide the effective leadership. Fine (1989) documented that before nurse managers can effectively lead employees, they must overcome role ambiguity. The result of this study supported previous study by Wilmot (1998) who explored the experiences of ward managers and found a degree of confusion about the role. Wilmot found that ward managers received conflicting information about the scope of their roles and were unclear about role autonomy. These multi dimensional roles (manager, clinical expert, resource manager, problem solver and fixer) require organisational support if NUMs are to be successful. The increasing role intensification of NUMs in turn creates ambiguity, which in turn hinders a sense of clarity in the role of NUM. This is problematic when an organisation is attempting to develop effective ongoing education and support programs for NUMs when the role has not been sufficiently defined.
5.6 LEADERSHIP PRACTICES OF NURSING UNIT MANAGERS

According to Kouzes and Posner (1995) there are five fundamental leadership practices that contribute to exemplary leadership: challenging the process, inspiring a shared vision, enabling others to act, modelling the way and encouraging from the heart. Embedded in each of these practices are behaviours that serve as the basis for leading and enabling leaders to get goals accomplished in their organisations. One of the aims of the study was to explore the leadership practices of NUMs. Using the mean scores, the NUMs rated themselves highest in leadership behaviours associated with challenging the process (which leadership practice involving constantly searching for opportunities to change, seeking innovation) and modelling the way (this involves being a role model and or leading by example). These findings are different from those of Loke (2001), and Kouzes and Posner (2002) where managers rated themselves highest in enabling others to act. One of the factors that might have contributed to this difference in results could be that the NUMs in this study were experiencing organisational restructuring at the time the study was conducted and there was an amalgamation of two area health services. Both NUMs and RNs rated leadership practices associated with inspiring a shared vision and enabling others to act the lowest of the five leadership practices. These results were similar to those of Loke (2001), and Kouzes and Posner (2002) and probably reflect the difficulty and changing circumstances within the organisation at the time.

The self reported ratings on the leadership practices of NUMs as measured by the LPI were higher when compared to the observer (RN) ratings. On average the NUMs display behaviours associated with the five leadership practices ‘fairly often’ but by no means ‘always’ according to NUMs. The RNs rated their NUMs slightly less than the NUMs ratings. It has not been unusual to find self-rated scores higher than observer scores in research settings (Plowman, 1991; McTavish, 2001) however some researchers have reported no significant differences between self and observer responses (Aubrey 1992; Oliver 2001) using LPI. Individual factors may play in the way participants rated LPI (Kouzes and Posner, 2002).
This study found that no significant difference in various demographic (gender, age, years of experience and educational level) differences in LPI results. These findings support those of Kouzes and Posner (2002), who found that the LPI scores are unrelated to demographic characteristics. These finding extend across a variety of non-business settings as well. Whilst no individual factors were identified that were associated with demographic characteristics and LPI scores, there may be other variables not identify in this study, such as span of control for nursing unit managers. Future research should include the observations of other workforce members such as enrolled nurses and clinical nurse specialists as part of the observer participants.

Challenging the process

NUMs reported that they usually engaged in the leadership behaviours associated with challenging the process. Challenging the process encourages the leader to be a risk taker and constantly seeking opportunities for improvement (Loke, 2001). NUMs must also have the courage to accept failures and use them as learning experiences (Loke, 2001). Hence, NUMs might need to “think outside the square” in times of financial and staffing constraints. For NUMs to survive the challenges of the health care system, they need to be innovative and creative leaders and question traditional management practices, which are more about stability rather than change, innovation and risk taking.
Modelling the way

Modelling the way was rated second by both NUM and RN participants as the leadership practices that NUMs engaged in fairly often to usually. As Schein (1992) stated leaders must endeavour to model desired behaviours through their actions. Leaders can empower staff by providing role models that embody and transmit the organisation’s vision of quality (Morrison, Jones & Fuller, 1997). NUMs must find ways to become more visible to staff. The NUM being visible and transparent in their leadership behaviours can be a means through which positive role modelling can be facilitated.

Encouraging from the heart

To be effective in developing staff NUMs need to provide consistent and appropriate support and feedback to their staff. NUMs perceived that they usually practice leadership behaviours associated with encouraging from the heart and RNs perceived that the NUMs engaged in this practice fairly often. To be an effective leader NUMs need to motivate staff and promote and support staff, and celebrate ward achievements. These practices provide staff with the spirit of striving for the best outcomes for their patients and themselves.

Enabling other to act

Critical to fostering a collaborative environment is the presence of trust, respect and staff empowerment (Loke, 2001). Enabling other to act engenders the development of departmental (organisational) vision through collaboration, empowerment and teamwork (Loke, 2001). Participants perceived that NUMs engaged in this behaviour “sometimes” to “usually”. NUMs can facilitate teamwork and staff empowerment by providing access to information, resources, ideas and support (Loke, 2001). Providing staff access
to ongoing development will keep them abreast of evidenced based practice that will assist them to provide optimal care to their patients. Empowering staff means that NUMs share influence and power to their staff. When employees are empowered, they are more likely to be satisfied with their job (McDermott, Laschinger & Shamian, 1996), more accountable for decisions they are making (Loke, 2001) and more productive (Sabiston & Laschinger, 1995).

**Inspiring a shared vision**

NUMs and RNs rated inspiring a shared vision the lowest in the LPI scores. Inspiring a shared vision requires NUMs to communicate departmental and organisational vision in such a way as to motivate staff to work towards its achievement. This leadership practice is important in influencing job satisfaction and organisational commitment in nursing staff (Loke, 2001). In keeping with other studies inspiring a shared vision was the weakest behaviour observed among NUMs participating in the study. The focus on key performance indicators and the lack of resources to achieve the goals could be a factor in this equation. Managers and staff become cynical about organisational vision and mission because of the unrealistic expectations about what will be achieved in a climate of change.

The results from the LPI in this study portray a promising view of the current leadership status of nursing unit managers. Registered nurses perceived that nursing unit managers do demonstrate Kouzes and Posner’s (1995) effective leadership practices “sometimes” to “usually.” Despite some differences in samples and setting, the findings from the LPI are consistent with previous studies.
5.7 EMPLOYEE OUTCOMES AND LEADERSHIP PRACTICES

Job satisfaction or the degree to which nursing unit managers and registered nurses enjoyed their jobs in general was moderate. There was no significant difference between NUMs and RNs level of job satisfaction. The findings of this study showed there is a correlation with leadership practices and job satisfaction but it was not a statistically significant result. This finding was different to Loke's (2001) study with her results showing a positive, significant correlation between leadership behaviour and job satisfaction. Inspiring a shared vision had the lowest correlation with job satisfaction in the present study (Table 18) and challenging the process has the highest correlation with job satisfaction. This was in contrast with McNeese-Smith’s (1997) research that showed that enabling others to act and inspiring a shared vision were significant predictors of job satisfaction. Although the correlation on all five leadership practices with job satisfaction was low, the results were positive.

The findings of this study supported Kanter’s (1977) theoretical proposition, where she believed that the mandate of management is to create conditions of work effectiveness by ensuring staff have access to necessary information, support and resources that will allow them to accomplish their work. Strong relationships between the dimensions of structural empowerment and nurses’ overall view of empowerment in their job highlight the importance for the organisation to provide nurses with access to opportunity, information, support, and resources as well as having access to formal and informal power in their workplace (Laschinger et al. 2001). The mean scores for the CWEQ-II subscales show similarities in ratings among RNs and NUMs. All CWEQ-II subscale scores are above midpoints of the scales, with both groups reporting that they have moderate degree of empowerment in their workplace. This result is surprising considering the fact that the NUMs frequently mentioned the lack of organisational support, lack of autonomy and the unclear role of NUMs in their responses.
Empowered managers are more likely to empower others and encourage teamwork. Empowered managers serve as positive role models for their staff. Nurses in this study identified opportunities to learn and grow as the most empowering condition in their workplace. This could be attributed to the hospital being a tertiary referral hospital and trauma centre that provides services to challenging and complex patients. NUMs rated access to support lowest in terms of the empowering structures in their workplace. RNs perceived they have minimal access to resources and formal power however they perceived their jobs to have moderate informal power. NUMs perceived that they have adequate access to information about the hospital’s goals, but believed they did not have access to necessary resources to achieve those goals. These findings differed from the magnet hospitals study by Armstrong, Laschinger, and Wong (2008) where support and resources were the most empowering structures for nurses. Hence, access to resources such as adequate staffing makes it possible to provide the kind of care nurses would expect for themselves (Laschinger et al. 2003).

This study supported previous findings on predictors of global empowerment that both formal and informal powers are equally important predictors of nurses’ global empowerment. Kanter (1993) maintains that power can be accumulated in two ways in organizations: through formal positions in the organisation (job activities) and through informal networks (staff, peers and supervisors). These results support the Kanter model where access to formal and informal power is related to access to work empowerment structures. These results resemble those in other nursing studies (Laschinger, 1996; Casier, Laschinger, Finegan, & Shamian 2000; Kutzcher, 1994).

According to Kanter (1993) powerful positions provide the role occupant with visibility, the ability to be creative and a sense of relevance to the organisation. In this study, the perception was that the power participants gained from informal alliances exceeded the power accumulated through job activities. NUMs believed they had access to opportunity and information, but had limited access to resources and support. The opportunities and information came because NUMs had opportunities to step into others roles such as patient flow management and after hours nurse managers. The lack of
access to resources and support is likely due to the current emphasis on improving efficiency within current budgets and resources. Access to support was an important empowering structure identified by nurses in the study by Laschinger et al. (2003). They found that nurses who work with others who are supportive are more flexible, creative, innovative and productive.

Nurses who perceive their managers to be supportive are more likely to stay with an organisation (Prestholdt, Lane & Matthews, 1989; Taunton, Krampitz & Woods, 1989). As previously discussed in the organisational support section, NUMs perceived that they were receiving no support or minimal support from their organisation and this was reflected in how they rated the CWEQ-II on access to support. A contributing factor in how NUMs perceived access to organisational support could be that at the time of the survey, the hospital was undergoing area health service restructuring. As a result of the restructuring there was a lean management structure with divisional management being replaced by an area clinical management structure, which made it difficult for NUM to have consistent contact with their line manager. Lee & Cummings (2008) found that high level of organisational support was an important predictor of managers’ feelings of empowerment and job satisfaction. As with previous studies of nurses (Kutzcher, 1994; Laschinger, 1996; Casier et al., 2000, Laschinger et al., 2006), no relationship was demonstrated between staff perception of empowerment and demographic factors such as years of experience, age and educational qualifications.

The concept of modern organisational management within a changing health care environment needs to focus on supporting managers (and staff) to use their abilities, skills, knowledge and competence for achieving organisational goals. Empowerment is a way to increase power and authority to help staff handle their roles and responsibility in an autonomous fashion. Senior nursing executives play a key role in creating empowering conditions for nursing unit managers. Kanter’s (1977) theory suggests that formal power can be develop through job descriptions, whereby the NUM has flexibility, opportunities for development and can make decisions for their area of responsibility.
In this study, total empowerment predicted NUMs’ job satisfaction but not for RNs (see Table16). There was a strong positive relationship between overall empowerment and job satisfaction for NUMs, supporting Kanter (1977), that when empowerment structures are in place, employees are satisfied in their work. Although overall empowerment was related to job satisfaction for NUMs, access to information was shown to have the strongest relationship with job satisfaction. This is finding is different from previous nursing studies, where access to support was shown to have the strongest relationship to job satisfaction (Casier et al. 2000; Laschinger & Havens 1996; Whyte 1995).

The findings from this study also highlight the importance of leadership behaviours of NUMs and their relationship to empowerment. There was a significant relationship between staff empowerment and the leadership practices of nursing unit managers. This suggests that not only do structural factors need to be in place for individuals to believe in his or her ability to have control over work, but also a strong leadership is necessary (Laschinger et al, 2006). This finding was similar to Laschinger and Shamian’s study (1994) on nurse leaders and their staff nurses perception of empowerment. They found that staff nurses experienced higher levels of empowerment when managers used leadership behaviours that fostered employee perceptions of autonomy, confidence and meaningfulness of their work.

Using regression analysis, the NUMs leadership behaviours explained only 9% of job satisfaction but 46% of staff empowerment. The scores in job satisfaction were lower than the Singapore study by Loke (2001). Bratt, Broome, Kelber and Lostoco (2000) found that nursing leadership was a strong predictor of job satisfaction. Finding from this current study was that there was a correlation between NUMs display of leadership behaviours to RN job satisfaction but it was not statistically significant. There are factors that could have influenced the result. Firstly the study only had a small response rate from RNs (29%). Despite this, the findings of this study highlight the importance of NUMs leadership potential influence on staff’s job satisfaction. The results underscore
the notion that the use of the five leadership practices by NUMs positively influences job satisfaction of staff. In today’s evolving health care environment RNs find it crucial to have NUM leaders that are able to provide support, challenge, take risks and motivate staff in providing quality care to patient. Although, the study found a significant relationship between leadership practices and empowerment, it did not find a significant relationship between leadership practices and job satisfaction as has been found in other cited studies (Laschinger et al., 1999). This suggests that effective leadership practices affect job satisfaction through increased empowerment.

While general management theory provides an array of information critical to improving strategies for management, the current health care organisational context needs to be considered. The business-like operation of health care has forced everyone to be creative and seek innovative strategies to achieve organisational goals. At the same time the autonomy of the NUMs appears to be restricted in relation to decision-making at ward level. Emphasis on the development of leadership skills needs to continue and should be advocated by health care organisations and nursing professional bodies. Nursing unit managers need to continue to develop as nursing leaders. This can be achieved with the provision of leadership training and executive and organisational support. With so many competing priorities and resource constraints NUMs need clarification of their roles and responsibilities. NUMs need to be able to change direction based on the changes in health care. Work by NSW Health (Hawes, 2008) and Queensland Health (2008) in reviewing the role of the NUM may go some way to addressing this issue.

The findings of this study concur with the previous findings in relation to leadership as a predictor of job satisfaction and empowerment. Leveck and Jones (1996) and Loke (2001) found that staff job satisfaction was associated with managers displaying effective leadership behaviours. The results of the study reported here highlight the importance of the NUMs leadership behaviours as components of job satisfaction and empowerment for RNs. This study demonstrated that nursing leadership that is perceived to be supportive and providing a cohesive environment in which nurses can collaborate effectively, has a positive influence on job satisfaction and empowerment.
5.8 LIMITATIONS OF THE STUDY

The study has a number of limitations, and there are issues that must be acknowledged when discussing the results. Firstly the sample size was small and the response rate was modest. The NUMs who participated in the study may not be representative of a broader population of NUMs who are employed in acute health care setting. The employee participants were all RNs and did not include enrolled nurses or other categories of ward staff. Some participants provided limited information in some of the open-ended questions, which affected the depth of the analysis.

Despite the limitations, this study provided data that provides a broad picture of the leadership and management development needs of NUMs and the need to address the role of NUM in the current health care system. This study has also provided valuable insights related to the importance of leadership practices of nursing unit managers in relation to employee outcomes.
CHAPTER 6

CONCLUSION

The findings from this study contribute to the literature in several ways. The aim of the study was to explore the relationship of leadership practices of NUMS and their influence on employee outcomes. This study has partially explained that leadership practices predict job satisfaction and empowerment. The effect of leadership behaviours on the staff empowerment was established; however, its influence on employees' job satisfaction was not established. Nevertheless, when these leadership behaviours are considered together, they do explain some of the employee outcomes.

NUMs face changes and challenges that can compromise their ability to perform in their roles. The change and expansion of their roles alluded to in this research is satisfying and dissatisfying. The challenge now for health care services and professional organisations is to define the role of NUM. In order for them to effectively lead their staff through health care challenges, they must overcome role ambiguity (Fine, 1989). Senior nursing executives who develop the position description for NUMs should develop a comprehensive specification for the roles and responsibilities of the NUM.

The need to define the role of nursing unit manager is an important concern in health care organisations because as the interface between patient care and management this position affects the success of an organisation.

The results of the study indicate that the nurses in this study were generally empowered and satisfied with their jobs, as measured by CWEQ-II and JIG instruments. The overall job satisfaction and empowerment of RNs tend to increase when their NUM displayed leadership. Although the generalisability of the results is limited due to sample size, the results suggest evidence to support the relationship of between leadership practices of NUM and employee outcomes. Hence it is important that all managers be trained to incorporate effective leadership behaviours into their management roles. The appropriate use of leadership behaviours becomes even more important in enhancing employee
performance as the health care system continues to evolve. Organisations need to provide resources and interventions such as leadership development programs for NUMs, as a means of improving staff empowerment and job satisfaction. Empowered managers serve as positive role models for their staff. Thus empowering work environments are not only vital to nursing unit managers but also for the future of nursing leadership.

Finally, both the quantitative and qualitative findings from this study of NUMs leadership practices, challenges, barriers to their current role and development needs can provide the foundation for the development of an evidence based leadership development program designed to meet the challenges of health care system and fortify NUM’s position as a nursing leader. Based on this study professional development programs for NUMs should include: leadership skills (particularly transformational leadership), the business of health care with strong emphasis on budgeting and financial skills; organisational skills and human resource management skills with emphasis on communication skills.

The focus must now be how we move forward in a new paradigm of health care delivery. According to Duffield (2008) the glue that holds the hospital together are NUMs, however these managers are caught in between the multiple needs of patients, staff and management. Additional expectations from these groups result in NUMs experiencing role overload and role ambiguity. More than ever the need to define the role of the NUM is an important concern for health care and professional organisation because of the pivotal position of the NUM and its impact on organisational effectiveness. Providing appropriate leadership and management programs is one solution to move forward. Leadership development for NUMs is not done solely to improve the leadership of one individual but is an essential component of the development of the organisation as a whole. Results of this study suggest that NUMs that display leadership behaviours can create an environment that is perceived by staff to be empowering and give them job satisfaction. This has implications for recruitment and retention of staff and the quality and safety of patient care.
This study brings together the NUMs role, leadership practices, barriers and facilitators to the role, leadership development needs and NUM and employee outcomes. By designing leadership interventions based on some of the findings from this study and the relative influence of leadership, nursing unit managers can help induced greater job satisfaction and empowerment.

6.1 Recommendations for practice

The study reaffirms previous findings that the role of the NUM is ill defined and continually changing and expanding. The role performance of a NUM is affected by the NUMs’ personal conception of their role and role expectations from staff and senior administration. The challenge is for NUMs and the organisation to define the NUM’s role, responsibilities and core functions. NUMs need role clarification and to be given time and resources, support and authority to fulfil the defined clinical and managerial responsibilities.

The findings from this study support the importance of NUM leadership and its potential influence in staff job satisfaction and empowerment. The findings reaffirm the need for organisation to provide a mechanism to help nursing unit managers become effective nursing leaders. Commitment should be made to design and implement management training and leadership development programs that focus on effective and facilitative leadership styles such as a transformational style of leadership.

It would also be beneficial for professional organisations to form partnerships with universities and collaborate to identify the gaps in the nursing curriculum in relation to nursing leadership at both undergraduate and postgraduate levels. A new approach to leadership development could change the future of the nursing profession and health care.
6.2 Recommendation for further research

The discussion section has already noted areas that would benefit from future research. These include 1) a similar study on leadership practices of NUMs with the observers’ ratings coming from different level of work force (CNS, RN, EN’s and as well as line manager); 2) further investigation of the relationship between nursing leadership and patient outcomes; 3) a study on the effect of leadership interventions and its impact on NUMs, staff and patient outcomes; and 4) investigating the relationships studied here, using other individual factors such as span of control.

An additional direction for future research deals with the role of the NUM in the current health care environment, particularly after the implementations of the Garling recommendations regarding the review and redesigning of the role of nursing unit manager (Garling, 2008).
REFERENCES


Fine, E.L. (1989) Community hospital merger; the challenge to nursing management Nursing Management. 23(6); 24-27.


Hancock, L (ed) 1999 Health policy in the market state, Sydney, Allen and Unwin.


Hart, P.D (2001) The Nurse Shortage: Perspectives from Current Direct Care Nurses and Former Direct Care Nurses (The Federation of Nurses and Health Care Professionals).


Thyer, G.L. (2003). Dare to be different: transformational leadership may hold the key to reducing nursing shortage. *Nursing Management*, 11 (2), 73-79.


APPENDIX A  LETTER TO AREA DIRECTOR OF NURSING AND MIDWIFERY

To: XXXXXXXXXX  
Area Director of Nursing and Midwifery  
Sydney South West Area Health Service

Dear XXXXXXX,

I am currently working at Liverpool Hospital as the Nurse Unit Manager of Paediatric Ward and undertaking Master of Science (Honours) degree at University of Western Sydney-Nepean. I am writing to gain your support and assistance in relation to conducting my research on the Leadership practices of Nursing Unit Managers.

The aim of this research project is to explore the self-reported leadership practices of Nursing Unit Managers (NUM's), examine their leadership strengths from the perspectives of their staff and the impact on workplace outcomes such as empowerment and job satisfaction of staff. Furthermore, the study aims to examine the leadership development needs of Nursing Unit Managers and to use that information to inform the development of a model for professional leadership development within the Australian context. For this research to be conducted an Ethics Submission is required and I am seeking your support in signing the relevant sections in the Ethics Submission document. I am willing to discuss the research project with you if required. I am hoping for your kind consideration

Yours truly
Michael Peregrina  
Nursing Unit Manager  
Paediatric Ward
APPENDIX B LETTER TO DIRECTOR OF NURSING AND MIDWIFERY

To: XXXXXXXXX
Director of Nursing and Midwifery
Liverpool Hospital

Dear XXXXXXXXX,

I am currently working at Liverpool Hospital as the Nurse Unit Manager of Paediatric Ward and undertaking Master of Science (Honours) degree at University of Western Sydney-Nepean. I am writing to gain your support and assistance in relation to conducting my research on the Leadership practices of Nursing Unit Managers.

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I am willing to discuss the research project with you if required. I am hoping for your kind consideration

Yours truly
Michael Peregrina
Nursing Unit Manager
Paediatric Ward
Liverpool Hospital
APPENDIX C: NURSING UNIT MANAGER SURVEY

Title of Project:  A Study of the Leadership Practices of Nursing Unit Managers
Investigator:    Mr. Michael Peregrina

Demographics

1. Where is your current place of work?
   □ Liverpool Health Service

2. What is your Gender?
   □ Female  □ Male

3. What is your age?  ____________

4. Total number of years in nursing practice
   □ 1< 2 years  □ 2< 3 years  □ 3< 5 years
   □ 5< 7 years  □ 7-10 years  □ more than 10 years

5. How long have you been a Nursing Unit Manager?
   □ 1year  □ 1< 2 years  □ 2< 3 years
   □ 3< 5 years  □ 5< 7 years  □ 7-10 years
   □ more than 10 years

6. What is your highest academic qualification?
   □ Hospital Certificate
   □ Undergraduate Diploma
   □ Bachelor of Nursing
   □ Graduate Certificate in..............................
   □ Graduate Diploma in.................................
   □ Master ’s Degree in.................................
   □ Others: please specify...........................

Please list other qualifications e.g Health Service Management..................................
7. In your opinion, what do you believe to be the essential leadership skills of a Nursing Unit Manager?

1. 
2. 
3. 
4. 
5. 

8. Have you had any leadership and or management training courses, workshop, seminars)? If yes please list titles and description of training. Please indicate if training was valuable or not valuable.

<table>
<thead>
<tr>
<th>Training Type</th>
<th>Name</th>
<th>Description</th>
<th>Valuable-Yes</th>
<th>Not Valuable-No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

9. How would you describe your role as Nursing Unit Manager in today’s health care environment?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

10. What are the five most critical elements to the Nursing Unit Manager role?

a. ______________________________________________________________________
b.

c.

d.

e.

11. What kind of organisational support is there in your organisation to support the development of NUM's as nursing leaders?

12. Please list what you see as the barriers and challenges to fulfilling the role of NUM in today’s health care environment?

13. Please list what you see as the facilitators or enablers to fulfilling the role of NUM in today’s health care environment?

14. List what you see as the positive aspects of the role of the NUM in today’s health care environment.

15. What do you believe are the most important leadership and management developmental needs of NUM’s that are not currently being addressed by the health service or professional organisations?

Thank you for providing this important data. Please turn over the page and complete the attached survey forms. Your participation in this research project is very much appreciated.
Leadership Practices Inventory (LPI)

Below are thirty statements describing various leadership behaviours. Please read each carefully. Then look at the rating scale and decide how frequently you engage in the behaviours described.

All Questions on the LPI questionnaire must be answered to obtain a complete score.

Here is the rating scale that you will be using

Instructions:
• Please answer in terms of how you would typically behave on most days, on most projects and with most people
• Be thoughtful of your responses.
• If you feel that a statement does not apply to you, it’s probably because you don’t frequently engage in the behaviour. In that case, assign a rating of 3 or lower.

Ratings:
1 = Almost Never
2 = Rarely I am not skilled in this area
3 = Seldom
4 = Once in a while
5 = Occasionally
6 = Sometimes
7 = Fairly Often
8 = Usually
9 = Very Frequently
10 = Almost Always
To what extent do you typically engage in the following behaviours? Choose the response number that best applies to each statement and record it in the box to the right of that statement.

<table>
<thead>
<tr>
<th>Leadership Behaviours</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I set a personal example of what I expect of others.</td>
<td></td>
</tr>
<tr>
<td>2. I talk about future trends that will influence how our work gets done.</td>
<td></td>
</tr>
<tr>
<td>3. I seek out challenging opportunities that test my own skills and abilities.</td>
<td></td>
</tr>
<tr>
<td>4. I develop cooperative relationships among the people I work with.</td>
<td></td>
</tr>
<tr>
<td>5. I praise people for a job well done.</td>
<td></td>
</tr>
<tr>
<td>6. I spend time and energy making certain that the people I work with adhere to the principles and standards we have agreed on.</td>
<td></td>
</tr>
<tr>
<td>7. I describe a compelling image of what our future could be like.</td>
<td></td>
</tr>
<tr>
<td>8. I challenge people to try out new and innovative ways to do their work.</td>
<td></td>
</tr>
<tr>
<td>9. I actively listen to diverse points</td>
<td></td>
</tr>
<tr>
<td>10. I make it a point to let people know about my confidence in their abilities.</td>
<td></td>
</tr>
<tr>
<td>11. I follow through on the promises and commitments that I make</td>
<td></td>
</tr>
<tr>
<td>12. I appeal to others to share an exciting dream of the future.</td>
<td></td>
</tr>
<tr>
<td>13. I search outside the formal boundaries of my organisation for innovative ways to improve what we do.</td>
<td></td>
</tr>
<tr>
<td>14. I treat others with dignity and respect</td>
<td></td>
</tr>
<tr>
<td>15. I make sure that the people are creatively rewarded for their contributions to the success of our projects.</td>
<td></td>
</tr>
<tr>
<td>16. I ask for feedback on how my actions affect other people's performance.</td>
<td></td>
</tr>
<tr>
<td>17. I show others how their long term interest can be realized by enlisting in common vision.</td>
<td></td>
</tr>
<tr>
<td>18. I ask “What can we learn?&quot; when things don't go as expected.</td>
<td></td>
</tr>
<tr>
<td>19. I support the decision that people make on their own.</td>
<td></td>
</tr>
<tr>
<td>20. I publicly recognize people who exemplify commitment to shared values.</td>
<td></td>
</tr>
<tr>
<td>21. I build consensus around a common set of values for running our department.</td>
<td></td>
</tr>
<tr>
<td>22. I paint a big picture of what we aspire to accomplish.</td>
<td></td>
</tr>
</tbody>
</table>
23. I make certain that we set achievable goals, make concrete plans, and establish measurable milestones for the projects and programs that we work on.

24. I give people a great deal of freedom and choice in deciding how to do their work.

25. I find ways to celebrate accomplishments.

26. I am clear about my philosophy of leadership.

27. I speak with genuine conviction about the higher meaning and purpose of our work.

28. I EXPERIMENT AND TAKE RISKS, EVEN WHEN THERE IS A CHANCE OF FAILURE.

29. I ensure people grow in their jobs by learning new skills and developing themselves.

30. I give members of the team lots of appreciation and support for their contributions.

**CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE – II**

*(Laschinger et al. 1999)*

*Please circle the number for each item that best describes your opportunities, access to information, support and resources that you have in your current work.*

**HOW MUCH OF EACH KIND OF OPPORTUNITY DO YOU HAVE IN YOUR PRESENT JOB?**

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Challenging work</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. The chance to gain new skills and knowledge on the job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Tasks that use all of your own skills and knowledge</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**HOW MUCH ACCESS TO INFORMATION DO YOU HAVE IN YOUR PRESENT JOB?**

<table>
<thead>
<tr>
<th>Access to Information</th>
<th>None</th>
<th>Some Knowledge</th>
<th>Knowledge</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
<td>Some Knowledge</td>
<td>Knowledge</td>
<td>A Lot</td>
</tr>
</tbody>
</table>
1. The current state of the hospital. | 1 | 2 | 3 | 4 | 5
2. The values of top management. | 1 | 2 | 3 | 4 | 5
3. The goals of top management. | 1 | 2 | 3 | 4 | 5

HOW MUCH ACCESS TO SUPPORT DO YOU HAVE IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
</table>
1. Specific information about things you do well. | 1 | 2 | 3 | 4 | 5
2. Specific comments about things you could improve | 1 | 2 | 3 | 4 | 5
3. Helpful hints or problem solving advice. | 1 | 2 | 3 | 4 | 5

HOW MUCH ACCESS TO RESOURCES DO YOU HAVE IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
</table>
1. Time available to do necessary paperwork. | 1 | 2 | 3 | 4 | 5
2. Time available to accomplish job requirements. | 1 | 2 | 3 | 4 | 5
3. Acquiring temporary help when needed. | 1 | 2 | 3 | 4 | 5

IN MY WORK SETTING/JOB:

<table>
<thead>
<tr>
<th>None</th>
<th>A Lot</th>
</tr>
</thead>
</table>
1. The rewards for innovation on the job are | 1 | 2 | 3 | 4 | 5
2. The amount of flexibility in my job is | 1 | 2 | 3 | 4 | 5
3. The amount of visibility of my work-related activities within the institution is | 1 | 2 | 3 | 4 | 5

HOW MUCH OPPORTUNITY DO YOU HAVE FOR THESE ACTIVITIES IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th>None</th>
<th>A Lot</th>
</tr>
</thead>
</table>
1. Collaborating on patient care with physicians. | 1 | 2 | 3 | 4 | 5
2. Being sought out by peers for help with problems. | 1 | 2 | 3 | 4 | 5
3. Being sought out by managers for help with problems | 1 | 2 | 3 | 4 | 5
4. Seeking out ideas from professionals other than physicians, e.g., Physiotherapists, Occupational Therapists, Dietici | 1 | 2 | 3 | 4 | 5
1. Overall, my current work environment empowers me to accomplish my work in an effective manner.  
   | Strongly Disagree | Agree | Strongly Agree |
   | 1 | 2 | 3 | 4 | 5 |

2. Overall, I consider my workplace to be an empowering environment.  
   | Strongly Disagree | Agree | Strongly Agree |
   | 1 | 2 | 3 | 4 | 5 |

**JOB IN GENERAL SCALE**  
(Bowling Green, 1985)

Think of your job in general. All in all, what is it like most of the time? In the blank beside each word or phrase below, write:

Y for “Yes if it describes your job
N for “No” if it does not describe it
? for “?” if you cannot decide

<table>
<thead>
<tr>
<th>Pleasant</th>
<th>Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bad</td>
<td>Better than most</td>
</tr>
<tr>
<td>Ideal</td>
<td>Disagreeable</td>
</tr>
<tr>
<td>Waste of time</td>
<td>Makes me content</td>
</tr>
<tr>
<td>Good</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Undesirable</td>
<td>Excellent</td>
</tr>
<tr>
<td>Worthwhile</td>
<td>Rotten</td>
</tr>
<tr>
<td>Worst than most</td>
<td>Enjoyable</td>
</tr>
<tr>
<td>Acceptable</td>
<td>Poor</td>
</tr>
</tbody>
</table>

Thank you for completing this survey.

Please return all of these forms in the return, self-addressed envelope to:
Michael Peregrina
Nurse Unit Manager- Paediatric Ward
Liverpool Hospital, Locked Bag 7103, Liverpool BC NSW 1871

If you decide not to complete the survey, please return all the forms as instructed above.
APPENDIX D: REGISTERED NURSE SURVEY

Title of Project: A Study of the Leadership Practices of Nursing Unit Managers
Investigator: Mr. Michael Peregrina

Demographics

1. Where is your current place of work?
   - [ ] Liverpool Health Service

2. What is your Gender?
   - [ ] Female
   - [ ] Male

3. What is your age? ___________

4. How long have you been a working as a Registered Nurse?
   - [ ] 1< 2 years
   - [ ] 2< 3 years
   - [ ] 3< 5 years
   - [ ] 5< 7 years
   - [ ] 7-10 years
   - [ ] more than 10 years

5. How long have you been a working as a Registered Nurse in your current ward?
   - [ ] 1year
   - [ ] 3< 5 years
   - [ ] more than 10 years
   - [ ] 1< 2 years
   - [ ] 5< 7 years
   - [ ] 2< 3 years
   - [ ] 7-10 years

6. What is your highest academic qualification?
   - [ ] Hospital Certificate
   - [ ] Undergraduate Diploma
   - [ ] Bachelor of Nursing
   - [ ] Graduate Certificate in..........................
   - [ ] Graduate Diploma in............................
   - [ ] Master’s Degree in.............................
   - [ ] Others: please specify.........................

7. In your opinion, what do you believe to be the essential leadership skills of a Nursing Unit Manager?
   1. ........................................................................
   2. ........................................................................
   3. ........................................................................
4.  

5.  

8. In your opinion, what are the five most critical elements of a Nursing Unit Manager role?

1.  

2.  

3.  

4.  

5.  

Thank you for providing this important data. Please turn over the page and complete the attached survey forms. Your participation in this research project is very much appreciated.
Leadership Practices Inventory

Below are thirty statements describing various leadership behaviours. Please read each carefully. Then look at the rating scale and assess your Nurse Unit Manager’s leadership behaviours.

All Questions on the LPI questionnaire must be answered to obtain a complete score.
Here is the rating scale that you will be using.

Instructions:
• Be realistic about the extent to which your NUM actually engages in the behaviour.
• Do answer in terms of how your NUM typically behaves on most days, on most projects and with most people.
• Be as honest and accurate as you can be.

If you feel that a statement does not apply, it’s probably because you don’t see or experience the behaviour. That means this NUM does not frequently engage in the behaviour, at least around you. In that case, assign a rating of 3 or lower.

Ratings:

1 = Almost Never  
2 = Rarely, I am not skilled in this area  
3 = Seldom  
4 = Once in a while  
5 = Occasionally  
6 = Sometimes  
7 = Fairly Often  
8 = Usually  
9 = Very Frequently  
10 = Almost Always

To what extent does your NUM typically engage in the following behaviours? Choose the response number that best applies to each statement and record it in the box to the right of that statement.
He or She:

<table>
<thead>
<tr>
<th>Leadership Behaviours</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sets a personal example of what I expect of others.</td>
<td></td>
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<tr>
<td>2. Talks about future trends that will influence how our work gets done.</td>
<td></td>
</tr>
<tr>
<td>3. Seeks out challenging opportunities that test my own skills and abilities.</td>
<td></td>
</tr>
<tr>
<td>4. Develops cooperative relationships among the people I work with.</td>
<td></td>
</tr>
<tr>
<td>5. Praises people for a job well done.</td>
<td></td>
</tr>
<tr>
<td>6. Spends time and energy making certain that the people I work with adhere to the principles and standards we have agreed on.</td>
<td></td>
</tr>
<tr>
<td>7. Describes a compelling image of what our future could be like.</td>
<td></td>
</tr>
<tr>
<td>8. Challenges people to try out new and innovative ways to do their work.</td>
<td></td>
</tr>
<tr>
<td>9. Actively listens to diverse points</td>
<td></td>
</tr>
<tr>
<td>10. Makes it a point to let people know about my confidence in their abilities.</td>
<td></td>
</tr>
<tr>
<td>11. Follows through on the promises and commitments that I make</td>
<td></td>
</tr>
<tr>
<td>12. Appeals to others to share an exciting dream of the future.</td>
<td></td>
</tr>
<tr>
<td>13. Searches outside the formal boundaries of my organisation for innovative ways to improve what we do.</td>
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<td>14. Treats others with dignity and respect</td>
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<td>15. Makes sure that the people are creatively rewarded for their contributions to the success of our projects.</td>
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<td>16. Asks for feedback on how my actions affect other people’s performance.</td>
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<tr>
<td>17. Shows others how their long term interest can be realized by enlisting in common vision.</td>
<td></td>
</tr>
<tr>
<td>18. Asks “What can we learn?” when things don’t go as expected.</td>
<td></td>
</tr>
<tr>
<td>19. Supports the decision that people make on their own.</td>
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<tr>
<td>20. Publicly recognizes people who exemplify commitment to shared values.</td>
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<tr>
<td>21. Builds consensus around a common set of values for running our department.</td>
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</tr>
<tr>
<td>22. Paints a big picture of what we aspire to accomplish.</td>
<td></td>
</tr>
<tr>
<td>23. Makes certain that we set achievable goals, make concrete plans, and establish measurable milestones for the projects and programs that we work on.</td>
<td></td>
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</table>
135

<p>| | | | | |</p>
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<tr>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>24.</td>
<td>Gives people a great deal of freedom and choice in deciding how to do their work.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Finds ways to celebrate accomplishments.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Is clear about his/her philosophy of leadership.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>Speaks with genuine conviction about the higher meaning and purpose of our work.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Experiments and take risks, even when there is a chance of failure.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>Ensures people grow in their jobs by learning new skills and developing themselves</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Gives members of the team lots of appreciation and support for their contributions.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE – II**

*(Laschinger et al. 1999)*

*Please circle the number for each item that best describes your opportunities, access to information, support and resources that you have in your current work.*

**HOW MUCH OF EACH KIND OF OPPORTUNITY DO YOU HAVE IN YOUR PRESENT JOB?**

<table>
<thead>
<tr>
<th></th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Challenging work</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. The chance to gain new skills and knowledge on the job.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Tasks that use all of your own skills and knowledge</td>
<td>.1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**HOW MUCH ACCESS TO INFORMATION DO YOU HAVE IN YOUR PRESENT JOB?**

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Some Knowledge</th>
<th>Knowledge</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The current state of the hospital.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. The values of top management.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. The goals of top management.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
HOW MUCH ACCESS TO SUPPORT DO YOU HAVE IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th>Access Type</th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Specific information about things you do well.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Specific comments about things you could improve</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Helpful hints or problem solving advice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

HOW MUCH ACCESS TO RESOURCES DO YOU HAVE IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th>Access Type</th>
<th>None</th>
<th>Some</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Time available to do necessary paperwork.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Time available to accomplish job requirements.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Acquiring temporary help when needed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

IN MY WORK SETTING/JOB:

<table>
<thead>
<tr>
<th>Access Type</th>
<th>None</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. The rewards for innovation on the job are</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. The amount of flexibility in my job is</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. The amount of visibility of my work-related activities within the institution is</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

HOW MUCH OPPORTUNITY DO YOU HAVE FOR THESE ACTIVITIES IN YOUR PRESENT JOB?

<table>
<thead>
<tr>
<th>Opportunity Type</th>
<th>None</th>
<th>A Lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Collaborating on patient care with physicians.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. Being sought out by peers for help with problems.</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3. Being sought out by managers for help with problems</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>4. Seeking out ideas from professionals other than physicians, e.g., Physiotherapists, Occupational Therapists, Dietici</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agreement Level</th>
<th>Strongly Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall, my current work environment empowers me to accomplish my work in an effective manner.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Overall, I consider my workplace to be an empowering environment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
**JOB IN GENERAL SCALE**  
*(Bowling Green, 1985)*

Think of your job in general. All in all, what is it like most of the time? In the blank beside each word or phrase below, write:

- **Y** for “Yes if it describes your job
- **N** for “No” if it does not describe it
- **?** for “?” if you cannot decide

<table>
<thead>
<tr>
<th>Word or Phrase</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pleasant</td>
<td></td>
</tr>
<tr>
<td>Bad</td>
<td>Better than most</td>
</tr>
<tr>
<td>Ideal</td>
<td>Disagreeable</td>
</tr>
<tr>
<td>Waste of time</td>
<td>Makes me content</td>
</tr>
<tr>
<td>Good</td>
<td>Inadequate</td>
</tr>
<tr>
<td>Undesirable</td>
<td>Excellent</td>
</tr>
<tr>
<td>Worthwhile</td>
<td>Rotten</td>
</tr>
<tr>
<td>Worst than most</td>
<td>Enjoyable</td>
</tr>
<tr>
<td>Acceptable</td>
<td>Poor</td>
</tr>
</tbody>
</table>

Thank you for completing this survey.

Please return all of these forms in the return, self-addressed envelope to:

Michael Peregrina  
Nurse Unit Manager- Paediatric Ward  
Liverpool Hospital, Locked Bag 7103, Liverpool BC NSW 1871

If you decide not to complete the survey, please return all the forms as instructed above.
APPENDIX E: INFORMATION LETTER

A STUDY OF THE LEADERSHIP PRACTICES OF NURSING UNIT MANAGER

The proposed study has been approved by the Human Research Ethics Committee of Sydney South West Area Health Service and University of Western Sydney.

The study is being conducted by Michael Peregrina (Acting Manager-Nursing Workforce) as part of his Masters of Science (Hons) degree at University of Western Sydney.

The aim of this research project is to explore the self-reported leadership practices of Nursing Unit Managers (NUM’s), examine their leadership strengths from the perspectives of their staff and the impact on workplace outcomes such as empowerment and job satisfaction of staff. The investigators are seeking the participation of Nursing Unit Managers and Registered Nurses in Sydney South West Area Health Service (SSWAHS)- Western Zone.

I am requesting your support in this study. The Study of the Leadership practices Of Nurse Unit Managers will help identify the leadership practices of Nurse Unit Managers from your own perspectives and from the perspectives of the Nursing Unit Managers and will have the potential to inform organisation regarding impact of the leadership practices of Nursing Unit Managers on workplace outcomes such as staff job satisfaction and empowerment.

Three instruments will be included in the survey packet: the Leadership Practices Inventory questionnaire, Job-in General Questionnaire and Conditions of Work Effectiveness II questionnaire.
The first part of the study is a survey of nursing unit managers and the second part will involve the survey of registered nurses who works under the NUM’s who have completed the initial survey.

The research team will be mailing a copy of the survey in the near future. I am hoping that you will be able to support this study. I am available to discuss the study further if needed.

Thank you.

Michael Peregrina

<table>
<thead>
<tr>
<th>Research Student</th>
<th>Michael Peregrina</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisors:</td>
<td>Associate Professor Lorraine Ferguson (Principal Supervisor) Professor John Daly (Co-Supervisor) Professor Esther Chang</td>
</tr>
<tr>
<td></td>
<td>School of Nursing, College of Health and Science University of Western Sydney Locked Bag 1797 Penrith South DC NSW 1797</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:Michael.Peregrina@sswahs.nsw.gov.au">Michael.Peregrina@sswahs.nsw.gov.au</a></td>
</tr>
<tr>
<td>Phone</td>
<td>02 8777 5237</td>
</tr>
</tbody>
</table>
A Study of the Leadership Practices of Nurse Unit Managers

The aim of this research project is to explore the self-reported leadership practices of Nursing Unit Managers (NUMs), examine their leadership strengths from the perspectives of their staff and the impact on workplace outcomes such as empowerment and job satisfaction of staff. The investigators are seeking the participation of Nurse Unit Managers in Sydney South West Area Health Service (SSWAHS)- Western Zone.

I am requesting your participation in this study. The Study of the Leadership practices Of Nurse Unit Mangers will help identify the leadership practices of Nurse Unit Managers from your own perspectives and from the perspectives of nursing staff and the impact of the leadership practices of Nursing Unit Managers on workplace outcomes such as empowerment and job satisfaction of staff. Furthermore, the study aims to examine the leadership development needs of Nursing Unit Managers and to use that information to inform the development of a model for professional leadership development within the Australian context.

Three instruments will be included in the survey packet: the Leadership Practices Inventory questionnaire, Job-in General Questionnaire and Conditions of Work Effectiveness II questionnaire. I am aware that there are a lot of demands on your time as a Nurse Unit Manager. The completion of the survey will only take 20-25 minutes. The nature if the questions contained in some of the questions might lead you to think about the stressful aspects of your job.
The survey is easy to complete. Most questions only need the answers to be rated or ticked but there are a few that may require you to write. When it is completed please return it to me using the self-addressed envelope provided.

Your participation is voluntary. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. No names or identifying information will be published. I would like to thank you for your participation and time in undertaking this important survey.

Your decision whether or not to participate will not prejudice your present or future treatment or your relationship with Sydney South West Area Health Service or any other institution cooperating in this study or any person treating you. If you decide to participate, you are free to withdraw your consent and to discontinue your participation at any time without prejudice.

If you have any questions or concerns about this research please contact me on telephone 02 9828 5665 and I will be happy to answer them.

You are making a decision whether or not to participate. Your signature on the consent form indicates that, having read the information provided above, you have decided to participate.

Complaints may be directed to the Ethics Secretariat (Western Zone), SSWAHS Area Health Service, Locked Bag 7017, LIVERPOOL BC, NSW, 1871 (phone 9828 5727, fax 9828 5962, email jennie.grech@swaahs.nsw.gov.au). You will be given a copy of this form to keep.
APPENDIX G: PARTICIPANT INFORMATION STATEMENT

PARTICIPANT INFORMATION STATEMENT

Registered Nurses

A Study of the Leadership Practices of Nurse Unit Managers

The aim of this research project is to explore the self-reported leadership practices of Nursing Unit Managers (NUMs), examine their leadership strengths from the perspectives of their staff and the impact on workplace outcomes such as empowerment and job satisfaction of staff. The investigators are seeking the participation of Registered Nurses in Sydney South West Area Health Service (SSWAHS)- Western Zone.

I am requesting your participation in this study. The Study of the Leadership practices Of Nurse Unit Managers will help identify the leadership practices of Nurse Unit Managers from your own perspectives and from the perspectives of the Nursing Unit Managers and will have the potential to inform organisation regarding impact of the leadership practices of Nursing Unit Managers on workplace outcomes such as staff job satisfaction and empowerment.

Three instruments will be included in the survey packet: the Leadership Practices Inventory questionnaire, Job-in General Questionnaire and Conditions of Work Effectiveness II questionnaire. I am aware that there are a lot of demands on your time as a Registered Nurse. The completion of the survey will only take 20-25 minutes. The nature if the questions contained in some of the questions might lead you to think about the stressful aspects of your job and question your NUM’s leadership practices. The survey is easy to complete. Most questions only need to rated or ticked but there are a few that may require you to write short answer. When it is completed please return it to me using the self-addressed envelope provided.
Your participation is voluntary. Comments will not be fed back to the Nursing Unit Manager. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or except as required by law. No names or identifying information will be published. I would like to thank you for your participation and time in undertaking this important survey.

Your decision whether or not to participate will not prejudice your present or future treatment or your relationship with Sydney South West Area Health Service or any other institution cooperating in this study or any person treating you. If you decide to participate, you are free to withdraw your consent and to discontinue your participation at any time without prejudice.

If you have any questions or concerns about this research please contact me on telephone 02 9828 5665 and I will be happy to answer them.

You are making a decision whether or not to participate. Your signature on the consent form indicates that, having read the information provided above, you have decided to participate.

Complaints may be directed to the Ethics Secretariat (Western Zone), SSWAHS Area Health Service, Locked Bag 7017, LIVERPOOL BC, NSW, 1871 (phone 9828 5727, fax 9828 5962, email jennie.grech@swaahs.nsw.gov.au).

You will be given a copy of this form to keep.
CONSENT FORM TO PARTICIPATE IN RESEARCH

Title of Research Project: A study on the Leadership Practices of Nursing Unit Managers

1. I, .................................................................................. of ........................................... ................................, agree to participate as a subject in the study described in the subject information statement attached to this form.

2. I acknowledge that I have read the Subject Information Statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

3. Before signing this Consent Form, I have been given the opportunity to ask any questions relating to any possible physical and mental harm I might suffer as a result of my participation. I have received satisfactory answers to any questions that I have asked.

4. My decision whether or not to participate will not prejudice my present or future treatment or my relationship with Sydney South West Area Health Service or any other institution cooperating in this study or any person treating me. If I decide to participate, I am free to withdraw my consent and to discontinue my participation at any time without prejudice.

5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

6. I understand that if I have any questions relating to my participation in this research, I may contact the study Michael Peregrina on telephone 02 9828 5665, who will be happy to answer them.

7. I acknowledge receipt of a copy of this Consent Form and the Subject Information Statement.
Complaints may be directed to the Ethics Secretariat (Western Zone), Sydney South West Area Health Service, Locked Bag 7017, LIVERPOOL BC, NSW, 1871 (phone 9828 5727, fax 9828 5962, email jennie.grech@swsahs.nsw.gov.au).

<table>
<thead>
<tr>
<th>Signature of subject</th>
<th>Signature of witness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please PRINT name</td>
<td>Please PRINT name</td>
</tr>
<tr>
<td>Date</td>
<td>Date</td>
</tr>
<tr>
<td>Signature(s) of investigator(s)</td>
<td></td>
</tr>
<tr>
<td>Please PRINT Name</td>
<td>Date: ___</td>
</tr>
</tbody>
</table>
September 8, 2004

Mr. Michael Peregrina
7 Linara Circuit
Glensmore Park, New South Wales 2745 Australia
Email: Michael.Peregrina@swsahs.nsw.gov.au

Dear Michael:

Thank you for your request to use the Leadership Practices Inventory (LPI) in your masters’ thesis. We are willing to allow you to reproduce the instrument as outlined in your facsimile, at no charge, with the following understandings:

1. That the LPI is used only for research purposes and is not sold or used in conjunction with any compensated management development activities;
2. That copyright of the LPI, or any derivation of the instrument, is retained by Kouzes Posner International, and that the following copyright statement is included on all copies of the instrument: "Copyright © 2003 James M. Kouzes and Barry Z. Posner. All rights reserved. Used with permission."
3. That one (1) bound copy of your thesis and one (1) copy of all papers, reports, articles, and the like which make use of the LPI data be sent promptly to our attention; and,
4. That you agree to allow us to include an abstract of your study and any other published papers utilizing the LPI on our various websites.

If the terms outlined above are acceptable, would you indicate so by signing one (1) copy of this letter and returning it to us. Best wishes for every success with your
research project.

Cordially,

Barry Z. Posner, Ph.D.
Managing Partner

I understand and agree to abide by these conditions:

(Signed)__________________
Date ____________________