2008

The leadership characteristics registered nurses perceive as important in their clinical nurses

Linda May Aitken
Edith Cowan University

Edith Cowan University

Copyright Warning

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

The leadership characteristics registered nurses perceive as important in their clinical nurses.

by

Linda May Aitken R.N., B.N.

A thesis submitted as partial fulfilment of the requirement for the Degree of Bachelor of Science with Honours (Nursing) at the Faculty of Computing Health and Science, Edith Cowan University, Joondalup, Western Australia.

Principal Supervisor
Dr Carol Thorogood

Date of Submission: 7th November, 2008.

Abstract

Limited research exists about the leadership attributes registered nurses (RNs) want from their clinical nurses (CNs). This study explored the leadership attributes Western Australian RNs considered important in CNs and determine if there were differences in the choice of preferred CN attributes according to RNs years of experience; types of nursing education; level of seniority and nursing specialty. A modified version of the *Emerging Workforce's Preference Survey* was distributed to 403 RNs with a 30% response rate. The respondents ranked their top three preferences from 4 clusters of traits. S.P.S.S. 15.0 was used to summarise demographic data and then analyse data from the 4 clusters of traits for the main group. Cross tabulations identified between group variations. The RNs wanted CNs to be *clinically competent, approachable and supportive;* to show *understanding* and *integrity* whilst being *team players* and *good communicators*. The between groups analysis revealed similar patterns. However, RNs with >5years nursing experience also wanted their CNs to show *respect for subordinates* while those with <5years experience selected *mentoring* as an important quality for a CN to possess. Hospital-diploma educated RNs most preferred the attributes of *motivator of others; respect for subordinates*, and *integrity;* whilst university educated RNs chose *team player*, followed by *calm* and *understanding.* RNs educated via hospital diploma then university favoured the attribute of *motivated.* RNs employed as Level 1 nurses chose similar attitudes to Level 2 RNs although the former selected the intrinsic quality of *understanding* while Level 2 RNs preferred *dependable.* Unlike the main group, RNs in peri-operative and critical care units favoured the personal attribute *receptive to people and ideas* while nurses employed in management preferred the intrinsic quality of *intelligent.* Some respondents commented on the negative effect that heavy workloads have on CNs' performance. Others mentioned that RNs are not prepared for the CN role. Competent CNs create a positive work environment which aids staff retention and improves morale. If CNs are to be effective first-line leaders, employers and the nursing profession must espouse both current and potential CNs in developing the knowledge and skills needed for the leadership and mentoring roles required of the CN.

COPYRIGHT AND ACCESS DECLARATION

I certify that this thesis does not, to the best of my knowledge and belief:

i. incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education;

ii. contain any material previously published or written by another person except where due reference is made in the text; or

iii. contain any defamatory material.

Signature.. ...

Date..... 1.7.09 .....

Acknowledgements

Thanks to the following people who have guided and supported me through this study:

Dr Carol Thorogood, for her academic supervision, whose guidance and encouragement has made this study possible:

Lorraine Burt, for her help in conceptualising this study and preparation of my proposal:

K. Lynn Wieck, PhD., RN, FAAN who gave permission to use and modify the evaluation tool for this study, and for her encouragement:

The Director of Clinical Services, at the study hospital, for her positive input and permission for this research to be conducted:

The nurses, who took the time to participate in this investigation:

Colleagues and supervisors from the study hospital, who encouraged me to conduct this study and helped make a way for the study to become realty:

Lesley Mettam and Bronwyn Kort who lent an ear and encouraged me in my personal endeavours:

Members of Victory Life Church and Reverend Dr Margaret Court, who supported me spiritually, emotionally and encouraged me to continue on in my goals and visions:

Lastly, but definitely not least, I would like to thank my husband Vincent, my children Daniel, Althea, Kate and Alexandra, and my mother, Beverly Melton for their support, understanding and patience, without which I would never have completed this study.

Table of Contents

Table of Figures

List of Tables

Chapter 1 Introduction

1.1 Background

Leadership studies in nursing often discuss, from a management perspective, the attributes required for nursing leaders. While hospital management's requirements for nursing leaders are important, it is also important to discern the leadership characteristics that Registered Nurses (RNs), working under Clinical Nurse (CN) leaders, consider important for CNs to have. Most nurses have the potential to lead, but do not always know how to lead. Research shows nurses believe exemplary leadership is not always modelled in their nursing experience (Bondas, 2006; Mumford, Zaccaro, Harding, Jacobs, & Fleishman, 2000). In Western Australia, the CN is the first line of leadership for the RN, being primarily responsible for managing the day-to-day work environment. Wards with effective CNs demonstrate low staff attrition rates (Boyle, Bott, Hansen, Woods, & Taunton, 1999). Therefore, it is important to listen to what RNs are saying about their leadership needs in the health care field because little is known about their perceptions of the leadership skills they consider important in their CNs.

It has been observed anecdotally that in some areas the nurses say they are happy and content in their practice, but in other areas, nurses are exhausted and looking for other employment. A previous study by Kaur (2006) shows that, while insufficient remuneration is considered an important contributing factor in the current shortage of nurses, the work environment, and how that work environment is managed are also important considerations when a nurse is deciding whether to remain with the employing organisation, or within the nursing profession.

This descriptive study used a quantitative approach to explore, from the RNs' perspectives, the attributes they consider important in a CN. A modified version of the Emerging Workforce Preferences Survey, devised by Dr K. Lynn Wieck (Appendix D), was employed, with the opportunity for the respondents to make further qualitative comment. Results of this study will add to what is known about leadership in nursing and will be of use to those designing leadership courses for current and potential CNs.

1.2 Purpose of study

The goal of this study was to identify, from the RNs' perspective, the leadership characteristics of CNs they consider most important to facilitate their nursing practice.

1.3 Conceptual Framework

This study sought the opinions of full-time and part-time RNs, employed in a private Western Australian hospital, about the leadership characteristics they consider important in CNs. This was achieved by implementing a modified version of Wieck's Emerging Workforce Preferences Survey (Appendix E).

As shown in figure 1 the independent variables tested were:

- RNs working in different specialties: Medical, Surgical, Critical Care, Peri-operative, Procedural, Palliative Care, Psychiatry and Nursing Management;
- Different forms of education received by RNs: Hospital-based diplomas, University-based or Both;
- Years of nursing experience;
- Nursing levels (Level 1 or 2 and higher). These terms are defined on page 14 of the thesis.

Figure 1 displays the dependant variables divided into four clusters of traits: attitudes, intrinsic qualities, acquired skills and personal characteristics. Each of the four clusters of traits has descriptors the RNs were asked to select from in order of importance. The manner in which the results from this investigation could benefit the respondents is represented diagrammatically in this figure.

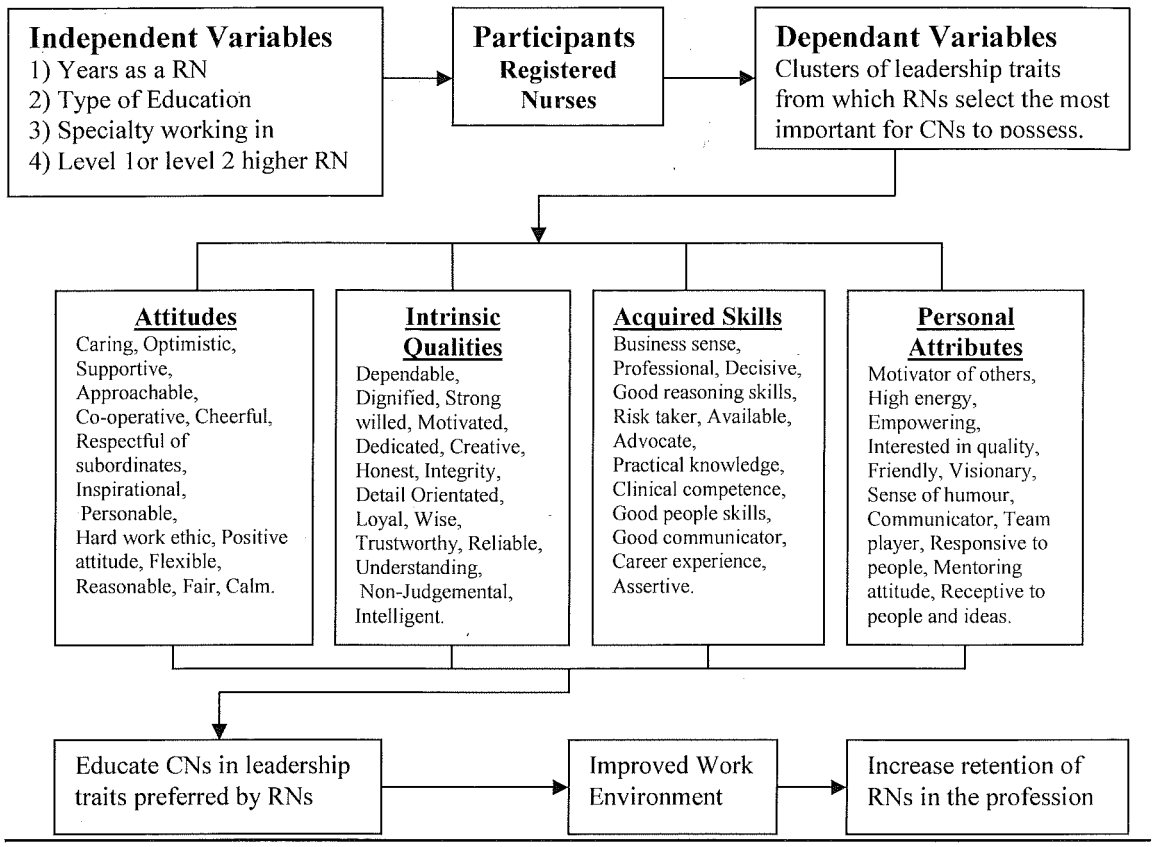

Figure 1.1: The relationship between RNs independent variables and their choice of preferred dependent variables for CN leadership traits with possible benefits to the nursing profession.

1.4 Research Questions:

1) What leadership characteristics do RNs perceive as important in their CNs?

2) Do RNs in different specialties of nursing perceive differing leadership characteristics in their CNs as being important?

3) Is an RN's type of nursing education or years of experience since qualification associated with differences in the leadership characteristics they perceive as important in CNs?

4) Is there a difference between Level 1 and Level 2 or higher RNs' perceptions of important leadership characteristics in a CN?

1.5 Operational definitions

Characteristic: "A distinguishing feature or quality" (Krebs, 1999). The peculiar unique and distinctive qualities or traits displayed by a person (Knight, 2003).

Clinical Nurse (CN) and Level 2 or higher CN: for the purpose of this investigation the study hospital's CN position description as quoted below will be used as the operational definition of a CN. The position description for a CN at this hospital includes:

"Providing effective clinical care of patients.

Contributing to operational functioning of the unit.

Providing a quality focused service.

Contributing to professional development of self and others.

Essential criteria for a CN to have at this hospital is:

1) To be eligible for registration with the Nurses board of Western Australia as a Registered Nurse.
2) To have completed three years post registration clinical experience.
3) Advanced level of knowledge and skills in specialty.
4) Effective communication and interpersonal skills.
5) Ability to plan and facilitate the management of a ward/unit.
6) Ability to plan and conduct patient and staff education.
7) Knowledge of and participation in quality improvement process.
8) Knowledge of legislation relevant to nursing practice.
9) Willingness to accept and promote the study hospital's Core Values.

Desirable Criteria

To have a relevant tertiary qualification or progression towards requirement." (Appendix A)

Full Time Equivalent (FTE): is the number of hours a fulltime nurse works. This is 36 hours a week in Western Australia (Australian Bureau of Statistics, 2005).

Registered Nurse (RN) and Level 1 RN: in Australia is "a person licensed to practice nursing under an Australian State or Territory Nurses Act or Health Professionals Act. Referred to as a Registered Nurse Division 1..."(Australian Nursing and Midwifery Council, 2005). According to part 4 section 26 of the Nurses and Midwives Act of Western

Australia ("Nurses and Midwives Act," 2006), a RN is a person eligible to be registered under division 1 of the register.

Trait: "Characteristic feature" (Krebs, 1999).

1.6 Organisation of the Thesis

Chapter one includes the background, purpose, conceptual framework, research questions, significance of this study and operational definitions for this investigation. Chapter two consists of a review of the literature relevant to this study, with chapter three describing the research methods employed in the investigation. The investigation findings are reported in chapter four; chapter five examines the qualitative comments from the respondents; and the final chapter, chapter six, discusses the findings and presents the conclusions of this study.

Chapter 2: Literature Review

This literature review initially examines definitions of leadership, then presents an overview of theories and research about leadership, styles of leadership and how this affects nursing. Next, the review discusses the undersupply of nurses in the workplace and highlights the data which reflects the shortage as well as the increasing age of nurses both in Western Australia and globally. Thirdly, retention of nurses is explored, management of the nursing work environment is probed, and the different paths to CN leadership reviewed. Finally, similar overseas studies, identifying preferred leadership traits, are reviewed.

Electronic databases including AusStats, CINAHL, Cochrane, Google, MEDLINE, ProQuest, OVID, PsychINFO, PsychArticles and Sage were used to search for studies about leadership, leadership in nursing and retention of nurses. Keywords used include, leadership, nursing, nurses, nurse managers, nurse retention, nurse shortage, nursing leadership and leadership theories. Published and unpublished studies from Edith Cowan University were also reviewed.

Definitions and theories about attributes possessed by successful leaders abound, some of which are reviewed below. In his historical overview of leadership theory and research, Chelmers (2000, p. 27) defines leadership as: "a process of social influence in which one person is able to enlist the aid and support of others in the accomplishment of a common task." Vroom & Jago (2007, p. 18), in their discussion of how context affects leadership, added another dimension in describing it as "a process of motivating people to work together collaboratively to accomplish great things." Similarly Mumford et al., (2000, p. 12), suggest leadership performance is affected by the leader's problem solving skills within an organisation, defining this by stating, "... leaders exercise influence, taking actions that, in one way or another, shape the behaviour of others." These definitions of leadership all share the commonality of influencing or motivating a group of people. However, whilst the leadership definitions by Chelmers (2000) and Vroom & Jago (2007) include achieving a common goal, the definition by Mumford et al., (2000) involves shaping the behaviour of others. When these definitions are incorporated together, leadership is defined as a process of influencing, motivating and shaping the behaviour of a group of people to accomplish a common goal. In their discussion of clinical nursing

leadership in Australia, Davidson, Elliott, & Daly (2006, p. 182) define leadership as "...a multifaceted process of identifying a goal or target, motivating other people to act, and providing support and motivation to achieve mutually negotiated goals. Leadership may occur in formal and informal settings and structures." However, for CNs, who are at the first level of nursing leaders (see operational definitions p. 14), leadership not only incorporates these definitions, but, according to Stanley whose research aimed to identify clinical nurse leaders, clinical nurse leaders are those "who is [are] an expert in their field" (Stanley, 2006b, p. 111) and whose values and beliefs are congruent with their nursing practice (Stanley, 2006a, 2006b). In addition, Cook, cited in an editorial commentary by Osborne, Fong and Keogh (2003, p. 5), defines a clinical nurse leader as a nurse, "...who is directly involved in providing clinical care and who continuously improves care by guiding, influencing and empowering others." At the hospital where this research was conducted, the key functions and responsibilities within the job description of a CN incorporate "provide effective clinical care of patients, contribute to the operational functioning of the unit, provide a quality focused service and contribute to professional development of self and others" (Appendix A. p. 4).

Whilst CN leaders have a list of criteria and tasks to fulfil within their leadership role the manner of achieving those outcomes, described in the previous paragraph, is vital. There are different models of leadership with Finkelman (2006, p. 6) describing four stages of leadership theory development. Firstly, until the 1940s theories about traits of leaders was the focus of research, these being identified and studied with the assumption that a leader is born with particular leadership characteristics. Secondly, leadership styles theories focusing on how to train leaders were emphasised from the late 1940s to the late 1960s. Thirdly, from the late 1960s to the early 1980s, contingency approach was the leadership theory of choice, where the influence of context, situation and organisational factors on leadership was researched. Finally, the newer approaches to leadership theory emerged, for example; transformational, charismatic and visionary leadership. The influence that organisational culture has on leaders, and leaders in their turn, have on organisational culture are theories currently being developed and researched. Furthermore, Finkelman (2006, p. 6) describes three styles of leadership firstly, autocratic, where the leaders assume a paternalistic role making the decisions, assuming people are externally motivated and unable to make decisions independently. Secondly, the bureaucratic style of leadership,

which is similar to autocratic style, except the leader follows the rules and policies of the organisation without flexibility. Thirdly, a laissez-faire leadership style where the leader does not tell the staff what to do, believing the group is internally motivated by recognition, achievement and increased responsibility. Chelmers (2000), argues leaders must be perceived as proficient and trustworthy by those they lead and that they need to establish the legitimacy of their position of leadership. He also encourages leaders to mentor, coach and encourage those they lead. Leaders must know those they lead, their capabilities, value systems and qualities so that the leader is able to come along side developing each member effectively to achieve their potential. Chelmers position is similar to the transformational style of leadership described by Morrison, Jones, & Fuller (1997, p. 28), who delineate transformational leadership having four areas "idealised influence, inspiration, intellectual stimulation and individualised consideration." Additionally, Finkelman (2006, p. 15) lists the qualities of a transformational leader as: "self-confidence, self-direction, honesty, energy, loyalty, commitment, and the ability to develop and implement a vision." In contrast, Morrison et al. (1997) describes transactional leaders as those who intervene only if something goes wrong or expected outcomes are not being met. From this perspective, there is an agreed reward for effort with a clear understanding of what is to be achieved. Nonetheless, transactional leaders react to situations, and do not have regular interaction with those they lead. In contrast, transformational leaders develop a relationship and work toward developing the potential of those they lead.

Authors such as David Stanley (Stanley, 2006a, 2006b) have made an important contribution to leadership theory within the nursing context. Stanley (2006b) argues transformational leadership theory does not support insights gained from his research of clinical leadership. Stanley's study, in which a questionnaire was devised and sent to 830 potential participants, received a response rate of 22.6%. He then interviewed 42 qualified nurses from the NHS trust in the English Midlands using a grounded theory approach. His findings revealed that the participants did not identify visionary leadership as a preferred clinical leadership characteristic. However, based on his research findings Stanley (2006a; 2006b) proposed a new model of leadership, which he named congruent leadership, wherein CNs' values and beliefs match their actions. Furthermore, Schewchuk's (2003, p. 22) paper on integrity parallels Stanley's model of leadership commenting that leaders should "Make decisions based on values, standards and principles. Be true to yourself." In

addition, motivation researchers, comment that, " ... individual's beliefs, values and goals relate to their achievement behaviours" (Eccles & Wigfield, 2002, p. 127). This conclusion is similar to what the RNs in Stanley's study desired - congruent leadership, where values and beliefs match the actions of the CN.

Regardless of different leadership models, a leader's role is not only to exert influence, but to choose where their influence is best put into effect if they are to attain their goals (Mumford et al., 2000). Mumford et al., (2000, p.21) in a discussion of leadership problem solving skills, describe three phases of leading: creative problem solving, social judgement skills and knowledge. In addition, they commented that the potential for leadership is present in many individuals, and emerges through experience. Cohen (1998) in a paper summarising his research findings and Osborne et al., (2003) in their editorial, agree that a successful leader is not born with special abilities for leadership, but is able to learn and appropriate leadership skills. Indeed, Cohen (1998, p. 38) suggests "eight universal laws of leadership," these 'laws' being: "maintain absolute integrity, know your stuff, declare your expectations, show uncommon commitment, expect positive results, take care of your people or customers, put duty before self and get out in front." In contrast, Thresia Naygam (cited in Osborne et al., 2003, p. 7) identifies three key characteristics to be developed in a leader: firstly knowledge which includes clinical, managerial and self knowledge; secondly, courage and commitment, having the initiative to innovate and holding a standpoint; and thirdly, having heart, that is caring, coaching and supporting those led.

Stogdill (1981) in a review of leadership theory and research asserts leaders more often than not need to be more knowledgeable and experienced than those they lead. Similarly, Smolenyak (1992), in a discussion of the nursing leadership role and a mentoring culture, affirms a view of leadership wherein the leader guides people to achieve what they are capable of, recognising their strengths, potential and weaknesses, whilst coaching and mentoring them to achieve their potential. Bally (2007) maintains that mentoring augments staff satisfaction, as does Davidson et al., (2006) who also contend that mentoring needs to be fostered by nurse leaders. Mentoring and coaching is encouraged within Australia by the Australian Nursing and Midwifery Council (ANMC) who state in section 4.3 of their National Competency Standards for the Registered Nurse (2005, p. 4), "... [the RN]

participates where possible in preceptorship, coaching and mentoring to assist and develop colleagues." Furthermore, Anthony et al., (2005) claim that coaching and mentoring facilitates the retention of nurses within the teams they lead.

Across the world including Australia, retention of nurses within the workplace is a key issue faced by nurse leaders and managers (Anthony et al., 2005; Bally, 2007; Boyle et al., 1999; Cline, Reilly, & Moore, 2003; Dockery, 2004; Duffield & O'Brien-Pallas, 2003; Hogan, Moxham, & Dwyer, 2007; Swearingen & Liberman, 2004; Thyer, 2003; Wieck, Prydun, & Walsh, 2002). An additional consideration to the difficulty of retaining nurses is that nurses are significantly undersupplied in Australia and globally (Anthony et al., 2005; Duffield & O'Brien-Pallas, 2003; O'Brien-Pallas & Duffield, 2006; Swearingen & Liberman, 2004; Thompson, Wieck, & Warner, 2003; Thyer, 2003). Postulated reasons for this phenomenon range from an inadequate number of university graduates, to nurses leaving the profession for what they consider better options, according to the report by Karmel & Li (2002) on the factors impacting supply and demand for nurses. The 'casualisation' of the workforce has also played a role in the nurse shortfall. For example, the percentage of part-time nursing workers has increased from 37% in 1986 to 49% in 2001 (Australian Bureau of Statistics, 2005). Furthermore, in Australia between 1986 and 2001 the number of full time equivalent (FTE) nurses decreased from 10.9 to 9.8 per thousand of the population, with the number of registered nurses (RNs) increasing at half the rate of other professions during this period (Australian Bureau of Statistics, 2005). The Australian nursing population is ageing (Australian Bureau of Statistics, 2005; Australian Institute of Health and Welfare, 2008; Duffield & O'Brien-Pallas, 2003), in 2005 the average age of the Australian nurse was 45 years with the same survey revealing the average age of the Western Australian nurse was 46.7 years (Australian Institute of Health and Welfare, 2008). In addition, a study investigating Australian nursing workforce experience and retention, by Dockery (2004, p. 96) comments "the evidence is consistent with numerous existing reports on the nursing profession that paint a picture of an aging and disenchanted registered nurse workforce."

Whilst lack of remuneration has been considered a contributing reason for nurses leaving the profession (Kaur, 2006), statistics show that a Full Time Equivalent (FTE) RN earned an average weekly wage of $1028.00 before penalties, which is considerably more

than the average weekly wage of $867.50 earned by adult non-managerial workers (Australian Bureau of Statistics, 2005). Therefore, the issue of nurse retention goes beyond that of remuneration. Dr K.L. Wieck, a US nurse academic explained, "I believe that pay is the knee-jerk response to "What's wrong?" And I believe it [pay] can never be adequately addressed" (personal communication, April 27, 2006). Furthermore, Dockery (2004, p. 74) comments "dissatisfaction with non-pay aspects of the job appears to have a stronger influence on overall job satisfaction and on intentions to leave the profession."

In the USA, Thompson, Wiecke, & Warner (2003, p. 249), proposed that, with numerous job prospects available to them, neophyte graduate nurses are changing their employment more frequently than more experienced nurses, thus contributing to the recruitment and retention issues faced by employers. In light of this, these USA researchers conducted a quantitative study comparing what 35 peri-operative and 57 emerging nursing workforce nurses require of their nurse managers. This study found both groups cited the same seven traits as being important in a nurse manager, with both groups ranking these traits differently with a Spearman ranked correlation of $r = 0.417$. Based on their study's findings, they recommended these neophyte nurses receive mentoring and nurturing to facilitate their job satisfaction and their integration into the healthcare team. Similarly, Cline, Reilly, & Moore (2003, p. 51), in a USA qualitative study investigated the reasons pre-empting RNs' decisions to leave employment in acute care environments. They implemented focus groups with seven self-selected RNs who had resigned from two major health care providers in Nevada. Participants cited "lack of support, ineffective measures, and failure to listen or respond to concerns topped the reasons why nurses chose to voluntarily leave employment." Other studies have found that a nurse manager's leadership characteristics influence the work environment, which in turn affects the decision of nurse employees intent to stay or leave the work unit or hospital (Boyle et al., 1999). Indeed, "Effective leadership can promote a satisfying and productive work environment..." according to the results from a descriptive survey of 70 RNs in the surgical services department of a USA hospital (Feltner, Mitchell, Norris, & Wolfle, 2008, p. 363). In fact, when nurse employees leave their employment, they are leaving their managers and supervisors rather than leaving the organisation that employs them according to Hogan et al., (2007, p. 198), in their review of the literature from Australian state and federal government reports into retention of nurses.

Importantly, management of the work environment is an important consideration for the RNs' decisions about their intention to stay or to move on to another employer, according to the USA study by Boyle et al., (1999). Their study of 255 RNs from four large acute care hospitals, investigated the effects of nurse managers' leadership on critical care nurses intent to stay in their place of employment. Swearingen & Liberman (2004) in their paper discussed the feasibility of using a servant-leadership model as a method to aid the recruitment and retention of nursing staff; they argued that experience shows hospitals can implement a number of measures to recruit nurses but their retention will be difficult unless the workplace environment and conditions are improved. In fact, Heath, Johanson & Blake (2004, p. 524), in a qualitative study which asked 24 nurses in four focus groups to respond to three open-ended questions about their experiences in healthy and unhealthy work environments, and the solutions to improve them, found that unhealthy work environments lead to "absenteeism, ineffectiveness in healthcare delivery, stress, and discord among healthcare colleagues." An unhealthy environment can be fertile ground for dysfunctional behaviour, i.e. bullying and horizontal violence to occur, especially if managers 'look the other way' (Baltimore, 2006; Duffield & O'Brien-Pallas, 2003; Gerardi & Connell, 2007; Hader, 2008; Willis, 2002). In a qualitative research study asking 32 nurse managers in four focus groups about their "roles, and the characteristics they need to promote retention", Anthony et al., (2005, p. 146) concluded that CNs, being first-line leaders are "close to the action" and thus are in the best place to facilitate healthy work environments. Likewise, O'Brien-Pallas & Duffield (2006, p. 268), in research using data taken from two earlier studies used factor analysis to compare the opinions of nurse executives and nurses who have left nursing about key retention strategies. The authors commented, "It is the nurse manager at the unit level who is in a better position to know and understand what might be important in retaining nurses at the unit level." As well as having "an attentive ear" to hear what those they are leading have to say (Bennis, 1999p. 79). In the same vein, an editorial piece by Willis (2002) makes the case for CNs being well placed to shape the culture in an organisation. Moreover, in their analysis of research about the training and role of Australian first-line nurse managers, Duffield and Franks (2001) argue that whilst first-line nurse managers, or CNs, are in a unique position, many lack preparation for these positions.

Often nurses are placed in leadership positions without preparation to lead (Anthony et al., 2005; Bondas, 2006; Duffield & Franks, 2001). This is similar to the 'Peter principal' cited in Finkelman (2006, p. 21) where employees, performing to satisfaction, are promoted to positions beyond their level of competence, which they are not skilled to perform. Bondas (2006) in her qualitative research on a sample of 68 Finnish nurse leaders invited them to complete a semi-structured, self-report questionnaire in order to ascertain their opinions about why nurses become nurse leaders. This research identified four paths to leadership in nursing. The first group becomes a leader because of an altruistic motivation, to make a beneficial difference within the nursing profession. The second type of leader makes a career choice to assume managerial positions rather than work directly with patients. The third leads by chance, assuming leadership positions because of situations that arise which do not follow a planned path to leadership. The final type of leader is one who does not want the position of leadership, leading provisionally to the abandonment of the position as soon as the opportunity arises. In addition, Bondas (2006, p. 339) identifies good and bad nursing leadership role modelling to occur with her comment that, "Situational factors and role models of good but also bad nursing leadership, besides motivational and educational factors, have played a significant role when Finnish nurses have entered nursing leadership."

Importantly, in a paper concerned with clinical leadership in Australia, Davidson et al., (2006, p.180) propose that "systematic, strategic initiatives are required to nurture and develop clinical leaders." Preparation to lead is important for any CN assuming a leadership role; however, suitable training in leadership is, in many cases, lacking for the first line leaders (Duffield & Franks, 2001). In fact, Bonczek & Woodward (2006) recommend succession planning for potential leaders, proposing employers identify potential leaders and educate them, in preparation for future leadership. Furthermore, a qualitative research study using grounded theory to "identify the attributes of effective clinical nurse leaders" by Cook (2001, pp. 33 - 36), takes this concept further by recommending "generic leadership preparation" should occur in undergraduate nursing programmes, thereby preparing graduates for future leadership positions. In their qualitative research to determine the profile of the future nurse leader, Scoble and Russell (2003) also recommended leadership training for current and future nurse leaders.

Whilst both leadership styles and preparation for leadership have been explored and studied, in this instance, it is important to ask the RNs who are being led, about the leadership characteristics they require from their CN leaders. In a review of Magnet hospital research, conducted since the 1980s in the United States (USA), Scott, Sochalski & Aiken (1999) examined the factors that encourage professional nurses to remain in their positions. The most important leadership attributes were that the leader; is visionary and enthusiastic, supportive and knowledgeable, has high standards and high expectations of their staff, values education and professional development of all nurses, is highly visible to nurses under them, has open lines of communication and is actively involved in organisations related to the nursing profession (Scott et al., 1999). However, in their literature review these authors commented that the study of Magnet hospitals provided a biased sample because they did not research what other hospitals were doing that affected their staff retention.

A quantitative study conducted in the USA with the aim of "describing the desired [leadership] traits as perceived by emerging [108 nursing students aged 18-35 years of age] and entrenched [nursing] workforce members [126 managers and nurses aged over 35 years]" by Wiecke, Prydin & Walsh (2002, p. 283), identified, firstly the current workforce as requiring different leadership characteristics from their colleagues in the 1980s. Secondly, the authors found the leadership qualities identified in Magnet research from the 1980s; visionary, supportive, knowledgeable, responsive to people and organisational participation (Scott et al., 1999), were not identified as being important to their 2002 study sample. In addition Wieck et al. (2002) and later Thompson et al. (2003) demonstrated similarities in the preferred leadership characteristics for both experienced and newer nurses. Whilst these studies aimed to identify any differences between groups of most preferred leadership characteristics, the UK qualitative investigation by Stanley (2004; 2006a; 2006b) sought to identify clinical leaders within nursing, and the clinical leadership attributes perceived as important by the nurses they lead. From this work, Stanley conceptualised a new model of leadership which he termed congruent leadership. In this model, clinical leaders are "approachable, visible, clinically skilled, competent, good communicators and role models with high standards of care." It is interesting that the attribute of a leader, one who is visible, was consistent with the 1980s Magnet hospital (Scott et al., 1999) research findings but not with research by Wieck et al., (2002) and

Thompson et al., (Thompson et al., 2003). This may be because of differences in the aims of these studies. For example, Wieck et al., (2002) and Thompson et al., (2003) compared two groups' preferred leadership characteristics, whereas Stanley (2004; 2006a; 2006b) and Magnet hospital research from the 1980s, (Schull, 1984), conducted research aimed at identifying the qualities and characteristics of clinical nurse leaders.

In summary, with the current nursing shortage being experienced in Western Australia, an investigation into what RNs consider important leadership characteristics in their CNs is vital. The CN is the first line of leadership affecting the RNs' work environment, which if well-managed minimises staff turnover. This literature review has identified that some of the leadership characteristics acknowledged in the 1980s as important to nurses but which are not as important to nurses currently working in the profession. However, most of this research has been conducted in the USA and the UK, so it is important to identify the leadership characteristics important to Western Australian nurses currently, in order that education programmes can be initiated and devised to help develop these preferred characteristics in current and potential nurse leaders. In essence, the literature review has revealed most nurses to have the potential to lead, but they are in need of the opportunity to learn the skills of leadership, especially given these have not always been modelled suitably in the nursing profession. This literature review has shown that, if they are going to be effective, nurse leaders must be afforded a platform of leadership on which to base their skills, and should not be expected to learn their role by trial and error once they have assumed positions as clinical nurse leaders.

Significance of study

Australia is suffering a shortage of professional nurses; this has been well documented. As a matter of urgency, nurse leaders and researchers must devise strategies designed to recruit and retain nurses in the workforce. One way to do this is to ascertain the leadership traits Western Australian nurses require of their CNs; findings of this study will provide information about the required characteristics RNs perceive as important in their leaders. This information will give direction to the important leadership traits necessary in leaders and potential nurse leaders, thereby ensuring an improved working environment and, in all likelihood, contribute to other initiatives designed to retain nurses in the profession.

Chapter 3 Methodology

3.1 Introduction

The purpose of this chapter is to explain the research methods employed for this study. Characteristics of the study setting, sample of participants and variables of significance are described. In addition the instrument used for this study, procedure for data collection and data analysis, ethical considerations and limitations will be discussed.

3.2 Study Setting

This study was undertaken at a private hospital, which is an acute care teaching hospital in Perth, Western Australia. This hospital is able to treat 653 patients at any one time and provides care for private patients, war veterans and their widows. The study hospital employs four hundred and ninety five registered nurses on a part time and fulltime basis. This hospital was chosen for the study because it provides differing specialties of care including medical, surgical, critical care, palliative, peri-operative and psychiatric care. Secondly, this hospital and senior management were keen for one of their employees to conduct this research at their facility.

3.3 Study Sample

The study sample comprised 495 division 1 registered nurses (RNs), who are employed fulltime or part time at the study hospital. Casual pool or agency RNs were excluded from this study, as they are not consistently employed in one specialty. The sample included RNs working in surgical, medical, palliative, psychiatric, peri-operative, critical care and psychiatric specialties as well as nursing management. Because only a few nurses are employed in some specialties, data from these specialty areas were combined prior to data analysis, i.e. palliative care with oncology and cardiac care with intensive care.

3.4 Design

A quantitative, exploratory descriptive design was used for this study. Questionnaires were distributed to participants (see section 3.5 Data Collection Instrument). Descriptive research is used to describe and discover what is happening in an environment to produce new information where a small number or no studies have been conducted (Burns & Grove, 2001). The questionnaire included a section for comment giving the RNs

opportunity to make further remarks if they chose. The aim was to analyse this data for common themes and ideas, and to enhance the quantitative findings.

3.5 Data Collection Instrument

In order to collect data for this study a self-administered survey was distributed to study participants. The survey was based on the *"Emerging Workforce Preferences Survey"* (Appendix B). Permission to use and modify the survey was given by the primary investigator and author Dr K. Lynn Wieck (Appendix C). This tool was originally developed by her in three stages using 56 descriptors broken down into four areas: intrinsic qualities, acquired skills, attitudes and personal characteristics. The final phase of the survey was tested in the United States on five groups of emerging workforce nurses. These groups were a community college junior class and senior class, a university junior and senior class, and a national meeting of nursing students. The differences between the rankings of these samples were tested. A nonparametric Kruskall-Wallis analysis identified differences in three characteristics: "non-judgmental" ($\chi^2 = 13.5$, df = 4, $p = .009$), "empowering" ($\chi^2 = 18.9$, df = 4, $p = .001$), and "advocate" ($\chi^2 = 17.4$, df = 4, $p = .002$). None of these characteristics were in the top ten in any of the four groups of descriptors. There were no significant differences in the other 53 descriptors among the five groups tested. This confirms that the instrument measured reliably amongst different areas of the target population. A copy of measures of reliability and validity coefficients for this instrument is attached (Appendix D).

Dr Wieck in a personal communication (Appendix C) has commented that the instrument has been used successfully even when the occupational role (managers, educators, or leaders) changed. She has also found this instrument provided excellent general information about how to make the hospital environment more "user friendly" and this has helped nurse managers in managing an intergenerational work place.

3.6 Questionnaire Modifications

The questionnaire was modified for this study and for the Australian context. Section one of the questionnaire provides demographic information, which are the independent variables for this study; and section two explores the dependent variables. A

copy of the modified demographic section of the questionnaire can be found in Appendix E. Permission was been given by Dr K. Lynne Wieck to modify the proposed questionnaire (Appendix C) and the minor modifications in this survey were:

Section one demographics

- Tick boxes were used to make the questionnaire easier and quicker to complete:
- Question 3 has been included to determine whether the respondent is already in a position of leadership:
- Question 4 was changed to identify the type of nursing education received by the respondent:
- Question 5 has been included to determine the registered nurse's specialty.

Section two

The third question in the original questionnaire asks respondents to put a cross over the least desired trait. This was omitted after personal communication, on the 04/06/2007, from Dr Wieck who suggested omitting this question as she had "used it for information only in her study, and that the results were interesting but not essential to developing effective managers." See Appendix E for a copy of the modified Section Two of the questionnaire.

Section three

This section was included to give the participants opportunity to make qualitative comments relevant to the research questions.

3.7 Reliability and Validity

Dr Wieck measured the instrument's reliability and validity in a number of different contexts and populations (Appendix C). For this study, Wieck's original estimations of the reliability and validity co-efficients cannot hold true because: the questionnaire has been modified; different research questions were asked; and the questionnaire was used in a different culture and nursing population.

Pilot study

A small pilot study was conducted using nursing leaders to complete the modified questionnaire. The leadership group was asked to comment on the questionnaire. Their feed back was used to refine the questionnaire and methodology. As a result, question three was modified to clarify nursing Level in section one and an example of how to rank traits was included at the beginning of section two of the questionnaire.

3.8 Procedure and Data Collection

After the study was approved by ECU's Faculty of Computing, Health and Science Ethic's Sub-Committee, a formal letter of introduction (Appendix G) with a copy of the proposal was sent to the Director of Clinical Services (DCS) at the study hospital, requesting written permission for this study to take place there. The letter requested written permission for an introductory letter, questionnaire and pre-addressed envelope to be stapled to each registered nurse's pay slip. During a preliminary meeting with the DCS, she advised the researcher it would not be necessary for the proposal to be sent to the study hospital's Ethics Committee, as she was responsible for approving this study to be done using RNs from the study hospital.

After the proposal was approved by the Faculty of Computing, Health and Science Ethics sub-committee and the DCS, a letter of introduction (Appendix H) was hand delivered by the researcher to each of the nurse managers at the hospital with a copy of the proposal. The study's aims, purposes and method were explained to each of them and any queries they had about the study were answered. In the introductory letter and during the face-to-face meeting, the managers were assured that the purpose of the study was not to evaluate their particular leadership style or the management of their ward, but to find out what the RNs want from CNs in terms of their leadership.

3.9 Data Integrity

The RNs were asked not to discuss their responses with one another to maintain the data's integrity. It was, however, not possible to prevent the nurses from discussing the study.

3.10 Distribution of the Questionnaires

Written permission was given by the DCS (Appendix I) to attach the questionnaires and pre-addressed envelopes to the RNs' pay slips. A total of 403 questionnaires were distributed to the RNs. At the time of data collection, 495 RNs were employed at the study hospital, those on maternity leave and holidays were excluded from the study because they did not have pay slips for the attachment of questionnaires. The RNs were asked to return the completed questionnaires in the pre-addressed envelopes, sealed, to the researcher care of the Human Resources (HR) Department in the internal mail. The DCS gave permission for HR personnel to store the envelopes in a locked box in the department. The collection box was secured with numbered cable ties. The internal mail is collected at least three times a day; and the collection of questionnaires was over a two-week period.

3.11 Data Analysis

The Statistical Package for Social Sciences (SPSS) 15.0 data analysis package was used to organise, analyse and collect data. All data were coded numerically. Descriptive statistics (mean, mode, median, range and standard deviation) were used to describe, organise and summarise the raw data (Polit, Beck, & Hungler, 2001) by: years as a RN, RN Level, type of nursing education and specialty. The ordinal data from each of the clusters of traits, were entered and analysed together, and then the data were cross-tabulated to determine any group variations (specialty in nursing, type of nurse education, years of nursing experience and RN Level), and the traits (dependent variables) that RNs believe to be important leadership attributes exhibited in their CNs. Multiple response sets were used to analyse the multiple independent groups categorised in this study: years as RN, RN level, specialty and education.

Qualitative comments made by the RNs were analysed for recurrent themes using qualitative content analysis. The analysis was reviewed by the supervisor of this study to aid the elimination of bias.

3.12 Limitations

Firstly, one private hospital was utilised to provide the study sample thereby preventing generalisation of the findings. Further research should include public and private hospitals. Secondly, the data collection instrument had not been tested before in the

Australian context. Thirdly, responses to the questionnaire could have been influenced by discussion between RNs on the ward although this could be positive in that discussions may have promote further thought about the characteristics of good leadership in a CN. Finally, because of the small number of RNs in the study, some of the data was collapsed to prevent any Nurse Managers in the hospital surveyed feeling that they or their ward have been singled out.

3.13 Ethical Considerations

Ethical approval for this proposal was given by the Faculty of Computing, Health and Science Ethics Sub-Committee at ECU. At a preliminary meeting with the study hospital DCS, the DCS advised that ethical approval from the hospital would not be necessary as the RNs there are employed by the hospital and approval for the research to take place was a HR decision to be decided by the DCS.

An information letter to potential study participants, (see Appendix F), was attached to the questionnaire introducing the author of the study, the reasons why this research was being conducted, and what the participants were asked to do. The letter stated that participation was voluntary and that completion and submission of the questionnaire was considered consent for their participation in this study.

To ensure the respondents' anonymity and their right to confidentiality participants were asked not to put any identifying marks on the questionnaires. The plastic box used to collect the questionnaires in the Human Resources' department had slits big enough to take the envelopes with the completed questionnaires and was sealed with numbered cable ties. The researcher opened the box and the cable tie numbers were checked as correct.

The data collected from this study was entered on the researcher's laptop computer, which is only accessed by the researcher, supervisor and statistician. During the study, data were kept in a locked cupboard at the researcher's home. The completed questionnaires and all other study documents, including computer discs, were be kept in a locked cabinet at ECU School of Nursing, Midwifery and Post Graduate Medicine for 5 years after thesis submission and then shredded. On completion of the study all data will be deleted from the hard drive of the researcher's computer and USB.

Chapter 4 Results

4.1 Introduction

This chapter presents the research findings for this study by analysing the data. The purpose of this study is to identify, from the RNs' perspective, the leadership characteristics of CNs which they consider most important in facilitating their nursing practice, using the four research questions below.

1) What leadership characteristics do RNs perceive as important in their CNs?
2) Do RNs in different specialties of nursing perceive differing leadership characteristics in their CNs as important?
3) Is an RN's type of nursing education or years of experience since qualification, associated with differences in the characteristics perceived as important in CNs?
4) Are there differences between Level 1 and Level 2 or higher RNs' perceptions of important leadership characteristics in a CN?

Firstly, the participants' demographic characteristics are described. Then the preferred characteristics chosen by the respondents will be identified in each of the four clusters of traits (attitudes, intrinsic qualities, acquired skills and personal attributes). Initially, the data were analysed as a whole, then as a between groups' analysis of the preferred traits within the following independent variables: years as a RN, nursing Level of responsibility, type of nursing education and nursing specialty. Following the quantitative analysis the analysis of the qualitative data is described.

The respondents, were asked to select the three most important traits they considered a clinical nurse (CN) should demonstrate from a list of four clusters of attributes (attitudes, intrinsic qualities, acquired skills and personal attributes), and then rank these in order of importance with one being most important and three the least important. The first preferences were collated using the Statistical Package for Social Sciences (SPSS) 15.0. On the advice of a statistician, the three most preferred traits in each cluster were combined to increase the number of responses in each cell and non-parametric tests were unable to be performed because of the small cell sizes. Respondents were asked to indicate their age range but, upon initial analysis, years of experience were considered a more valid measure and so age range data was not included in the analysis. Of the 403 questionnaires

distributed to the RNs, 120 were returned, giving a 30% response rate. Five questionnaires were excluded from the analysis because they were not completed correctly. One of these questionnaires had comments suitable for qualitative analysis and this data has been considered later in this chapter. In summary, one hundred and fifteen questionnaires were used for the quantitative statistical analysis which is 28.5% of the total number of distributed questionnaires.

4.2 Demographic Data of the Respondents

4.2.1 Age of respondents

The demographic data was collated and Figure 4.1 shows that the age of respondents was evenly distributed with two exceptions: the age range of 27 to 30 years and over the age of 60. The mean age of respondents was 42.38 years, this being 2.6 years less than the Australian RNs' mean age of 45 years (Australian Institute of Health and Welfare, 2006). The respondents' ages ranged from 22 to 69 years of age (range = 47 years). The median age was 42 years which is close to the mean of 42.38 years. The standard deviation for this data is 12.032 years which indicates the majority of the respondents were between the ages of 30 and 54 years of age. Two respondents did not answer this question.

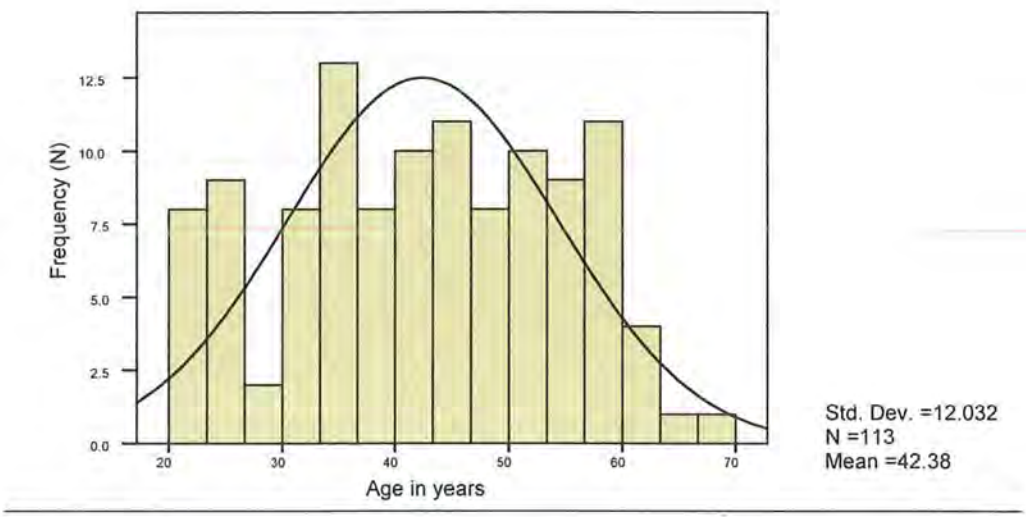

Figure 4.1. Age of respondents

4.2.2 Years as a RN

Respondents were asked how many years they had been a registered nurse. Table 4.1 shows that almost sixty three percent (62.6%) of respondents had been a RN for ten years or more. Another, 34.7% had between 0-10 years of experience as a registered nurse. Fifteen (13%) of this cohort had been a registered nurse for less than two years. Three respondents did not answer this question.

Table 4.1 *Years as a RN*

		Frequency	Percent
Valid	0-2 yrs	15	13.0
	2-5 yrs	12	10.4
	5-10 yrs	13	11.3
	10-25 yrs	37	32.2
	> 25 yrs	35	30.4
	Total	112	97.4
Missing	System	3	2.6
	Total	115	100.0

4.2.3 Nursing Level

In the study setting a Level 2 or higher RN is classified as a Clinical Nurse (CN). The participants were asked to identify their level of seniority and position. Figure 4.2 shows the majority of the cohort was Level 1 RNs (66%). The remainder were Level 2 or higher (33%). However, the latter category included those RNs who worked both as a Level 1 and Level 2 RN. Since their substantive positions were Level 2 they were included in this category. Consequently just over a third of the respondents were level 2 or higher RNs and thus, according to their job description, CNs and functioning in a leadership capacity.

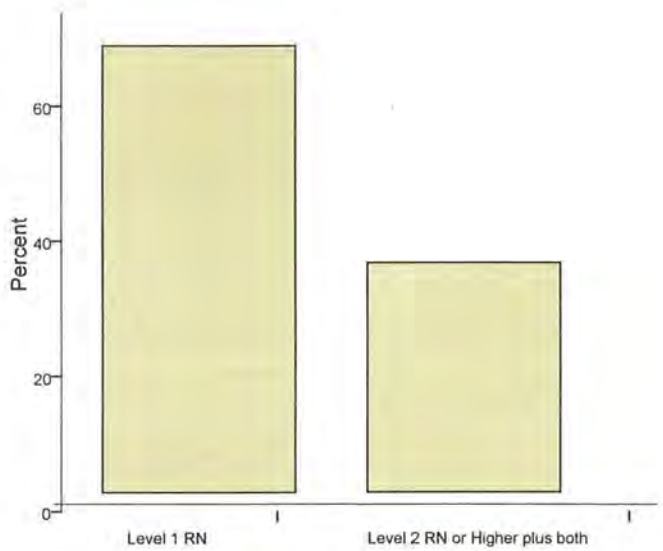

Figure 4.2 Nursing level of responsibility

4.2.4 Type of nursing education

The participants were asked how they achieved their nursing qualification. Figure 4.3 shows that 40% (n = 46) of the respondents received their initial registered nursing qualification in a university and the remaining 60% (n = 69) received their initial registered nursing qualification through a hospital-based diploma. Of these, 30% (n = 31) converted their hospital-based diploma to a university degree. Hence 70% of respondents had a university degree.

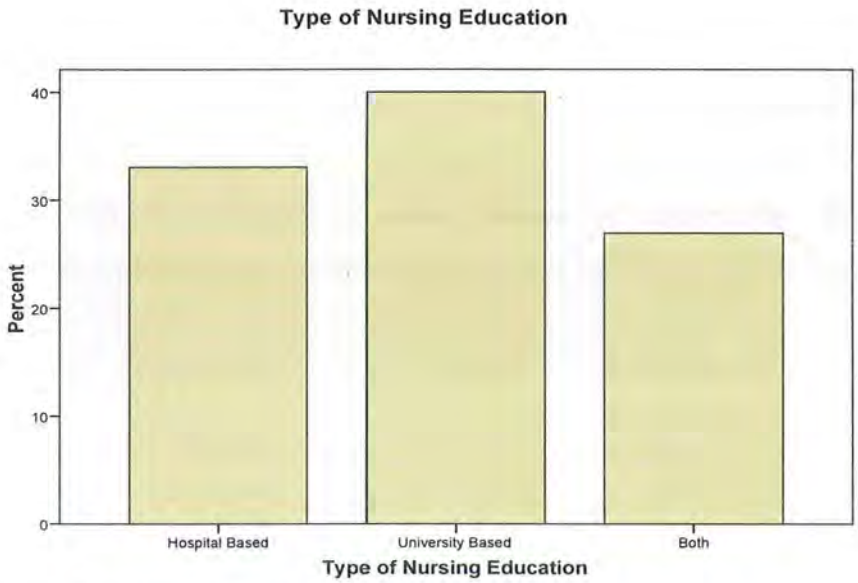

Figure 4.3 Type of nursing education.

4.2.5 Nursing specialty

The participants identified their nursing specialty. Because of the small number of responses received from palliative care nurses ($n = 4$) and procedural nurses ($n = 5$), the responses of; palliative care nurses were included with the data from nurses who worked in medical wards, and nurses from the procedural department were included with the data of nurses who worked in the peri-operative specialty.

Table 4.2 illustrates that over a third of the respondents were employed on medical wards, with a quarter of respondents employed on surgical wards and one fifth in the peri-operative field. The percentage of RNs in each specialty is reflective of the distribution of RNs in each specialty at the hospital where the investigation was conducted (as per personal communication with the study hospital Clinical Services Co-ordinator).

Table 4.2 *No of Respondents from each specialty*

Specialty	%	n
Medical	34	39
Surgical	24	27
Perioperative	19	22
Critical Care	10	12
Nursing Management	7	8
Psychiatry	6	7
Total	100	115

4.3 Analysis of the four trait clusters

This section presents the results of the four clusters of traits which the participants were asked to rank in order to answer research questions one, two, three, and four.

4.3.1 Cluster 1: Attitudes

4.3.1.1 Introduction

In order to answer the research questions the respondents were asked to select the three most preferred attitudes they would like their CNs to possess. This cluster had fifteen different attitudes for the respondents to select from. The three most preferred traits selected by the participants as a whole were identified first and then a between groups analysis was performed and examined according to; years as a RN, nursing Level, type of nursing education and nursing specialty in which they worked. All 115 respondents completed this part of the questionnaire, however two did not identify their age and three did not complete the question about how many years they had been a RN.

4.3.1.2 Attitude: Cohort

The data were analysed by combining the first three preferences of the cohort. Table 4.3 shows that *approachable* and *supportive* were the most desired attitudes for a CN to have with *approachable* receiving 21.7% ($n = 75$) and *supportive* receiving 21.2% ($n = 73$) of all preferences. The trait of *calm* received 8.1% ($n = 28$) of combined preferences followed by the attitudes of *respectful of subordinates* and a *positive attitude* both with 7.8% ($n = 27$). The other 10 attitudinal traits received 7% or fewer preferences.

Table 4.3 *Preferred Attitudes: All Respondents*

Attitude Traits	Responses N	Percent
Caring	18	5.2%
Co-operative	7	2.0%
Inspirational	18	5.2%
Flexible	8	2.3%
Optimistic	4	1.2%
Cheerful	4	1.2%
Personable	5	1.4%
Reasonable	8	2.3%
Supportive	**73**	**21.2%**
Respectful of subordinates	**27**	**7.8%**
Hard work ethic	19	5.5%
Fair	24	7.0%
Approachable	**75**	**21.7%**
Positive attitude	**27**	**7.8%**
Calm	**28**	**8.1%**
Total	345	100.0%

4.3.1.3 Attitude: Years as RN

A between groups' analysis was performed to determine if years of experience as a RN affected the attitudinal traits preferred in a CN. The 15 attitudinal traits were analysed according to years as a RN. Table 4.4 displays the similarities and differences between RNs with differing years of experience and their preferred attitudes. As before, all groups ranked *approachable* and *supportive* as their most preferred attitudes. Table 4.4 demonstrates that with few exceptions years of experience did not affect the RNs preferred leadership characteristics – *approachable* and *supportive* were the dominant traits identified by each group of nurses.

As would be expected, there were slight variations in that some groups identified different traits they considered important. Others chose the same traits but ranked them differently. Table 4.4 shows for example, that those RNs who had been nursing for between 0-2 years (33%, n =5) and 2-5 years (42%, n = 5) identified *calmness* as their third preferred attitude although they still wanted their CNs to be *approachable* (93%, n = 14) and *supportive* (80%, n = 12). The 35 RNs who had been nursing for over 25 years cited *approachable* (69%, n = 24) as their most preferred trait followed by *supportive* (54%, n = 19). However, in contrast to their less experienced colleagues they ranked *respectful of subordinates* as their third most preferred trait with 40% (n = 14) of preferences. This was followed by *caring* (31%, n = 11), *hard work ethic* (23%, n = 8) and *calm* (20%, n = 7).

Table 4.4 *Attitude: Years as a RN*

Years as a RN	Attitude Traits	Caring	Co-operative	Inspirational	Flexible	Optimistic	Cheerful	Personable	Reasonable	Supportive	Respectful of subordinates	Hard work ethic	Fair	Approachable	Positive attitude	Calm	Total Respondents
0-2 yrs	N	1	1	2	0	1	0	2	2	12	2	0	2	14	1	5	15
	%	7	7	13	0	7	0	13	13	**80**	13	0	13	**93**	7	**33**	
2-5 yrs	N	3	0	2	2	0	1	1	1	8	0	2	2	6	3	5	12
	%	25	0	17	17	0	8	8	8	**67**	0	17	17	**50**	25	**42**	
5-10 yrs	N	1	0	2	0	0	3	0	1	10	2	1	3	8	5	3	13
	%	8	0	15	0	0	23	0	8	**77**	15	8	23	**62**	38	23	
10-25 yrs	N	2	4	8	4	1	0	0	3	24	8	6	12	22	10	7	37
	%	5	11	22	11	3	0	0	8	**65**	22	16	32	**59**	**27**	19	
> 25 yrs	N	11	2	4	2	1	0	2	1	19	14	8	4	24	6	7	35
	%	**31**	6	11	6	3	0	6	3	**54**	**40**	**23**	11	**69**	17	**20**	
Total	N	18	7	18	8	3	4	5	8	73	26	17	23	74	25	27	112

N.B. Percentages and totals are based on responses.

4.3.1.4 Attitude: Nursing Level

Table 4.5 confirms that with only slight differences the nurses' level of seniority and position did not change the rankings or the selection of preferred traits – so that *supportive* and/or *approachable* were still the most desired attitudinal traits for a CN to possess after combining the three most preferred attitudinal traits for both Level 1 and Level 2 or higher RNs. Table 4.5 also illustrates that the attitudes of *respectful to subordinates* and *calmness* were next most important to Level 1 RNs. However, for Level 2 or higher RNs the spread of preferences was greater with *inspirational* and *positive* attitudes being the next most preferred attitudinal traits. In addition Level Two nurses ranked *hard work ethic* (23%) and *calm* (23%, $n = 9$) highly.

Table 4.5 *Attitude Nursing Level*

Nursing Level	Attitude Traits	Caring	Co-operative	Inspirational	Flexible	Optimistic	Cheerful	Personable	Reasonable	Supportive	Respectful of subordinates	Hard work ethic	Fair	Approachable	Positive attitude	Calm	Total
Level 1 RN	n	12	4	8	5	1	4	3	7	51	19	10	16	52	17	19	76
	%	16	5	11	7	1	5	4	9	**67**	**25**	13	21	**68**	22	**25**	
Level 2 RN or higher, and both	n	6	3	10	3	3	0	2	1	22	8	9	8	23	10	9	39
	%	15	8	**26**	8	8	0	5	3	**56**	21	**23**	21	**59**	**26**	**23**	
Total	n	18	7	18	8	4	4	5	8	73	27	19	24	75	27	28	115

Percentages and totals are based on responses.

4.3.1.5 Attitude: Type of nursing education

The respondents were asked to identify which path of education they used for their registered nursing qualification. The between groups analysis found once again that *approachable* and *supportive* were the most preferred attitudinal traits, although there were slight differences in rankings.

Table: 4.6 shows that irrespective of the level of nursing education the respondents received, they tended to select the same three preferred traits. The three groups ranked either *approachable* or *supportive* as the preferred attributes they wanted their CNs to possess. Of note is that unlike their university educated colleagues 34% of RNs educated

via a hospital-based diploma ranked *respectful of subordinates* as an important CN attitude followed by *caring* (29%).

Nurses who had converted their hospital-based diploma to a nursing degree chose *approachable* and *supportive* as the most desired traits in a CN but 26% ranked *respect of subordinates* as important. While university educated RNs also ranked *supportive* (76%, $n = 35$) first with *approachable* (67%, $n = 31$) second, they ranked *calm* (35%, $n = 16$) and having a *positive attitude* (26%, $n = 12$) highly.

Table 4.6 *Attitude Type of Education*

Type of education	Attitude Traits	Caring	Co-operative	Inspirational	Flexible	Optimistic	Cheerful	Personable	Reasonable	Supportive	Respectful of subordinates	Hard work ethic	Fair	Approachable	Positive attitude	Calm	Total
Hospital educated	n	11	2	5	4	1	0	1	3	20	13	9	9	21	9	6	38
	%	**29**	5	13	11	3	0	3	8	**53**	**34**	24	24	**55**	24	16	
University educated	n	3	3	7	3	1	4	3	2	35	6	4	8	31	12	16	46
	%	7	7	15	7	2	9	7	4	**76**	13	9	17	**67**	**26**	**35**	
Both	n	4	2	6	1	2	0	1	3	18	8	6	7	23	6	6	31
	%	13	6	19	3	6	0	3	10	**58**	**26**	19	23	**74**	19	19	
Total	n	18	7	18	8	4	4	5	8	73	27	19	24	75	27	28	115

Percentages and totals are based on responses.

Nonetheless these findings need to be treated somewhat with caution because of the differences in cell sizes. Table 4.7 shows the four most preferred attitudes for each group. It is beyond the remit of this study to conduct a more in depth study about why the nurses who were educated via hospital-based diplomas (even though some had later converted their diploma to a university award) ranked *respectful of subordinates* so highly but these issues are considered in more detail in the next chapter. It is noteworthy that university educated nurses (who tend to be younger and less experienced) wanted their CNs to be *calm* and to have a *positive attitude*.

Table 4.7 *Ranking of preferred attitudes*

Type of education	1st Attitude	2nd Attitude	3rd Attitude	4th Attitude
Hospital	Approachable	Supportive	Respectful of subordinates	Caring
University	Supportive	Approachable	Calm	Positive attitude
Both	Approachable	Supportive	Respectful of subordinates	Fair

4.3.1.6 Attitude: Nursing specialty

Nursing specialty makes little difference to the way nurses ranked the most preferred attitudinal traits for their CNs. *Supportive* and *approachable* were still the most preferred attitudinal traits as illustrated in Table 4.8. Nurses working in different specialties ranked the traits slightly differently. This may be an artefact of the study and the sample and cell sizes but these differences may also be because of different working work environments as well as the nature of the speciality. For example nurses in the surgical wards ranked *calm* as their third most desired CN attitude while those RNs in the medical wards had *positive attitude* third with *calm* next. However, nurses in the critical care areas, like those in the medical wards, selected *positive attitude* (42%, $n = 5$) as their third most preferred CN attitude with both *inspirational* and *respectful of subordinates* polling 25% ($n = 3$) as fourth most preferred CN attitudes. Those RNs who worked within the peri-operative field placed importance on the traits of *respect of subordinates* and *fair* as equal third, 36% ($n = 8$), preferred attitudinal traits. The RNs who worked within the psychiatric specialty gave both the attitudinal traits of *approachable* and *fair* second most preferences. As the cell size for this group is so small, $n = 7$, these findings would need further research to establish their validity. In contrast to the other specialties nurse managers' preferred attitudinal traits were *inspirational, supportive, hard work ethic, fair, and approachable* equal preference as first traits with 38% ($n = 3$). However, these results would also need to be examined with caution as there were only eight respondents in the nurse manager group.

Table 4.8 *Nursing Speciality: Attitude*

Specialty	Attitude Traits	Caring	Co-operative	Inspirational	Flexible	Optimistic	Cheerful	Personable	Reasonable	Supportive	Respectful of subordinates	Hard work ethic	Fair	Approachable	Positive attitude	Calm	Total
Medical	N	8	5	5	2	1	3	1	1	26	7	6	3	27	12	10	39
	%	21	13	13	5	3	8	3	3	**67**	18	15	8	**69**	**31**	**26**	
Surgical	N	4	1	2	3	0	0	3	4	19	5	2	5	22	4	7	27
	%	15	4	7	11	0	0	11	15	**70**	19	7	19	**81**	15	**26**	
Critical Care	N	2	0	3	2	0	0	0	0	8	3	1	2	8	5	2	12
	%	17	0	**25**	17	0	0	0	0	**67**	**25**	8	17	**67**	**42**	17	
Peri Operative	N	2	0	4	1	1	1	0	3	12	8	6	8	12	4	4	22
	%	9	0	18	5	5	5	0	14	**55**	**36**	27	**36**	**55**	18	18	
Psychiatry	N	0	1	1	0	0	0	0	0	5	2	1	3	3	2	3	7
	%	0	14	14	0	0	0	0	0	**71**	29	14	**43**	**43**	29	**43**	
Nursing Management	N	2	0	3	0	2	0	1	0	3	2	3	3	3	0	2	8
	%	25	0	**38**	0	25	0	13	0	**38**	25	**38**	**38**	**38**	0	25	
Total		18	7	18	8	4	4	5	8	73	27	19	24	75	27	28	115

Percentages and totals are based on responses

4.3.2 Cluster 2: Intrinsic Qualities

4.3.2.1. Introduction

In order to answer the research questions the respondents were asked to select the three most preferred intrinsic qualities they would like their CNs to possess. This cluster had 16 intrinsic qualities, for the respondents to choose from. The three most preferred intrinsic qualities from the respondents were analysed as a group and then as a between groups' analysis to identify preferred traits according to the variables: years as a RN; nursing Level; type of nursing education and nursing specialty. One respondent did not rank this cluster of traits making a total of 114 respondents in this section. Two respondents did not provide their age and three did not give their years as a RN, resulting in missing data in those groups.

4.3.2.2 Intrinsic Quality: All respondents

After combining the three most preferred intrinsic qualities, *understanding* (12.6%, $n = 43$) was the most preferred intrinsic quality for the cohort with *motivated* (12.3%, $n = 42$) next. These were followed by the intrinsic qualities of *integrity* (11.1%, $n = 38$), and then, *dependable* with 10.5% ($n = 36$) preferences. *Dignified, creative, strong willed*, and *loyal* were the least popular intrinsic qualities with responses of 0.9%, 1.2%, 0.6%, and 0.9% respectively. These results are shown in Table 4.9.

Table 4.9 Intrinsic Qualities: All Respondents

Intrinsic Qualities	N	Percent
Dependable	**36**	**10.5%**
Dedicated	20	5.8%
Trustworthy	14	4.1%
Reliable	33	9.6%
Dignified	3	.9%
Detail Orientated	11	3.2%
Non-Judgemental	29	8.5%
Creative	4	1.2%
Strong Willed	2	.6%
Loyal	3	.9%
Understanding	**43**	**12.6%**
Intelligent	34	9.9%
Motivated	**42**	**12.3%**
Wise	14	4.1%
Integrity	**38**	**11.1%**
Honest	16	4.7%
Total	342	100.0%

4.3.2.3 Intrinsic Quality: Years as RN

A between groups' analysis was conducted to determine if years of experience as a RN affected the intrinsic qualities preferred in a CN. Once the 16 intrinsic qualities were analysed according to years of experience as a RN, the data, as displayed in Table 4.10, showed that while the 0-2 years of nursing experience group of RNs ranked *understanding* (80%) as their most preferred intrinsic quality, the slightly more experienced nurses in the 2-5 year group put *reliable* as their most preferred CN intrinsic quality although a third ranked *understanding* highly. Furthermore, the 5-10 year group's most preferred intrinsic qualities for a CN were both *dependable* and *understanding*, while the intrinsic quality of *motivated* polled most preferences for those RNs with 10-25 years of experience. Finally, those who had been RNs for >25 years ranked *integrity* as their most preferred intrinsic quality.

The between group analysis showed other differences in the three most preferred traits according to years of experience. For example, 80% ($n = 12$) of RNs with 0-2 years experience put *understanding* as their most preferred intrinsic quality, followed by *reliable* (47%, $n = 7$). *Motivated* and *honest* shared equal third preferences with 33% ($n = 5$) followed by *dependable* and *integrity* equal fourth with 27% ($n = 4$). In contrast RNs with 2-5 years experience gave the intrinsic quality of *reliability* most preferences, 50% ($n = 6$), followed by *dedicated, non-judgmental, understanding, intelligent and motivated* with 33% ($n = 4$) responses each, and then, *integrity* receiving 25% ($n = 3$). However, as there are such a small number of respondents in the latter group trends from the data needed to be validated by further research.

The RNs with 5-10 years experience equally preferred the intrinsic qualities of *understanding* and *dependable* with 46% ($n = 6$) of preferences. *Non-Judgemental* was the next most preferred for this group with 38% ($n = 5$) followed by the intrinsic qualities of intelligent, motivated and integrity, all with 31% ($n = 4$).

Those RNs with 10-25 years experience had *motivated* (46%, $n = 17$) as their most preferred CN intrinsic quality. This was followed by *integrity* (38%, $n = 14$), *dependable* (35%, $n = 13$), *understanding* (32%, $n = 12$) and, finally, *non-judgmental* and *intelligent*

both with 30% (n = 11). The most preferred intrinsic quality for RNs who had >25 years experience was *integrity* with 34% (n = 12) of preferences, followed by *dependable, reliable, intelligent* and *motivated* all with 31% (n = 11) of responses each. The next ranked CN intrinsic qualities for this group were *understanding* (26%, n = 9), *trustworthy* (23%, n = 8), *dedicated, non-judgmental*, and *wise* each with 20% (n = 7).

Table 4.10 Intrinsic Quality: Years as a RN

Years as a RN	Intrinsic Quality Traits	Dependable	Dedicated	Trustworthy	Reliable	Dignified	Detail Orientated	Non-Judgmental	Creative	Loyal	Understanding	Intelligent	Motivated	Wise	Integrity	Honest	Total
0-2 yrs	N	4	2	0	7	0	2	2	0	0	12	2	5	0	4	5	15
	%	**27**	13	0	**47**	0	13	13	0	0	**80**	13	**33**	0	**27**	**33**	
2-5 yrs	N	2	4	0	6	0	1	4	0	1	4	4	4	2	3	1	12
	%	17	**33**	0	**50**	0	8	**33**	0	8	**33**	**33**	**33**	17	**25**	8	
5-10 yrs	N	6	2	0	3	0	2	5	0	1	6	4	4	0	4	2	13
	%	**46**	15	0	**23**	0	15	**38**	0	8	**46**	**31**	**31**	0	**31**	15	
10-25 yrs	N	13	5	5	5	1	4	11	2	1	12	11	17	5	14	4	37
	%	**35**	14	14	14	3	11	**30**	5	3	**32**	**30**	**46**	14	**38**	11	
> 25 yrs	N	11	7	8	11	2	2	7	2	0	9	11	11	7	12	4	35
	%	**31**	**20**	**23**	31	6	6	**20**	6	0	**26**	**31**	**31**	**20**	**34**	11	
Total	N	36	20	13	32	3	11	29	4	3	43	32	41	14	37	16	112

Percentages and totals are based on responses

4.3.2.4 Intrinsic Quality: Nursing level

When the most preferred CN intrinsic qualities were combined according to seniority Level 1 RNs gave the trait of *understanding* the most preferences but the Level 2 or higher RNs gave most preferences to *dependable* with *integrity* next. These findings are illustrated in Table 4.11. Given that Level 2 nurses are expected to manage patient staff ratios for their shifts it is not surprising that they ranked *dependable* highly.

Level 1 RNs, the least experienced and usually younger nurses without responsibility for ward management and staffing placed *understanding* with 43% (n = 32) of preferences first, followed by *motivated* with 36% (n = 27). These were followed by the intrinsic qualities of *reliable, nonjudgmental, intelligent* and *integrity* polled 29% (n = 22) of preferences with *dependable* receiving 25% (n = 19) and *dedicated* 20% (n = 15).

As has already been explained and probably reflecting their 'job description' and responsibilities Level 2 or higher RNs positioned the CN intrinsic quality of *dependable* (44%, $n = 17$) first with *integrity* (41%, $n = 16$) next. The trait *motivated* received 38% ($n = 15$) with *intelligent* 31% ($n = 12$), and both *reliable* and *understanding* 28% ($n = 11$) of preferences.

Table 4.11 *Intrinsic Qualities Level 1 and 2 or higher RNs*

Nursing Level	Intrinsic Quality Traits	Dependable	Dedicated	Trustworthy	Reliable	Dignified	Detail Orientated	Non-Judgmental	Creative	Strong willed	Loyal	Understanding	Intelligent	Motivated	Wise	Integrity	Honest	Total
Level 1 RN	n	19	15	8	22	2	7	22	2	0	3	32	22	27	9	22	13	75
	%	**25**	**20**	11	**29**	3	9	**29**	3	0	4	**43**	**29**	**36**	12	**29**	17	
Level 2 RN or Higher plus both	n	17	5	6	11	1	4	7	2	2	0	11	12	15	5	16	3	39
	%	**44**	13	15	**28**	3	10	18	5	5	0	**28**	**31**	**38**	**13**	**41**	8	
Total	n	36	20	14	33	3	11	29	4	2	3	43	34	42	14	38	16	114

Percentages and totals are based on responses.

4.3.2.5 Intrinsic Quality: Type of nursing education

After identifying the type of nursing qualifications the respondents had attained a between groups' analysis was performed to see if there were any differences between the type of qualification the nurses possessed and their preferred traits. Nurses with a hospital-based diploma gave most preferences equally to the intrinsic qualities of *motivated* and *integrity*. In contrast nurses educated initially at university wanted their CNs most to posses the intrinsic quality of *understanding*. Like their peers with a nursing diploma RNs educated first with a hospital-based diploma and then later at university gave the intrinsic quality of *motivated* most preferences. Of note is that on the whole nurses educated via hospital-based diplomas tend to be older and to have more years of experience than their colleagues who have been educated only at University. Further details of the rankings of intrinsic qualities polled are described below and illustrated in Table 4.12.

Hospital diploma educated RNs gave each of the intrinsic qualities *integrity* and *motivated* 39% ($n = 15$) of preferences, with *dependable* polling 37% ($n = 14$) closely

behind. *Understanding* (34%, $n = 13$) was the next most preferred intrinsic quality, for a CN to have, in this group. University educated RNs placed *understanding* (43%, $n = 20$) as their most preferred CN intrinsic quality with *reliable* and *intelligent* next, both with 37% ($n = 17$) of preferences. *Dependable* (30%, $n = 14$) was the next most preferred CN intrinsic quality trait for this group. RNs educated at both hospital and university placed *motivated*, with 47% ($n = 14$) of preferences, as their favourite CN intrinsic quality with *understanding* and *integrity* next, both with 33% ($n = 10$) preferences. The nurses educated only at university were the only respondents to rank *intelligent* as a preferred characteristic. Cell sizes are too small to make definitive conclusions about this finding and further research will need to be conducted to determine why this group rank this attribute so highly.

Table 4.12 *Intrinsic Quality: Type of nursing education*

Type of nursing education	Intrinsic Qualities	Dependable	Dedicated	Trustworthy	Reliable	Dignified	Detail Orientated	Non-Judgmental	Creative	Strong willed	Loyal	Understanding	Intelligent	Motivated	Wise	Integrity	Honest	Total
Hospital educated	n	14	7	8	8	2	1	10	1	0	0	13	9	15	6	15	5	38
	%	**37**	18	21	21	5	3	26	3	0	0	**34**	24	**39**	16	**39**	13	
University educated	n	14	7	1	17	1	6	13	1	0	2	20	17	13	4	13	9	46
	%	**30**	15	2	**37**	2	13	28	2	0	4	**43**	**37**	28	9	28	**20**	
Both	n	8	6	5	8	0	4	6	2	2	1	10	8	14	4	10	2	30
	%	27	20	17	27	0	13	20	7	7	3	**33**	27	**47**	13	**33**	7	
Total	n	36	20	14	33	3	11	29	4	2	3	43	34	42	14	38	16	114

Proportions and totals are based on responses.

4.3.2.6 Intrinsic Quality: Nursing specialty

The between groups' analysis showed some differences in the rankings as well as the selected traits between groups divided according to nursing speciality and these differences are described in this section. Table 4.13 demonstrates these rankings. The intrinsic quality of *understanding* was the most preferred trait for RNs who worked in medical and surgical wards. The RNs who worked in critical care and possibly because of the nature of their work gave equal highest preferences to the intrinsic qualities of *non-judgemental, intelligent* and *integrity*. In contrast those RNs who work in the peri-operative specialty wanted their CNs to posses the intrinsic quality of *motivated* with RNs who work

in nursing management most preferring the intrinsic quality of *intelligence*. The intrinsic qualities of *reliable* and *honest* were the most preferred CNs traits for RNs who are employed within the field of psychiatry. It is not possible to determine if these differences are because of the nature of the work in these specialties, because of traits of those who choose to work in the areas or perhaps differences in the ages and experiences of the nurses working in particular specialties. Despite these confounding factors further analysis of these rankings is described in more detail below.

As shown in Table 14.13 the most preferred intrinsic qualities preferred by RNs who worked in medical wards was the intrinsic quality of *understanding*, 44% (n = 17), with *dependable* and *reliable* polling the second most preferences, each with 36% (n = 14). As did their peers working in medical wards the RNs who were employed in surgical wards also gave the intrinsic quality of *understanding* most preferences (56%, n = 15). However the latter group gave *motivated* 44% (n = 12) of their preferences, followed by the intrinsic quality of *integrity* which received 37% (n = 10) of preferences, then the trait of *reliable* with 33% (n = 9) and finally *dependable* with 30% (n = 8) of preferences.

RNs working in critical care areas gave the intrinsic qualities of *nonjudgmental, intelligent*, and *integrity* equal first preferences (45%, n = 5). However they also ranked *motivated* highly with 36% (n = 4) of this group's preferences. Similarly those RNs from the perioperative area had *motivated* (45%, n = 10) as their most preferred intrinsic quality for a CN to possess. However the nurses in this area did not select *understanding* as a highly preferred trait. They preferred the intrinsic qualities of *dependable* and *integrity* each with 41% (n = 9). While the seven RNs who practised in the psychiatric field most preferred the intrinsic qualities of *reliable* and *honest*, both with 57% (n = 4), as ideal CN traits. Of interest is the few RNs who were employed within nursing management put *intelligent* (63%, n = 5) as their most preferred CN trait with *motivated* and *integrity* equal second with 50% (n = 4) of their preferences rather than the quality of *understanding*.

Table 4.13 *Intrinsic Quality: Nursing speciality*

Specialty	Intrinsic Qualities	Dependable	Dedicated	Trustworthy	Reliable	Dignified	Detail Orientated	Non-Judgmental	Creative	Strong willed	Loyal	Understanding	Intelligent	Motivated	Wise	Integrity	Honest	Total
Medical	n	14	9	6	14	2	3	7	2	1	1	17	10	10	7	9	5	39
	%	**36**	**23**	15	**36**	5	8	18	5	3	3	**44**	26	26	18	23	13	
Surgical	n	8	3	2	9	0	1	7	0	0	2	15	7	12	2	10	3	27
	%	**30**	11	7	**33**	0	4	26	0	0	7	**56**	26	**44**	7	**37**	11	
Critical Care	n	1	2	1	2	0	2	5	1	0	0	2	5	4	2	5	1	11
	%	9	18	9	18	0	18	**45**	9	0	0	18	**45**	**36**	18	**45**	9	
Peri-operative	n	9	5	2	3	1	3	6	1	1	0	6	6	10	2	9	2	22
	%	**41**	23	9	14	5	14	27	5	5	0	27	27	**45**	9	**41**	9	
Psychiatry	n	1	1	1	4	0	1	2	0	0	0	2	1	2	1	1	4	7
	%	14	14	14	**57**	0	14	**29**	0	0	0	**29**	14	**29**	14	14	**57**	
Nursing Management	n	3	0	2	1	0	1	2	0	0	0	1	5	4	0	4	1	8
	%	38	0	25	13	0	13	25	0	0	0	13	**63**	**50**	0	**50**	13	
Total	n	36	20	14	33	3	11	29	4	2	3	43	34	42	14	38	16	114

Percentages and totals are based on responses.

4.3.3 Cluster 3: Acquired Skills

4.3.3.1 Introduction

In order to answer the four research questions the respondents were asked to select the three most preferred acquired skills they would like their CNs to possess. This cluster had 13 traits, acquired skills, for the participants to choose from. The three most preferred traits from the respondents as a whole were identified, and then were analysed according to: years as a RN, nursing level, type of nursing education and nursing specialty to determine if there were any between group differences in the preferred traits. One respondent did not complete this section of the questionnaire making a total of 114 respondents for this cluster. Two participants did not give their age and three did not provide their years of experience as a RN.

4.3.3.2 Acquired Skills: All respondents

Table 4.14 illustrates that, overall for the main group the most valued acquired skill for a CN to possess was *clinical competence* with 27.8 % ($n = 95$) of preferences. This was followed by the traits of: *good communicator* (17.8%, $n = 61$), *good people skills* (13.5%, $n = 46$) and *practical knowledge* (12%, $n = 41$). Table 4.14 shows overall the acquired skills of *risk taker*, *business sense*, *good reasoning skills*, *advocate* and *assertive* were the least preferred CN traits in with proportionally 2% or fewer responses.

Table 4.14 *Acquired Skills: All Respondents*

Acquired Skills	N	%
Business Sense	5	1.5%
Risk Taker	1	.3%
Clinical Competence	**95**	**27.8%**
Career Experience	14	4.1%
Professional	33	9.6%
Available	9	2.6%
Assertive	7	2.0%
Decisive	17	5.0%
Advocate	7	2.0%
Good People Skills	**46**	**13.5%**
Good Reasoning Skills	6	1.8%
Practical Knowledge	**41**	**12.0%**
Good Communicator	**61**	**17.8%**
Total	342	100.0%

4.3.3.3 Acquired Skill: Years as a RN

In the between groups' analysis the 13 acquired skills were examined according to years as a RN. Compared to the main group there were some similarities and differences in the rankings and the preferred traits. Table 4.15 reveals that the most preferred CN acquired skill was *clinical competence* across all groups. *Good communicator* was still the second most preferred CN acquired skill across the groups except for those in the 10-25 years group who preferred good *people skills.* It is important to note that irrespective of years of experience respondents rank effective 'communication skills' as a very important quality for their CNs to have. However "communication" does not rank as highly as the respondents' need to have CNs who are *clinically competent.*

Table 4.15 *Acquired Skills: Years as a RN*

		Acquired skill traits														
Years as a RN	Acquired Skill Traits	Business sense	Risk taker	Clinical competence	Career experience	Professional	Available	Assertive	Decisive	Advocate	Good people skills	Good reasoning skills	Practical knowledge	Good communicator	Total
0-2 yrs	N	0	0	11	3	5	2	0	1	2	5	0	5	11	45
	%	0	0	**24**	7	11	4	0	2	4	11	0	11	**24**	
2-5 yrs	N	1	0	12	0	2	2	1	1	0	5	0	6	6	36
	%	3	0	**33**	0	6	6	3	3	0	14	0	17	**17**	
5-10 yrs	N	0	0	11	2	5	1	1	5	0	4	0	3	7	39
	%	0	0	**28**	5	13	3	3	13	0	10	0	8	**18**	
10-25 yrs	N	1	0	32	6	10	1	3	5	2	19	2	12	18	111
	%	1	0	**29**	5	9	1	3	5	2	**17**	2	11	16	
> 25 yrs	N	3	1	28	3	10	3	2	5	3	11	4	14	18	105
	%	3	1	**27**	3	10	3	2	5	3	10	4	13	**17**	
Total	N	5	1	**94**	14	32	9	7	17	7	**44**	6	40	**60**	336

Percentages and totals are based on responses.

4.3.3.4 Nursing Level: Acquired Skill

Following the main group analysis the data were re-analysed in a between groups' analysis to see if there were any differences in the selection of traits according to nursing seniority. The trait of *clinical competence* remained the most preferred CN trait for both groups. Table 4.16 shows that Level 1 RNs most preferred the acquired skill of *clinical competence* as an ideal CN trait with 82% ($n = 62$) of preferences, followed by *good communicator* with preferences of 51% ($n = 39$). The acquired skill of good *people skills*

was next with, 43% (n = 33) of responses, followed by *professional* and *practical knowledge* both with 33% (n = 25) of preferences.

When Level 2 or higher RN responses were analysed there were few differences. Level 2 or higher RNs also placed the acquired skill of *clinical competence* first with 87% (n = 33) of preferences, followed by *good communicator* (58% n = 22). However, in contrast to Level 1 nurses this group ranked *practical knowledge* next with 42% (n = 16), before *good people skills* 34% (n = 13), and *professional* and *decisive* both with 21 % (n = 8) of preferences.

Table 4.16 *Acquired skills: Nursing Level*

Nursing Level	Acquired Skill Traits	Business Sense	Risk Taker	Clinical Competence	Career Experience	Professional	Available	Assertive	Decisive	Advocate	Good People Skills	Good Reasoning Skills	Practical Knowledge	Good Communicator	Total
Level 1 RN	N	3	0	62	10	25	8	4	9	5	33	5	25	39	76
	%	4	0	**82**	13	**33**	11	5	12	7	**43**	7	**33**	**51**	
Level 2 RN or Higher plus both	N	2	1	33	4	8	1	3	8	2	13	1	16	22	38
	%	5	3	**87**	11	**21**	3	8	**21**	5	**34**	3	**42**	**58**	
Total	N	5	1	95	14	33	9	7	17	7	46	6	41	61	114

Percentages and totals are based on responses.

4.3.3.5 Acquired Skill: Type of education

The respondents were asked to identify which path of education they following for their initial and ongoing registered nursing qualification. The between group analysis showed that once again, the most preferred CN acquired skill was *clinical competence*. However, there were slight differences between the second and third rankings. The collated data in Table 4.17 shows that hospital diploma educated RNs put *clinical competence* first with 79% (n = 30) of preferences followed by *good communicator* (50%, n = 19). *Professional* and *good people skills* were the next most preferred CN acquired skills both with 37% (n = 14) of preferences, with *practical knowledge* (34%, n = 13) next.

Those RNs who received their nursing education at university also put *clinical competence* as their most preferred CN acquired skill (83%, $n = 38$) with *good communicator* (57%, $n = 26$) second. The acquired skill of *good people skills* (46%, $n = 21$) was next most preferred. In contrast to the nurses with hospital diplomas they put *practical knowledge* (35%, $n = 16$) followed by *professional* (26%, $n = 12$).

The group of RNs educated by a hospital-based diploma and later at university also placed *clinical competence* (90%, $n = 27$) as their most preferred acquired skill with *good communicator* (53%, n = 16) next. *Practical knowledge* (40%, $n = 12$) followed, and then, *good people skills* (37%, $n = 11$) with *professional* skills receiving 23% ($n = 7$) of preferences.

Table 4.17 *Acquired skills: Type of Nursing Education*

		Acquired Skill Traits													
Type of Nursing Education	**Acquired Skill Traits**	Business sense	Risk taker	Clinical competence	Career experience	Professional	Available	Assertive	Decisive	Advocate	Good people skills	Good reasoning skills	Practical knowledge	Good communicator	**Total**
Hospital educated	N	1	0	30	4	14	3	2	5	4	14	5	13	19	38
	%	3	0	**79**	11	**37**	8	5	13	11	**37**	13	**34**	**50**	
University educated	N	2	0	38	6	12	4	4	6	2	21	1	16	26	46
	%	4	0	**83**	13	**26**	9	9	13	4	**46**	2	**35**	**57**	
Both	N	2	1	27	4	7	2	1	6	1	11	0	12	16	30
	%	7	3	**90**	13	**23**	7	3	20	3	**37**	0	**40**	**53**	
Total	N	5	1	95	14	33	9	7	17	7	46	6	41	61	114

Percentages and totals are based on responses

4.3.3.6 Acquired Skills: Nursing Specialty

Irrespective of specialty the respondents, with slight variations, ranked the same ideal CN acquired skills. Overall, RNs in all specialties considered *clinical competence* the most preferred acquired skill as shown in Table 4.18 and in the between group analysis.

The RNs who are employed in medical wards gave most of their preferences to the acquired CN skill of *clinical competence* (82%, $n = 32$). This was followed by *good communicator* (59%, $n = 23$), *practical knowledge* (38%, $n = 15$), *good people skills* (33%, $n = 13$) and *professional* (28%, $n = 11$) respectively.

RNs working in the surgical wards also followed exactly the same pattern giving the acquired CN skill of *clinical competence* (93%, $n = 25$) most preferences, with *good communicator* (56%, $n = 15$) next, followed by *practical knowledge* (41%, $n = 11$), *good people skills* (33%, $n = 9$) and *professional* (26%, $n = 7$).

Those RNs from the critical care areas followed the same pattern of preferences as the previous groups although the proportions were slightly different. *Clinical competence* (92% $n = 11$) was the most preferred CN acquired skill followed by *good people skills* and *good communicator* both with 50% ($n = 6$) of preferences. The acquired skill of *professional* (33%, $n = 4$) was next, and then, *practical knowledge* with 25% ($n = 3$) of preferences.

Again the RNs from the peri-operative specialty also put *clinical competence* (77%, $n = 17$) as the most preferred CN acquired skill, followed by *good people skills* (59%, $n = 13$), *good communicator* (45%, $n = 10$), *practical knowledge* (27%, $n = 6$) and *professional* (23%, $n = 5$) in that order.

Once more, like the other specialties, those RNs who were employed in the psychiatric specialty gave most preferences to the acquired skill of *clinical competence* (71%, $n = 5$). However unlike their peers working in other specialities they put *professional* (57%, $n = 4$) next, then *good people skills* and *good communicator* both with 43% ($n = 3$). These differences may reflect the nature of nursing the mentally ill or the work environment but the very small cell sizes and the research questions do not permit further speculation of these differences.

Yet again, like the previous groups, RNs in nursing management's most preferred CN acquired skill was *clinical competence* (71%, $n = 5$), with *practical knowledge* and *good communicator* next, both with 57% ($n = 4$) of preferences. *Professional*, *decisive* and *good people skills* were the next most preferred CN acquired skills for this group, all with 29% ($n = 2$) of preferences.

Table 4.18 *Acquired Skills: Nursing Speciality*

Specialty	Acquired Skill Traits	Business sense	Risk taker	Clinical competence	Career experience	Professional	Available	Assertive	Decisive	Advocate	Good people skills	Good reasoning skills	Practical knowledge	Good communicator	Total respondents
Medical	n	2	0	32	7	11	3	2	6	0	13	3	15	23	39
	%	5	0	**82**	18	**28**	8	5	15	0	**33**	8	**38**	**59**	
Surgical	n	0	0	25	2	7	3	1	4	4	9	0	11	15	27
	%	0	0	**93**	7	**26**	11	4	15	15	**33**	0	**41**	**56**	
Critical Care	n	0	0	11	1	4	1	1	1	0	6	2	3	6	12
	%	0	0	**92**	8	**33**	8	8	8	0	**50**	17	**25**	**50**	
Peri-Operative	n	1	1	17	2	5	2	3	3	2	13	1	6	10	22
	%	5	5	**77**	9	**23**	9	14	14	9	**59**	5	**27**	**45**	
Psychiatry	n	1	0	5	1	4	0	0	1	1	3	0	2	3	7
	%	14	0	**71**	14	**57**	0	0	14	14	**43**	0	29	**43**	
Nursing Management	n	1	0	5	1	2	0	0	2	0	2	0	4	4	7
	%	14	0	**71**	14	**29**	0	0	**29**	0	**29**	0	**57**	**57**	
Total	n	5	1	95	14	33	9	7	17	7	46	6	41	61	114

Percentages and totals are based on responses.

4.3.4 Cluster 4: Personal Attributes

4.3.4.1. Introduction

In order to answer the four research questions the respondents were asked to select the three personal attributes they most preferred their CNs to have. This cluster had twelve personal attributes for the respondents to choose from. The three most preferred personal attributes were analysed in a main group analysis and then as a between groups' analysis to identify differences according to the variables: years as a RN; nursing Level; type of nursing education and nursing specialty worked in. All 115 respondents completed this part of the questionnaire, but two respondents did not identify their age and three did not state their years as a RN.

4.3.4.2 Personal Attributes: All respondents

The data were analysed by combining the three most preferred personal attributes of the cohort. There was some variation in the spread of the responses so that the attributes of *motivator of others, team player, receptive to people and ideas, empowering, communicator* and *mentoring attitude* were ranked highly. Of note is the attributes of *high energy* and *visionary leadership* received less than 3% of preferences. Table 4.19 illustrates that in the main group 17% ($n = 57$) respondents put *team player* as a top preferred CN personal attribute followed by *mentoring attitude* (13%, $n = 46$) and *receptive to people and ideas* (12%, $n = 42$). Next were the attributes of *motivator of others* (11%, $n = 38$) followed by *communicator* (11%, $n = 37$), *empowering* (8%, $n = 29$) and *sense of humour* (7%, $n = 23$).

Table 4.19 *Personal Attributes: All Respondents*

Traits	n	%
Motivator of others	**38**	**11**
Friendly	20	6
Team player	**57**	**17**
Receptive to people and ideas	**42**	**12**
High Energy	3	1
Visionary	11	3
Responsive to People	19	6
Empowering	**29**	**8**
Sense of humour	**23**	**7**
Interested in Quality	20	6
Communicator	**37**	**11**
Mentoring attitude	**46**	**13**
Total	345	100

4.3.4.3. Personal Attributes: Years as RN

A between groups' analysis was performed to determine if years of experience as a RN affected the rankings of the twelve personal attributes preferred in a CN. For the two groups of RNs with between 0-5 years' experience, there were slight variations compared to nurses with more nursing experience. In the former groups *team player* and *mentoring attitude* were the most preferred CN personal attributes. However the RNs with 5-10 years of nursing experience, (some of whom are CNs) most preferred their CN to be *friendly*. While those RNs with 10-25 years experience thought that *communicator* was the ideal personal attribute for CNs to have. Notably RNs who had been qualified nurses for over 25 years preferred the same CN personal attributes as their colleagues with 0-5 years of nursing experience, *team player* and *mentoring attitude,* as demonstrated in Table 4.20.

The group of RNs with 0-2 years experience most preferred the CN personal attribute of *mentoring attitude* (53%, $n = 8$) followed by *team player* with 47% ($n = 7$) of preferences. Next most preferred were the personal attributes of *empowering* (33%, $n = 5$) and both, *friendly* and *receptive to people and ideas* (27%, $n = 4$). Those respondents who had been RNs for 2-5 years also ranked *team player* (75%, $n = 9$) highly and they ranked the personal attribute of *mentoring attitude* second highest (50%, n = 6), with *receptive to people and ideas* next (33%, n = 4). RNs who had been nursing for 5-10 years put *friendly* (46%, $n = 6$) as their most preferred CN personal attribute with *motivator of others, team player, receptive to people and ideas, sense of humour* and *mentoring attitude* all receiving 38% ($n = 5$) preferences. Similarly the group of RNs with 10-25 years experience followed a similar pattern ranking attributes related to effective "interpersonal skills" most highly. For example their most preferred ideal CN personal attribute was *communicator* (46%, $n = 17$) with *motivator of others, team player* and *receptive to people and ideas* the next preferred traits all with 43% ($n = 16$) of preferences. These were followed by *mentoring attitude* (35% $n = 13$) and empowering with 24% ($n = 9$). The final group, those RNs nursing for over 25 years, most preferred *team player* (54%, $n = 19$) as a CN personal attribute followed by *mentoring attitude* (37% $n = 13$), *motivator of others* (34% $n = 12$), *receptive to people and ideas* and *interested in quality*, both with 31% ($n = 11$). These results are demonstrated in Table 4.20. It shows that only the 2-5 years of nursing group were looking for *visionary leadership* in their CNs.

Table 4.20 *Personal Attributes: Years as a RN*

Years as RN	Personal Attribute Traits	Motivator of others	Friendly	Team payer	Receptive to people and ideas	High energy	Visionary	Responsive to people	Empowering	Sense of humour	Interested in quality	Communicator	Mentoring attitude	Total
0-2 yrs	N	3	4	7	4	1	0	3	5	3	2	5	8	15
	%	**20**	**27**	**47**	**27**	7	0	**20**	**33**	**20**	13	33	**53**	
2-5 yrs	N	2	2	9	4	0	3	1	3	1	3	2	6	12
	%	17	17	**75**	**33**	0	**25**	8	**25**	8	**25**	17	**50**	
5-10 yrs	N	5	6	5	5	1	0	0	2	5	1	4	5	13
	%	**38**	**46**	**38**	**38**	8	0	0	15	**38**	8	31	**38**	
10-25 yrs	N	16	6	16	16	0	4	6	9	6	2	17	13	37
	%	**43**	16	**43**	**43**	0	11	16	**24**	16	5	**46**	**35**	
> 25 yrs	N	12	1	19	11	1	4	8	10	7	11	8	13	35
	%	**34**	3	**54**	**31**	3	11	23	29	20	**31**	23	**37**	
Total	N	38	19	56	40	3	11	18	29	22	19	36	45	112

Percentages and totals are based on responses.

4.3.4.4 Personal Attributes: Nursing Level

The data were analysed to ascertain if there were any differences in the distribution of preferred personal attribute preferences according to level of seniority. There were similar patterns although there were slight differences in the frequency attributes were selected. Irrespective of the level of nursing seniority RNs wanted their CNs to be a *team player*. As demonstrated in Table 4.21, Level 1 RNs ranked *team player* (47%, $n = 35$) as their most preferred personal attribute with *mentoring attitude* (42%, $n = 32$), next. These preferred attributes were followed by *receptive to people and ideas* (37%, $n = 28$), *communicator* (33%, $n = 25$), *motivator of others* (28%, $n = 21$), *friendly* and *responsive to people* both with 21% ($n = 16$) and finally *empowering, sense of humour* and *interested in quality* each with 20% ($n = 15$). The Level 2 or higher RNs also had *team player* (54%, $n = 21$) as their most preferred personal attribute with *motivator of others* (44% $n = 17$) next. The personal attributes of *receptive to people and ideas*, *empowering* and *mentoring attitude* all received 36% ($n = 14$) of preferences followed by *communicator* (31%, $n = 12$) and then *sense of humour* (21%, $n = 8$). In essence the only difference between the two groups is that Level 2 RNs did not list *interested in quality* as a preferred personal attribute but 20% (n = 15) of the Level 1 RNs did. This is an interesting finding given that RNs

classified as Level 2 nurses are more "senior" and should support less senior staff "adhere to standards of best practice."

Table 4.21 *Personal Attributes: Nursing Level*

Nursing Level	Personal Attribute Traits	Motivator of others	Friendly	Team player	Receptive to people and ideas	High energy	Visionary	Responsive to people	Empowering	Sense of humour	Interested in quality	Communicator	Mentoring attitude	Total
Level 1 RN	n	21	16	36	28	2	7	16	15	15	15	25	32	76
	%	**28**	**21**	**47**	**37**	3	9	**21**	20	20	20	**33**	**42**	
Level 2 RN or Higher plus both	n	17	4	21	14	1	4	3	14	8	5	12	14	39
	%	**44**	10	**54**	**36**	3	10	8	**36**	**21**	13	**31**	**36**	
Total	n	38	20	57	42	3	11	19	29	23	20	37	46	115

Percentages and totals are based on responses.

4.3.4.5 Personal Attributes: Type of nursing education

A between groups analysis was done to determine if there were any differences between the nurses' type of nursing education and their selected preferences of the traits they wanted in their CNs. As illustrated in Table 4.22, each of the three groups (university educated, hospital-diploma education and hospital-based diploma followed by university study) chose different attributes. However the traits of *mentoring* and *team player* were in the top three preferred personal attributes for each of the three groups, with slight differences in the proportions of rankings.

As demonstrated in Table 4.22 hospital diploma educated RNs gave the personal attribute of *motivator of others* (47%, $n = 18$) the most preferences, with *mentoring attitude* (45%, $n = 17$) next, followed by *team player* was next with 42% ($n = 16$). The trait of *receptive to people and ideas* (37%, $n = 14$) polled the next most preferences from this group with both *empowering* and *communicator* receiving 26% ($n = 10$) of preferences. However, university educated RNs most preferred the personal attribute of *team player* (57%, $n = 26$) for their CNs to have, with the trait of *mentoring attitude* (41%, $n = 19$) next. The next most preferred CN personal attributes by the university educated RNs were; *communicator* (35%, $n = 16$) and *receptive to people and ideas* (33%, $n = 15$). Whilst RNs educated at both university and with a hospital-based diploma also gave the CN personal

attribute of *team player* (48%, *n* = 14) the most preferences. Their next most preferred trait of *receptive to people and ideas* (42%, *n* = 13) differed to the previous groups. The personal attributes of *communicator* (35%, n = 11), *mentoring attitude* (32%, n = 10) and *motivator of others* (29%, *n* = 9) were the next most preferred personal attributes, respectively, for this group.

Table 4.22 *Personal Attributes: Type of Education*

Type of Nursing Education	Personal Attributes	Motivator of others	Friendly	Team player	Receptive to people and ideas	High energy	Visionary	Responsive to people	Empowering	Sense of humour	Interested in quality	Communicator	Mentoring attitude	Total
Hospital Educated	N	18	3	16	14	0	4	8	10	5	9	10	17	38
	%	**47**	8	**42**	**37**	0	11	21	**26**	13	24	**26**	**45**	
University Educated	N	11	12	26	15	2	3	6	13	11	4	16	19	46
	%	24	26	**57**	**33**	4	7	13	28	24	9	**35**	**41**	
Both	N	9	5	15	13	1	4	5	6	7	7	11	10	31
	%	**29**	16	**48**	**42**	3	13	16	19	23	23	**35**	**32**	
Total	N	38	20	57	42	3	11	19	29	23	20	37	46	115

Percentages and totals are based on responses.

4.3.4.6 Personal Attributes: Nursing Specialty

The respondents were asked to identify which specialty they were employed in. A between groups' analysis was performed to determine if there were any differences between the attributes selected by the main group and between nurses choice of nursing specialty. As Table 4.23 shows RNs who worked in the medical, surgical, critical care and peri-operative specialties all selected the personal attribute of *team player* as one of their three most preferred CN personal attributes. Neither of the other two specialties chose *team player* as a preferred personal attribute, but because of their small cell size, this finding needs to be tested with further research.

As has been explained above and as Table 4.23 illustrates those RNs who work in medical wards most wanted their CNs to possess the personal attribute of a *team player* (51%, *n* = 20). They also wanted their CNs to have a *mentoring attitude* (49%, *n* = 19), with the personal attributes of *communicator* (41%, *n* = 16), *motivator of others* (31%, *n* = 12), *receptive to people and ideas* (26%, *n* = 10) and *sense of humour* (23%, *n* = 9) next.

Similarly, the RNs who worked in surgical wards for the most part wanted their CNs to have the personal attributes of a *team player* (56%, n = 15) along with a *mentoring attitude* (48%, *n* = 13) next, followed by *receptive to people and ideas* (30%, *n* = 8).

In contrast, those RNs who work in the critical care environment gave most preferences for a CN having the personal attribute of *receptive to people and ideas* (58%, *n* = 12) with *motivator of others* (50%, *n* = 6) second and *team player* (42%, *n* = 5) third. Similarly those RNs who worked in the peri-operative field placed the personal attribute of *receptive to people and ideas* first with 55% (*n* = 12) of preferences, and then *team player* (50%, *n* = 11) second followed by *motivator of others, empowering, communicator* and *mentoring attitude* equal third with 32% (*n* = 7).

Possibly because of the nature of their work, the RNs who worked in the psychiatric field, unlike their peers in the medical, surgical, critical care and peri-operative fields, gave most preferences to the traits of *empowering* and *communicator* (57%, *n* = 4), followed by *motivator of others* and *team player* both with 43% (*n* = 3).

Those RNs in nursing management gave most preferences to both the personal attributes of *mentoring attitude* and *motivator of others* in this cluster with 50% (*n* = 4) of preferences.

Table 4.23 *Personal Attributes: Nursing Speciality*

Specialty	Personal Attributes	Motivator of Others	Friendly	Team Player	Receptive to People and Ideas	High Energy	Visionary	Responsive to People	Empowering	Sense of Humour	Interested in Quality	Communicator	Mentoring Attitude	Total
Medical	N	12	8	20	10	1	2	7	6	9	7	16	19	39
	%	**31**	21	**51**	**26**	3	5	18	15	**23**	18	**41**	**49**	
Surgical	N	6	7	15	8	0	3	6	7	4	6	6	13	27
	%	22	26	**56**	**30**	0	11	22	26	15	22	22	**48**	
Critical Care	N	6	2	5	7	0	0	3	3	3	1	3	3	12
	%	**50**	17	**42**	**58**	0	0	**25**	**25**	**25**	8	25	25	
Peri Operative	N	7	1	11	12	1	2	3	7	4	4	7	7	22
	%	**32**	5	**50**	**55**	5	9	14	**32**	18	18	**32**	**32**	
Psychiatry	N	3	2	3	2	1	2	0	4	0	0	4	0	7
	%	**43**	29	**43**	29	14	29	0	**57**	0	0	**57**	0	
Nursing Management	N	4	0	3	3	0	2	0	2	3	2	1	4	8
	%	**50**	0	38	38	0	25	0	25	38	25	13	**50**	
Total	N	38	20	57	42	3	11	19	29	23	20	37	46	115

Percentages and totals are based on responses.

4.4 Qualitative Analysis

4.4.1 Introduction

All 403 RNs eligible for participation in this investigation had the option to make comments relevant to the study at the end of the questionnaire. Of the 120 questionnaires returned 20 (17%) respondents chose to make comment. This was 5% of the sample of 403 potential respondents. A qualitative section was included in this study to expound and identify from the RN's perspective, leadership characteristics they perceive as important in their CNs using the varied dimension of qualitative analysis.

A content analysis of this qualitative data, to organize and integrate the comments according to emerging subjects and concepts, was attempted. However, there were not enough responses for a substantive content analysis. The comments that expound on the rational for choosing preferred traits in the clusters of the quantitative section of the questionnaire have been identified and are discussed in chapter 5. A few respondents commented on subjects not related to the traits of the questionnaire and these are analysed in this section. These topics identified will be analysed concurrently in this chapter. These results need to be treated with caution because in most cases only one or two respondents commented about particular topics.

4.4.2 Topics identified affirming quantitative results

Qualitative comments which relate directly to preferred traits identified in this study's quantitative section; *clinical competence, mentoring, team player, supportive* (including bullying), *and respect*, are discussed in chapter 5.

4.4.3 Additional subjects identified

Some respondents made comments which could not be directly related to specific traits, but were related to clinical nurse leadership. Further topics identified within the qualitative comments from the study hospital respondents are: lack of education and preparation for the leadership role, acquisition of the leadership role, allocated time to perform the requirements of the CN position, constraints on the leadership role, and allocations of staff skill mix within the nursing healthcare environment.

Education and preparation of CNs for the role of leadership was of concern to respondent 071 who commented *"Traditionally nurses have not been taught how to lead and teach."* Respondent 071 wants CNs to have the knowledge to solve clinical problems, to be able to manage those they lead adeptly and as respondent 115 states, *"should own the problems/complaints rather than passing the buck to the Level 3."* It is difficult to sort out issues as a CN though, if you are not prepared for the role. Bondas (2006), in her investigation of why nurses enter nursing leadership, identified a "path of chance" where the nurse does not have a planned path to be a leader but becomes a leader because of circumstances that arise and consider their role of leadership as a task to be accomplished. As leadership is not a goal of these nurses, they don't plan for the leadership role by being educated and mentored for leadership. Furthermore, Duffield & Franks (2001, p. 89) comment "Many first-line managers lack appropriate educational qualifications to do their jobs effectively" and that "nurses tend to take on the roles [nurse leadership] by chance rather than choosing this career path themselves, or being selected by others as having management potential." Making available leadership courses to those already within a leadership role would improve their leadership skills and management of their areas of responsibility. Respondent 088 commented on this stating *"The role (CN) should include staff development as well for each different specialty."*

Additionally, Bonczek & Woodard (2006) recommend that leaders plan for succession which ensures there are qualified people within the organisation when leadership vacancies occur. Succession planning is preparing future leaders by mentoring, coaching and sending them to leadership preparation courses. In fact Cook (2001) recommends that generic leadership preparation is needed within the nursing profession. They suggest this could be done during initial nurse education courses. According to Davidson, Elliott, & Daly (2006, p. 180) "systematic, strategic initiatives are required to nurture and develop clinical leaders." They recommend these strategies be developed between academic and health care organisations. Regardless of how leadership training is performed, nurses need education and training in leadership to be able to maximise their positive effectiveness within their environment of responsibility. Interestingly respondent 080 comments, *"In my opinion the most important [leadership] characteristic is the willingness to do the job."*

Constraints on the leadership role of a CN include lack of time to complete the large workload the job requires. CNs are responsible for mentoring, staff development, education, role modelling competent nursing practice, planning and facilitating the management of a ward or unit, participating in quality improvement and are expected to have knowledge of relevant legislation. According to respondent 075 the managerial tasks required of the CN prevent them performing, in their opinion, what are more important roles on the ward with the comment *"CNs here [the study hospital] obsess with trend-care without seeing, hearing or meeting the real needs of the floor."* Work load of CNs affects their ability to lead as respondent 071 comments *" ... We are a very diverse group of people who can be adversely effected by the pressures of caring for our patients and colleagues, some of the above traits [referring to the questionnaire] are not often appreciated and disappear under the work load ..."* In fact respondent 072 comments that the solution for this is to allocate time for CNs to mentor and educate those they lead stating *"CNs need time to be all these things [referring to the leadership traits in the questionnaire] in their work areas apart from patient care allocated hours."* Respondent 071 also commented on the difficulty of providing leadership in an environment constrained by financial pressure which also leads to an increased workload and increased responsibilities. While respondent 088 comments that *"CNs should work a minimum number of hours per week i.e. 4 shifts. The role (CN) should include staff development as well for each different specialty, i.e. a resource person too."* To enable this to occur time needs to be allocated so CNs are able to educate staff, conduct appraisals, learn the latest skills, supervise junior nurses and to be able to be approachable and supportive of staff, decreasing the pressure of trying to achieve all the tasks required, often with a full patient load.

The allocation of staff that has varied levels of nursing skills and competencies was a topic of concern to respondents 087 and 071. CNs are responsible for the daily allocation of nursing staff. This is made difficult because of nursing staff shortages. As a result junior and inexperienced staff often does not have the recommended supervision required or educational opportunity because of the workload needed to be accomplished. Respondent 087 commented that *"When doing allocations, [CNs] should look at staff mixing and their level of skills and competencies – to avoid staff being "lost" doing procedures unfamiliar to them."*

4.4.4 Conclusion

This section has reviewed the demographic data of the qualitative responses for this study and then explained the analysis performed on the data. Topics identified and discussed were education and preparation of CNs and potential CNs for the role of leadership, constraints on the leadership role of a CN and allocations of staff with differing nursing skills and abilities. Recommendations include education about the role of leadership, succession planning for future leaders, and time to be allocated for CNs to perform all the duties and leadership roles required of them and finally CNs should be made aware of nursing staff's competencies before allocating daily workloads to enable them to manage skill mix of staff.

4.5 Conclusion

This chapter has presented the research findings and analysed the data for this study to answer the research questions. Initially the demographic characteristics of the study cohort were analysed and then the preferred leadership characteristics for a CN to possess were identified according to the clusters of attitudes, intrinsic qualities, acquired skills and personal attributes. An in between groups analysis of the preferred traits was conducted identifying preferred CN leadership traits within the independent variables of; years as a RN, nursing Level, type of nursing education and nursing specialty.

For the cohort the most preferred attitudes were *approachable* and *supportive*, this was the same for all groups in the variables, of years as a RN, Nursing Level, type of nursing education and nursing specialty. The respondents most preferred the CN intrinsic qualities of *understanding* and then, *motivated*. The between groups analysis identified that nurses with 0-2 years experience, Level 1 RNs, university educated RNs and nurses who worked in medical and surgical wards most preferred the intrinsic quality of *understanding* for their CNs to possess. The most preferred CN acquired skill for the cohort and the independent groups of years of experience, nursing level, type of nursing education and nursing specialty were *clinical competence* and then *good communicator*. The personal attributes most preferred by the participants of this study were *team player* followed by *mentoring attitude*. The personal attribute of *team player* was also preferred by RNs with 0-5 years and >25 years experience, RNs of both nursing levels, those RNs educated at

university and both hospital and university and RNs who work in the medical, surgical and critical care wards. These results identified in this chapter will be discussed in more detail in chapter five.

The qualitative analysis and discussion identified topics of concern to some of the respondents including, education and preparation of CNs for the role of leadership, constraints on the leadership role of a CN, and staff allocation issues.

Chapter 5: Discussion

5.1 Introduction

This chapter discusses the results of this study. Initially response rates are examined, and demographic data analysed, before the results are presented within the framework of the four research questions. Next, noteworthy responses are reviewed within the registered nurse (RN) groups according to specialisations, type of nursing education, years of experience and level of nursing (i.e. Level 1 or 2 RN). Finally, presentation of the implications for nursing leaders, limitations of this study and recommendations are made.

The purpose of this descriptive study was to identify, from the RNs' perspective, the leadership characteristics of clinical nurses (CNs) considered by them to be most important for facilitating their nursing practice. This study investigated whether RNs in different specialties of nursing, type of nursing education or years of nursing experience require their CNs to exhibit different leadership characteristics. In addition, this study explored the different perceptions between Level 1 RNs and Level 2 or higher RNs, about the preferred leadership characteristics of CNs.

The participants were asked to select the three most important leadership traits necessary for a CN to possess, in each of four clusters of attributes: attitudes, intrinsic qualities, acquired skills, and personal attributes. They then ranked the selected attributes in order of importance with one being the most important to three being least important. The respondents were afforded the opportunity to make further comments.

5.2 Response rate

Data were collected by implementing a self-administered questionnaire. In general response rates using this method are not as large as other data collection methods, such as in face-to-face interviews (Polit et al., 2001). According to Polit and Beck (2004), a response rate of 65% or more is adequate for minimising non-response bias; however, response rates are frequently less. The response rate for this study was 30% (n = 120). Time constraints did not allow for reminders to be sent to participants. The low response rate probably decreased the validity of the results and limited any generalisation of the study's findings. Of the 115 respondents who returned the questionnaire 5% (n = 20) chose to make qualitative comments which were analysed in Chapter Four. These data are used to enhance discussion of the quantitative findings.

5.3 Demographic characteristics

The RNs' average age was 42.4 years, which is 2.6 years less than the mean age of an Australian RN (Australian Institute of Health and Welfare, 2008). The participants' ages are reflective of the ageing nursing population in Australia (Australian Bureau of Statistics, 2005; Australian Institute of Health and Welfare, 2008; Karmel & Li, 2002), and world wide (Hogan et al., 2007; O'Brien-Pallas & Duffield, 2006; Swearingen & Liberman, 2004; Thompson et al., 2003; Wieck et al., 2002). The RNs ages ranged from 22 to 69 years; however, few respondents were aged between 27-30 years, and even fewer were over 60 years old. As would be expected, the RNs who were aged more than 60 years comprise a smaller group. According to the most recent ABS statistics (2008b), in Australia in 2007, 58% of women had retired before turning 55 years of age, whilst 35% retired between the ages of 55-64 years. The small number of RNs in the 27-30 age group is probably an indication of the demographic trend, women in this age range frequently break their career to have children. The median age for women having babies in Australia has increased from 29.1 years in 1995 to 30.7 years in 2005 (Australian Bureau of Statistics, 2008a); this classifies this cohort of RNs in that category. Approximately two thirds of the respondents had been RNs for ten years or more, suggesting that most had many years of nursing experience. A third of the respondents were Level 2 or higher RNs and thus currently functioning in a leadership capacity. Respondents were not asked to identify their gender as there were so few male RNs working at the study hospital, their confidentiality could not be guaranteed. The percentage of respondents from differing nursing specialties reflected the proportions of RNs employed within each specialty at the study hospital.

Given that relatively few RNs are employed in management and psychiatry at this hospital, responses from these areas of expertise are low. However, their data were not collapsed into other specialties, as their areas of care are markedly different.

5.4 Research question 1

What leadership characteristics do RNs perceive as important in their CNs?

This section discusses the participants' salient responses for this study. Of note is that findings from studies by Thompson, Wieck, & Warner (2003); Wieck, Prydun, & Walsh (2002) of the USA and two UK studies by Stanley (2004; 2006a), produced similar results to this investigation. In essence, the respondents wanted a CN who was *approachable* and *supportive* with *understanding* and *integrity*, whilst being *clinically competent, a team player, mentor* and *receptive to people and ideas* simultaneously. The following sections will discuss these findings further.

5.4.1. Acquired Skill

In this cluster, the respondents were given 13 acquired skills from which to select. An acquired skill is one in which a person gains the ability to do something well (Knight, 2003). Of the 13 traits, the acquired skill of *clinically competent* was the most frequently selected attribute, being identified as the most preferred trait for a CN to have by 95 of the 115 participants (refer table 4.14). A CN showing *clinical competence* is defined as one who demonstrated skills and knowledge of the area for which they are responsible (Osborne et al., 2003). Indeed, Stanley (2006a, p. 30) defined *clinical competence* as " ... being able to show, or to do, as well as know or teach others about clinical issues." Furthermore, an earlier pilot study conducted in the United Kingdom (Stanley, 2004) to identify clinical nurse leaders within a paediatric nursing unit also identified *clinical competence* as being an acquired skill highly desirable in CNs. This attribute was also acknowledged as important to nurses in Magnet Hospital research conducted in the 1980s and 1999 in the USA (Scott et al., 1999). Similarly, Thompson et al.'s (2003) study of peri-operative and emerging workforce nurses in the USA showed they considered *clinical competence* was a desired trait for a manager with both peri-operative nurses and nursing students. However, in an earlier study in the USA, describing the desired leadership traits as perceived by the emerging and entrenched nursing workforce by Wieck, Prydun & Walsh (2002), respondents did not choose *clinical competence* as a most desirable or least desirable trait of a leader. This contrary opinion may have been caused by the cultural differences of respondents in these two studies.

In summary, the RNs in this study wanted their CNs to be *clinically competent.* For example, respondent 086 commented, "... *there are different ideas/knowledge to clinical practice, so a clinical nurse who can give out a standard and correct solution is most appreciated.*" Similarly, respondent 076 an RN for 19 months, commented that relatively inexperienced RNs wanted a CN who " ....*share[s] their knowledge with others." Clinical competence* is a leadership trait that the respondents of this investigation perceive as important in their CNs. A belief in the fundamental importance of this trait was shared by their colleagues in the UK and the USA.

The second most preferred acquired skill for a CN was to be a *good communicator* according to 61 of the 115 respondents. A *good communicator* is someone who is competent at passing news or information to someone, being able to exchange information easily and well (Knight, 2003). Respondent 076 wanted a CN who, "...*shares their knowledge with others.*" Other studies (Scott et al., 1999; Stanley, 2004, 2006; Thompson, Wieck, & Warner, 2003; Wieck, Prydun, & Walsh, 2002) have also affirmed that RNs want their CNs to be *good communicators.* Indeed Stanley (2006a, p. 31), in a qualitative study which explored clinical nurse leadership, says, "All the participants indicated that this [effective communication] was a central attribute of clinical leadership." Osborne et al. (2003, p. 6) concur with this finding by commenting that "a good leader is a good communicator."

The remaining 11 acquired skills in this cluster were not chosen often as one of the top three preferences from the study respondents; thus they were not considered to be as important as the traits of *clinical competence* and *good communicator.* In summary, this investigation has confirmed earlier findings that RNs consider it important for the CNs who lead them to be proficient in their clinical skills, and who communicate their knowledge and clinical expertise effectively. Furthermore, CNs should be encouraged to improve their communication skills by participating in relevant courses and seeking pertinent feedback from colleagues and the RNs they lead.

5.4.2. Attitude

An attitude is a "way of thinking or behaving" (Knight, 2003, p. 18). For this cluster, the participants were invited to select the most preferred attitudes from 15 traits. The most frequently selected trait was *approachable,* with 75 of the 115 respondents selecting this as a top three preferred attitudinal trait. *Approachable* is defined as

"accessible, affable, easygoing, friendly" (Knight, 2003, p. 13). The next most frequent trait chosen was *supportive*, with 73 of the 115 respondents giving top three preferences for this trait. *Supportive* means to be "caring, encouraging, helpful, sympathetic and understanding" (Knight, 2003, p. 289). The RNs wanted their CNs to be someone to whom it was easy to talk, sympathetic, able to perceive and interpret what was being discussed. These attributes could be classified as nurturing or pastoral attitudes. Respondent 076, a neophyte RN of 19 months experience supports this finding commenting, "*As a relatively new RN I do look up to the CNs on the ward to support me and guide me.*" Respondent 079, a senior RN with 30 years experience, explained, "*CNs should be a senior staff member who instils confidence and support and safety in junior staff members.*" Other qualitative and quantitative studies in the USA and the UK (Osborne et al. 2003; Stanley, 2004: 2006; Thompson et al., 2003; Wieck et al., 2002) have also recognised being *approachable* and *supportive* as important attitudes for nurse leaders to possess.

Despite the study hospital's workplace anti-bullying policy, which can be accessed by staff on the hospital intranet, it is of concern that two respondents referred to episodes of workplace bullying, which is the antithesis of *supportive* and *approachable* behaviours. Respondent 079 opined "*They [CNs] should not reduce junior staff to tears and be unsupportive and uncaring. It's a disgrace! [to the nursing profession].*" Respondent 087 also touched upon bullying, remarking, "*CNs should not force their will to get things going or assume that particular staff would work or stay overtime without even asking first.*" While only two of the 115 respondents commented about bullying, this is a serious issue, which needs to be explored in more detail. According to Baltimore (2006), Gerardi & Connell (2007) and Hader (2008), bullying and horizontal violence are still occurring in the workplace of the nursing profession. Horizontal violence is defined by Gerardi & Connell (2007, p. 16) as, "... a phenomenon characterised by repetitive covert and overt nonverbal and verbal behaviours designed to degrade, humiliate and undervalue a co-worker. It is behaviour that occurs between co-workers, either on a one to one level or through mobbing or scapegoating." Amongst nurses, bullying involves similar behaviours but is undertaken by nursing leaders as well as colleagues; whilst horizontal violence occurs within groups of peers (Baltimore, 2006). Baltimore asserts novices and newly appointed staff are particularly vulnerable to bullying and horizontal violence. Two of the study hospital's core values (Appendix A) are "respect for the individual" and "teamwork."

The researcher, an employee of the study hospital, knew of the anti-bullying policy, and, after searching the hospital intranet accessed it. This hospital does have processes in place for an immediate response to bullying and horizontal violence should either of these be identified, but anecdotal evidence reveals that not all the staff members and CNs are cognisant of the policy. The two unsavoury incidents reported in this research clearly indicated regular awareness raising education should be conducted with emphasis on the anti-bullying policy of the hospital. It is beyond the remit of this study to determine whether the bullying in these instances were reported to authorities; however, the literature declares nurses, who are bullied or not treated appropriately are reluctant to report the matter but change jobs if bullying persists, rather than address the perpetrator or report the behaviour to management (Baltimore, 2006; Hader, 2008). Furthermore, bullying affects the ability of an organisation to retain staff. CNs, being the first level of leadership, are well placed to identify and discourage this inter-personal misbehaviour by shaping the culture of their area of influence (Willis, 2002). Nonetheless, evidence of bullying or horizontal violence should it be observed, should be reported to senior management.

It is significant that the research cohort of RNs from this study desire their CNs to have *supportive* and *approachable* attitudes towards their peers. If CNs are *approachable* and *supportive*, RNs should feel comfortable discussing with them their many workplace concerns, for example, issues that affect their duties including bullying.

5.4.3. Intrinsic Qualities

Intrinsic qualities are those characteristics a person possesses inherently (Knight, 2003). Of the sixteen intrinsic qualities from which to select, 43 of the 115 RNs chose the trait of *understanding* with top three preferences, closely followed by *motivated* polling 42 top three preferences. The intrinsic quality of *integrity* was selected by 38 of the 115 respondents, with 36 of the cohort opting for *dependable*. These four most preferred intrinsic qualities are discussed next in this section:

The intrinsic quality of *understanding* is a pastoral trait defined as the sympathetic, empathetic or tolerant acknowledgement of another person's nature or circumstances (Knight, 2003). The RNs in this study gave most of their top three preferences to this intrinsic quality, suggesting the respondents desired their CNs to be

understanding as defined above and to acknowledge the RNs circumstances. While the job description of a CN at the study hospital (Appendix A) incorporates mentoring of staff, contributing to effective communication and facilitating teamwork, the intrinsic quality of *understanding* is not mentioned specifically. Even though unmentioned in the job description of a CN, (Appendix A), this trait is inferred in the hospital CN selection criteria, which includes, "effective communication and interpersonal skills." Furthermore, the cohort of participants considered the pastoral caring quality of *understanding* to be an important trait for CNs to possess. A number of studies, including that of Feltner, Mitchell, Norris, & Wolfle (2008) set down the importance nurses and their nurse leaders place on these traits. In a qualitative USA study by Anthony et al., (2005, p. 150) investigating leadership and nurse retention, a nurse manager illustrated these values by commenting "in this day and age, I am the staff morale booster, and problem solver, and counsellor, and anything else I can think of to keep people relatively happy." Since the intrinsic quality of *understanding* is perceived as a very important trait for CNs to possess by the participants contributing to this research, it is also important for agencies such as the study hospital to have strategies in place that enabling its leaders to develop and demonstrate this quality.

The second most preferred intrinsic quality was *motivated*, a person who has the incentive to accomplish tasks (Knight, 2003). According to Eccles & Wigfield, (2002) motivation is derived from the Latin root word 'mot' meaning to move. These authors also discuss that an individual, who is intrinsically, or inherently, motivated, takes on activities they enjoy and are of interest. Forty-two participants in this investigation gave top three preferences to this trait thereby indicating they want their CNs to be *motivated*. With the previous definitions in mind it is interesting that respondents in both the USA studies of Thompson et al. (2003) and Wieck et al. (2002), which deployed a similar instrument to that used in this study, did not select the trait *motivated* as one of the desirable traits in a manager, which was in contrast to the choice of this investigation's respondents. The possible reason for this finding could be that RNs working in an Australian context, being of another culture and population, differ in this preferred intrinsic quality. In the final analysis here, when considering persons for the role of CN, being *motivated* must be taken into account before any positions are decided.

The third most preferred intrinsic quality in this study was the trait of *integrity*, 38 of the 115 respondents giving it a top three preference. Knight (2003) defines

integrity as honesty; it was also one of the characteristics and qualities most associated with clinical leadership in a qualitative UK study (Stanley, 2006a, p. 27). *Integrity* and *honesty* were also identified as important intrinsic qualities in the descriptive US studies by Wieck et al. (2002, p. 286) and Thompson et al. (2003, p. 255). Authors such as Cohen (1998) and Shewchuk (2003) go as far to argue that integrity is a core component of leadership. Furthermore, William Cohen, author of the best seller *The stuff of heroes: The eight universal laws of leadership* (1998, p.38) has stated that one of his eight universal laws for becoming a great leader was "maintain absolute *integrity*." Whilst Cohen does not list these eight laws in any particular order or priority he does list the law to "maintain absolute *integrity*" first. In addition, Shewchuk (2003, p. 24) maintains "*integrity* is a core component of leadership." Cohen (1998, p. 38) contends that maintaining *integrity* is the foundation upon which everything else is built. "This is because leadership is a trust," and leaders who do not maintain absolute *integrity* will not be trusted, irrespective of their implementation of the other laws (Cohen, 1998, p. 38). In addition, a qualitative study which "describes seasoned nurse leaders' opinions about the educational preparation, experiences, and competencies desired in nurse managers for the year 2020" by (Scoble & Russell, 2003, p. 1) includes *integrity* as one of twelve key competencies for successful nurse leaders in 2020. Indeed Shewchuk (2003, p. 23) extends this notion by arguing that leaders need to be transparent as hidden agendas bring ruin to a leader's *integrity*. Publications by Cohen (1998), Scoble & Russell (2003), Shewchuk (2003), Stanley (2004; 2006a; 2006b), Thompson et al., (2003) and Wieck et al., (2002) affirm the role and importance of *integrity* in leadership. This study's findings show the respondents to recognize the importance of *integrity*, therefore, *integrity* should be a quality divined in a nurse by those responsible for appointments before promotion to CN. Nurses expect an extremely high level of *integrity* and honesty in their leaders.

Finally, the intrinsic quality, *dependable*, received 36 top three preferences from 115 respondents. While this study found no evidence that the research participants thought their CNs were not *dependable*, the number of preferences allocated to this intrinsic quality shows the high value respondents place on this attribute. To be *dependable* is to be reliable (Knight, 2003), that is, when a CN says they will attend to a matter it will be assuredly done *Dependability* is a similar quality to *integrity* in that both require transparency and honesty from the CN leader to the RNs. According to a descriptive USA study (Feltner et al., 2008, p. 366), being *dependable* was considered

an important leadership characteristic by their respondents, their descriptive study associating leadership *dependability* with leaders "being visible and accessible and practicing an open-door policy." These authors (2008, p. 366) also asserted with conviction that "an effective leader is dependable, reliable and consistent." In contra-distinction, descriptive studies by Stanley (2004; 2006a), Thompson et al., (2003) and Wieck et al., (2002) did not have the intrinsic quality of *dependable* as a preferred leadership characteristic. Nevertheless, the respondents from this investigation consider the attribute, *dependable*, important, thus this intrinsic quality should be demonstrated prior to promotion of a RN to CN.

In essence, RNs want their CNs to be effective leaders by being *understanding* and *motivated*, possessing *integrity* and being *dependable*. Thus, if this hospital's CNs are to be leaders, these aspirants must be prepared to set the 'moral' tone in their organisation by exhibiting these preferred intrinsic qualities, which are inherent in the CN role of their profession.

5.4.4. Personal Attributes

Personal attributes are qualities or characteristics belonging to a particular person (Knight, 2003), in this instance a CN. The questionnaire completed by the cohort of 115 participants had twelve personal attributes from which to select, and of these, *team player* received most of the top three preferences (n = 57); *mentoring attitude* received 46 preferences; *receptive to people and ideas* was next with 42 preferences; *motivator of others* polled 38 preferences; and *communicator* 37 preferences. The four most preferred personal attributes are discussed next in this section.

The personal attribute of *team player* received a top three preference from 50% of the hospital study cohort. Teamwork is one of this hospital's core values, and as such is recognised as important by hospital management for both leaders and employees. Respondent 070 highlighted the importance of a CN being a *team player*, remarking "*Instead of being dictators, get involved in the work, earns others respect, teach as you work with others.*" Given the definition of *team player* is someone who is a member of a group of people working together (Knight, 2003), this comment and study result indicate the study hospital RNs to want their CNs to be a part of their nursing team. Magnet hospital research has also identified *team player* as a preferred leadership attribute (Scott et al., 1999); and likewise, this attribute was also identified as important

by Anthony et al., (2005, p.153) who deduce in their qualitative study "if a nurse manager (or CN) focuses on good team construction (structure), then it increases the likelihood of having good teamwork (process), which leads to better patient outcomes." *Team player* was also identified as a desirable CN trait in descriptive studies concerning preferred leadership characteristics, conducted by Thompson et al.(2003), and Wieck et al. (2002). Similarly, for the RNs in this investigation, the personal attribute of *team player*, is important. Thus, educational programmes to assist in development of team structure, building teams and being a *team player* are important for those nurses in the role of CN.

The personal attribute of *mentoring* received 46 top three preferences. *Mentoring* can be defined as advising, counselling or tutoring (Knight, 2003) a person in a profession or workplace. Bally (2007, p.5) argues that "*mentoring* is one method that can enhance staff satisfaction, and therefore, can reduce the feeling among nurses that they are being devalued, discriminated against, and disempowered by their own peers." Despite the importance RNs, who participated in this investigation, placed on CNs having the ability of *mentoring*, other studies have not identified it as a most desirable trait, such as studies in the USA by Wieck et al. (2002) and Thompson et al. (2003), both posing similar research questions and employing similar evaluation instruments as the current investigation. These latter descriptive studies aimed to determine what the emerging and entrenched workforce nurses see as desirable in a manager, and it is possible that these observed differences may be attributable to cultural differences.

In Australia, the attribute of *mentoring* is important to the Australian Nursing and Midwifery Council (2005, p. 4) which state in their competency standards under section 4.3, the RN "Participates where possible in preceptorship, coaching and *mentoring* to assist and develop colleagues." The Competency Standards for the Australian RN reinforce the skills associated with *mentoring* within the Australian nursing context. It is noteworthy that the Australian RNs in this study, who, as qualified nurses are expected to mentor colleagues as part of their professional role, are also asking their CN leaders to mentor them and aid them in the improvement of their practice as a RN.

Given *mentoring* is a Competency Standard required by the ANMC for Australian RNs to achieve, it would be expected that an RN who has been promoted to CN would exhibit this attribute, but this may not always be the case. For example, one research participant (072) commented that lack of time inhibited her ability to mentor staff, stating, "*CNs need time to be all these things in their work areas apart from patient care allocated hours.*" This respondent's comment draws attention to the difficulty CNs have in exhibiting all the traits desired of them by the RNs, if they are not allocated time to achieve these. Another respondent highlighted *mentoring* a colleague or RN to be time consuming, especially if the CN is allocated a full patient load, which inhibits the ability to teach and mentor as effectively. In fact, Feltner et al.,(2008) discusses this dilemma, describing the challenge of balancing time for accomplishing the tasks of leadership responsibilities and meeting the needs of staff. Mentors certainly need time to listen so they can mentor and be *receptive to people and ideas*, the latter being the third most preferred personal attribute and discussed in the next paragraph.

Respondent 071 remarked:

> *... we (CNs) are a diverse group of people who can be adversely effected by the pressures of caring for our patients and colleagues, some of the above traits [referring to the questionnaire] are often not appreciated and disappear under the workload as financial pressures dictate things like staff numbers, skill mix, staff/patient ratio, learning opportunities etc. etc.*

While *mentoring* was a preferred CN personal attribute the RNs participating in this study wanted their leaders to have, it is also noted that for CNs to be able to mentor those they lead, education about how to *mentor,* and time allocated for *mentoring* should be set aside.

The personal attribute of being *receptive to people and ideas* received 42 top three preferences from the respondents. Being *receptive to people and ideas* means that the individual is quick to receive people and ideas, i.e. plans and opinions from others (Knight, 2003). Other research has found that this attribute was also a preferred trait for the emerging and entrenched nursing workforce in the USA studies by Wieck (2002) and Thompson et al. (2003). As Wieck et al (2002, p. 287) point out, being *receptive to people and ideas* does not mean that a response must be made or action must be taken by the CN or leader, but that RNs want their ideas to be heard and acknowledged

irrespective of whether their ideas and plans are adopted. As observed by Feltner et al.,(2008), CNs having an open door policy and being available to the RNs would facilitate this attribute in the leaders at the study hospital.

Motivator of others was the fourth most preferred personal attribute receiving 38 top three preferences. A motivator gives a person reason or incentive to do something (Knight, 2003), consequently to be a *motivator of others* is someone who gives others a reason or incentive to complete the common goals and tasks at hand. The ability to motivate others entails the pulling of a team together to complete a common task or goal. This is similar to Vroom & Jago's (2007, p. 18) working definition of leadership, which affirms "We see leadership as a process of motivating people together collaboratively to accomplish great things." Vroom & Jago see the attribute, *motivator of others*, as fundamental to leadership. Research by Wieck et al., (2002) in the USA, reveals the emerging workforce between 18-35 years identified *motivates others* as a desirable leadership trait although those nurses over 35 years of age did not rank this attribute as a most desirable trait in their leaders. This would indicate that the younger group of nurses wants a leader who motivates others; whereas the older nurses in Wieck's study do not see this as important. In contrast, the respondents in the Thompson et al.'s (2003) USA study did not list *motivator of others* as a most desirable leadership trait. Nonetheless, the participants of this investigation considered *motivator of others* a preferred personal attribute for a CN to possess.

A number of theories of motivation exist, some of which are discussed by Eccles & Wigfield (2002) in their review of recent research on motivation. Briefly, motivation theories speculate about the commonalities and differences between internal or intrinsic and external or extrinsic motivation. CNs must to discover how individuals are motivated to work towards personally meaningful goals. Some of the most effective ways for CN leaders to motivate their staff include recognition, providing positive performance feed back and challenging employees to learn new things. In fact, Bennis (1999) talks about leaders who understand the "power of appreciation" as a powerful motivator. Furthermore Feltner et al. (2008, p. 367) suggest that leaders are able to motivate those they lead using "incentives and rewards for successful work." As the participants of this investigation discerned, a CN who is able to *motivate others*, both individually and as a group, and to carry out the daily and long term tasks required, is important to both those they lead and their employer.

In summary, according to the results of this study, the leadership characteristics RNs perceive as important in their CNs are; the acquired skills of *clinical competence* and a *good communicator*, the attitudes of being *approachable* and *supportive*, the intrinsic qualities of *understanding*, *motivated, integrity* and *dependable*, and the personal attributes of being a *team player*, having a *mentoring attitude*, being *receptive to people and ideas* and ability to be a *motivator of others*. With the exception of *clinical competence*, all of the leadership characteristics identified as important by the RNs in this research study are leadership characteristics that are important and transferable to any leadership environment where there are or is a leader(s). This will be discussed in the concluding remarks.

5.5 Research Question Two

Do RNs in different specialties of nursing perceive differing leadership characteristics in their CNs as important?

This question aimed to determine whether there were any differences in RNs' preferred leadership characteristics of a CN according to various nursing specialties. The participants were asked to identify which was their specialty from among eight categories: medical, surgical, critical care, peri-operative, procedural, palliative care, psychiatry, and nursing management. The specialty known as "procedural" consisted of RNs who worked in the: cardiac catheter laboratory (CCU), day procedure unit (DPU) and gastrointestinal unit (GIU). This procedural group was combined with the peri-operative specialty. Similarly, those respondents who worked in palliative care were combined with respondents from the medical specialty group. These groups were combined as there were not enough procedural and palliative care respondents to warrant separate data analysis. However, while responses from the specialties of psychiatry and nursing management were also small, their specialties were so dissimilar it was decided not to combine their data with another specialty.

5.5.1. Acquired Skills

To answer Research Question Two the data were re-analysed to investigate whether any similarities or differences could be discerned in the preferred acquired CN skills between specialties. Table 4.18 illustrates there was no difference between the groups of specialties for the most preferred acquired skill. Irrespective of specialty,

clinical competence remained the most preferred acquired skill for a CN; however, small differences were detected between specialties for the second and third most preferred acquired skills in a CN, and these are discussed in the following sections.

The entire cohort of RNs, comprising all specialties, gave the acquired skill of *good communicator* the second most preferences. Similarly, the RNs working in medical and surgical wards second most preferred acquired skill was also *good communicator*. However, the RNs employed in the critical care specialty gave second most top three preferences equally to both the acquired skills of *good people skills* and *good communicator*. The RNs who have responsibility in the peri-operative specialty gave *good people skills* second most top three preferences for a CN acquired skill, with *good communicator* being the third preferred acquired skill. It is noteworthy that peri-operative nurses in the descriptive study by Thompson et al.(2003) also preferred the same acquired skills of *good communicator* and *good people skills* for a nurse manager. In this study, it was not possible to identify second and third most preferred CN acquired skills in the specialties of psychiatric and nurse management, this is because these groups were very small.

For the complete group, that is all specialties, the second most preferred acquired skill was *good communicator*. When the data were re-analysed according to specialty, slight differences between specialties emerged. RNs who worked on medical and surgical wards chose the same second most preferred acquired skill as the main cohort, that is *good communicator*. However, those RNs who function in the acute care settings of peri-operative and critical care, also considered it important that a CN has *good people skills*. Furthermore, Boyle et al., (1999) in a descriptive study of managers' leadership and critical care nurses intention to stay in employment, found that educating managers about effective interpersonal skills induces positive changes within the work environment. Furthermore, the participants in the studies by Wieck et al., (2002) and Thompson et al., (2003) also identified *good people skills* as desired skills for a nursing manager to acquire. Similarly, this study hospital's investigation reveals that RNs from other specialties want their CNs to be *good communicators*, but the RNs working in the peri-operative and critical care environments want their CNs to have *good people skills* also. It is beyond the remit of this study to evaluate the validity of this finding; therefore, further research with a much larger population needs to be conducted to determine if differences such as these are significant and their causation.

Nevertheless, CNs from the study hospital could improve their *communication* and *people skills* by attending relevant courses and seeking objective feedback from the RNs they lead and other CNs.

5.5.2. Attitude

When the data were re-analysed, only slight differences were detected between respondents' preferred attitudinal traits, for a CN to have, according to their nursing specialty, compared with the main cohort. When the data were separated according to specialty, the attitudes of *approachable* and *supportive* were still the most frequently selected traits. However, data from the nursing manager group ($n = 8$) were inconclusive because of the small number of respondents in this group and the top three preferences being spread over 10 attributes with no preferred attitudes identifiable.

5.5.3 Intrinsic Qualities

The data were re-analysed to identify any differences between preferred intrinsic qualities of a CN according to specialties. Similar to the main group, for the cluster of intrinsic qualities, 17 of 39 RNs from medical wards and 15 of 27 RNs from the surgical wards gave top three preferences to the trait of *understanding*, making this the most preferred CN trait for both groups.

Unlike the main group, 10 of the 22 RNs working in the peri-operative environment gave top three preferences to the intrinsic quality of *motivated*, which was the second most preferred intrinsic quality for the main cohort of participants in this study. In contrast to the main cohort and the peri-operative RNs, RNs from the critical care unit gave equal preferences to the intrinsic qualities of *non-judgemental*, *intelligent* and *integrity*. Four of seven psychiatric RNs gave top three preferences to both intrinsic qualities of *reliable* and *honest*; these were not preferred traits by RNs in the main cohort or other specialties. Whilst *honesty* was not a highly rated trait for a CN in other specialty groups, four of the seven psychiatric nurses gave *honesty* top three preferences. However, one definition of *integrity* is being honest (Knight, 2003) so *integrity* was a preferred intrinsic quality for CNs by the RNs in critical care areas, hospital educated RNs and Level 2 or higher RNs. This indicates the psychiatric RNs preferences in this study are not unusual or different.

Of interest is that the trait, *intelligent*, was given five top three preferences from eight nursing managers although this trait was not one of the most preferred intrinsic qualities for the main group. Whilst the intrinsic quality of *intelligent* received preferences in other groups of this study it was not considered a highly preferred trait for a CN to possess. In addition, the respondents in the studies by Wieck et al. (2002), and Thompson et al.(2003) did not identify *intelligence* as a preferred intrinsic quality in a nurse manager either. It is not possible to determine why these differences occurred and further research is needed to establish possible reasons, especially since there was such a small number ($n = 8$) of respondents in the nursing management group for this study.

As was found in the main research cohort, *understanding* was found to be an important leadership trait for CNs at the study hospital to possess by the RNs working in medical and surgical wards. Nevertheless, it was noteworthy that respondents in the other groups ranked other qualities more highly. Similarly the trait of *understanding* was not one of the most desirable traits of nurse leaders in the studies of Wieck et al. (2002) and Thompson et al., (2003) both of which implemented a similar questionnaire to that deployed in this study. These observed differences might be because of the changes made to the questionnaire for this investigation, or because of the different context and culture of the participants.

5.5.4. Personal Attributes

The data were re-examined to see if there were any differences between nursing specialties of preferred personal attributes for a CN to possess. The main group of respondents gave most preferences to the personal attribute of *team player. Team player* was still the most preferred personal attribute for 20 of 39 RNs from medical wards and 15 of 27 RNs from surgical wards. The second most preferred personal attribute for 19 of 39 RNs from medical wards and 13 of 27 RNs from surgical wards was a *mentoring attitude*, the same as the cohort of respondents. But, unlike the cohort, *receptive to people and ideas* was the most preferred attribute with top three preferences from 12 of 22 peri-operative RNs and 7 of 12 critical care RNs. *Team player* was the second most preferred attribute for 11 of 22 RNs from peri-operative areas. Critical care RNs' second preferred personal attribute was *motivator of others* with 6 preferences. The other two specialties of psychiatric and nursing management RNs did not provide definitive data from their preferences. An interesting finding is that, while the RNs on medical and

surgical wards want their CN nurse leaders to be *team players*, the RNs working in acute settings of theatre (peri-operative) and ICU (critical care) wanted their CNs to be *receptive to people and ideas*, followed closely by the attribute of a *team player*.

While a *mentoring attitude* was the second most preferred personal attribute of RNs working in medical and surgical specialties and the research cohort, this attribute was not preferred by RNs in critical care and theatre specialties. This would indicate that RNs in peri-operative and critical care at the study hospital do not place as high an importance on their CNs having a *mentoring attitude* as those in the other groups from this study. Furthermore, like the critical care and peri-operative nurses from this investigation, the peri-operative nurses who participated in the study by Thompson et al.(2003, p. 255) also placed *receptive to people and ideas* as a desirable trait in a manager, indicating this attribute could be peculiar to this group of RNs. Because the operating suite is a different setting, RNs in this environment often need to be creative to solve the unexpected problems that may arise. The RNs from these environments want a CN who is *receptive to people and ideas* and listens to alternate solutions suggested to solve issues that may occur within the operating suite and in the critical care unit. RNs in these surroundings must work collaboratively with such other medical professionals as consultant doctors and anaesthetists, caring for one patient who is either anaesthetised or in need of a high degree of care. RNs in medical and surgical wards work independently, supervised by the shift coordinator, and have the responsibility of caring for four or more patients each shift. These differing work environments could be the reason for these groups differing in their second most preferred personal attribute for a CN leader. Further research must be conducted to confirm this finding.

5.6 Research Question 3

Is an RN's type of nursing education or years of experience since qualification associated with differences in the characteristics perceived as important in CNs'?

This question sought to determine whether there were any differences or similarities in RNs' preferred leadership characteristics in a CN according to the formers' type of nursing education or years of experience. To answer this question, the respondents were asked how many years they had been a RN, and to indicate the type of nursing education they had received: hospital based, university based, or both, and other. One respondent did not complete this section correctly thus their data were

excluded from the analysis, thereby making the research cohort 114 instead of 115. Years of experience was broken down into five groups of: 0-2 years, 2-5 years, 5-10 years, 10-25 years and >25 years. The following sections discuss the study's findings according to the RNs type of nursing education and their years of experience in each cluster of attributes: acquired skills, attitudes, intrinsic qualities, and personal attributes.

5.6.1 Acquired Skills

When the data were re-analysed, years of nursing experience did not affect respondents' selection of the top three preferred acquired skills for their CNs – a similar finding to that of the cohort. Irrespective of nursing experience, the acquired skill, *clinical competence*, was the most preferred skill, the second being a *good communicator* for all years of experience groups, except the 10-25 years of experience, the latter's second preference being *good people skills*.

Regardless of the type of education, all three groups gave the acquired skill of *clinical competence*, most preferences with *good communicator* next showing no differences to exist in the preferred acquired skill for a CN within these groups. These preferred acquired skills were discussed earlier in this chapter.

5.6.2 Attitude

The cohort of respondents' in this study preferred the leadership attitudes of *approachable* and *supportive* most, as evidenced when the between groups data was re-examined according to years of experience, these leadership attitudes receiving the most top three preferences within each sub-set. Those RNs with 0-2 years and >25 years of experience most preferred the attitude *approachable*, while the RNs with 2-5, 5-10 and 10-25 years of experience most preferred the *supportive* attitude. This might be reflective of the 0-2 year group being new to nursing and insecure about approaching their CNs, while the >25 year group responses may be indicative of not finding the CNs, who are possibly younger and less experienced than them, *approachable*. The slight difference between the years of experience groups' preferences of *approachable* or *supportive* being the first or second most preferred attitudes, infers that both of these attitudes were highly regarded CN leadership traits by all these groups.

When re-analysing the data between the groups according to type of nursing education, *approachable* and *supportive* were still the most preferred attitudes for a CN

to have. The next most preferred attitude for hospital, and both hospital and university educated RNs was *respectful of subordinates*; whilst university educated RNs third preferred attitude for a CN was *calm*. The first two groups mentioned are older than the university educated RNs because hospital-based education has not been conducted in WA since 1990, (F. Gilroy, Nurses Board of W.A., personal communication, September 3, 2008). These older RNs consider that being *respectful of subordinates* was an important leadership attitude for CNs to possess, consequently giving the trait third most preferences. Their opinions are confirmed by respondent 081's comment, "*Young clinical nurses sometimes think they know more than older nurses and have a superior attitude.*" In addition, respondent 087 refers to what she believes to be CNs' disrespectful behaviour in her comment, "*CNs should not force upon their will to get things going or assume that particular staff would work or stay overtime without even asking first.*" Indeed if a CN requires an RN to do an extra task or shift it is courteous if the RN concerned is consulted first. This courtesy shows *respect for subordinates.*

5.6.3 Intrinsic Qualities

The main group's most preferred intrinsic qualities for this cluster were *understanding, motivated, integrity, dependable* in that order. When re-examining the data for this cluster a greater variation between the preferred CN intrinsic qualities for each age group was noted. The 15 RNs with 0-2 years experience gave 12 preferences to the trait of *understanding* and 7 preferences to *reliable*. Of the 12 RNs in the 2-5 year group 6 preferred the trait of *reliable*. Of the 13 RNs in the 5-10 year group, the trait of *understanding* received 4 preferences. The 37 RNs in the 10-25 year group nominated *motivated* 17 times and *integrity* 14. *Integrity* received 12 preferences from the 35 RNs in the >25 years experience group and 4 intrinsic qualities received 11 preferences: *dependable, reliability, intelligent* and *motivated*. A trend is difficult to identify other than the RNs with less experience seem to prefer the intrinsic quality of *understanding* in a CN whilst those with >10 years experience opt for a CN to exhibit *integrity*. In Wieck's (2002), study the entrenched workforce, those who were >35 years of age, ranked *high integrity* as a most desirable trait of a leader, while those younger did not rank this trait. The peri-operative nurses, in Thompson et al.'s (2003) study of what peri-operative and emerging workforce nurses want in a manager, also placed *integrity* among the top ten desirable managerial traits although the nursing students did not rank the trait that high. Thus a tentative conclusion can be drawn to the effect that age

influences how RNs perceive their leaders, for example, in this study older RNs prefer their leaders to display *integrity* more than *understanding.*

The preferred CN intrinsic qualities were evaluated next according to an RNs type of nursing education. Those RNs educated in hospital-based programmes of education were older than their colleagues whose undergraduate education occurred in tertiary institutions, and this accounted for some of the differences displayed.

The group of 38 hospital-diploma educated RNs gave 15 top three preferences to each of the intrinsic qualities of *integrity* and *motivated*; but, of the 46 RNs educated at university, 20 gave their top three preferences to the intrinsic quality of *understanding* and 17 top three preferences to both *reliable* and *intelligent.* Whilst those 30 RNs educated at both hospital and university gave 14 top three preferences to the intrinsic quality of *motivated* and 10 preferences to both *understanding* and *integrity.*

The RNs who received their nursing education at both hospital and university had the most preferred intrinsic qualities of the first two groups as their equal second preferences. Therefore, all three groups are agreed that the most important intrinsic qualities for a CN to possess are *integrity, understanding* and *motivated.*

5.6.4 Personal Attributes

The most preferred personal attributes for the whole group of respondents seriatim, was *team player, mentoring attitude, receptive to people and ideas, motivator* and *communicator.* The data for this cluster were re-examined according to age groups. The RNs with fewer years of experience, 0-2 years and 0-5 years, gave most of their top three preferences to the *mentoring* and *team player* traits; the cohort of respondents preferred these CN personal attributes as well. Furthermore, respondent 076, aged 22 years outlined how important mentoring is for relatively inexperienced nurses, commenting, "*As a relatively new registered nurse I do look up to the CNs on the ward to support me and guide me in the right direction sharing their knowledge with others.*" This statement confirms the newer RNs' desire to be mentored.

In contrast to the less experienced nurses, *friendly* was the most preferred CN personal attribute for the 5-10 year group polling 6 preferences. The following personal attributes received 5 preferences: *motivator of others, team player, receptive to people*

and ideas, sense of humour and mentoring attitude. As there were only 13 respondents in this group the data from this group is weak and any trends for this cluster of personal attributes would need further research.

The 37 RNs with 10-25 years experience required their CNs to exhibit the personal attribute, *communicator*, with 17 preferences. The personal attributes of: *motivator of others, team player and receptive to people and ideas*, received 16 preferences. Noteworthy is the small difference only between this group's most preferred personal attributes required in a CN to possess compared with that of the research cohort.

Those 35 RNs who have been nursing for >25 years gave 19 preferences to the personal attribute of *team player* with 13 preferences given to the trait of *mentoring*. The cohort of respondents for this study also preferred these attributes. Respondent 070, who is 51 years of age, reaffirms these preferred traits for a CN commenting, "*Instead of being dictators, get involved in the work, earns others respect, teach as you work with others*."

The data were re-analysed by groups according to the three types of nursing education RNs received, in order to identify differences or similarities of preferred CN personal attributes between the groups. Hospital educated RNs gave most preferences to the personal attribute, *motivator of others*, while those RNs educated at university and at both university and hospital programmes gave the most top three CN personal attribute preferences to *team player*. These results indicate a difference in the preferred personal attribute for a CN between those who have been educated at university and those RNs who were educated through a hospital. The hospital educated RNs preference for *motivator of others* indicates they require their CNs to be the driving force within the work environment; whereas those educated at university want their CNs to be part of the team, which undertakes prescribed hospital duties.

The second most preferred personal attributes emphasised that those RNs educated within the different environments of university and hospital indicated that *mentoring* was of priority to them whilst those RNs educated at both university and hospital had *receptive to people and ideas*. Further research would need to be conducted to establish whether these small differences are significant or not.

5.7 Research Question 4

Are there differences between Level 1 RNs' and Level 2 or higher RNs' perceptions of important leadership characteristics in a CN?

This question was posed to determine whether any differences could be noted in preferred CN leadership traits between Level 1 and Level 2 or higher RNs. That is, does seniority affect the traits and attributes the study respondents want their CN nurse leaders to display? The cohort was asked to identify what level RN they were. In Australia, a Level 1 RN is "a person licensed to practice nursing under an Australian State or Territory Nurses Act or Health Professionals Act. Referred to as a Registered Nurse Division 1 ... " (Australian Nursing and Midwifery Council, 2005, p. 8). A Level 2 or higher RN is a nurse who is eligible for registration and has the position of a CN or manager. This sub-section discusses the data, comparing the responses from RNs of Level 1 and Level 2 or higher in each cluster of: Acquired skills, Attitudes, Intrinsic qualities and Personal attributes.

5.7.1 Acquired Skills

The main group's most preferred acquired skills were *clinically competent* and *good communicator*. The data were re-analysed into Level 1 and Level 2 or higher RNs' responses to identify any differences or similarities between these groups for preferred CN acquired skills.

Clinical competence was the most preferred acquired skill with 62 of 76 Level 1 RNs and 33 of 38 Level 2 or higher RNs giving their top three preferences to this trait. Level 1 RNs gave the next most preferences ($n = 39$) to the acquired skill of *good communicator* and then 33 preferences to the trait of *good people skills.* Level 2 and higher RNs gave their second most preferences ($n = 22$) to the acquired skill of *good communicator*, and then 16 preferences to the trait of *practical knowledge*.

The study concludes that a CN who is *clinically competent* is preferred by Level 1 and Level 2 or higher RNs, with being a *good communicator* being the next highest priority. Osborne et al (2003 p. 6) confirm this result, declaring, "To be able to lead in a particular field one must possess the skills and knowledge of that area." Donoghue and Pelletier (cited in Duffield & Franks, 2001, p. 88) reinforce this claim by observing the difficulty a CN has in maintaining clinical skills while leading in the work environment,

"In the struggle to develop management skills and establish themselves as managers they have forfeited some of their clinical credibility."

This investigation infers the two groups differ in their selection of the third most preferred acquired leadership skill of a CN. Level 1 RNs third most preferred acquired skill was *good people skills* whilst the Level 2 or higher CNs chose *practical knowledge*. Anthony et al. (2005) comment on the importance of managing relationships in the retention of nurses. This result from the Level 1 RNs affirms this with *good people skills* being a preferred acquired skill for this group. The more experienced Level 2 or higher RNs were slightly less concerned with *people skills* than with the acquired skill of *practical knowledge* which is the possession of information, facts and real life experience. This skill is a similar trait to the acquired skill of *clinical competence.* However, *good people skills* were still important to them and the attribute was one of their preferred attributes.

In summary, in this cluster, both groups of RNs want the same acquired skills from their CNs other than their third preferred acquired skills of *good people skills* for Level 1 RNs and *practical knowledge* for Level 2 or higher RNs.

5.7.2. Attitudes

Like the main cohort's preferences when the data were re-analysed, *approachable* and *supportive* were the first and second most preferred attitudes for both groups in this cluster. The 76 Level 1 RNs gave 52 preferences to the attitude of *approachable* and 51 preferences to *supportive*, while, of the 39 Level 2 or higher RNs 23 gave preferences to *approachable* and 22 to *supportive*. This is again is a strong result showing that both groups agree for the two most preferred attitudes.

The third most preferred attitude for Level 1 RNs were *respectful of subordinates* and *calm* with 19 preferences each, while Level 2 or higher RNs third most preferred attitude was *inspirational* and a *positive attitude* with 10 preferences each. This is the only group, Level 2 or higher RNs, that had *inspirational* as a preferred attitude, and the trait of a *positive attitude* was only preferred by the critical care nurses group. The Level 1 RNs' preference for CNs who are *respectful of subordinates* was selected as a preferred attitude by the more experienced RNs; those RNs educated in both hospital, and hospital and university environments. The attitude *calm* was preferred

by both the less experienced and the university educated RNs. This discloses the third most preferred attitudes selected by the Level 2 or higher RNs are not to be the same as those most preferred by the other groups in this study. Further investigation is needed to examine this result.

5.7.3 Intrinsic Qualities

The main groups' most preferred intrinsic qualities were *understanding, motivated, integrity* and *dependable* respectively. When re-analysing the data, 32 of 75 Level 1 RNs gave their top three preferences to the intrinsic quality of *understanding* with *motivated* gaining 27 preferences, while 17 of the 39 Level 2 or higher RNs gave their top three preferences to the intrinsic quality of *dependable* and 16 preferences to *integrity.*

The intrinsic qualities of *understanding* and *motivated*, preferred by the Level 1 RNs, imply this group desires their CNs to be both nurturing and inspired. Other groups in this study preferred these intrinsic qualities. The Level 2 or higher RNs were the only group for this study who selected *dependable* as a most preferred intrinsic quality. However, when the data from all the respondents are combined, the intrinsic quality, *dependable*, received the fourth highest number of preferences. This intrinsic quality is an outcome based preference, i.e. if CNs are *dependable* they get the task done and so it is not surprising that nurses put such store on colleagues who can be relied on to complete the work. Interestingly, the Level 2 or higher RNs second preferred intrinsic quality, *integrity*, was also a preferred intrinsic quality for the hospital educated group.

5.7.4 Personal Attributes

Of the 76 Level 1 RNs, 36 gave their top three preferences to the personal attribute of *team player* as did 21 of the 39 Level 2 or higher RNs. The second most preferred CN personal attribute for the Level 1 RNs was *mentoring attitude* with 32 top three preferences; and for the Level 2 or higher RNs *motivator of others* polled 17 of their top three preferences. For both groups and the cohort of respondents, the trait of *team player* is a preferred characteristic of a CN.

Of interest is that, in the previous cluster, intrinsic qualities, the Level 1 RNs required their CNs to be *motivated,* but for this cluster the RNs Level 2 or higher want

CNs to be a *motivator of others*. The Level 1 RNs felt the trait of *mentoring attitude* was an important characteristic; this characteristic was discussed earlier in this chapter.

5.8 Limitations of the study

Whilst the findings of this study have relevance for the study hospital, the researcher acknowledges there were considerable limitations. Firstly, generalisation of the findings to other settings is limited because only one study site was used. This was in part due to time constraints, which precluded the research involving RNs from other hospitals, including public hospitals. Secondly, the data collection instrument used for this study had not been used before in Australia, and was modified for the Australian context and it's reliability and validity was not ascertained. Thirdly, all RNs at the study hospital were invited to participate in this investigation, and, participation was voluntary but those RNs who chose to participate may not have been a typical sample of all the RNs employed by that hospital. Fourthly, a limited sample size and response rate meant some of the data had to be collapsed because of small cell sizes. It was also important to maintain respondents confidentiality and prevent particular nurse managers from the study hospital feeling they or their ward had been singled out for negative feedback. Fifthly, participants' responses to the questionnaire may have been influenced by discussion between the participating RNs, though this could be a positive factor in that discussion may increase considerations of the attributes inculcated in a CN. Finally, the response rate of 28.5% increases the possibility of non-response bias and limits the generalisation of these findings. Because of time and financial constraints, reminders were not forwarded to potential respondents.

5.9 Conclusion

This research, using the framework of four research questions, endeavoured to ascertain the leadership attributes perceived by RNs as important in their CNs; and differences in the preferred CN attributes between RNs with differing years of experience, nursing education, nursing Level and specialties. The results of this descriptive study were derived from modification of the "*Emerging workforce preference survey*", for the Australian context. The questionnaire was distributed to 403 RNs at a private hospital in Perth, Western Australia with at 28.5% response rate. The participants ranked their top three preferences from four clusters of traits and were

given the opportunity to make further comments of relevance to the study if they chose. These provided a small qualitative addition to the study.

The results revealed that RNs wanted their CNs to have the attitudes of *approachable* and *supportive* while being *clinically competent* and a *good communicator*. The RNs also were desirous of their CNs being *understanding, motivated, dependable* and possessing *integrity* while being a *team player*, who is *receptive to people and ideas* and has a *mentoring attitude.* Figure 5.1 below illustrates the RNs from this investigation's perception of the ideal CN.

Figure 5.1 The "Ideal CN"

The RNs in differing specialties all wanted their CNs to have the acquired skills of being *clinically competent* and a *good communicator*, although, additionally, those RNs who are employed in the peri-operative and critical care specialties wanted their CNs to have *good people skills*. All specialties wanted their CNs to have an *approachable* and *supportive* attitude. Those RNs in medical and surgical wards wanted their CNs to have the intrinsic quality of *understanding*, while those RNs who worked in theatre preferred the intrinsic quality of being *motivated* in their CNs. Whilst the RNs who worked in the psychiatric field placed importance on *honesty* and those in nursing management preferred *intelligence* as intrinsic qualities for CNs. For personal attributes, RNs in surgical and medical wards wanted their CNs to be *team players* with

a *mentoring attitude*. The RNs in the settings of theatre and ICU preferred that their CNs possess the personal attributes of being *receptive to people and ideas*, and a *team player* while *mentoring* was not a high a priority for these groups of RNs.

RNs with differing years of nursing experience gave most preferences to the acquired skill of *clinical competence*. The next most preferred acquired skill for all groups except those in the 10-25 year of experience bracket was being a *good communicator*, the latter preferring *good people skills*. All of the groups of RNs gave most preferences to the attitudes of *approachable* and *supportive*, with those RNs with the least experience and those with most nursing experience preferring the attitude of *approachable* for their CNs as the top preference. However, those RNs with 2-25 years experience placed the attitude of *supportive* first. For the cluster of intrinsic qualities, *understanding* was the trait preferred by RNs with less experience, while those RNs with >10years experience preferred the intrinsic quality of *integrity*. Interestingly, the RNs with 0-5 and >25 years experience most preferred the personal attributes of *mentoring* and *team player* whilst those with 5-10 years experience preferred the *friendly* attribute, and those RNs with 10-25 years experience preferred *communicator*.

The groups of RNs in different types of nursing education programmes had few differences in preferred CN leadership attributes. The differences identified were; that, like the RNs with more nursing experience, RNs who received their nursing education at a hospital and both a hospital and university polled *respectful of subordinates* as their third most preferred CN attitude whilst university educated RNs, like those with less nursing experience, polled the CN attitude of *calm* third. In contrast, among the hospital educated RNs, the most preferred the CN personal attribute was *motivator of others*, whilst the rest of the RNs in this group most preferred the personal attribute of *team player.*

Interestingly, again, one of the differences between RN groups of Level 1 and Level 2 or higher RNs was that Level 1 RNs third most preferred CN attitude was equally *respectful of subordinates* and *calm,* which were also preferred CN attitudes for RNs with more and less experience, and hospital educated and university educated RNs. However Level 2 or higher RNs third most preferred CN attitudes were *inspirational* and *a positive attitude* which were attributes not selected by the cohort or other groups.

From the results of this investigation it can be concluded that RNs look for a CN who is a pastoral coach and is *clinically competent*. Indeed, Anthony et al. (2005, p. 152) comment that nurse managers who utilise nurturing and teamwork aid staff retention, and encourage a positive work culture and environment. RNs require their CNs to be *clinically competent* and this should be a pre-requisite for promotion to the CN role. *Clinical competence* is not the only skill a potential CN needs. They also need the knowledge and skills required to lead and to possess the preferred leadership characteristics and attributes identified by the RNs in this investigation. Cohen (1998, p. 1) says, "effectiveness as a leader depends less on some innate trait you are born with, and much more on specific principles that anyone can follow." Perhaps because nursing is considered to be a "caring" profession it is expected that the CNs should care for the RNs in the workplace with the same dedication and skill they display in patient care. Irrespective of whether or not the CNs possess the "caring" attributes described in this study, the nature of the CNs responsibilities and work load means the CN is unable to fulfil the expectations of the RNs they lead as well as meet the expectations of their employer. Never the less it is possible to support and encourage CNs and prospective CNs to develop leadership traits identified by this investigation and to provide them with the knowledge and skills required for effective leadership. Indeed, all the traits identified as important by the participants in this study, with the exception of *clinical competencies* required for specific specialties, are transferable between leadership roles within various work environments.

5.10 Recommendations

Based on the results of this investigation there are five recommendations. The recommendations are that;

- Employers provide education programmes designed to prepare CNs and potential CNs for leadership roles, which include the traits of team building, communication, people skills and mentoring;

- Workloads are re-structured to enable CNs time to perform the tasks required of them. These tasks include mentoring and clinical support;

- The study hospital conducts a series of mentoring workshops specifically designed for existing and potential CNs;

- The study hospital revisits its anti-bullying programme and reinforce to its staff that it will not tolerate bullying. Also that all staff are made aware of the study hospital's anti-bullying policy and know the processes involved for reporting cases of bullying and horizontal violence;

- Further research should be conducted to confirm the tentative results of this study.

References

Anthony, M. K., Standing, T. S., Glick, J., Duffy, M., Paschall, F., Sauer, M. R., et al. (2005). Leadership and nurse retention: The pivotal role of nurse managers. *Journal of Nursing Administration, 35*(3), 146-155

Australian Bureau of Statistics. (2005). Australian Social Trends, 2005, Nursing Workers. In Australian Bureau of Statistics (Ed.).

Australian Bureau of Statistics. (2008a). Feature article 2: recent increases in Australia's fertility. In Australian Bureau of Statistics (Ed.) (pp. 1-4): Australian Bureau of Statistics.

Australian Bureau of Statistics. (2008b). Retirement and retirement intentions, Australia, July 2006 to June 2007. In Australian Bureau of Statistics (Ed.) (pp. 1 - 8): Australian Bureau of Statistics.

Australian Institute of Health and Welfare. (2006). *Nursing and midwifery labour force 2004* (No. 1327-4309). Canberra: Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare. (2008). *Nursing and midwifery labour force 2005.* (No. 40). Canberra: Australian Institute of Health and Welfare.

Australian Nursing and Midwifery Council. (2005). *National Competency Standards for the Registered Nurse*. Dickson: Australian Nursing & Midwifery Council.

Bally, J. M. G. (2007). The role of nursing leadership in creating a mentoring culture in acute care environments. *Nursing Economist, 25*(3), 143-148.

Baltimore, J. (2006). Nurse collegiality: fact or fiction? *Nursing Management, 37*(5), 28-36.

Bennis, W. (1999). The end of leadership: Exemplary leadership is impossible without full inclusion, initiatives and cooperation of followers. *Organisational Dynamics, 27*(1), 71-80.

Bonczek, M. E., & Woodard, E. K. (2006). Who'll replace you when you're gone? *Nursing Management, 37*(8), 30-34.

Bondas, T. (2006). Paths to nursing leadership. *Journal of Nursing Management, 14*, 332-339.

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

Burns, N., & Grove, S. K. (2001). *The practice of nursing research: Conduct, critique & utilization* (4th ed.). Philadelphia: W.B. Saunders Company.

Chemers, M. M. (2000). Leadership Research and Theory: a Functional Integration. *Group dynamics: Theory, Research and Practice, 4*(1), 27-43.

Cline, D., Reilly, C., & Moore, J. F. (2003). What's behind RN turnover? *Nursing Management, 34*(10), 50-53.

Cohen, W. A. (1998). Eight universal laws for becoming a great leader. *Network World, 15*(51), 38.

Cook, M. J. (2001). The attributes of effective clinical nurse leaders. *Nursing Standard, 15*(35), 33-36.

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

Dockery, A. M. (2004). Workforce experience and retention in nursing in Australia. *Australian Bulletin of Labour, 30*(2), 74-101.

Duffield, C., & Franks, H. (2001). The role and preparation of first-line managers in Australia: where are we going and how do we get there? *Journal of Nursing Management, 9*(2), 87-91.

Duffield, C., & O'Brien-Pallas, L. (2003). The causes and consequences of nursing shortages: a helicopter view of the research. *Australian Health Review, 26*(1), 186-193.

Eccles, J. S., & Wigfield, A. (2002). Motivational beliefs, values and goals. *Annual Review of Psychology, 53*, 109-132.

Feltner, A., Mitchell, B., Norris, E., & Wolfle, C. (2008). Nurses' views of the characteristics of an effective leader. *Australian operative room nurses, 87*(2), 363-372.

Finkelman, A. W. (2006). *Leadership and management in nursing*. New Jersey: Pearson Education, Inc.

Gerardi, D., & Connell, M. K. (2007). The emerging culture of health care: from horizontal violence to true collaboration. *Nebraska Nurse, 40*(3), 16-19.

Hader, R. (2008). Workplace violence survey 2008: unsettling findings. *Nursing Management, 39*(7), 13-19.

Heath, H., Johanson, W., & Blake, N. (2004). Healthy work environments. *Journal of Nursing Administration, 34*(11), 524-530.

Hogan, P., Moxham, L., & Dwyer, T. (2007). Human resource management strategies for the retention of nurses in acute care settings in hospitals in Australia. *Contemporary Nurse, 24*(2), 189-199.

Karmel, T., & Li, J. (2002). *The Nursing Workforce - 2010* (Report No. 0642773114). Canberra: Department of Education, Science and Training.

Kaur, S. J. (2006). Retention of Nurses: An Australian Private Hospital Perspective., *Edith Cowan University* (Vol. Masters, pp. 99). Perth: Edith Cowan University.

Knight, A. (2003). *The Australian integrated school file dictionary & thesaurus*. South Melbourne: Oxford university press.

Krebs, W. A. (1999). *Collins gem Australian English dictionary* (4th Australian ed.). Sydney: Harper Collins.

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

Mumford, M. D., Zaccaro, S. J., Harding, F. D., Jacobs, T. O., & Fleishman, E. A. (2000). Leadership skills for a changing world: Solving complex social problems. *Leadership Quarterly, 11*(1), 11-35.

Western Australian Nurses and Midwives Act, 2006/050 7 (2006).

O'Brien-Pallas, L., & Duffield, C. (2006). Do we really understand how to retain nurses? *Journal of Nursing Management, 14*, 262-270.

Osborne, S., Fong, J., & Keogh, M. (2003). Leading opinions. *Collegian, 10*(3), 5-7.

Polit, D. F., & Beck, C. T. (2004). *Nursing Research: Principles and Methods* (7 ed.). Philadelphia: Lippincott Williams & Wilkins.

Polit, D. F., Beck, C. T., & Hungler, B. P. (2001). *Essentials of NURSING RESEARCH, Methods, Appraisal and Utilization* (5th ed.). Philadelphia: Lippincott Williams & Wilkins.

Schull, P. D. (1984). Magnet hospitals: Why they attract nurses. *Nursing, 14*(10), 50-53.

Scoble, K. B., & Russell, G. (2003). Vision 2020, part 1: Profile of the future nurse leader. *Journal of Nursing Administration, 33*(6), 324-330.

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

Shewchuk, M. (2003). Integrity - a staff expectation of their leaders. *Canadian operating room nursing journal, 21*(4), 22-24.

Smolenyak, M. M. A. (1992). What is leadership? *The Journal for Quality and Participation, 15*(4), 28-32.

Stanley, D. (2004). Clinical leaders in paediatric nursing: a pilot study. *Paediatric Nursing, 16*(3), 39-42.

Stanley, D. (2006a). In command of care: clinical nurse leadership explored. *Journal of Research in Nursing, 11*(1), 20-39.

Stanley, D. (2006b). Recognizing and defining clinical nurse leaders. *British Journal of Nursing, 15*(2), 108-111.

Stogdill, R. M. (1981). *Stogdill's Handbook of Leadership, a survey of Theory and Research* (1st revised ed.). New York: The Free Press.

Swearingen, S., & Liberman, A. (2004). Nursing leadership, serving those who serve others. *The Health Care Manager, 23*(2), 100-109.

Thompson, J., Wieck, K. L., & Warner, A. (2003). What perioperative and emerging workforce nurses want in a manager. *AORN Journal, 78*(2), 246-261.

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

Vroom, V. H., & Jago, A. G. (2007). The role of the situation in leadership. *American Psychologist, 62*(1), 17-24.

Wieck, K. L., Prydun, M., & Walsh, T. (2002). What the emerging workforce wants in it's leaders. *Journal of Nursing Scholarship, 34*(3), 283-288.

Willis, S. (2002). The problem of bullying. *Nursing Management, 9*(2), 35-36.

Appendices

Appendix A

Job description of CN at the "study hospital"

	POSITION DESCRIPTION
POSITION:	CLINICAL NURSE
DIVISION:	CLINICAL SERVICES
DEPARTMENT:	NURSING
REPORTS TO:	CLINICAL NURSE MANAGER

The "Study Hospital" is a large, acute-care private teaching hospital. The hospital has 24-hour medical cover and support services on site. The hospital provides for general, medical and surgical specialities and has palliative care and psychiatric facilities. Hollywood offers special benefits to staff including: a caring and family friendly workplace; free parking; close access to child care facilities and hospital based school holiday programs; health and fitness facilities; a supportive working environment; a fun place to work, and ongoing training and development opportunities *are* available.

OUR VISION, MISSION AND MOTTO

*** *VISION* ***

Leading the way in health care provision

** ' *MISSION* ***

To provide safe, high quality and personalised care that makes a difference to the patients' hospital experience

'"*MOTTO****

Caring for you is our commitment

Signed... .....
Director of Clinical Services

"Study" Hospital

CODE OF BEHAVIOUR

In addition to your specific duties, your behaviour while performing your duties should at all times be in accordance with the Hospital's Core Values and Principles of Service.

CORE VALUES

Respect for the individual
At "study hospital" we believe in treating our patient/customer holistically, as someone who deserves our best in assisting them to reach a desired outcome. Our energy and skill is offered in the pursuit of our job and "this hospital" supports its staff and helps to celebrate their successes. We pursue professional and personal development and are supportive of our co-workers. We strive for integrity, credibility and respect for the individual.

Pursuit of excellence
"Study Hospital" is committed to building a reputation for leading the way as a health care provider through quality of care and service. Excellence is a dynamic state and to achieve excellence we are innovative and look beyond the boundaries of our positions within the organisation. We take pride in our work and actively seek new ways of doing things better.

Teamwork
We work as a team to achieve the strategic goals of the organisation. Each staff member's contribution to creating a flexible, trusting, caring and supportive team environment is valued. We build constructive relationships to achieve positive outcomes for all. It is our responsibility to recognise the value of others and to contribute to the success of the team and that of the hospital.

Contribution to the community
The "Study Hospital's" community includes our patients, ex-service organisations, service organisations, the health professions and the wider community. Through our communities we actively promote the interests of the health care industry. We each play a vital role in contributing to the community and assist in strengthening our relationships through good communication and by striving for mutual benefit.

The 'Study Hospital' spirit
We bring to this hospital our energy and creativity. We work hard and have fun. Our qualifications include honesty, integrity, loyalty, commitment and enthusiasm. We are caring, progressive, enjoy our work and use a positive spirit to get things done. We have a 'can do' attitude which has no boundaries.

"The Study Hospital'

PRINCIPLES OF SERVICE

1. Our MOTTO is "Caring for you is our commitment".

2. Be an ambassador of this Hospital in and outside the workplace. Always talk positively and do not discuss internal problems in public areas.

3. Always maintain an appropriate environment by limiting noise and keeping areas free from clutter.

4. Use proper telephone etiquette. Start with a greeting, identify your organisation/department and then yourself, and offer to help the caller.

5. Participate in and support the hospital's quality approach.

6. Treat your customer just as you would want to be treated.

7. If you receive a customer complaint, own the complaint. Customers who complain are often giving you an opportunity to win back their support.

8. Acknowledge the four basic customer needs:

   - To feel understood
   - To feel welcome
   - To feel important
   - To be comfortable

9. Code of dress is important. Be appropriately attired at all times. Wear proper, safe and clean footwear. Take pride and care in your personal appearance.

10. Courtesy is reflected in your attitude, words and actions.

"Study" HOSPITAL

POSITION
DESCRIPTION

POSITION:
CLINICAL NURSE

KEY FUNCTIONS & RESPONSIBILITIES

Provides effective clinical care of patients

- Assesses plans, delivers, facilitates, and evaluates patient care.
- Identifies complex care needs and supports required interventions.
- Maintains and monitors standards of nursing practice.
- Contributes to evidence based policy/guidelines development within the ward/unit.
- Initiates reviews of care provided to patient specialty groups.

Contributes to operational functioning of the unit

- Determines staffing requirements and ensures effective use of rostered staff.
- Manages nursing hours utilising patient dependency system/other systems within agreed performance indicators.
- *Participates in performance management of unit staff.*
- Promotes and contributes to effective communication, facilitating teamwork and cooperation within ward/unit and with other departments.
- Monitors and ensures availability of supplies and equipment.
- Contributes to the provision of safe working environment.
- Contributes to the achievement of hospital and Clinical Services objectives.
- Performs duties in accordance with Hospital policies, guidelines and relevant legislation including:
    - o Equal Opportunity Act 1985
    - o Occupational Health and Safety Act 1984
    - o Poisons Act 1964
    - o Nurses Act 2006
    - o "The Study Hospital" Infection Control Guidelines 2005
    - o Privacy Act 2000

Provides a quality focused service

- Supports and participates in achievement of the unit quality plan.
- Manages complaints related to patient care and service delivery.

Contributes to professional development of self and others

- Undertakes ongoing professional development, applies and shares knowledge and skill.
- Identifies developmental needs for unit and initiates in-service and other education programs.
- Assists the CNM in planning the requirements for and participates in the preceptoring and mentoring of staff,
- Relieves in senior and specialised roles.

"The Study Hospital"

SELECTION CRITERIA
POSITION: CLINICAL NURSE

ESSENTIAL CRITERIA

- Eligible for registration with Nurses Board of Western Australia as a Registered Nurse.
- Completed three years post registration clinical experience.
- Advanced level of knowledge and skills in specialty.
- Effective communication and interpersonal skills.
- Ability to plan and facilitate the management of a ward/unit.
- Ability to plan and conduct patient and staff education.
- Knowledge of and participation in Quality Improvement process.
- Knowledge of legislation relevant to nursing practice.
- Willingness to accept and promote "The Study Hospital" Core Values.

DESIRABLE CRITERIA

- Relevant tertiary qualification or progression towards requirement.

Appendix B

Original Emerging Workforce Preferences Survey

WHAT NURSES VALUE IN THEIR MANAGERS

1. Age _____ 2. Gender ____ Female _____Male 3. Ethnicity _____

4. Type of school: ___ Diploma ___ Associate Degree ___ Baccalaureate Degree

5. Do you recommend going to nursing school to your friends and relatives? ___Yes ___No

DIRECTIONS
For <u>each</u> of the four clusters of traits, please

a. *Circle the three (3) most important traits in a manager that you admire and respect, the one that brings out the best in you.*
b. *Then mark each circled trait in order of importance by placing a #1 next to the most important trait in your faculty, a #2 by the second most important and a #3 by the third most important.*
c. *Please place an "X" on the least important trait.*

ATTITUDES:
[Circle top 3; rank them 1-2-3; X-out least important]

Caring Optimistic Supportive Approachable Cooperative Respectful of subordinates Inspirational

Personable Hard work ethic Cheerful Positive attitude Flexible Reasonable Fair Calm

INTRINSIC QUALITIES:
[Circle top 3; rank them 1-2-3; X-out least important]

Dependable Dignified Strong willed Motivated Dedicated Detail oriented Loyal Wise Trustworthy Non-judgmental Understanding Integrity Reliable Creative Intelligent Honest

ACQUIRED SKILLS:
[Circle top 3; rank them 1-2-3; X-out least important]

Business sense Professional Decisive Good reasoning skills Risk taker Available Advocate Practical knowledge Clinical competence Good people skills Good communicator Career experience Assertive

PERSONAL:
[Circle top 3; rank them 1-2-3; X-out least important]

Motivator of others High energy Empowering Interested in quality Friendly Visionary Sense of humor Communicator Team player Responsive to people Mentoring attitude Receptive to people & ideas

Thanks so much for your input.

K. Lynn Wieck RN, Ph.D., FAAN, lynn@drwieck.com The University of Texas at Tyler

Appendix C

Permission to use and modify "Emerging Workforce Preferences Survey"

K. Lynn Wieck, Ph.D., RN

Management Solutions for HEALTHCARE

Research • Presentations • Program Design

2203 Red Bird Lane
Brookshire, TX 77423
www.drwieck.com

office 281.375.815
fax 281.375.8154
lynn@drwieck.co

April 26, 2006

Linda Aitken
Edith Cowan University

Dear Ms. Aitken:

It is my pleasure to grant you permission to utilize the "Emerging Workforce Preferences Survey" in your research and class work. I am attaching a copy of the version used with managers. We have interchanged the type of role we are assessing (managers, educators, or leaders) by simply changing the name in the title line "What Nurses Value in their _____." That has worked for us, and you may use it to collect data on whichever group you choose. You may also revise the instrument as you wish, but revisions will alter the ability to compare and contrast with studies using previous iterations of the instrument.

Scoring is simply a summated rank. For each group of characteristics, the respondent will mark a 1st, 2nd, and 3rd choice which receive 3, 2, and 1 point respectively (a first choice gets 3 points). For the least desired trait in each of the 4 sections, the trait is scored as one point. We sum all of the scores for desired traits and take them in descending order as rankings. For the least preferred trait, the points are added in a separate file, and the traits with the highest scores are ranked in descending order. If you have any problems or would like to have a template of my SPSS file, please let me know.

Thank you for your interest in this important topic of attracting and retaining young people into health careers. We have found the Emerging Workforce Preferences Survey to be an excellent instrument for making general comments about the 18-35 year old group and for discussing how to make the hospital environment more user-friendly. It has also helped us to work with nurse managers to assist them in managing an intergenerational workplace. I wish you good luck in your studies. We would like to be kept informed about your findings at your convenience.

Respectfully,

K. Lynn Wieck

K. Lynn Wieck, Ph.D., RN, FAAN
Chief Executive Officer
Management Solutions for Healthcare

Primary Investigator: Cultivating Leadership in the Emerging Workforce Research Program

Appendix D

Reliability and validity of the Emerging Workforce Preferences Survey

From: K. Lynn Wieck, RN, Ph.D., FAAN
Date: April 26, 2006

From: Wieck, KL. (2003). Faculty for the Millennium: Changes needed to attract the emerging workforce into nursing. Journal of Nursing Education, 42(4), 151-158.

The instrument used to gather information about the preferences of the emerging workforce in relation to their leader, educator, and manager was developed from a review of the relevant literature as well as from direct input from emerging workforce members. A compendium of descriptors were elicited from young people in the emerging generation (n=35) using a modified Delphi technique. These descriptors were then tested with a group of nurse administrators and leaders from throughout the nation who rated each of the 100+ traits on a Likert Scale to determine their relevance to leadership qualities. A list of 56 descriptors evolved to determine what the emerging workforce wants in its leaders. This same survey has subsequently been used to examine what they want in their faculty members and managers.

The Emerging Workforce Preferences Survey lists 56 descriptors which are broken down into four areas: intrinsic qualities, acquired skills, attitudes, and personal characteristics (Figure 1). The participants were asked to identify and rank the three most important characteristics in each of the four subscales in regard to what they value in their faculty members. The ranked traits were scored a total point score of 3 when listed as the most desired trait, a score of 2 for being the second-most desired trait, and a score of 1 when indicated as the third most desired trait. Respondents were also asked to indicate the least important characteristic in each subscale. Each of the traits received a least desirable characteristic score of 1. The scores for each trait were then simply summed to determine the least desirable characteristics for a leader. It is important to note that all of the

descriptors were seen as positive. The goal was a prioritized ranking which would demonstrate which were more important to each group and which were least important. Least important is not the same thing as "not important."

From: Wieck, KL, Prydun, M., & Walsh, T. (2002). What the emerging workforce wants in its leaders. The Journal of Nursing Scholarship, 34(3), 283-288.

Methods

Data were collected via survey of young nurses and nursing students to identify the characteristics they wanted in leaders. The emerging workforce was defined as all individuals, male or female, between the age of 18 and 35. The survey was designed in three stages.

Stage 1 included 35 participants between the age of 18 and 35 years. These participants represented a convenience sample of nurses and nursing students who met the age criteria. They were asked to list what characteristics of a leader were most important to them. After removal of redundant responses, a list of 50 characteristics was generated as the basis for further study with additional panels.

In stage 2 the original list was taken to a national group of nursing administrators (n=42) who meet annually for the purpose of serving as a "think tank" on nursing issues. These nurse leaders were asked to evaluate the list using a 10-point Likert scale (1 = "Not at all important in a leader" and 10 = "Extremely important in a leader"). The nursing leaders were also asked to add characteristics that they thought were missing from the original list. This revised list consisted of words which scored above a minimum acceptable level of 3 and included the non-redundant new words. This list of leadership characteristics formed the basis of the survey taken to emerging workforce members for input. For the sake of aesthetic appeal and to facilitate description, the resulting leadership characteristics (n=56) were arbitrarily divided into four subcategories by the researchers. These categories

were based on attitudinal qualities, innate qualities, skills that could be learned, and personal qualities. The 4 subscales were labelled attitudes, intrinsic qualities, acquired skills, and personal.

Stage 3 was dissemination of the survey to members of the emerging and entrenched workforces. Two groups were selected because their membership was thought to reflect the two age groups under study. The Emerging Workforce was targeted at a conference of the National Student Nurses Association because of the likelihood of large numbers fitting the 18-35 years age group. The Entrenched Workforce target group was a meeting of mid-managers and educators in a large Midwestern medical center where the participants were expected to be mostly over the age of 35. The participants were asked to identify and rank the three most important and one least important characteristics in each of the four subscales.

The final survey was administered to a group of hospital and nursing administrators and managers (n=129) from a medical centre and several universities in the Midwestern U.S. After completing the survey, they were asked to document any missing or unclear items. This input resulted in changing four items for clarification. The survey was administered to five groups of emerging workforce members. Those groups were a community college junior class and senior class, a university junior and senior class, and a national meeting of nursing student.

Difference between the rankings of these five samples in the same age groups who took the survey was tested. A Kruskall-Wallis nonparametric analysis showed differences in three characteristics, none of which were ranked in the top ten of any of the groups. The characteristics were "non-judgmental" (χ^2=13.5, df=4, p=.009), "empowering" (χ^2=18.9, df=4, p=.001), and "advocate" (χ^2=17.4, df=4, p=.002. None of the other 56 characteristics showed significant differences in the five emerging workforce groups which

lends some confidence that the instrument measured reliably among different subsets of the target population.

The survey of leader characteristics was administered to two groups: a national meeting of student nurses from throughout the US and a system-wide meeting of management staff at a large Midwestern medical centre. Of the three hundred surveys distributed to students in a large meeting, 112 were returned for a return rate of 37%. Of those surveys, 108 were complete. Of the 175 questionnaires distributed to hospital management team members at a large medical centre, 129 were returned for a return rate of 74%. Returning the completed questionnaire signified agreement to be in the study. Questionnaires were considered incomplete if they did not indicate age.

Appendix E

Modified questionnaire for this study

ECU Logo

The leadership characteristics registered nurses perceive as important in their clinical nurses

SECTION 1
Demographic data

1) How old are you?

Years___ Months___

2) How many years have you been a registered nurse?

Years___ Months___

3) Are you a:

Level 1 RN ☐

Level 2 or Higher RN ☐

Please tick the appropriate box for the following questions.

4) What type of nursing education did you receive?

Hospital Based ☐

University Based ☐

Both ☐

Other ☐

5) Which specialty, or specialities, of nursing do you currently work?
(Tick one or more boxes)

Medical ☐

Surgical ☐

Critical Care ☐

Peri-operative ☐

Procedural (CCL, DPU, GIU) ☐

Palliative Care ☐

Psychiatry ☐

Nursing Management ☐

Other ☐ Please Specify_____

Please see over the page...

SECTION 2

Instructions: For each of the four clusters of traits, please

1) Tick the three (3) most important traits that you admire and respect in Clinical Nurses (CNs) you have worked with during your career, which brought out the best in you and your practice as a Registered Nurse.

2) Rank each trait you ticked placing 1 next to the most important trait, 2 next to the second most important and 3 next to the third most important, i.e.

Caring	✓	**2**
Co-operative		
Inspirational	✓	**1**
Flexible		
Optimistic		
Cheerful	✓	**3**

Cluster 1: Attitudes	Tick 3 important Traits (for CN to have)	Rank ticked traits 1 most important to 3 least important
Caring		
Co-Operative		
Inspirational		
Flexible		
Optimistic		
Cheerful		
Personable		
Reasonable		
Supportive		
Respectful of Subordinates		
Hard work ethic		
Fair		
Approachable		
Positive Attitude		
Calm		

Cluster 2: Intrinsic Qualities	Tick 3 important Traits (for CN to have)	Rank ticked traits 1 most important to 3 least important
Dependable		
Dedicated		
Trustworthy		
Reliable		
Dignified		
Detail Orientated		
Non-Judgemental		
Creative		
Strong willed		
Loyal		
Understanding		
Intelligent		
Motivated		
Wise		
Integrity		
Honest		

Cluster 3: **Acquired Skills**	Tick 3 important Traits (for CN to have)	Rank ticked traits 1 most important to 3 least important
Business Sense		
Risk Taker		
Clinical Competence		
Career Experience		
Professional		
Available		
Assertive		
Decisive		
Advocate		
Good People Skills		
Good Reasoning Skills		
Practical Knowledge		
Good Communicator		

Cluster 4: **Personal Attributes**	Tick 3 important Traits (for CN to have)	Rank ticked traits 1 most important to 3 least important
Motivator of Others		
Friendly		
Team Player		
Receptive to People and Ideas		
High Energy		
Visionary		
Responsive to People		
Empowering		
Sense of Humour		
Interested in Quality		
Communicator		
Mentoring Attitude		

- **If you wish, please add further comments relevant to this study below.**

- **Place your competed questionnaire in the preaddressed envelope provided and put it in the hospital internal mail.**

Thank you for your input and support.
Linda M. Aitken RN, B.N
This questionnaire was used and modified with permission from K. Lynn Wieck RN, Ph.D., FAAN, the University of Texas at Tyler.

Appendix F

Letter of introduction to RNs participating in this research

ECU Letterhead

Dear Registered Nurse,

As part of my studies, for the award of Bachelor of Nursing with Honours at Edith Cowan University (ECU), I am conducting a study on the leadership attributes Registered Nurses (RNs) consider important in their Clinical Nurses (CNs). Permission for this study has been given by "The Study Hospital's" Director of Clinical Services and the Faculty of Computing Health and Science Sub-Committee for the Conduct of Ethical Research at ECU.

Purpose
To identify, from the RNs' perspective, the leadership characteristics of CNs' they consider most important, that facilitate their nursing practice. .

Research Questions:
1) What leadership characteristics do RNs perceive as important in their CNs?
2) Do RNs in different specialties of nursing perceive differing leadership characteristics in their CNs as important?
3) Is a RN's initial education, years of experience since qualification or current age associated with differences in the characteristics perceived as important in CNs?
4) Are there differences in the leadership characteristics level 1 RNs consider important in their CNs and the leadership characteristics perceived as important by RNs that are level 2 or higher.

Findings of this study will provide information about characteristics RNs perceive as important in their leadership. This information gives direction of important leadership traits to be developed in leaders and potential leaders of the nursing profession, providing an improved working environment and contributing to the retention of nurses in the profession.

Instructions
Complete the attached questionnaire, which should take no longer than 5 minutes to do. Do not put your name on the questionnaire or envelope, put the completed questionnaire in the preaddressed envelope provided, seal the envelope and then place it in the internal mail at the ward clerk's desk.
Please do not discuss this study with other colleagues until they have all completed their questionnaires.

Your anonymity will be maintained and it will not be possible to identify you in any report or publication. The researcher and her supervisor will be the only persons to have access to the questionnaires.

Consent
Your participation is voluntary. Return of the completed questionnaire will be taken as your consent to participating in this study. Completion/non-completion of the questionnaire will have no impact on your employment at the hospital.

If you have any queries contact the researcher, Linda Aitken on 0413 755 929, by email at laitken@iinet.net.au or on 08 9405 6893.

The supervisor for this study is Dr Carol Thorogood RN, PhD, at ECU, Perth, Western Australia, 6018 and she can be contacted on 08 9273 8623.

Thank you for your co-operation.
Yours sincerely

Linda Aitken RN, BN
Date

Appendix G

Letter to Director of Clinical Services requesting permission for this investigation to occur

ECU Letterhead

15th June, 2007

Director of Clinical Services
Study Hospital

Dear
RE: Study on: The leadership attributes Registered Nurses (RNs) perceive as important in Clinical Nurses (CNs).

I am a Registered Nurse employed by this hospital in the operating theatre and am writing to formally seek permission to conduct the above study at this hospital. I have selected this study for my honours thesis at Edith Cowan University.

The purpose of this study is to identify, from the RNs' perspective, the leadership characteristics of CNs' they consider most important, that facilitate their nursing practice.

Research Questions:
1) What leadership characteristics do RNs perceive as important in their CNs?
2) Do RNs in different specialties of nursing perceive differing leadership characteristics in their CNs as important?
3) Is a RN's initial education, years of experience since qualification or current age associated with differences in the characteristics perceived as important in CNs?
4) Are there differences in the leadership characteristics level 1 RNs consider important in their CNs and the leadership characteristics perceived as important by RNs that are level 2 or higher.

This study explores the characteristics RNs perceive as important in their leadership, giving direction of important leadership traits to be developed in leaders and potential leaders of the nursing profession, which in turn provides an improved working environment for RNs and CNs.

This proposal has been approved by ECU Faculty of Computing Health and Science Ethics Sub-Committee.

With your written approval, data will be collected by the distribution of a questionnaire attached to the RN's pay slip, after a letter of introduction to the study has been sent to and meeting the ward managers. The competed questionnaires will be returned to the researcher via the HR department at "the study hospital." I will need access to a list of all RNs (Div. 1) who are employed fulltime or part time at "the study hospital." This list will not be removed form the HR office.

A copy of the proposal for this study, which includes copies of all proposed correspondence to the staff at "the study hospital" and the questionnaire to be distributed, is attached to this letter for your reference.

A copy of the completed project will be sent to you after being reviewed by the board of examiners at ECU.

My supervisor at ECU for this study is Dr Carol Thorogood R.N, PhD.
She can be contacted at 08 9273 86223.

If you have any queries I can be contacted on 0413 755 929 or by email laitken@iinet.net.au, alternatively please contact Dr Carol Thorogood on 08 9273 8623.

I look forward to your support and response.
Yours sincerely

Linda Aitken R.N., B.Nu.

Appendix H

Memo giving ethical approval for this study

EDITH COWAN UNIVERSITY MEMO
FACULTY OF COMPUTING, HEALTH AND SCIENCE

Human Ethics Subcommittee

TO: **Tamara Harold, Admin. Officer, Higher Degrees**
FROM: **Angus Stewart, Chair, Faculty Human Ethics Subcommittee**
SUBJECT: **Human Ethics Clearance Application/s**
DATE: **12th June, 2007**

Dear Tammie,

The following ethics application is approved (category 1).

Linda Aitken	The leadership characteristics registered nurses perceive as important in their clinical nurses.

Best wishes,

Angus.

Appendix I

DCS letter approving study

11 July 2007

BY EMAIL to laitken@iinet.net.au

Ms Linda Aitken

Dear Linda

Study on: The leadership attributes Registered Nurses (RNs) perceive as important in Clinical Nurses (CNs)

Further to our meeting on Tuesday, 10 July 2007 this letter is to confirm my support to your conducting the above study at XXXXXXX Hospital.

Yours sincerely
FOR AND ON BEHALF OF
XXXXXXXXX HOSPITAL

Director of Clinical Services

Appendix J

Letter to Nurse Managers

ECU Logo

The Manager
_____ward
Study Hospital

Dear _____,

RE: Study on: The Leadership Attributes Registered Nurses (RNs) Perceive as Important in Clinical Nurses (CNs).

I am writing to introduce myself and the study I am conducting at this hospital as part of the award of Bachelor of Nursing with Honours at Edith Cowan University (ECU).

Permission for this study to be conducted has been given by the Director of Clinical Services at this hospital and the Faculty of Computing Health and Science Ethics Sub-Committee at ECU.

The purpose of this study is to identify, from the RNs' perspective, the leadership characteristics of CNs' they consider most important, that facilitate their nursing practice. .

Research Questions:
1) What leadership characteristics do RNs perceive as important in their CNs?
2) Do RNs in different specialties of nursing perceive differing leadership characteristics in their CNs as important?
3) Is a RN's initial education, years of experience since qualification or current age associated with differences in the characteristics perceived as important in CNs?
4) Are there differences in the leadership characteristics level 1 RNs consider important in their CNs and the leadership characteristics perceived as important by RNs that are level 2 or higher.

Findings of this study will provide information about characteristics RNs perceive as important in their leadership. This information gives direction of important leadership traits to be developed in leaders and potential leaders of the nursing profession, providing an improved working environment and contributing to the retention of nurses in the profession.

Data will be collected by the distribution of a questionnaire to RNs attached to their pay slips. A copy of this questionnaire is attached with the covering letter. Approximately 500 questionnaires will be distributed to all Registered Nurses working in the clinical areas throughout HOSPITAL X. Please note that it will not be possible to identify particular nurse managers through this study.

A copy of the proposal for this study is attached for your reference.

My supervisor at ECU for this study is Dr Carol Thorogood R.N, PhD.
She can be contacted at 08 9273 86223.
If you have any queries I can be contacted on 0413 755 929 or by email laitken@iinet.net.au.
I look forward to your support.
Yours sincerely,

Linda Aitken R.N., B.Nu.