

University of Southampton Research Repository
ePrints Soton

Copyright © and Moral Rights for this thesis are retained by the author and/or other copyright owners. A copy can be downloaded for personal non-commercial research or study, without prior permission or charge. This thesis cannot be reproduced or quoted extensively from without first obtaining permission in writing from the copyright holder/s. The content must not be changed in any way or sold commercially in any format or medium without the formal permission of the copyright holders.

When referring to this work, full bibliographic details including the author, title, awarding institution and date of the thesis must be given e.g.

AUTHOR (year of submission) "Full thesis title", University of Southampton, name of the University School or Department, PhD Thesis, pagination

University of Southampton
Faculty of Health Sciences

Leading and Following: An Exploration of the
Factors that Facilitate or Inhibit Effective
Leadership in Critical Care Settings in Bahrain

By

Shawqi Ali Isa (MSc, BSc)

Thesis Submitted for the Degree of Doctorate in
Clinical Practice (DClinP)

JUNE 2012

Doctorate in Clinical Practice (Commenced 2007/2011)
Faculty of Health Sciences, University of Southampton

Supervisory Team:

Professor Judith Lathlean
Professor of Health Research
Faculty of Health Sciences, University of Southampton, United Kingdom

Dr Sue Colley

Director of Employer Engagement and Enterprise
Faculty of Health Sciences, University of Southampton, United Kingdom

Address:

Building 67
Postgraduate Research Students' Office
Faculty of Health Sciences, University of Southampton
Highfield
Southampton
SO17 1BJ, United Kingdom

Sponsored by: Ministry of Health, Kingdom of Bahrain

UNIVERSITY OF SOUTHAMPTON

ABSTRACT

FACULTY OF HEALTH SCIENCES

School of Nursing

Doctorate in Clinical Practice (DClinP)

AN EXPLORATION OF THE FACTORS THAT FACILITATE OR INHIBIT EFFECTIVE LEADERSHIP IN CRITICAL CARE SETTINGS IN BAHRAIN by Shawqi A Isa

The intention of this case study research is to explore the factors that facilitate or inhibit effective leadership in Critical Care Settings (CCSs) in a government hospital in Bahrain. The study focuses on Head Nurses (HNs) working in the CCSs, since those positions play a pivotal role in creating and maintaining a Healthy Working Environment (HWE) for nursing practice. In this research the abbreviation 'Head Nurse (HN)' will be used and it stands for Charge Nurse/ Ward Sister/ Nurse Supervisor.

According to Ministry of Health (MoH) policies, the leadership in Bahrain encounters a variety of challenges including: demands for efficiency, cost cutting and a value for money service; finding alternative ways of funding; ensuring appropriate human resources; supporting improved management practices; developing a proper structure; higher customer expectations; and knowledge armed customers.

A qualitative case study design was used. This approach allows the study to explore the important factors that facilitate or hinder leadership effectiveness such as the individual professional factors (e.g. leadership style, communication, the relationship, and the educational factors) and the organizational factors which include for example healthy working environment and the organizational structure.

Data were gathered through in-depth semi-structured interviews with key informants (KIs), HNs and Senior Staff Nurses (SSN), as well as through observing HNs in clinical practice and document analysis (e.g. minutes of meetings and department annual reports). The emerging qualitative data have been analyzed through coding and grouping according to themes.

The findings revealed that effective HN leaders were recruited, and designated to the posts without development plans or without formal preparation. There was a lack of effective HN leaders who have the capabilities that are considered crucial in such a role (e.g. characteristics of emotional intelligence and authenticity). The study findings generated generic issues surrounding leadership in healthcare settings which resonate with the literature. The participants in this study talked about the characteristics of effective leaders in general rather than specifically emphasizing on issues like being in the frontline during a crisis to make quick decision that are required in critical situations.

Key Messages from the research indicate that effective head nurse leaders play a pivotal role in establishing and sustaining a healthy working environment. Also head nurses working in critical care settings should exhibit specific characteristics such as being: empathetic, open and honest, optimistic, visionary, accessible to be effective leaders.

Table of Contents	Page
Table of Contents	iv
Declaration of Authorship.....	ix
Acknowledgements	xi
Glossary of Terms	xiii
List of Appendices	xiv
CHAPTER 1 INTRODUCTION.....	1
1.1 Introduction and Justification for the Study.....	1
1.2 My Role as a Nursing Researcher	6
1.3 Research Aims, Objectives, and Questions	9
1.3.1 Research Aims and Objectives	9
1.3.2 Research Questions.....	9
1.3.3 Research Setting	10
1.4 Summary and Structure of the Research	10
CHAPTER 2 LITERATURE REVIEW	15
2.1 Introduction.....	15
2.2 Literature Search Approach	15
2.3 Developing a Definition of Effective Leadership.....	16
2.4 Driving Forces for the Development of Effective Leadership at Local, National, and Global Levels.....	17
2.4.1 At Local/ National Level	17
2.4.2 Global Level	20
2.5 Styles of Leadership	24
2.6 Emotional Intelligence and Leadership	25
2.7 Developing Self-Awareness in Leadership	26

2.8 Authenticity and Leadership.....	27
2.9 Authentic Leadership and Different Schools of Thought.....	28
2.10 Authentic Leadership and Healthy Work Environment (HWE) in Nursing	29
2.11 Intuition, Rationality and Leadership	33
2.12 Particular Consideration of Leadership in Critical Care Settings: The Head Nurse Roles	34
2.13 Summary	35
CHAPTER 3 METHODOLOGY, RESEARCH DESIGN AND METHODS	39
3.1 Introduction.....	39
3.2 Description of the Study Setting.....	39
3.2.1 The Study Setting	39
3.3 The Research Design.....	39
3.4 Research Phases.....	43
3.5 Piloting	43
3.6 Recruitment of Participants	44
3.7 Inclusion and Exclusion Criteria.....	44
3.7.1 Inclusion Criteria	44
3.7.2 Exclusion Criteria.....	45
3.8 Observation	46
3.9 Data Management	47
3.9.1 Steps of Data Processing, Analysis and Interpretation.....	47
3.9.2 Analysis of observation and documentary data.....	49
3.10 Ethical Considerations.....	49
3.10.1 Gaining Access.....	49
3.10.2 Ethics.....	50
3.11 Role of Researcher as an Insider and Outsider	50

3.12 Building Rapport	51
3.13 Conclusion.....	52
CHAPTER 4 FINDINGS.....	55
4.1 Introduction.....	55
4.2 Demographic Data	55
4.3 Emerging Themes.....	57
4.4 Leadership Style	59
4.4.1 Being Empathetic	59
4.4.2 Being Open and Honest.....	60
4.4.3 Being Optimistic.....	61
4.4.4 Being Visionary.....	61
4.4.5 Initiating and Introducing Change	62
4.4.6 Leading and Managing in Different Situations	63
4.4.7 Inspiring Staff	64
4.4.8 Engaging with the Work	64
4.5 Networking and Communication.....	65
4.5.1 Networking and Rapport	65
4.5.2 Opening Dialogue with Policy Makers	66
4.5.3 Building and Strengthening Relationships.....	66
4.5.4 Building a Harmonious Team	67
4.5.5 Open Style of Communication.....	68
4.5.6 Being Accessible	69
4.6 Education and Development.....	69
4.6.1 Cultivating a ‘Learning Organization’	70
4.6.2 Developing and Preparing Leaders for their Role.....	70
4.6.3 Developing a Creative Thinking Environment.....	72
4.6.4 Developing Role Model Skills	73
4.7 Developing a Healthy Working Environment (HWE).....	75
4.7.1 Having a Facilitative Organizational Structure	75

4.7.2 Creating an Empowering Working Environment.....	76
4.7.3 Being Valued and Lack of Acknowledgement	77
4.7.4 Being Clear about Leadership Role.....	78
4.7.5 Related Factors	78
4.7.6 The Impact of the Economic Downturn	79
4.7.7 Conclusion	80
CHAPTER 5 Discussion	83
5.1 Introduction	83
5.2 Overview of the Research.....	83
5.3 Discussion of the Findings	83
5.4 Factors Facilitating or Inhibiting Effective Leadership	84
5.4.1 The Individual Head Nurse Initiatives	84
5.4.1.2 Networking and Rapport.....	85
5.4.2 The Organization Drivers.....	85
5.4.2.2 Organization Structure.....	86
5.4.3.2 Strengthening the Quality of Education and Training of the Future HN Leaders.....	88
5.4.3.3 Head Nurse Leaders Role Preparation	90
5.4.3.4 Level of Thinking and 'Cognitive Development' in Critical Care Settings.....	92
5.5 Characteristics of Effective Head Nurse Leaders	93
5.6 Abilities of Effective Head Nurse Leaders	97
5.6.1 Developer.....	97
5.6.2 Creator	97
5.7 Special considerations regarding leadership in a critical care setting	98
5.8 Summary	100
CHAPTER 6 Conclusions and Recommendations.....	103
6.1 Introduction	103

6.2 Conclusions	103
6.3 Recommendations	105
6.4 Opportunities for Future Research.....	107
6.5 Refections Relating to Conducting the Study.....	107
6.5.1 Nature of the Study.....	107
6.5.2 The implications of being an insider researcher	108
6.6 Implications for Practice.....	108
References	111
Appendices	124

Declaration of Authorship

I, SHAWQI ALI ISA declare that the thesis submitted for the degree of Doctorate in Nursing Clinical Practice (DClinP) entitled Leading and Following: An Exploration of the Factors that Facilitate or Inhibit Effective Leadership in Critical Care Settings in Bahrain and the work presented in this report are both my own, and have been generated by me as the result of my own original research. I confirm that:

- This work was done wholly or mainly while in candidature for a research degree at University;
- Where any part of this report has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- Where I have consulted the published work of others, this is always clearly attributed;
- Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this report is entirely my own work;
- I have acknowledged all main sources of help;
- Where the report is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- None of this work has been published before submission.

Signed:

Date:

Acknowledgements

I would like to acknowledge and extend my heartfelt gratitude to the following persons who have made the completion of this research study possible: First, I thank my God, who made all things possible. Then, my supervisors Professor Judith Lathlean and Dr Sue Colley for their vital encouragement and continuous support in completion of the Thesis for the degree of Doctorate in Clinical Practice. Judith and Sue were always there to listen and give advice. I also thank the Ministry of Health, in particular the Directorate of Training and Nursing Services Directorate for funding and giving me the opportunity to complete my higher studies.

A special thanks goes to my parents, my wife, my children (Ahmed, Reem, and Osama), and my friends, for unconditional support and encouragement to pursue my interests, even when the interest went beyond boundaries of language, field and geography.

Last, but not least, I thank all participants who were involved directly or indirectly in this research study, for their time, efforts and for their encouragement in reminding me that my research should always be useful and serve good purpose for all humankind.

Glossary of Terms

AACN	American Association of Critical-Care Nurses
MoH	Ministry of Health (Bahrain)
CCS	Critical Care Settings
NDC	Nursing Development Consultant
CNE	Chief Nurse Executive
HNO	Head Nursing Officer
NM	Nurse Manager
KI	Key Informants
HN	Head Nurse
SSN	Senior Staff Nurse
A&E	Accident & Emergency
ICU	Intensive Care Unit
CCU	Coronary Care Unit
CCN	Critical Care Nursing
OT	Operation Theatre
B&PU	Burn & Plastic Unit
AND	Associated Degree in Nursing (Diploma in Nursing)
HWE	Healthy Work Environment
WHO	World Health Organization
NHS	National Health Service
UK	United Kingdom
SMC	Salmaniya Medical Complex
EMRO	Eastern Mediterranean Regional Office
RCN	Royal College of Nursing
NLC	National Leadership Council
EI	Emotional Intelligence
EQ	Emotional Intelligence Quotient
GCC	Gulf Cooperation Council
GCCNTC	Gulf Cooperation Council Nursing Technical Committee
QIPP	Quality, Innovation, Productivity and Prevention
NSR	Next Stage Review
DH	Department of Health

List of Appendices

<u>Appendices</u>	<u>Page</u>
Appendix 1 Ministry of Health Organization Layers	125
Appendix 2 Literature Search Approach	126
Appendix 3 Leadership Style and Associated Competencies	127
Appendix 4 Cognitive Continuum	128
Appendix 5 Invitation letters for participating in the study	129
Appendix 6 Research In-Depth Interview Guide	130
Appendix 7 Research Information Sheet	133
Appendix 8 An Extract of Observation Notes	135
Appendix 9 An Excerpt of an Interview Transcript	136
Appendix 10 Personnel Letter to the Chief Nurse Executive of Nursing	137
Appendix 11 Cover letter to the Head of Research Committee	138
Appendix 12 Informed Consent Form	139

CHAPTER 1 INTRODUCTION

1.1 Introduction and Justification for the Study

An effective leadership role for the Head Nurses (HNs) within Critical Care Settings (CCS) in Bahrain is essential. According to Elliott, Aitken and Chaboyer (2007) HNs are required to inspire their staff by articulating a clear vision and expectation of organization, as well as to establish standards within the CCS and to achieve growth and development in nursing care and the nursing workforce. The characteristics of effective HNs in CCS, as articulated by the American Association of Critical-Care Nurses (AACN 2005), include: effective communication with other health professionals, collaboration with other levels of management, effective decision-making, ensuring appropriate staffing, meaningful recognition of their employees, and trustworthiness. Within the current economic climate in Bahrain and the critical need for cost containment within healthcare organizations, developing effective ways of HNs working in CCS in Bahrain is important for the cost effective allocation and utilization of human and material resources.

The demand for critical care within the medical system of Bahrain is high because critical care services provide specialized care to critically ill patients, in particular those patients who have life-threatening illnesses or who are severely injured. Such patients are clinically unstable, have complex needs, and require special attention and intensive care (Lippincott, Williams & Wilkins 2008). A research study by Dorothy et al (2010) showed that nurses leave the job of critical care provider for different reasons: unrelieved job stress, nature of the job, insufficient resources (medical or personal), and negative perceptions of managers and team leaders that contribute to the development of job stress. Effective HNs within CCS will facilitate the development of the standard of healthcare, through initiating decision-making at the grassroots level, by establishing and maintaining effective communication and collaboration within CCS (AACN 2005). Employing effective HNs in CCS might help in reducing the problems relating to staff retention, staff shortages, and enhancing the abilities of HNs to cope with the extraordinary demands of critical care.

The Kingdom of Bahrain's Government is fully committed to providing comprehensive free healthcare services and treatment to all citizens. The Ministry of Health (MoH) budget is derived from the Ministry of Finance, which determines the overall health sector's budget and sets accounting standards. Thus, healthcare is financed mainly through the central government's general revenue (WHO 2007a). General revenues depend on different sources of income: oil and petrochemicals

Introduction

(around 70%), manufacturing such as aluminium, dry dock services for super tankers, and banking and commercial services (WHO 2007b). In addition to these sources, there is revenue from transportation, as Bahrain is located in the centre of the Middle East and this has made it a favourable transit spot for many airlines, especially from Western countries. The nation's healthcare services are provided through an integrated preventive and curative primary, secondary and tertiary system. The Ministry of Health is the official body responsible for offering integrated healthcare. The Minister of Health is a member of the Council of Ministers, which is chaired by the Prime Minister of the Kingdom. The Minister of Health is assisted by the Undersecretary and four Assistant Undersecretaries. They are administratively responsible for the MoH's finance, training and planning, hospitals, as well as primary and public health care services.

The Kingdom of Bahrain is considered as a developing country whose healthcare organizations encounter various challenges. Despite the particular challenges that developing countries must tackle, there are similarities with the challenges to be overcome in Britain. Mcsherry and Haddock (1999), when referring to the UK's health system, stated that healthcare organizations face challenges such as demands for efficiency, cost cutting and a value for money service. Such things happen in today's life where the world faces economic recession, rapid changes in technology, furious global competition, and the need to ensure employee retention. In addition, the knowledge level of customers has increased dramatically which, in turn, increases their expectations. Healthcare systems have to address those challenges through strengthening their internal structure; in critical care settings this can be achieved by empowering HNs leadership effectiveness.

In the existing era of financial challenges in the United Kingdom (UK), there is a growing emphasis on improving quality and productivity, through engaging, inspiring and empowering staff, and creating a legacy of leaders and a quality culture. This emphasis is an attempt to respond to economic challenges and to better position healthcare services in the NHS to meet the needs of patients and to provide a healthy work environment (Tribal 2010). The financial crisis is a global problem, and the consequence of economic recession has affected the Sub/Regional Gulf Countries (Bahrain, Oman, Kuwait, Saudi Arabia, United Arab Emirates and Qatar). The financial recession has affected the healthcare organization of these six countries. The financial crisis is one of the major challenges that exist for the health systems in those countries. Other challenges are the inadequate leadership capacity in policy analysis and strategic planning, shortages of suitable personnel in the health workforce; lack of national strategic planning; and an increasing demand for reform of existing nursing services (WHO

2009).

According to the World Health Organization (WHO 2007a) the Bahrain healthcare profile reports that the MoH in Bahrain also faces changes in healthcare policies, demographic changes in society, rapid advances in health technology, and a lack of public confidence about healthcare services. In 2006, the number of complaints that culminated in legal action increased by 45% compared to 2005, with the majority of those complaints being received through a range of different sources directly to the Minister Office, Newspapers, Local TV and Radio, Direct Telephone Line, and in and Out-Patients Clinics). These complaints show that there is a rising public expectation for more services and a demand for high quality services (MoH 2006).

The MoH in Bahrain is an organization that encompasses multiple organizational layers (see Appendix 1). The MoH's multiple, organizational layers have led to some negative effects such as that each department has its own goals. This multiplicity of goals at different departmental level means that there is a danger that the MoH in Bahrain will not meet its overall goals. In addition there could be duplication of effort as the same issues are addressed at different layers of the organization. The MoH, historically, has followed a hierarchical structure of management, in particular a bureaucratic model that is physician-dominated (WHO 2001). This bureaucratic model, known as the task centred model, represents an organization system that lays emphasis on control exercised through hierarchical authority and formal rule enforcement (Lake 2002). This model mainly uses a 'top down' style of management. The communication and networking in those layers are not organized, and are fragmented and fragile. Moreover, each department plans and implements uncoordinated quality issues in isolation from other departmental concerns. It seems that the essence of multi-layer management system tends to be top down decision-making, from one layer to another, until it reaches the lowest level of command.

The structure of the NHS in the UK, when established in 1948, was hierarchical and followed a 'bureaucratic' style of management which was similar to Bahrain's existing healthcare system, as described above. Harrison and Pollitt (1994) stated that hospitals were normally managed by a team consisting of a Hospital Secretary, Matron, and Medical Superintendent or Medical Administrator. The government gave the medical profession a very free hand and a lot of power to run health services (Blakemore and Griggs 2007). But in 1974 the U.K.'s nursing reform journey started and the typical function of the senior role of matron ceased to exist. At that period the NHS established the English Regional Hospital boards and Area

Introduction

Health Authorities. The reforms in 1974 benefited nurses and physicians by enabling them to have an important voice on the new management teams. In the early '80s, because of the political direction of the government, which brought in general management, the development of professional leadership was diminished (Baggott 1994).

Therefore, in the 1980s, Griffiths began a period of reform when he started an inquiry into the effective use of manpower and related resources in the NHS. The reform brought about significant changes in the way that the NHS was managed, as well as reflecting government concern about public dissatisfaction with the health service and the frequent questioning about the effectiveness of the medical profession (Blakemore and Griggs 2007). Griffith's reform of management replaced the 1974-style of management, and it was heavily influenced by the underpinning policy driver of 'managerialism'. 'Managerialism' is a policy driver that applies managerialist approaches to the delivery of services (such as performance management; efficiency savings, outcome measurement). The Griffiths reforms challenged the power of the medical profession. Managers assumed more power than clinicians and could challenge their decision making, hence the tensions between 'managerialism' and 'professionalism'. The Griffiths reforms influenced managerial agendas that were dominated by issues that emphasise rules and regulation as key elements of performance definition for organizations or individuals (Exworthy et al 2009).

At the stage of Griffiths' report implementation, nursing power had been subsumed under leadership of the trust or hospital, and nurses felt that they were losing: their power to manage nurses, promotion opportunities, and their equal status with other professions, such as Medicine in shaping health policy (Fyffe 2009, Baggott 1994). At this stage in the 'reform cycle', the relationship between nurses and doctors was strong as they formed a coalition against managers. Many doctors show interest in taking a role in management of services to retain their influential status within the NHS (Le Grand et al 1998). However, managerialism was implemented at such a fast pace that doctors became unhappy about its impact on their own work. Doctors who were appointed as managers started resigning. This is because they were unhappy about the way they had been instructed how to do their jobs; in particular physicians felt that they had lost their clinical freedom (Smith et al 1989). The implementation of the Griffiths' report was accelerated by the NHS reforms of the 1990s, and laid the foundations of what was to become the 'internal market', decentralization of managerial responsibility, and establishment of autonomous hospitals and primary care units. (Buchan 2000).

Introduction

At a time, in the NHS in the UK, according to the Darzi (2009) vision, there has been more emphasis on encouraging nurses to develop and adopt advances in patient care. Such advances involve the breaking down of boundaries between professions to create closer team work and identifying areas where innovations are needed. It is claimed by the (DH 2009a) that the implementation of the Darzi vision facilitates an appropriately skilled nurse to identify areas where such innovation is needed, given that such a nurse will be sufficiently prepared to be competent and to deliver against the NHS strategy to effectively spend the budget more innovatively (DH 2009a). In recent years, the DH (2010) issued a framework in response to the white paper *Equity and Excellence: Liberating the NHS*. The white paper lays out the future vision of the NHS. The necessary values and principles of the NHS are to put patients at the heart of everything the NHS does; focus on continuously improving issues and concerns that actually matter to patients (e.g. the outcome of their healthcare); and empower and liberate clinicians to innovate with the freedom to focus on improving healthcare services.

In Bahrain, the MoH management system and organizational structure tend to work against the aspiration of change and inhibit innovation and creativity. Because the organizational structure of healthcare in Bahrain is hierarchical, following a bureaucratic model of leadership where male doctors are dominant, and the flow of communication is downward through the hierarchy, it has more centralised authority, and tends to have control systems based less on trust but more on rules, regulations and procedures. However, Bahrain itself now has an obligation to have a close look at how its healthcare organizations spend money. This means that the adoption of “Managerialism” could become an issue in Bahrain, and it will be interesting to understand how it affects, as in influences professional relationships in the way the Managerialism model has done in the UK.

The Salmaniya Medical Complex (SMC) is the main secondary and tertiary care facility in Bahrain. The level of command in SMC starts from the MoH, through the hospital management board and ends down at the level of the nurses (Appendix 1). Williams (1991) stated that this is in contradiction with today’s global, prevailing, management belief where decisions should be encouraged at the grassroots; the lowest possible organizational level. Prescott (2007) stated that the advantages of initiating decision-making at the grassroots level include: developing the profession; empowering nurses; influencing public policy in healthcare matters; protecting the health and interests of the public (patients); and allowing the voice of nursing to be heard in both the workplace and in matters relating to public policy. Indeed, initiating decision-making at the grassroots level requires effective HNs, who have certain capabilities i.e. effective HNs who tend to reduce top-down

Introduction

communication and increase horizontal communication. According to Keith (1996), re-structuring organization layers (flattening) has cut personnel costs, fostered more open communication and empowered its workers, which leads them to think and work collaboratively.

The MoH in Bahrain has an obligation to provide every possible support to empower and strengthen leadership in the lower levels of command, such as Head Nurses (HNs) in CCS, and build up their capabilities to improve nursing care services in the CCS. Thus, those HNs with effective leadership skills will be ready to cope with the existing leadership challenges in nursing such as: an increase in the turnover in Bahraini and non-Bahraini nurses, numbers of leavers through sickness, job dissatisfaction, job related stress, and psychological stress. These challenges have subsequently affected the stability of the nursing population's human resources, where there were continuous nursing shortages, which have resulted in inefficient patient care. According to Nursing Workforce Ratios in Bahrain (AWahed 2005, p.12), the actual ratio of nurses to 10,000 population is 44.4 nurses. This ratio is considered to be low compared to USA, Canada and Japan. Aiken et al (2004) identified the nursing workforce ratio per 10,000 populations in USA as 78.2 nurses and in Canada 74.1 nurses. Therefore, empowering HNs in CCS with relevant competencies might facilitate nursing effectiveness and minimize the nursing turnover and improve working conditions.

1.2 My Role as a Nursing Researcher

The nursing field is very complex and the application of research activities to it is required to cope with the recent challenges facing nursing. This pressurises us, as nurses, to work effectively focusing on professional challenges and introducing and applying research into clinical practice. As a senior nurse officer, my role is to gain a better understanding of nursing issues and to seek ways to improve patient nursing care, to provide a healthy working environment for nurses, and to study the factors that facilitate and hinder the effectiveness of nurse leaders working in CCSs.

My own professional background is that of nurse and nurse manager. I started working in nursing during the early 1980s after I graduated with the BSN degree from the College of Health Science in Bahrain. Then I worked for nearly 10 years before I continued my studies with a post graduate degree in the UK. All of my post-registration experience has been in clinical and administrative work in the hospital in Bahrain. I worked in different positions for 28 years. I have worked as a staff nurse, charge nurse, and nurse officer in nursing administration. Throughout those posts I tried to keep in touch with patients and nurses in the clinical practice. I

Introduction

maintained a line of communication upward with hospital and nursing administration as well as downward with all staff categories; I consider that this communication effort has facilitated me in developing myself and my career. I am now a full time research student sponsored by the Government of the Kingdom of Bahrain.

My whole experience inspired me to carry on developing myself through continuing my higher degree studies and obtaining my Doctorate in Clinical Nursing Practice (DCLinP) at the University of Southampton in the UK, and to develop my knowledge and skills in nursing research. More specifically my studies should enable me to introduce nursing research into clinical practice in Bahrain to improve nursing services (for example, in critical care settings). This will facilitate the development of my knowledge in the area of managing and leading Critical Care Nursing as well as maintain the awareness about the need for nursing research and to catch-up with global changes in the nursing field.

This thesis is an example of how important it is to introducing a case study research to explore the factors that facilitate and hinder the leadership effectiveness of the HNs' in Critical Care Settings in Bahrain is. The value of introducing such research is to develop the capacity of future, effective HN leaders in CCSs and in other levels, since highly effective leaders in critical care are extremely required to facilitate and cope with the current and future challenges.

In conclusion, there have been similarities between the UK and Bahrain in the challenges and demands facing the organization of healthcare in both countries, i.e. the economic situation; technological advancement, employee retention, and increasing public demands for quality services. The early days of NHS management share similarities with the current Bahrain bureaucratic, hierarchical, healthcare system that focuses on initiating communication and change from the highest level downwards in the organization rather than initiating communication and change at the lower, 'grassroots' level.

The debates about the need to introduce change in management and leadership in the NHS have been on-going since the Griffiths Report on NHS management in 1983 (NHS 2009). This is because effective nursing leadership is considered to be a vehicle through which both nursing practice and health policy can be influenced and shaped (Antrobus and Kitson 1999). The UK approaches the development of effective leaders through the Department of Health's (DH) commitment to introducing talent and leadership plans to improve leadership capacity and capability (DH 2009a). In addition, the NHS Next Stage Review (NSR): High Quality

Introduction

Care for All (2008) emphasised the importance of effective leadership. The NSR report revealed that leadership has been an overlooked element of the reforms in the NHS until quite recently (NHS 2009). The King's Fund (NHS 2008) argued that the NSRs final report suggested a number of guidelines designed for developing effective leadership. The Guidelines include the following eight action plans. First, evaluating leadership programmes and integrating leadership development into professional education and training. Second, developing a variety of leadership programmes relevant to the health profession and educate nurse leaders up to the master's level. Third, identifying and supporting the top 250 clinical and non-clinical leaders. Fourth, produce direction on talent management. Six, create a clinical leadership fellowship scheme. Seven, identify incentives and eliminating the barriers to allow a greater proportion of leadership posts to be occupied by clinicians. Eight, establish a Nursing Leadership Council (NLC). The commitment of the NHS Next Stage Review was to create a NLC which aim is to identify and develop leaders to create a step change in the development of leadership in order to provide high quality care across healthcare. It will have a particular focus on setting standards and expectations for leadership and leadership development programmes for all professionals in the NHS (DH 2009b). The NSR acknowledged that the effective clinical leadership role is pivotal in achieving quality of care in the NHS. Clinical leaders are at the frontline with patients and are equipped with knowledge of what patients require. Given the impact of the global economic situation on the healthcare service it is essential that frontline clinical leaders have the leadership competencies to inspire, lead by example, mentor, coach, facilitate teamwork, possess vision, and motivate (NHS 2010).

This has encouraged me to develop a study which explores leadership effectiveness of the HNs in Bahrain as an attempt to uncover and understand the current status and the factors that facilitate or hinder HNs leadership effectiveness in Bahrain. The decision was made particularly to focus on studying CCSs, because developing an effective HNs leadership, from my experience, is required in CCSs in Bahrain because the scope of practicing nursing in CCSs is escalating and needs highly qualified personnel. In addition, effective HNs are essential to motivate nurses by articulating a clear vision and expectations relating to effective HN leadership role, to establish standards within the CCSs, to achieve effective patient care, to develop nurses through effective coaching and mentoring, and to meet healthcare's expanding challenges, especially the increase in healthcare cost. Furthermore, the study will identify the challenges faced by healthcare in Bahrain and explore its effects on HNs leadership effectiveness. The study will provide recommendations to strengthen HNs leadership effectiveness in CCSs and build their capacities.

Introduction

1.3 Research Aims, Objectives, and Questions

Although there is considerable information in the literature about leadership in nursing and in other fields e.g. business, there is very little literature addressing the factors that facilitate or hinder the effectiveness of leadership in Critical Care Settings (CCSs). Similarly, there are few studies that show interest in strengthening leadership by investigating the above mentioned challenges that many health organizations in Bahrain face. In addition, strengthening the internal structure of organization and empowering nursing leaders. Consequently, the intention of this research is to address the following aims and objectives.

1.3.1 Research Aims and Objectives

The overall aim in conducting this study is to explore the factors that facilitate or inhibit effective HNs leadership in the CCSs in Bahrain, with a view to making recommendations to the Hospital Top-Management Board as to HNs leadership future development. The objectives of this research are as follows:

- To better understand the qualities of an effective HN in relationship to leadership.
- To better understand the context of day-to-day practice of HNs by exploring their views on the problems, obstacles and frustrations associated with their leadership roles.
- To identify factors which facilitate or inhibit effective HNs in their leadership roles.
- To identify the educational needs for developing future HNs' leadership roles.
- To make recommendations regarding how to prepare future nursing leaders for effective leadership roles.

1.3.2 Research Questions

As a result of the aims, the study has been designed to address the following research questions:

- What are the factors that facilitate or inhibit HNs to be effective leaders in CCS?
- What are the characteristics of the HN who is considered to be effective in their (his/her) leadership role?
- What abilities do HNs perceive as important to be effective day-to-day leaders in nursing practice?

Introduction

1.3.3 Research Setting

This study has been conducted in one general government hospital in Bahrain and has taken the form of an in-depth case study, involving Head Nurses, Senior Staff Nurses and key informants from within a Critical Care Settings. CCS is a stressful environment where critically ill patients are admitted and aided by sophisticated technology i.e. ventilators and cardiac monitors. According to the MoH (2009) annual report, the total admission in CCSs in 2009 was 245 patients and the total bed capacity is 23 beds. The statistics presented the average length of stay in the CCS as 16.9 days. Critical Care Settings treat different critically ill patients. Critical care nurses have education and training beyond their basic preparation as a registered nurse. Most of the Bahraini nurses working in CCSs have completed the Cardiac Care and Intensive Care Post Basic Diploma.

1.4 Summary and Structure of the Research

This thesis is presented in six chapters as follows. In chapter one I have illustrated the importance of conducting the study, the challenges facing healthcare organization in Bahrain, in the UK or in general, and the reform in UK healthcare organization with a view to compare later the Bahrain system with the UK's. I have also identified my aims and objectives for this study.

In chapter two, I review the existing literature that focuses on the definition of effective leadership, and the qualities to be acquired by a leader. The literature review illustrates how to develop and maintain a healthy work environment that encourages good relationships, robust characteristics of emotional intelligence, and authentic leadership. I have shown the relationship the literature review has to the research aims and objectives of this study.

Chapter three details the case study design as a methodological framework, opening with an overview of study settings, culture and context which have influence on CCS practice development. Then I explore the three Phases of data collection. This chapter highlights the steps of data analysis and interpretation, and shows the importance of establishing a rapport with participants.

Chapter four describes the process of data analysis and outlines the research findings. It presents the key themes of effective HN leadership: the style of effective leadership, networking and communication, education and the development needs of and for effective leadership, and the need for developing a healthy working environment are examples of themes emerging from the data.

Introduction

Chapter five presents an overview of the thesis and discusses the findings and how they relate to the recent literature about the effective leadership role in nursing. This chapter addresses research questions, fulfils the aims, and illustrates the insights gained through this research.

Chapter six details the insights from this research and draws the conclusions. Then, it lists the recommendations for the sponsors of this research, and examines the implications from this research. A reflection draws the thesis to a close.

CHAPTER 2 LITERATURE REVIEW

2.1 Introduction

In this chapter, literature relating to effective leadership from the perspectives of healthcare organization, business and management, nurses and nurse leaders is being reviewed. The review begins by tracing the definition of the concept of effective leadership; it outlines the issues of the driving forces empowering the development of effective leadership at local/national levels as well as the global context and the attributes (authenticity, emotional intelligence) which are considered as core components of effective leadership. Literature from the U.K and other developed countries, such as the United State of America (USA) and Canada was used in this study to illuminate, and to enable a wider understanding and analysis of, the issue of leadership effectiveness. Attention is given to the new initiatives in the area of UK healthcare leadership and in business; to the distinction between the UK's and Bahrain's healthcare organization's strategic directions toward effective leadership and finally, the plans of the UK to develop effective world class healthcare leaders. All of these aspects sets the context for the study. A literature search has been carried out to identify the existing evidence relating to effective leadership in a healthcare setting and particularly in relation to Bahrain. The literature review had to concentrate on global literature because there was only a limited quantity of literature specifically coming out of, and relating to, Bahrain. However, in terms of general literature source about leadership whether it is in the UK, USA, or Canada they all show relatively similar information in their discussion concerning leadership importance in different contexts. The purpose of this literature review was to look into leadership in a wider context to find out the available knowledge base, to identify gaps, and to refine the research questions.

2.2 Literature Search Approach

The topic of leadership is vast and rapidly growing; for example, Grint (2010) identified that in 2003 there were in excess of 14,000 books on the subject in an Amazon search, and then just over eight years later in 2011 the number had increased to nearly 173,000 books. Thus it is important for this research to be very focussed and selective. The search started by defining the terms and concepts such as: 'effective nurse leader'; 'effective nurse role'; 'future leadership in the UK'; 'leadership in Bahrain'; 'critical care head nurse'; 'factors that facilitate leadership'; 'barriers to leadership'; 'leading in critical care'; 'emotional Intelligence'; 'authentic leadership'; 'healthy work environment'; 'clinical judgment and decision-making';

Literature Review

'appreciative inquiry'; 'organisation culture', 'leadership styles', and 'work engagement'. The search conducted through electronic and manual source of periodicals and journals to identify English research studies published between 1998-2009 in the United Kingdom (UK), the United States of America (USA), and in Canada. The search included searching by subject using database and indexes through CINAHL, MEDLINE, SCOPUS, and COCHRANE. For the detail of the search strategy (see Appendix 2).

2.3 Developing a Definition of Effective Leadership

According to Marquis and Huston (2009), the word 'leader' has been used since the 1300s, but the term leadership was not familiar in the English language until the early 19th century. In contemporary literature, a leader is someone who practices interpersonal skills to influence others to achieve a specific goal (Sullivan and Decker 2009). Effective leadership has been defined by different authors in the literature. However, most of these definitions share common features. For example, Sperry (2002) stated that effective leaders are considered to be those who look beyond their own needs and concerns to the needs of the organization and of the community. Also, an effective leader is the one who has the capacity to establish future direction of nursing and to influence and align others toward a common goal, motivating and committing them to action and making them responsible for their performance (Douglass 1996). For the purpose of this research, the definition of effective leadership is based on a combination of the references that seemed to be most appropriate (including AACN 2005, Marquis and Huston 2009, Huston 2008, and RCN 2009). Through looking at these references, I arrived at an overarching description of the definition of an effective leader as a person who is passionate, confident, courageous, intelligent, self-aware, trusting and trustworthy, optimistic, and able to:

- Create a clear vision and share it with other employees,
- Keep the team focussed on the bigger goals of the organization,
- Inspire, motivate, and reward employees,
- Establish and sustain a learning culture,
- Come to the forefront in a crisis and step outside the box by thinking creatively in different situations,
- Encourage employees to be more involved in organizational decision-making,
- Engage employees in organization success,
- Build effective coalitions and partnerships with other professionals,
- Start a dialogue within all levels in healthcare organization,

Literature Review

- Define the circumstances that support collaboration and effective communication,
- Inspire and lead to a change,
- Establish a healthy working environment.

2.4 Driving Forces for the Development of Effective Leadership at Local, National, and Global Levels

2.4.1 At Local/ National Level

Developing effective head nurse leadership in Bahrain should facilitate the creation of the vision of a 'modernized' healthcare organization. In this context, modernization refers to developing critical care nursing services in Bahrain based on the experiences and lessons learned from other countries like the UK and the USA. The MoH in Bahrain is striving hard to increase the number of Bahraini nurses in nursing services. This is referred to as nationalising healthcare services and is a government policy, which means gradually replacing expatriate workers with Bahraini workers. In nursing services, the policy of nationalisation of healthcare services was initiated by the Prime Minister's Cabinet in 1990. Managerial nursing positions mostly occupied by expatriates have been replaced by Bahraini Senior Nurses since early 1991. According to Al-Darazi (1991) the plan of nationalising healthcare services was to replace 50% of non-Bahraini nursing workforce by the year 2000. Nursing Administration officials appoint the newly registered nurses from the College of Health Science (CHS) who qualify with an Associated Degree in Nursing (ADN) which is equal to Diploma in Nursing, and who have a minimum of 5 years of clinical experience in a managerial nursing position, i.e. HN position. As a consequence of applying this policy, it is not uncommon for nurses designated in the HN position to be without structured leadership or management training. It was not until the late 1990s the MoH officials recognized the need to develop the leadership skills of those HNs to improve the quality of healthcare services. Unfortunately the process of developing HNs has been slow due to budget constraints and instability in the higher authority positions at the MoH in Bahrain. This has led to having HNs in position who are often academically and administratively unprepared to assume that position. HNs face difficulties in coping with the advances and current changes in nursing and in the healthcare arena.

According to the local statistics obtained from the Human Resource Head Nursing registry in nursing administration in 2008, only 25% of the HNs are bachelor degree holders, 2% have a management diploma, while the majority holds a Nursing Diploma. This undermines the tactical plan that has been evolved for nursing development at the national level in Bahrain as well as with the nursing strategic direction. As a result of low educational attainment/a lack of graduates may suggest a lack of leadership ability. The actual situation does not reflect the vision of the MoH as articulated by Al-

Literature Review

Gasseer, who was a researcher and an advisor in the Eastern Mediterranean Regional Office (EMRO) in the WHO. Al-Gasseer et al's (2003) work was a key piece of research because it is the only research I was able to trace that included a focus on developing nursing leadership in Bahrain. The aim of nursing leadership development as Al-Gasseer et al (2003) mentioned was to position nursing on the health agenda and to ensure nurses' involvement to accomplish the WHO goal of 'Health for All' (WHO 1998a). Al-Gasseer et al (2003) have addressed this initiative at three contextual levels: local level within Bahrain; sub/regional with the Six Gulf Cooperation Council (6 GCC) countries of Bahrain, Kuwait, Oman, Saudi Arabia, United Arab Emirates, and Qatar and within the International World Health Organization (WHO).

At the Six GCC, two drivers led the development of the nursing strategic plan in Bahrain. The first driver was the establishment of the GCC Nursing Technical Committee (GCCNTC) by the Ministers of Health of the GCC countries. The GCCNTC was designated as a forum for nurse leaders in the six GCCs to discuss and share information, exchange views, and recommend strategies to enhance development of nursing to the Ministers of Health. The second major driver was the WHO strategy for nursing and midwifery development in the WHO. The plan has focused on what nurses in Bahrain need to do in order to contribute to cost-effective and high-quality health services. It raised concerns in regards to: regulation of nursing; reform of nursing education; development of nursing services; development of a nursing information system and development of nursing leadership. The project team (Al-Gasseer et al, 2003) set objectives which included:

- Development of clear goals based on shared and internalized values and principles,
- Gaining political commitment,
- Identifying strategies to bring about change and which would enhance each other's development.

Taking this into consideration, Al-Gasseer et al (2003) presented an action plan for developing nursing leadership which involved: creating a sense of unity and goal directedness; developing strategies and management capacity of nurses; analyzing the environment to take advantage of opportunities, and networking and supporting each other. Al-Gasseer et al's (2003) strategic plan has been developed in Bahrain and has been adopted by the six GCC countries through formulating the Nursing Development Committee (NDC) from a multidisciplinary team of nursing services, education, regulation, and human resources development. The NDC has scaled down the gaps between the top pyramid levels of authority by reporting issues, concerns, strategies, and making recommendations to improve nursing services in the country directly to the Minister of Health as illustrated in Appendix 1.

Al-Gasseer et al's (2003) framework achieved results at sub/regional level which included networking, unity, collaboration, and developing strong leadership between the Six GCC countries. At a local level, the project has not yet been fully implemented. This demonstrates a disjunction between how Bahrain is engaging at an international level and within the GCC in influencing nursing leadership, yet when it comes down to its own territory it is not yet completely implemented. This

Literature Review

could be as a result of the unavailability of resources needed to put forward this framework, i.e. effective leaders who visualize the importance of such a plan, who understand and have the authority to implement the content of the strategic plan.

In addition, the nursing strategy, as described in the document (MoH 2005), focuses on the following themes:

- Increased quality and efficiency of the nursing services, with evidence of proactive planning and action to improve nursing education and practice,
- Greater numbers of BSN graduates working in the services with necessary competencies required to provide quality nursing care,
- Improved recruitment and retention addressed through strengthening nursing resource planning, development and management, and promoting supportive working environments.

Since then, MoH officials have been concentrating on internal clinical concerns, such as effective and efficient nursing care, budget control, and other quality issues concerning shortage of beds and nurses as well as an effective appointment system. In Bahrain, MoH is seeking to align the quality of health care services with the Accreditation Canada International Board. The Canadian Accreditation Board is itself accredited by the International Society for Quality in Health Care (ISQua) and is one of the founding members of this International Society for Quality in Health Care which accredits accreditation bodies around the world (Accreditation Canada International 2011). The Board has established its collaboration and engagement with the six GCC countries through their Government official representatives of the Ministers of Health. This collaboration is designed to support a permanent and sustainable healthcare services accreditation program in Bahrain. The aim of accreditation of healthcare services in Bahrain is to set the highest standards of healthcare services, define and develop guidelines, and gain the international certification and approval from the credited body. However, the MoH officials appear to be concerned about planning, organizing, controlling and evaluating patient care issues rather than developing leadership through empowering HN leaders. This supports the argument of Vaill (1996), which is that good management skills are needed because they are considered important for day-to-day operations, as well as good leadership.

An effort is needed to establish a high standard health care system in Bahrain. The MoH top-management and the Accreditation Canada International Board have to consider the process of enhancing the role of HN leaders, as it is a vital issue to be seriously addressed. As discussed in Chapter One section (1.1), the health care

Literature Review

organization of MoH in Bahrain is a hierachal structure which consists of different layers. A hierachical structure tends not to be effective in communicating with lower levels, such as HN leaders in Bahrain, as it hinders HN leaders' ability to utilize the power within their role to lead and manage in their clinical practice. Marquis and Huston (2009) clarified that, to empower someone means to support, to advance, or to permit. The current organization structure in Bahrain is not sufficiently supportive to allow HN leaders to become more independent within their roles.

According to Marquis and Huston (2009) and Ellis and Hartley (2009) the important factors that enhance a HN leader's role are the ability to: communicate their vision, develop themselves, be creative in their work, intervene and influence public policy, collaborate and network within and outside of nursing profession, the ability to easily access information and the resources necessary to carry their job competently, and increase knowledge base and education. This aligns with the argument by Sullivan and Decker (2009) that suggests leader traits provide only a base for leadership effectiveness but real leaders are made through education, training, and life experience. According to the literature these factors clearly need to be taken into account to develop the role of HN leaders in nursing services in a country such as Bahrain.

2.4.2 Global Level

It is important to contextualise the literature relating to Bahrain within a wider context. Thus, in similar roles in the UK there is an emphasis on encouraging ward sisters and charge nurses to play a central role in decision-making. This will ensure that they have the authority and the responsibility to introduce changes in their clinical areas and to enhance standards of care, as well as have authority and responsibility to spend the budget. Mullally (DH 2004), the chief nursing officer, in a commentary on ward sisters and charge nurses, highlighted that it is the NHS who must ensure that those ward sisters and charge nurses have the preparation and assistance they need in order to undertake these responsibilities. The Royal College of Nursing (RCN 2005) launched the RCN Clinical Leadership Programme that aims to develop the leadership capabilities of health and social care practitioners and their teams. The aims of the programme are:

- Learning to manage self,
- Effective relationships within teams,
- Developing a consistent patient focus on care,
- Networking,
- Political awareness.

Mullally (DH 2004) added that in some cases, those capabilities have been expected without adequate preparation or in the absence of the necessary authority to make important decisions. Recently, the RCN (2009) conducted focus group research on nurses across England. The research aimed to look at ward sisters' current roles, best practice and areas where more support is needed. The report, 'Breaking down Barriers and Driving up Standards' (RCN 2009), highlighted a series of recommended strategies (for England only) to develop ward sisters / charge nurse roles in order for them to provide high quality care. The findings revealed that ward sisters have been taking the responsibility for arranging the care for a group of patients in addition to their leadership responsibilities and this places pressure on them. The report also discussed the modern pressures on the ward sister role which affects their morale. They lack clarity about their role as well as the time and authority to introduce quality services. The findings showed that ward sisters were overloaded with paperwork and had huge responsibilities which included: leadership and management, clinical practice, and education and teaching. The study revealed that ward sisters however were not given enough authority over the ward environment. They reported a lack of formal preparation and skill development for the ward sisters. There was no agreed role definitions and clarity about role aims, purpose and functions. In all, these findings do not align well with the Department of Health's (2009) ambitions to introduce talented leaders for the future of the NHS.

The RCN (2009) study recommended certain measures to strengthen and support ward sisters roles in ensuring high quality care. For example, it recommended that ward sisters become supernumerary to shifts, and that their role will focus on leadership responsibilities such as: supervising the clinical care; monitoring and maintaining nursing standards; teaching clinical practice and procedures; being a role model for good professional practice and behaviour; controlling the ward environment and being available as a nurse leader for the ward. The study recommendations suggested that ward sisters / charge nurses should have a title that conveys a clear identity as the nurse leader of the ward (RCN 2009). However, they revealed there was a disjunction between the ambition and rhetoric of the Darzi vision (as described below) and the day-to-day reality of the work of a ward sister acting as a leader. Furthermore, evidence suggested that there is a relationship between the impact of effective ward sister/charge nurse role and standards of patient care. Therefore, it is a priority to develop ward management for, as the Hay Group (2006) findings showed, an effective charge nurse has a major impact on resource use and on performance indicators such as: patient satisfaction, absenteeism; amount and nature of complaints; number of drug errors

Literature Review

and levels of severity and rates of staff turnover rates. These findings draw attention to the need to develop effective charge nurses in the UK and to ensure that they have the competency, time, resources and the authority to work collaboratively and coordinate with other healthcare teams to deliver high quality patient care.

The Royal College of Nursing's (2009) report illustrates the need for effective leadership development in today's healthcare organization and emphasises the robust characteristics of 'emotional intelligence' (EI), as well as the characteristics of 'authentic leadership' (Govier and Nash 2009). The challenges faced by healthcare organizations necessitate changing the way organizations manage and lead their people. Therefore, the strategic direction plan of the NHS in the UK is to develop effective leaders who are able to use a range of styles in dealing with different situations, such as those leaders who are able to bring people together in a common task and achieve the best from their team. Partnership working at all levels is considered to be important, for example, collaboration with hospitals and communities, between health and social care, between public and independent sectors, between clinicians and managers and between professional groups. The vision is to develop clinical leaders who are effective team players, who empower others to reach their potential within a team framework, and who are able to define and communicate vision and strategy (DH 2004). The aim is that this will be fulfilled through the recently established National Leadership Council (NLC) in the UK which attempts to ensure that world-class leadership talent and leadership development exists in clinical areas and at every level of the NHS. The NLC was established as a result of a commitment set out in the Government's strategy for the future of the NHS (DH 2009b). According to Fradd (2004), who reflected on his personal experience of working in positions of leadership in a variety of National Health Service roles. Fradd stated that, in today's healthcare organization, leaders should have competencies of working independently, effective collaboration, the ability to develop high trust relationships, self-confidence, have courage and be able to stand-fast in respect to their judgements, possess humbleness, have respect for the process of change, and have the ability to network across business functions and units.

Within the United States of America, the American Association of Critical-Care Nurses (AACN 2005) has developed standards to achieve efficiencies and high quality care in CCSs which is the particular setting of interest for this study. One of these standards is the development of a Healthy Work Environment (HWE). Pivotal to a HWE is effective leadership. Developing effective leadership in CCSs will facilitate establishing and sustaining HWEs based on the standard of the American

Literature Review

Association of Critical-Care Nurses (AACN 2005). The effective leader who recognizes the value of a HWE will display the ingredients for success: skilled communication; true collaboration; effective decision-making; appropriate staffing; meaningful recognition; self-awareness; and trustworthiness. A HWE will improve the quality of care for patients, ensure patient safety, enhance staff satisfaction and retention, and secure reliable and various sources of income (AACN 2005).

Carol Huston (Huston 2008) is an American nursing professor and former president of the International Honour Society of Nursing. At their Annual Founder's Day Celebration Programme 2008 in the USA she spoke about and discussed the concept of leadership and wrote a report on preparing nurses in which she outlined eight leadership competencies outlined below, considered central for every nurse leader of 2020. These competencies are evidently needed and will help to assist in developing leaders who have the capacity to influence the perception of both nursing as a profession and the outcomes that nurses are able to achieve and help in shaping nursing. They will be prepared to face some key challenges that act as barriers to nursing development. In addition, they will be qualified to drive nursing services in an extremely political environment because politics is a part of our daily work in every organization. Nurse leaders must have a clear understanding of the language of politics in the organization where they work. The eight competencies for leadership effectiveness include: a global perspective or mind-set about healthcare and professional nursing issues, having the technology skills which facilitate mobility and transferability of relationships, expert decision-making skills, having the ability to create organization cultures that consider quality healthcare and patient and employee safety, understanding and ability to intervene in political processes, developing collaborative and team building skills, the ability to balance authenticity and performance expectations, and being visionary and proactive to be able to respond to a healthcare system that rapidly changes.

According to Marquis and Huston (2009) who suggested strategies for leaders to be effective, it is essential for them to consider: leader presentation i.e. how a leader looks, acts, and talks; increasing their professional skills and knowledge; maintaining a broad vision which exceeds their unit or department, and involving the organization as well as the institution as a whole. Also it is necessary for them to consider developing visibility and a voice in the organization through involving themselves in different activities with different communities and groups, these groups being recognized by the organization as having authority and influence; having self-confidence and speaking up; recognizing and rewarding others for their contribution; and empowering others through sharing knowledge, maintaining

Literature Review

interconnectedness, valuing the profession, and supporting each other more specifically those nurses who are directly involved with patient care.

Alongside with the experience from the USA, members from the Royal College of Nursing looked at developing effective roles of contemporary nursing leadership. Antrobus and Kitson (1999), conducted an in-depth qualitative study to interview 24 nursing leaders, and the findings examined the broader socio-political factors' influence on nursing leadership and showed that effective leaders should take different roles and responsibilities, for example as 'interpreters and translators'. The role of leaders as interpreters assumes that through taking nursing issues and concerns and interpreting and translating them into a meaningful language for other health professionals within healthcare, more specifically to policy makers, and to healthcare consumers the values of nursing are not mislaid or incorrectly interpreted and nurse leaders, by doing that, will be visible. It is not possible to generalise the findings from this study because they are linked to specific situations and locations, and in qualitative studies there may be a researcher bias, but this study provided rich and in-depth data.

Both at the local level in Bahrain and at the global level, for example, in the UK, there appear to be differences between aspirations and reality. In the UK this is apparent when comparing the Darzi recommendations and the workplace realities as outlined in the findings of the RCN report. This occurs within the six sub/regional countries where the aspiration of implementing Al-Gasseer et al's (2003) framework and the realities within sub/regional countries are not balanced. In the sub/regional level there is a low nationalization rate of graduate nurses and the majority of their workforces are non-national. The level of entry into the nursing profession is a diploma in nursing, whereas in Bahrain recently the level is BSN. Within Bahrain, there are limited numbers of national nurses specializing in one area of care i.e. critical care, a limited number of national nursing leaders who have qualified with graduate and post graduate degrees, and a limited number of nursing research initiatives and researchers.

2.5 Styles of Leadership

In the past there has been distinction between leadership approaches such as bureaucratic, autocratic, and democratic approach. Since then considerable literature on leadership styles has been published and key references are included as table 2.5, in Appendix (3). In relation to the context of this particular study, the concepts of transformational leadership (Burns 1978), appreciative inquiry (David Cooperrider 1980) and primal leadership (Goleman et al 2004) are considered important. In considering the literature, there were certain concepts that were

Literature Review

particularly relevant to my study. According to Burns (1978) transformational leader enhance the staff motivation, staff morale, and staff performance. On the other hand, Cooperrider and Whitney (2005) stated that appreciative inquiry model emphasises learning from what is best about the organization rather than focusing on problems. Interestingly, the appreciative inquiry encourages engagement, visioning, and creation of ideas that inspire people in an organization. According to Goleman et al (2004), an effective leader is a 'primal' leader: one who is able to work through emotions and employ the six different leadership styles such as visionary, coaching, affiliative, democratic, pacesetting, and commanding interchangeably as the situation demands. Also such leaders are able to utilize their work related skills (i.e. motivation, creative, confidence, empathy, self-awareness, and willingness) to connect with their employees and create a shared work commitment. Alongside with these three leadership styles outlined briefly above, Emotional Intelligence (EI) and 'authentic' leadership style are considered important particularly in critical care settings. The essence of effective leadership is the ability to manage oneself and others in response to a variety of situations. In critical care settings where there is high stress and work over load, it is essential that leaders have the skills of emotional intelligence to be able to manage their emotional response to a variety of situations and others' reactions. Indeed, in today's healthcare organization, health officials have to acknowledge the importance of Emotional Intelligence and authentic leadership in building an intelligent workplace and developing effective leaders (Cherniss and Goleman 2001).

2.6 Emotional Intelligence and Leadership

Emotional Intelligence (EI) is a concept that has received widespread interest from different authors, in particular in psychology e.g. Ciarrochi et al (2001), Salovey et al (2004), Goleman (1995, 1998) and Luthans (1998). Emotional Intelligence is defined as a 'subset of social intelligence that involves the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and actions' (Salovey et al 2004, p. 5).

Furthermore, Daniel Goleman's first book in 1995 identified four components of EI:

- Self-awareness,
- Self-confidence,
- Self-control, commitment and integrity,
- Self-ability to communicate, influence, and initiate change and accept change.

More recent publications, for instance Sullivan and Decker (2009 p. 62), view EI as involving personal capability, which includes:

Literature Review

- Self-awareness,
- Self-management,
- Social awareness,
- Relationship management.

All those scholars, however, put forward models that share a common core of basic concepts including self-awareness, self-management, social-awareness, and relationship management. Emotional Intelligence therefore is a set of behaviours that may be performed and observed in conjunction with an emotion. Emotional intelligence as Cherniss and Adler (2000) argued, is the root for individual qualities such as self-confidence, honesty, knowledge of one's own strengths and weaknesses, self-motivation, relationships with others, initiative, and flexibility.

EI is defined in this study as a set of leadership competencies, demonstrating the ability of a leader to recognize his/her behaviour, assess and manage emotions of his/her own self and of other employees and to manage them best according to the work situation. It is generally defined as a set of core competencies for recognizing, processing and managing emotions that facilitate nurse leaders to cope with daily demands in a knowledgeable, approachable and supportive manner (Goleman et al 2004; Watson 2004).

2.7 Developing Self-Awareness in Leadership

According to Burnard (1997) self-awareness is the regular and developing process of getting to know who you are. He suggested that, when we think about self-awareness, we should acknowledge that there are two broad elements to each of us: the outer and the inner experience. The inner experience consists of five characteristics: thinking, feeling, sensing, intuiting and the sense of the body. The outer experience is that attribute of us that other people observe: our behaviour and presentation. Therefore, we must express our inner selves through the outer sense of self. In addition to that, we have to acknowledge that the outer sense of self is very much affected and influenced by the inner. The value of developing self-awareness in leaders, as argued by Burnard (1997, p 29), is as follows:

- To enhance self-understanding,
- To allow acceptance of others,
- To enable them to handle difficult situations,
- To increase conscious use of the self,
- To enable self-monitoring,
- To enhance personal autonomy.

Self-awareness helps us to have a deep understanding of one's emotions, as well as understand our strengths and weaknesses that will enable us to fill any skill gaps, needs, and drives. Leaders who perform accurate self-assessment are aware of their abilities and limitations, they accept criticism and learn from their mistakes, have full ideas of where they need to develop and when to collaborate with others who have complementary strengths (Cherniss and Goleman 2001). Developing leaders' self-awareness means achieving consciousness of the self. Leaders have two options: either to live life as it is without any awareness of how they appear to others or alternatively, leaders have to observe what they do and say and be consciously aware of their behaviour and their personality. This requires them to be prepared, to introduce change to themselves, others, and in the organization.

Therefore, Klenke (2007) reviews several contemporary conceptualizations of authentic leadership for the purpose of advancing the existing model of authentic leadership, and in his theoretical framework, focuses on the role of the self in authentic leadership. As argued by Klenke (2007), the self can be viewed as the knowledge a person has about him/her-self. To develop that knowledge of the self which is related to a leader's role, requires leaders first to be true with their self and explore their blind spots, to understand the cultures where they do well, the roles they are best in, their strengths and interests. Then they should put themselves in a place where they are able to shine (George and Sims 2007). According to the authentic leadership theories, there are various characteristics to the role of the self. These include: self-awareness, self-knowledge, self-regulation, self-esteem, self-efficacy, self-motivation, self-identity, self-development, and self-sacrifice (Klenke 2007). Goffee and Jones (2006, p. 32) added that:

“So to be yourself, you must know yourself and show yourself-enough”

2.8 Authenticity and Leadership

Authentic leadership theory has frequently been talked about in clinical practice; this could be because it is different from other leadership theories, such as situational leadership and charismatic leadership. Situational leadership focuses on evaluating the effectiveness of a leader in various situations of organizational settings involving a wide variety of organizational tasks (Northouse 2001). Charismatic leadership theory highlights influencing followers' need for achievement, need for relationship and need for power to empower practices (Choi 2006). On the other hand, authentic leadership theory stresses a leader's self-awareness and ethical decision-making (CFC 2009). The concept of authenticity

Literature Review

derives from the word 'authentic', which means being true to one-self. It is generally recognised to have its roots in ancient Greek philosophy 'To thine own self be true' (Gardner et al 2005, p.344). Authenticity is one of the key concepts in reflective human action. According to Shamir and Eilam (2005), authenticity is the state or quality of being authentic, honest, and genuine, free from insincerity.

The journey towards authenticity, as Goethals et al (2004) stated, starts when leaders link with their own spiritual journey. This is because leaders come to know themselves in deeper ways through reflection, which leads to the leader searching for greater meaning and the development of a relationship with inspiring power which usually follows. These processes are linked with increased spirituality like reflection, genuineness, being present, and searching for meaning. Goethals et al (2004 p. 881) suggested that spirituality means that leaders are leading with the power of a deep understanding of who they are and why they do what they do to lead with soul or in other words to lead from within.

Authentic leaders are described by Gardner et al (2005) as leaders who lead by example in promoting healthy ethical climates characterized by transparency, trust, integrity, and high moral standards. They are not only true to themselves, but lead others by helping them to equally achieve authenticity. George (2003) has defined authentic leadership as being yourself, being the person you were created to be, rather than developing the image or personality of a leader. Bhindi and Duignan (1997) argued that leadership is authentic to the degree that it is: ethical; sincere; genuine; and trustworthy in leadership action and interaction. They added that authentic leaders uphold honesty and integrity in their everyday dealings and constantly search for true self.

2.9 Authentic Leadership and Different Schools of Thought

In any business, and specifically in nursing, strong and effective leadership is needed to deliver high standards of care in an increasingly competitive global marketplace. The founders of authentic leadership are mostly researchers and practitioners from different schools around the globe. The influence started from schools of business and management (e.g. George 2003, Luthans and Avolio 2003, Gardner et al 2005), human service organizations such as the medical/nursing field (e.g. Storr 2004, and Kerfoot 2006a, Kerfoot 2006b, and Shirey 2006) and from education (e.g. Bhindi and Duignan 1997, and Begley 2006).

In business, Carr (2003) conducted a study to evaluate women's strengths and development needs. The focus of the study was the women's key competencies as

Literature Review

leaders. Data were gathered through different methods, firstly by consultation with senior women from 'blue chip' companies in the UK. The consultation aimed to obtain senior women's perceptions about what they believed the key competencies of women leaders. Secondly, Carr (2003) conducted several focus groups over two years with the women who attended the training. Thirdly, a training needs analysis was conducted to refine the final competencies. Finally, Carr (2003) studied academic literature and consulted experts in psychology and organizational behaviour, and worked closely with a key expert partner. The study identified five broad and interrelated dimensions of leadership which form the authentic leadership model: building relationships, developing self; leading change; leading people; and leading performance. The study findings recommended the facilitation of the development of an effective leader through evaluating oneself with leadership capabilities, finding out the strengths and weaknesses, and then identifying areas where you need to develop yourself or to delegate to others from the five categories and core competencies of the authentic leadership model. The strength in this study was that it included different respondents and used different methods of data collection. The findings should be used with caution and consideration for the type of settings since this research was conducted in business. In education, Begley (2006) recommended three conditions for authentic leadership: self-knowledge, a capacity for moral reasoning, and sympathy to the orientation of others. In nursing, Kerfoot (2006a) stated that authentic leaders 'love' to challenge people to do what they do not believe is possible, and generate the energy to make the impossible possible by their interest in their profession, their patients, and for doing the right thing.

2.10 Authentic Leadership and Healthy Work Environment (HWE) in Nursing

The role of authentic leadership in contemporary healthcare organizations is pivotal to this study, in that it is viewed as a core component of a HWE. 'Healthy work environment' was defined by Shirey (2006, p. 258) as the environment which is 'supportive of the whole human being', patient-centred, and a satisfying workplace. Maintaining a HWE requires effective nursing leadership at all levels, but in particular at CCS level, it is essential where front line staff work and patient care is delivered. In fact, it will ensure patient safety, enhance staff recruitment and retention, and maintain an organization's financial feasibility (Vollers et al 2009). Moreover, authentic leadership was acknowledged by the American Association of Critical-Care Nurses (AACN 2005) in their substantial publication entitled: AACN Standards for Establishing and Sustaining HWEs (Ulrich et al 2009). AACN (2005) acknowledge it as being a 'landmark report for Critical Care Nurses'. Also, it has

Literature Review

been described as 'the glue that holds together a healthy work environment' (Sherman and Pross 2010, p.3). The report is designed to actively promote the creation of HWEs that support and foster excellence in patient care and enhance acute and critical care nurses' practice. Therefore, six essential standards of an HWE were put together to improve Critical Care Nursing (CCN). Authentic leadership was identified as one of the six standards, the others being: communication skills; true collaboration; effective decision making; appropriate staffing, and meaningful recognition of staff. Fontaine and Gerardi (2005) argued that the authentic leader represents the important missing element of the success of the other five standards. Therefore, preparing authentic leaders necessitates self-discovery, selfimprovement, reflection, and self-renewal (Shirey 2006).

Shirey and Fisher (2008) conducted a large survey study in the USA which included 500,000 nurses from different acute and critical care settings in different hospitals. The study focuses on re-analysing both the AACN National Survey published in January 2006, and the National Critical Care Survey published in 2004. The aim was to determine their implications for nursing administration, and to relate the findings to evidence and best practice. The findings revealed four major themes specifically relevant to nursing administration practice: leadership, practice environment, staffing, and professional advancement and recognition. Under the leadership theme they emphasised that, although the results from the national survey showed that the nurse manager has to serve as coach, mentor and facilitator which are essential characteristics of leadership, the findings did not tackle the contemporary leadership 'art' and 'science' practiced in today's critical care settings. Shirey and Fisher's (2008) recommendation was to conduct additional studies to explore the status of leadership in today's CCSs. They recommended that both leadership and management are needed to move organization forward. This will facilitate clarifying the existing leadership status and determine the necessary interventions required to bridge the existing leadership and management gaps and enhance authentic leadership to create and sustain a HWE.

In addition to this recommendation, Shirey and Fisher (2008) developed a leadership agenda for change toward HWEs in acute and critical care. The agenda focuses on the following strategies: the importance of reviewing and implementing the AACN authentic leadership standard in nursing organization; providing new and aspiring nurse managers with a systematic orientation to essential knowledge; encouraging nurse mangers to be competent and gain training in nursing administration; providing on-going career and leadership development opportunities; developing nurse managers' expertise in financial management; evaluating governance structures to ensure that nurses are allowed shared decision-

Literature Review

making; evaluating unit-based performance improvement practices; evaluating the effectiveness of current professional advancement programmes and making changes as required; and considering best practices for staff recruitment strategies in the workplace. The findings from the study provide rich information about the effective leadership and healthy working environment which can facilitate disseminating the research results in critical care in Bahrain in order to evaluate the current standard of the working environment. But the findings from this retrospective study should be handled with caution because in retrospective studies there could be various biases in the main studies, and data collection cannot be retrospectively modified to minimize bias.

In another study in the USA, Heath et al (2004) conducted an extensive literature review and six focus groups to validate the findings from the literature. The focus groups were conducted using two methods, first two groups in person and the other four groups via conference calls. The focus of the study was 'healthy working environment'. The findings from the literature review and focus groups revealed three elements to help nursing leaders set the standard of practice for HWE which were effective communication, collaborative relationships, and promoting decision-making among nurses. The focus groups resulted in identifying nurse leaders developing skills needed for a healthy working environment such as self-awareness, dialogue, conflict resolution, and navigating change. The study identified four characteristics of authentic leaders in a HWE which were:

- Treating all members of staff in a respectful and fair manner,
- Exhibiting a strong sense of trust with all members of staff,
- Creating and maintaining an organization's culture that supports and facilitates communication and collaboration, and viewing individuals as a valuable asset,
- Maintaining an environment where individuals are encouraged to feel physically and emotionally protected.

Though this study is relevant to my research, accepting generalizations needs to be done with caution because of possible methodological weaknesses. For example, no mention was made of how the sample was selected and how data was analysed. The study used different methods of data collection, involved participants from different levels in nursing, and was conducted in different cities. However, the study generated in-depth data which helped in advancing nursing knowledge.

A study by Linton and Farrell (2009), specifically performed to explore intensive care unit nurses' perceptions of nurse leadership, was undertaken in a critical care

Literature Review

department in Australia and showed very similar needs for an effective leadership role in critical care, just as in any care setting. A face-to-face interview was conducted with six senior nurses from one hospital. The findings revealed five themes of leadership roles in critical care. Firstly, 'think outside the box' where a leader is able to see the bigger or overall picture. Secondly, 'leading by example' where a leader demonstrated their professional role, the leader creates and maintains an environment that is supportive and rewarding for nurses. Thirdly, 'effective communication' where a leader is able to speak and listen to everyone on the team, able to make decisions, communicate through enthusiasm or motivation, able to communicate knowledge, and is approachable. Fourthly, 'knowing their staff' where a leader is aware of staff strengths and weaknesses, is able to utilize their staff effectively or to their best ability and facilitating their growth. Finally, 'stepping up in time of crisis' where a leader is able to exhibit critical thinking skills, use knowledge and experience, reduce stress, and gets the job done. The literature showed that the role of leadership and management in critical care settings is important and requires specific qualities that qualify them as effective leaders in such a context. The strength in this study was the methodological design (e.g. participants were purposively selected, ethical consideration was addressed, action was taken to ensure credibility and rigour, and data was obtained with in-depth semi-structured interviews). The findings from this study are useful for improving leadership effectiveness in CCSs, but there is a limit to applicability of the findings due to the small sample and biases from researchers' interpretation of data or participants manipulated the findings.

In two different literature review studies related to authentic leadership Wong and Cummings (2009) in Canada conducted a study whose aim was to describe the relevance of authentic leadership to the advancement of nursing leadership practice and research. In the USA, Avolio and Gardner (2005) explored authentic leadership development. The findings from both studies revealed that the significance of developing authentic leadership is substantial for nurses' satisfaction and their engagement with work. Also, it builds their optimism and commitment, encourages transparent relationships and improves quality and safety of care provided to patients. Based on the foregoing discussion, developing authentic leadership concepts in clinical practice, such as in Bahrain, is crucial in promoting a HWE. The plan to implement it is to take the conceptual and theoretical frameworks of HWEs and authentic leadership from the AACN standard (2005) and translate this knowledge into practice. In doing so the following issues are taken into consideration:

- Clearly defining the authentic leadership,

Literature Review

- The strategies needed to develop authentic leadership,
- How individuals become authentic leaders,
- The mechanism by which authentic leaders create an HWE for practice.

The above discussion focused on the value of developing authentic leadership where authentic leaders have a special relationship with their followers based on mutual support and mutual trust. Authentic leaders perform in a manner that inspires others, and they act as role models to their staff and colleagues. They are a core component of shaping and sustaining a HWE. Thus, the objective of exploring the factors that facilitate or hinder the development of effective HNs in CCSs in Bahrain will facilitate the identification of the existing qualities of authentic leadership in HNs.

2.11 Intuition, Rationality and Leadership

In nursing and in other fields e.g. in psychology, people make judgments and choices in at least two ways that are labelled here 'intuitive' and 'analytic'. The Royal College of Nursing Steering Group (RCN 2003 p.3) defined nursing as 'the using of clinical judgement', which means that nurses have a professional and an ethical responsibility to 'justify, explain, and define their judgment and decisions' they have taken to perform an intervention. According to Benner and Tanner (1987) 'intuition' is defined as understanding without a justification. It is a way of thinking that just happens, that cannot be explained and is not rational.

The main belief of the intuitive approach the same authors said is that intuitive judgement distinguishes expert from novice nurse leaders. According to cognitive continuum theory (Hamm 1988), most healthcare decision-making falls somewhere in between purely intuitive (tacit) judgement or purely analytical (rationalised) judgement. The cognitive continuum theory is a framework used to explain decision-making in nursing. The framework uses a combination of intuitive and analytical reasoning to describe cognitive activities. Thompson and Dowding (2002) stated that intuitive judgement falls at the lower spectrum of the cognitive continuum (see Appendix 4), whereas rationality is placed at the higher spectrum of the cognitive continuum. Effective leaders should have the ability to use intuition to inform their decision-making. Leaders who lack appropriate practical skills, such as thinking outside the box and reflection will come across difficulties in making decisions (Wallis and Long 2002).

The distinctions between intuitive and analytic thinking were illustrated by Hammond (1996) who argued that one is not necessarily more accurate or valid than the other but that the important difference between intuition and analytic

Literature Review

thinking is that they produce different kinds of weaknesses, and that leads to different conclusions about trustworthiness. Nevertheless, most decisions usually involve both intuition and analytic thinking. Clinical decision-making is important to nursing practice because of patient care requirements increasingly becoming more complex and difficult. Therefore, it requires clinical reasoning (or practice decision-making) skills to maintain patient stability, to provide high standard quality care, and to avoid costly mistakes that are caused by inappropriate judgement and decision-making (Higgs and Jones 2000). In addition, the on-going advances in research and technology require nurses to be competent decision-makers and accountable in order to act in response to patients' needs (Hagbaghery et al 2004).

According to O'Neill et al (2005) in order to prepare effective nurse leaders you need a healthy working environment. A healthy working environment is one which facilitates a leader's involvement in decision-making. The Standard of the American Association of Critical Care Nurses (Shirey 2006) clarified that in a healthy work environment nurse leaders are given equal participation with physicians and enough space to make judgements and share their decisions in organizations. This is because clinical judgment and decision-making is one of the six elements to promote the creation of a HWE (ACCN 2005). In critical care, where there is sophisticated patient care nurse leaders are required to be knowledgeable and skilful in order to make quick and accurate decision-making and provide high standard care. Thus the literature recommends that healthcare organizations provide the climate for equal participation in decision-making, and empowering and strengthening nurse leaders.

2.12 Particular Consideration of Leadership in Critical Care Settings: The Head Nurse Roles

The importance of undertaking the literature review in this research was to shed light on what makes effective leaders in a head nurse role using critical care settings as an exemplar. In general, effective leadership is essential in providing high-quality care to patients, ensuring patient safety and encouraging staff development. More specifically, developing effective leadership in Critical Care Settings (CCSs) in Bahrain by the MoH will be an attempt to introduce change in critical care nursing services to enhance quality and efficiency. Effective HNs leadership, specifically in CCSs, is crucial. As discussed in Chapter One, the reason for that is that the global demand for critical care is higher than ever for seriously ill patients than ever (AACN 2005). In addition, effective leaders are able to involve staff in decision-making, thereby ensuring more overall effective clinical decision-making when decision-making is under time pressure and uncertainty, resulting in quick decisions in complex and real situations by thinking critically. The working

Literature Review

environment in critical care is usually stressful due to work-overload. This is why HN leaders need to be able to demonstrate empathy in the clinical decision-making situation, understand the emotions of other people, communicate their understanding of the world and of other people, and be responsible and accountable to justify their clinical decisions, based on a scientific rational model and on intuition through developing reflective thinking (Wallis and Long 2002).

According to Shirey and Fisher (2008) effective leaders in CCSs should have the ability to acknowledge and embrace both leadership and management roles. As a leader, there are specific issues to be considered such as creating a positive working environment in which employees are energised, interested and committed to work in; a leader must address effectiveness and focus on what needs to be done and why; and put emphasis on creating a vision and introducing new innovation through establishing coalition and relationships. On the other hand, as a manager, they focus on issues of coordinating actions and allocating resources; addressing quality and efficiency; and understanding processes and the quality of the final outcome of the process. As described in Shirey (2006) authentic leaders are considered as 'the glue' needed to hold together a healthy working environment. Effective HN leaders working in CCSs need to attain similar characteristics of authentic leaders, which include being genuine, trustworthy, reliable and believable, confident, optimistic, and resilient.

2.13 Summary

Despite the considerable literature about leadership, leadership effectiveness, and leadership empowerment, there is still very little research on the barriers to leadership effectiveness in nursing. However, the literature review showed that the role of leadership is pivotal. Findings from research in Bahrain and the UK provide information that illustrates there is a disjunction between the aspirations of nursing policy-makers and the reality of nursing. There is recognition that change is needed in the way people lead and, to facilitate that change, leaders have to understand themselves, as is demonstrated in the literature on authenticity. Leaders must control their emotion, which is considered as a contributing factor to a good healthy work environment. In order to provide a healthy working environment that treats everyone in a respectful manner, and builds a culture of open communication and collaboration it is essential to encourage organizations to acknowledge the significance of changes in their systems. The reason that healthcare professionals need to involve people's concerns in decision-making (e.g. HN leaders) is to enable them to take a helpful decision and avoid costly and deadly decisions at a time

Literature Review

where 'healthcare cost is continuously rising'. The literature review illustrates that there is some research about the importance of both leadership and management skills in this challenging days, the development of effective leadership through building the capacity of nurse leaders in CCSs, acknowledging the value of emotional intelligence, of authenticity, and creating and sustaining a HWE to ensure patient safety, engaging leaders in decision-making, enhancing quality, and to maintain organizational financial stability in the UK settings. However, there is very little in the literature specifically related to a society like Bahrain. There are three themes rooted in the literature which focuses on leadership effectiveness they are:

- Strong leadership in promoting a healthy work environment,
- The disjunction between policy makers' ambitions and the reality at the grass roots,
- Self-awareness is a basis of developing authenticity and emotional intelligence.

Therefore, I became interested in conducting this study in order to explore the factors that facilitate or inhibit effective leadership in CCS in order to elucidate the disjunction that exists between aspiration and reality in Bahrain, as well as in the UK within the context of the wider policy research that has been undertaken in the UK. Furthermore, I would like to make recommendations as to how we can close this gap between the rhetoric and reality, as well as how to persuade clinicians on the ground to sign up to the vision of policy-makers.

CHAPTER 3 METHODOLOGY, RESEARCH DESIGN AND METHODS

3.1 Introduction

This chapter details the design of the study, which is organized in three Phases, as well as the methods and processes used to conduct the project. It provides a description of the study setting. It looks at recruitment of participants, sampling strategy, the piloting process, and concludes with the ethical considerations, the data management and steps of data processing, analysis and interpretation. Finally the role of researcher as insider and outsider is considered.

3.2 Description of the Study Setting

3.2.1 The Study Setting

This study is being funded by the Government of the Kingdom of Bahrain under the sponsorship of the Ministry of Health, and it is being conducted in the Salmaniya Medical Complex (SMC), specifically in Critical Care Settings (CCS). This study was considered by the research committee in the SMC and accepted on the basis that the study should make a valuable contribution to nursing knowledge as well as to nursing practice. I am a senior Head Nurse and currently working as a nurse officer in the nursing administration in Bahrain. In addition, the subject of effective HNs leadership is of interest to me as the development of effective HNs is a part of my role as a nurse officer in SMC.

3.3 The Research Design

An exploratory, qualitative research design is being used in this study. The qualitative design focuses on gaining insight into people's attitudes, behaviours, value systems, concerns, motivations, ambitions, and cultures or lifestyles (Holloway and Wheeler 2002). Avis (2005) goes further to state that the qualitative design explores social phenomena from the point of view of the participants in the study. It involves the use of a Case Study Design (CSD) as a framework to allow the researcher to grasp the complexity of the study. Case study is defined by Yin (1989) as a realistic inquiry that investigates an existing phenomenon within its real life context, when the boundaries between phenomenon and context are not clearly evident, and when multiple sources of evidence are used to enhance construct validity. The reason behind using a CSD is 'when little is known about the/an issue' (Appleton 2002), it adds depth and breadth to the results (LoBiondo-Wood and Haber 2006), and it will increase the strength and consistency of evidence. Holloway

Methodology

and Wheeler (2002) stated that undertaking case study research is a way of exploring a phenomenon in its setting using various data collection sources; for example, observation, documentary sources, and interviews to investigate the case from different angles.

Therefore, in this case study I am aiming to undertake an in-depth and intensive examination which will explore the phenomenon of HNs leadership effectiveness in the Critical Care Settings using different approaches of data collection such as interviews, observation, and document consultation to obtain greater understanding about the case. In this study, I have employed the Yin (2009) case study approach as the appropriate research strategy to explore the phenomenon under investigation. Yin (2009 p.2) has delineated issues which need to be carefully considered when making a decision whether a case study approach is the appropriate research strategy to utilize in a specific study: "the type of research question, the control an investigator has over actual behavioural events and the focus on contemporary phenomenon within some real-life context". He mentioned that case studies are the appropriate approach when "how" and "why" questions are being asked (Yin 2009 p. 2).

A criticism of the case study approach is that it is difficult to generalise the results, because they relate to specific situations and locations. However, Yin (1994) and Woods (1997) argue that the case study is not concerned with statistical generalisation but rather with analytical generalisation and the rich and in-depth data gained from the participants. Thus, the method of generalisation is by 'analytic generalisation', where the researcher makes every effort to generalise a particular set of results to some broader theory. When the results of two or more cases are revealed to support the existing theory, then a degree of generalisation may be claimed.

The rigour of the research design and methods is equally important in qualitative, as in quantitative, research. In quantitative research the terms used are validity and reliability. In qualitative research the rigour of the research design are referred to using the terms 'credibility', 'dependability' and 'transferability' which describe various aspects of empirical trustworthiness (Patton 2002, Johnson 1997, and Polit and Beck 2006). In qualitative research credibility deals with the focus of the research and refers to levels of confidence the researcher's in how well data and processes of analysis address the intended focus (Polit and Hungler 1999). Therefore, researchers have to address issues concerning credibility when making a decision about the focus of the study, selection of context, participants and the approach or approaches to gathering data. Polit and Beck (2006) clarified the point

Methodology

that credibility is used in qualitative research whereas validity is used in quantitative research, and there is no credibility in qualitative research without dependability. Polit and Beck (2006) go further, stating that dependability of data refers to data constancy over time and over locations. The credibility of this case study is enhanced through the following means: collecting data from three different information sources (Executive Nurses, Head Nurses, and Senior Staff Nurses), precise typescripts of interviews, and accurate categorising of material. The methods of data collection used in this research are in-depth interviews, documentary sources and field observations. To examine HNs' leadership competencies, the boundaries of the case have been clarified in terms of the questions asked, the data sources used and the setting and persons involved. This study was carried out in three Phases (as shown in Table 3.1).

Methodology

Table 3.1 Research Phases

Research Phases	Participants	Interviews Plan	Observation Plan	Documents
Phase 1	<u>Interviews</u> 2 Key Informants 4 Head Nurses 1 Senior Nurse <u>Observation</u> 2 Head Nurses	<p>The main purpose is to:</p> <ul style="list-style-type: none"> . Gain Access . Gain their views on what makes for effective leaders at HN level. . Developing interview guide questions for PH 2. 	<p>Observation include watching and listening to the following:</p> <ul style="list-style-type: none"> . How HNs handle different situations. . How HNs make decisions. . The research setting. . How HNs communicate with nurses and other professionals. . How HNs use power and authority. 	.Circulars .Meeting Reports .Unit Plans
Phase 2	<u>Interviews</u> 2 Head Nurses 2 Senior Nurse <u>Observation</u> 2 Head Nurses	<p>Developed question guide to include:</p> <ul style="list-style-type: none"> . What they considered as a stressful situation. . How do they confront different stressful situations. . How they are able to manage themselves 	<p>Developing observation to include:</p> <ul style="list-style-type: none"> . The visibility of HNs in clinical area. . How confident HNs dealing with different situations. . How HNs approach nurses. 	.Circulars .Meeting Reports .Unit Plans .New Policies
Phase 3	<u>Interviews</u> 1 Key Informants 2 Head Nurses 2 Senior Nurse <u>Observation</u> 2 Head Nurses	<p>Developed question guide to include:</p> <ul style="list-style-type: none"> . Exploring whether leaders are born or made. . How HNs view their 'self' . What is self-development . Explore HNs Leadership journey. . Explore HNs rational thought versus tacit knowledge. . Exploring Bahrainization issues 	<p>Developing observation to include:</p> <ul style="list-style-type: none"> . How HNs communicate with other departments. . How HNs manage extended work. . The setting and the flow of works. . The problems occur while and how HNs cope with it. . Nurses development 	.Circulars .Meeting Reports .Unit Plans .Organization structure
Total :	<u>Interviews</u> 3 Key Informants 8 Head Nurses 5 Senior Nurse	<u>Observation</u> 6 Head Nurses		

3.4 Research Phases

The first Phase was concerned with gaining access to, and interviewing, the Key Informants (KIs) such as Chief Nurse Executive (CNE), the Nurse Development Consultant (NDC), and the Head Nurse Officer (HNO) of the Critical Care Settings. They were sent an invitation (Appendix 5) to take part in an in-depth interview as they represent the hierarchy of the nursing services in Bahrain. They were also involved in planning and implementing strategies for nursing. The purpose of interviewing the KIs was to explain my research objectives, gain access to participants, and involve them in the whole journey from access to dissemination of results. In addition, I wanted to gain their views on what makes for effective leaders at HN level. The interviews for this Phase started in August 2009. The data gathered from the interviews has been used to develop the interview guide questions in Phase Two. In Phase One I interviewed two KIs and the third person was interviewed in Phase Three. In Phase Two, as a result of preliminary analysis of Phase One interviews and observations I have raised additional questions which needed to be explored (as shown in Table 3.1). In Phase Two, I interviewed two HNs and two SSNs, as well as conducted observation for two HNs and issues that had been flagged from interviews and observations were considered in Phase three. The purpose of interviewing the SSNs was to see how they are related to the HN in terms of gaining their perceptions about what the role of the HN as a leader is in relation to these staff nurses. In the third Phase even more in-depth interviews took place and further observations were conducted in order to clarify those points. In Phase Three, in addition to observing and interviewing two HNs and two SSNs, the third KI was interviewed.

3.5 Piloting

A semi-structured interview guide containing open-ended questions was developed to explore factors that facilitate or inhibit effective leadership. The developed interview guide (Appendix 6) was piloted on one Nurse Supervisor from CCS during an audiotaped interview. Piloting provides ideas for useful probes, serves to identify any awkward ordering of questions, and other anomalies such as leading questions. Pre-testing also offers an experience to practice taping and to verify the quality of both the tape and the transcript (Norwood 2000). Clifford (1997) argued that the reasons why it is important to pilot an interview guide's questions are as follows:

- To test how long it takes to complete an interview,
- To check that the questions are not ambiguous,
- To check that the instructions are clear,
- To allow the researcher to eliminate questions that do not yield usable data.

Methodology

The pilot test conducted in this study has provided me with key points to remember before conducting the real interviews. Therefore, I verified the flow of interview guide questions and avoided any repetitive questions. I checked the tape-recorder's functionality before starting the in-depth interviews. I considered the interaction with interviewees and the atmosphere before and during interviews. The interviews are being carried out in English but I accepted certain local terminology the interviewee used to express concepts in Arabic language.

3.6 Recruitment of Participants

Research participants were purposively recruited from CCS, and they have been selected according to inclusion and exclusion criteria. I selected research informants according to the knowledge they have about the research topic. LoBiondo-Wood and Haber (2006) stated that the reasons for purposive sampling are to provide the qualitative researcher with the opportunity of recruiting participants who are familiar with the area under discussion; Polit and Beck (2006) added that this type of sampling tends to ensure richness in the data gathered. In addition, 'such knowledgeable participants' will provide rich descriptions based on their personal experiences. Purposive sampling enhances external validity, and increases the chance of generalizability of the results (LoBiondo-Wood and Haber 2006, Yin 2009).

I conducted introductory lectures to provide participants with an overview of the aims and the objectives of this study. I invited all participants to attend this lecture and an invitation letter (Appendix 5) with the research information sheet (Appendix 7) was given by the researcher to the selected HNs, to invite them to take part in this study and to explain the purpose and the procedure of the research. Two HNO's who cover CCS had showed interest in being involved in this research. I therefore included them within the sample of key research informants.

3.7 Inclusion and Exclusion Criteria

3.7.1 Inclusion Criteria

- A Head Nurse who has been in the same post for more than two years.
- A Head Nurse who holds a minimum of an Associated Degree in Nursing, or Post Basic Diploma in Critical Care.
- Bahraini HNs.
- HNs who works in CCS.

3.7.2 Exclusion Criteria

- HNs with less than two years' experience in the position.

The research sample was selected from a CCS that consists of the following: Accident & Emergency, Intensive-Care, Coronary Care and Step-down, and wards. Most of these settings have one HN only, except in the Accident & Emergency Department (A&E). The total number of HNs working in CCS is 14, and for the purpose of this study, qualitative data were gathered from a sample of Three KIs, Eight HNs, and Five Senior Staff Nurses from CCS. The participants were identified by me taking into consideration the diversity of the sample, gender, and experience. There were only 14 HNs working in CCS, and for the purpose of this study only eight Head Nurses were selected. All the interviews were conducted in a private office at SMC. The six observation sessions were scheduled with the six HNs, each observation session being done over three days and at different times during the day. The purpose of scheduling the observation sessions first was to observe the HNs in their natural setting. I observed the behaviour, the physical and social activities, human relationships, experiences, plans, and socio-cultural context in which HNs and other employees were working.

In Phase One, throughout the in-depth interviews an interview guide (Appendix 6) was used to keep the interview focused and to allow every participant to articulate their point of view. An interview guide is a framework rather than a precise set of questions that outlines the research topics or issues to be covered (Norwood 2000). Indeed, throughout the interviews, the interview guide helps the researcher to know when to prompt or probe for more in-depth responses and guide the conversation to make sure that all topics on the outline are covered. The probing questions used throughout the interviews were as follows: can you tell me more?; why do you think that is?; do you want to add anything else?; what do you mean? It is also important to retain flexibility so as not to hinder other important topics from being raised by the participants. Phase Two interviews were started in December 2009; it allowed me to follow-up on inadequately explored issues and concerns from Phase One. The participants were interviewed and observed based on a developed interview guide built on new issues raised from interviews and observations in each Phase such as issues to explore how HNs made decisions in any stressful situation, the flow of communication in the critical care settings, how HNs recognized the employee, and observed the whole setting and whether there were other factors that might facilitate or hinder HNs effectiveness.

3.8 Observation

Observational methods used in social science involve the systematic, detailed observation of behaviour: watching and documenting what people perform and articulate (Mays and Pope 1996). Observation means that the researcher is immersed in the fieldwork in order to gather information and becomes familiar with it (Watson and Whyte 2006). The observation element of the research included collecting data about HNs behaviours and interactions as well as analysing documents, i.e. meeting reports, circulars and memos. Observations were scheduled with six HNs from CCS and were carried out in critical care settings. These observations were used as a first method of data collection and took place before the in-depth interviews. Each HN was observed for three hours a day over three days and at different times during each day. The observation of participants was undertaken to allow the researcher to gain detailed information that could contribute to an understanding of the phenomena under study before the interviews took place. Structuring observations by day and time period helped in ensuring representation of time and day of the week (Bowling 2002). The scheduled observation included taking field notes or making/writing descriptive accounts as a result of this researcher watching and listening in relation to:

- How HNs handle different situations,
- How HNs react to different situations in ward / unit meetings,
- How HNs make decisions over different shifts,
- Attending shift duty with HNs that they are scheduled for to observe how they manage extended roles.

As it is represented in table 3.1 the data collection was in three Phases, and it involved observing CCS HNs. I started data collection by observing the CCU settings in August 2009. It was my first experience of collecting data by observation. It was difficult at the beginning to separate my role as a researcher from my role as a senior nurse officer working as an insider in the same clinical areas where I was conducting my study. It should be noted that the different classifications of participant observation by Gold (1958), Buford Junker (1960 cited by Jorgensen 1989, p.55), and Watson and Whyte (2006) include four major roles: participant as observer, observer as participant, complete participant, and complete observer. I thought that in order to reflect on what is going on in the clinical practice, I had to step aside and observe without passing any judgment. Therefore, I took the role of an observer as a participant. This role allowed me, as the researcher, to participate briefly in taken round with the nurse in-charge and attending meetings with informants but spend most of the time observing their behaviour and interactions. I

Methodology

explained to all informants that my position as observer will be clearly identified and I will not contribute to any clinical decisions, other than in an emergency. I have done my best to explain my role as a researcher to all participants to avoid participants involving me in playing the role of a senior N.O. This helped in avoiding misunderstanding my role as an observer participant, and helped by me not passing verbal comments during any situation.

As a novice observer I did not know exactly where to start my observation, and what I had to observe. I thought of formulating a list of things I wanted to observe, but this list did not cover everything. Therefore, I referred to Patton's (2002) work about clinical observation. Patton's (2002) work helped me to set the areas that I should mostly focus on, such as: location, time, people, settings, activities, facial expressions and verbal interaction (Appendix 8). I thought this would make my data collection easy because it facilitates the systematic collection of data and it enhances credibility through avoiding researchers reflecting on exactly what they experienced:

‘What people see is highly dependent on their interests, biases, and backgrounds’ (Patton 2002, p.260).

3.9 Data Management

3.9.1 Steps of Data Processing, Analysis and Interpretation

Data processing and analysis began soon after completing each Phase of interviews. It commenced with the preparation of a plan for the processing and analysis of data. The plan helped me to ensure that all the information needed from the research was being collected, and in a standardised way, as well as helping to avoid collecting unnecessary data which will never be analysed. The plan for data processing and analysis started after I carefully considered the study's aims and objectives. By adopting Taylor-Powell and Renner's (2003) guide for analysing and interpreting narrative data, I was able to analyse and interpret what participants were saying and doing. Their guides have five steps of analytical process as follows: get to know your data, focus the analysis, categorise information, identify patterns and connections within and between categories and interpretations, and finally bring data all together. The data gathering process started with transcribing the research interviews. The audiotape qualitative data collected from the in-depth interviews were transcribed and analysed while listening to the tape recording. Data analysis was done alongside data collection after each Phase which allowed questions to be refined and new avenues of inquiry to be developed. I transcribed all the interviews verbatim. The downside of performing the transcription was that it was very time-consuming. Each interview, which averaged an hour, took around ten

Methodology

to twelve hours to transcribe. I was able to complete all interview transcriptions myself, and had the advantage of being immersed in the data, which is considered a positive part of data analysis (Speziale & Carpenter 2007).

A structured analytical process is appropriate where each interview transcript is considered as a case analysis (Corbin and Strauss 2008). Such an analytical process started with reading all the transcripts and field notes that helped me, as the researcher, to a better understanding of the interview data. Any notes and comments were made in the margins of the text of each interview transcript. I also assigned a colour code for each different new theme which emerged from the data. Data was coded and grouped according to the themes and patterns that were identified by the researcher. In developing a main category, I generally grouped the related concepts together to facilitate the coding process. In addition, the findings of this research have included extracts of text from the interviews, in order to illustrate analytical points and represent the real voice of participants. Bassett (2004) indicated that, to ensure accurate representations of the spoken word in the text of the transcript, extracts from the transcripts were used. I have provided extracts containing sufficient detail and context for readers to assess my interpretations and my trustworthiness as an observer and reporter.

The analytic strategies of thinking about various meanings of a word, and the use of questioning were used in data analysis. Throughout the in-depth interviews, the technique of asking interviewees to clarify any ambiguous phrases or sentences and to describe the important aspects of the factors that facilitate or inhibit leadership effectiveness raised in the interviews helped to ensure that I was not making assumptions about the interviewees' meanings. I looked very closely at the interview transcripts for words and statements which had been left vague by the interviewees. I returned to the transcript and listened to the tape recording to revise the description if and when appropriate. I then developed the interview guide to clarify any issue un-intentionally left vague from the participants' point of view. I particularly looked for certain phrases and statements that related to the research interest. I considered all the possible meanings and omitted any material that was irrelevant to the research aims and objectives. Then I looked through transcripts searching for 'cues' to the emerging themes (Corbin and Strauss 2008, a process which enabled me to begin to see patterns and connections both within and between such themes and which also served to reveal different themes, as well as highlighting sub-groups under certain themes. During the analysis process I became confused about the themes and sub-groups but when I looked again at the data and developed a list of key themes or important findings, which were then presented in graphic form, (involving diagrams, boxes with arrows and in table

Methodology

format), this clarified the presentation of the research data. Therefore, I decided to present data under certain headings, and then the same headings changed to other headings through tracking the context of the quotes and selecting carefully the quotes which supported the themes and sub-groups. Finally, I decided to cut and paste of identical paragraph from data according to the themes emerged from data in Phase One. All themes and sub-groups were grouped together under particular themes. I have checked the initial analysis and interpretation with a reference group from the three categories (HNs, NOs, and SSNs) to assess my data interpretation and my trustworthiness as a researcher. I have presented the background data of research informants in tabular form and in figure 4.2. The only limitation I have encountered was my 'novice' experience in doing qualitative research, but with the support of my supervisors and my enthusiasm I was able to progress.

3.9.2 Analysis of observation and documentary data

In addition to the above analysis, I took field notes about certain activities and behaviours to facilitate data analysis. Speziale and Carpenter (2007) support the idea of researchers taking field notes that help in providing validation for important points raised by participants, as well as facilitating appropriate identification of emerging themes. The data gathered from observation, field notes, recorded thoughts, insights and other documents were analysed through coding and grouping according to the themes. They were linked and integrated with other themes generated from in-depth interviews.

3.10 Ethical Considerations

3.10.1 Gaining Access

Before going into the field, I identified a site that is suitable to the research topic, as well as the key actors and gatekeepers who have the authority to permit entry to the research setting (Polit and Beck 2006). Accessing the participants in this study was arranged through the nursing administration. I met with the Undersecretary of Health, NDC, and CNE and explained the research aims and objectives, methodology, and implications. A copy of the research proposal was given to the Undersecretary of Health. A letter was sent to the Chief Nurse Executive (Appendix 10) and to the head of the ethical committee (Appendix 11) requesting their permission to conduct this research.

Methodology

3.10.2 Ethics

To enable informed consent, participants in this research were fully informed about the study, its purpose, study procedures, and the potential benefits from the study before they signed the consent form (Appendix 12). Confidentiality has been assured in the following way:

- Names or workplaces have not been included in any tape recordings and transcripts or written reports,
- Anonymous codes have been used to track interview extracts in data analysis,
- Data protection and storage, according to Data Protection Act (DH 1998) emphasises that researchers are responsible for ensuring compliance with the Act, in relation to data storage and the way in which access to data is managed.

The data in this study have been stored in a locked cabinet for the duration of the project. Subsequently, data will be stored securely for up to 15 years from the date of research (as required by the university). Participants will have the right to refuse to participate or to withdraw from the study at any time without penalty or having to give a reason for doing so and if they withdraw their data will be destroyed.

Participants were given the opportunity to ask questions relating to the study.

Approval from the hospital research ethical committee in Bahrain has been granted for the study.

3.11 Role of Researcher as an Insider and Outsider

In order to avoid a potential conflict of interest between my role as a Senior Nurse Officer and that of a researcher, I have sent a letter inviting key informant participants and the HNs to take part in this research. Furthermore, the insider researcher's ideologies are built on establishing relationships between participants and the researcher, based on respect and trust. I believe that close relationships with participants facilitated the researcher learning about their lives. In addition, maintaining a culture of openness through being alert to participants' feelings helped in sustaining participants' confidence and in motivating them to keep them 'on board' for long periods. I maintained my role as a researcher and avoided any type of interference in any clinical decisions. I stayed back and observed what actions the participants took and asked for an explanation or elaboration at the interview time. I was anxious in case I was drawn into a situation where I was asked to give advice on issues related to policies, rules, and regulations. This seemed possible, since the HNs knew me as a nursing officer, therefore they might perceive me as a source of help and advice as a senior nurse. I anticipated that this potential

Methodology

dissonance might cause some conflict for me as a researcher and as a nursing officer. During the stage of data gathering and data analysis I had to be cautious about not being biased or manipulating participants' accounts of their experience. Thus, asking questions like "What do you mean?" "Can you explain more?" or "Can you make it clearer?" allowed me to bring out and emphasise the voices of participants rather than enforcing and promoting my own feelings.

3.12 Building Rapport

Establishing and maintaining a line of communication and good relationships with gatekeepers and participants was the first step in building rapport. I spent time explaining and integrating with gatekeepers and participants in the setting to gain their trust and acceptance. I conducted a lecture, of approximately one hour to provide participants with an overview of the aims and the objectives of this study and to make an effort to build and maintain rapport all the way through the study. Therefore, I prepared a protocol which included the interview schedule and the interview plan before I informed all participants about the time frame of their interview, and welcomed any clarifying questions from participants. I maintained mutual trust and respect with participants as those factors are a significant basis for rapport. I sustained empathetic listening to what participants had to say. Maintaining rapport with participants, from my experience, has helped me as a researcher to access closely held information, through providing the participants with the time to fully describe their experiences as well as protecting their confidentiality. In addition, I asked all participants before the interview about the place and the time that was most comfortable and convenient for them to be interviewed. This allowed them to share important information. The ways I presented myself, as a researcher, to participants encouraged them to participate in this study.

Measures have been taken to protect confidentiality and anonymity, and to control the likely use of data. I obtained participants' permission for the tape recording and note taking of their responses. Then I obtained their consent, after they had read the cover letter, to attain their acceptance in sharing this study. I maintained a rule of listening carefully, without interfering. I continually smiled and maintained my body language as a professional. I listened to other staff, physicians, and mentors and I answered their questions. Throughout the interviews I showed the respondents that I am interested in everything they said, through my nodding or saying "yeah" to allow them to talk and explore their attitudes and experiences for most of the time. I never showed any disapproval of the information received during the interview. I was also able to explore novel issues that had not been

Methodology

previously thought of when planning the study. Finally, when all data are analysed, I am planning to involve the participants in a discussion of the results and recommendations in a feedback session.

3.13 Conclusion

This chapter outlined the methods and processes used to conduct this study, including how data have been generated and analysed. The case study approach lends itself to studying how the role of HNs can be affected by factors that influence or hinder the effectiveness of leaders in CCS. The issue of recruitment and selection of research informants, and research phases, has been discussed in detail above. Chapter four is concerned with a presentation of the research findings.

CHAPTER 4 FINDINGS

4.1 Introduction

This chapter presents findings from the research, based on three Phases. In these Phases, in-depth interviews with a total of eight Head Nurses, five Senior Staff Nurses, and three Key Informants - one Nursing Development Consultant (NDC), one Chief Nurse Executive (CNE) and one Head Nursing Officer (HNO) - were conducted, as well as observation of the six HNs working in Critical Care Settings (CCSs). To present these findings, quotations will be used to illustrate the analysis, primarily from the interviews but also with some insights gained from observation and from documents. The quotes will be given an anonymous code representing a participant's designated title i.e. Key Informant (KI), Head Nurse (HN) and Senior Staff Nurse (SSN). In the presentation of the data, consideration has been given to allowing both multiple and lone voices to be heard. First, the demographic characteristics of the participants are presented; this is followed by an overview of the key themes emerging from the data analysis process (as discussed in chapter three). Each theme is then expanded upon.

4.2 Demographic Data

In total, 16 interviews with nurses working in Critical Care Settings at all levels were conducted, as presented in Table 4.2. The demographic data showed that, of the sample, 87% were female nurses and 13% were male nurses, which is in-line with the proportion of female to male nurses in the population in Bahrain (MoH 2009). The average age of participants was 39 years. The participants included five senior staff nurses, eight charge nurses, one head nursing officer, one chief nurse executive, and one nurse development consultant. The charge nurses in the study had an average of 7 years of charge nurse experience, ranging from 2-14 years. All participants were registered nurses, 50% were prepared to the baccalaureate level, 37.5% at the master's level, and the remainder 12.5% at diploma level. Only 45% of the participants had previously engaged in a formal or structured education programme focusing on leadership.

Findings

Table 4.2. Demographic Characteristics

Characteristics	No	Percentage
<u>Age group</u>		
30-35	9	56%
36-45	4	25%
46-55	3	19%
<u>Gender</u>		
Male	2	13%
Female	14	87%
<u>Nursing Role</u>		
Nurse Development Consultant	1	6.25%
Chief Nurse Executive	1	6.25%
Head Nurse Officer	1	6.25%
Charge Nurse	8	50%
Senior Nurse	5	31.25%
<u>Years of Experience as a Registered Nurse (n=16)</u>		
10-20	10	62%
21-30	4	25%
31-40	2	13%
<u>Charge Nurse By Years of Experience (n=8)</u>		
02-05	5	62.5%
06-10	0	
11-15	1	12.5%
16-20	1	12.5%
>20	1	12.5%
<u>Senior Staff Nurse By Years of Experience (n=5)</u>		
5-10	1	20%
11-15	4	80%
<u>Highest Qualification</u>		
1-MSc in Nursing	2	12.5%
2-MSc in Healthcare Management	4	25%
3-Bachelor Science in Nursing	8	50%
4-Diploma in Nursing and Midwifery	2	12.5%

4.3 Emerging Themes

There are four major themes emerging from the data analysis which relate to the HN leadership role and its impact. It was clear from the data that the style of leadership exhibited by a HN in the Critical Care Settings (CCSs) was an important factor in informing the way in which the HNs manage. Of equal importance was the ability of the HNs to network and communicate with colleagues and other professionals from the same settings as well as those from outside the CCSs. There was an emphasis from HNs on developing educational strategies and programmes for HN leadership effectiveness, as HNs considered those programmes to be a foundation for their professional development. The data showed the need for there to be a healthy working environment so that the HN leaders could work effectively. Each theme will be discussed further. These themes are summarised in Table 4.3, with the component category that make up the themes.

At the completion of data collection from Phase One and Two, and in order to check the authenticity of the initial interpretation of the findings from this research, as discussed in chapter three sections (3.9.1), I presented the themes to a reference group from the three categories. The group consisted of the Senior Staff Nurses (SSNs), the Head Nurses (HNs), and Head Nurse Officers (HNOs), who will not be interviewed, and was formed in order that the group members might check the preliminary findings and respond to my presentation and interpretation of the data. In addition, the aim of involving such a group was to ascertain the representative nature of the findings, and to check that the interpretation of data was not overly influenced by my knowledge, experience, and my position as a SNO. The outcome of this reference group's discussions is also included in the presentation of data in this chapter.

Table 4.3 Emergent Themes

Leadership Style	Networking and Communication	Education and Development	Healthy Working Environment
Being empathetic	Networking and rapport	Cultivating a 'learning organization'	Having a facilitative organizational structure
Being open and honest	Opening dialogue with policy makers	Developing and preparing leaders for their role	Creating an empowering working environment
Being optimistic	Building and strengthening relationships	Developing a creative thinking environment	Being valued and acknowledged
Being visionary	Building a harmonious team	Being a role model	Being clear about leadership roles
Initiating and introducing change	Open style of communication		Related Factors
Leading and managing in different situations	Being accessible		The impact of the economic downturn
Inspiring staff			
Engaging with the work			

4.4 Leadership Style

Leadership style was the first theme that emerged from the data. Participants from the three groups, when asked about what facilitates HN leadership effectiveness in the CCSs in Bahrain, identified different leadership styles of a HN. Their perception about those styles was that they will consistently have a positive effect on the climate of CCSs and on the outcomes of patient care. The participants mentioned that the HN leaders should have the skill of being aware of other people's emotions and show interest in their concerns. Similarly, a HN being open and honest has been identified as a crucial element in the effectiveness of a HN leader. It was interesting that participants considered a HN being optimistic was one of the most effective styles a HN leader might use to generate people's creativity in the area of CCSs. Participants highlighted the value of a HN leader being visionary in order to be able to direct his/her teams and services to a future goal. The value of working alongside the people in such teams, and inspiring them and engaging with the work to initiate and introduce change, was rated as a substantial component of effective HN leadership. Participants in this research believed that a leader's ability in 'leading and managing in different situations' is an important aspect of HN leaders in today's changing working environment.

4.4.1 Being Empathetic

Another key point raised by the SSNs was showing empathy. This centres on the key issue of HNs being empathetic through working closely with their employee, building rapport based on understanding their problems and complaints as well as having a complete view of the needs of the employee. As one SSN said:

“[In] my opinion, if you want to manage or lead [effectively], you have to keep yourself in others shoes to understand them and to be able to reach to their level of [understanding] and you [will be able to] build a good relationship with them....” (SSN8).

Similarly, one SSN, when asked about the qualities of effective HN leadership role, talked about the HN who is concerned about the staff's feelings and emotions:

“She has to [be] empathetic in some situations, and open-minded... she has to think with her brain and not with her heart only, actually both...” (SSN4).

Findings

In the same way, SSN talked about how an HN should be an example for his/her staff. For example, able to control his/her attitudes and behaviours as explained:

“I think a role model leader for example, cannot tell people to come early while she comes late. She has to [have] empathy in some situations, be open minded, and [be online with] up-to- date knowledge [and advancements in technology] ” (SSN4).

4.4.2 Being Open and Honest

Participants from the three group felt that trust and honesty were important qualities for an effective HN leadership role. As one HN said, the obstacle to HN leadership effectiveness is when there is a lack confidence, or the perception of dishonesty between HN and his higher authority (i.e. HNO):

“[One of] the barriers to effective leadership is the lack of clarity and [lack of] honest communication [between HN] with HNO. When the communication is not clear it will not be facilitating, it will be a hindering factor” (HN8).

Another KI talked about HNs not keeping a healthy climate that encourages openness and honesty, while working together with their nursing colleagues which leads to confusions:

“The nurse supervisors start hiding or keeping things [away] in order to [avoid] showing the [real situation]. It is very important that a nurse supervisor is trustful and honest” (KI1).

The desirability of ‘being open and honest’ was frequently raised in the interviews across the three groups. Within the reference group discussion of the findings, this was evident; for example, one of them said:

“Trust is important because when the Nurse Officer does not trust their HNs then they will not delegate work” (SSN).

4.4.3 Being Optimistic

One of the HNs said that effective HN leaders are professional people who encourage collaborative work and always see things with a positive eye, rather than looking at challenges solely from a negative side. For example, looking only to individual “failures and blames” can have a negative impact on individuals and on the organization, and can cause a leader to miss opportunities to change the current situation. According to the quotes below, an HN leader who uses positive analysis will concentrate primarily on positive actions because to do so will generate successful change in individuals and in the organization:

“An effective leader is one who takes something [confidently] and shares it to understand it. [As well as] be supportive, and see things not only from their negative side but also from their positive side.” (HN7).

Another HN said it is important to be a positive leader in clinical settings because this will facilitate organizational development as well as keep nurses motivated and productive:

“If I am a good leader, I can bring [advancements to the] department because people will be happy to work with me and they will be motivated” (HN3).

4.4.4 Being Visionary

It was interesting to listen to one participant in the interviews, who acknowledged effective HNs as the ones who were ‘future concerned’. It was said that the effective HN leaders should have the potential to set a clear vision to enable them to visualize the picture of successful performance in the organization. The future effective HN leaders should have the capacity to focus on both the existing tasks as well as connecting with their work as part of the future:

“[The effective] supervisor thinks at a different level than I do. So she will have a clearer vision about what are the aims of the organization [and] listen to [others] decisions which will help with more stability in the unit” (SSN4).

Findings

Another SSN thought that the HN should have the ability to visualize things from a distance to improve their performance and achieve goals:

“She has to see the things from distant, not [only] what happen currently. I mean...She has to see the consequences for the things and what will happen later and what we want in the coming five years” (SSN1).

One participant from Kis' group stated that the effective HN should have the ability of being oriented towards the future and about what they wish to create in the future as well as understanding what is going on around them:

“[Head nurses should have] personal attributes of a visionary leader, have a global picture, be highly intelligent, and have social intelligence” (KI3).

The same KI elaborated more about how HNs should plan to be future oriented. They should keep the bridges with other professionals in order to advance their careers:

“If HNs want to develop an agenda for the profession they should have an arm link to others or otherwise they will be isolated” (KI3)

4.4.5 Initiating and Introducing Change

In interviews, more than one HN talked about a leadership style which exhibits a good leadership role. They emphasized the leader who encourages staff to introduce change in practice, rather than leading staff with their power of position and authority, as illustrated in the following quotes:

“[An effective HN] leader through role modeling not by authority or by position, is [about] leading people and influencing them to bringing about change” (HN8).

Another HN said:

“We initiate changes....for example, we did the proposal for a team leader, and we also did a chart review for the critical care unit” (HN7).

Findings

The majority of participants from SSNs considered HNs being fair and treating staff equally as important factors for motivating nurses to initiate and introduce change in clinical practice:

“I have to be fair with everybody and treat them all equally.
Treat all staff with respect, understand they are human
beings and their needs, and work with them as a team”
(SSN6).

4.4.6 Leading and Managing in Different Situations

From the data analysis, it is clear that participants from HNs’ and SSNs’ groups specifically mentioned the value of having effective HNs who are able to lead and manage in different scenarios. For example, HNs should have the skills of listening to their staff in a difficult situation, and to be able to exert control in other situations, as illustrated from the following quotes:

“[An] Effective HN cannot maintain one leadership style because she works with different personalities. She has to use different management and leadership styles. For example, in a situation where [there] is staff frequently reporting sick leave, HN have to listen to staff and find-out why he/she is frequently absent from work then decide what type of management style will be applicable in this situation”
(SSN4).

Similarly one SSN said:

“My supervisor uses a democratic style of management and if things go wrong with patients then she will use an authoritarian style and she will take a decision [without involving staff]...She uses her friendly attitude and kindness sometimes.....[in another situation]” (SSN2)

Another HN said that effective HNs should have the ability to imagine better ways to intervene in different situations and change their basic style of managing problems:

“[HNs should] think outside the box, not only manage through the classical managerial style, [and] this is because situations are always changing [and] we [can] never expect what is going to happen within the next half an hour, so we

should have creativity, have [a thorough view] of things, and we should involve our team" (HN8)

4.4.7 Inspiring Staff

The ability and need to inspire staff was a common response in the interviews across the three research groups. When asked about the facilitators for effective leadership roles, participants' responses varied. For example, one SSN said that HNs should facilitate things for their staff, provide them with resources, involve them in the process of change from planning to implementation, and motivate them through developing ways to overcome their weaknesses:

"[HNs should] share their ideas and suggestions, motivate staff, involve them in plans, solve their problems, [and] provide them with resources. [HNs should also] develop their knowledge through assessing their needs and developing their weakness" (SSN4).

Another HN said an effective HN should inspire staff and should treat them in a respectful manner:

"In my opinion, a good leader or a good manager is [one] who can motivate the people, who can treat everyone respectfully and courteously" (HN8).

4.4.8 Engaging with the Work

Analysis showed that 'engagement with the work' was not a common response in the data analysis. A participant from the KIs group had been asked to discuss the inhibitors to leadership effectiveness in CCSs. It was suggested that leaders who are more concerned about material things and personal gain (i.e. wages), than having awareness and interest in the profession, will lose their focus on development and perhaps even weaken the development of their profession:

"We have a group of leaders which [in my opinion] is unhealthy to have them, because [they are] people who come just for the salary and don't care about the profession. These types of people are very difficult to please, very difficult to work with, and are the people who undermine the profession [rather] than developing it" (KI3).

Another KI said that the HN leaders, working in the CCSs, are unsatisfied about the increase of the workloads and about the perceived reduction of their status. They feel that they should be distinguished from other HNs in other clinical areas where there is less work and less stress:

“Because of the workload and the increase in patient’s [attending CCS] HNs lose their interest working in this [situation].ah...ah...[Because] they are not distinguished and they are treated similarly with other nurses who work in [other] light clinical areas like Out Patient Clinics and E.N.T wards” (KI2).

4.5 Networking and Communication

When participants were asked for their opinions about the facilitators and barriers to effectiveness of the HN leadership roles, they mentioned that networking and communication were important. Participants identified the different factors and influences in networking and communication. For example, they believed that building rapport with staff is a key factor that facilitates effectiveness of a HN leader, alongside the ability to network with other people. There was emphasis on a HN maintaining a line of communication with policy makers (i.e. the Hospital Top-Management Board) to discuss the issues of importance to HN leaders. Participants suggested such communication could be accomplished by HN leaders ‘building bridges’ and strengthening relationships with policy makers and other professionals. From the participants’ point of view, the ability of a HN leader to encourage cooperation and build teams will facilitate HN leadership effectiveness. Participants stated that this aspect of effectiveness depended on the HN leader’s ability to establish and maintain a line of communication with all fellow medical professionals, along with being close to the teams they were working with.

4.5.1 Networking and Rapport

Building an affiliation with other nursing professionals was one of the key elements identified as important by members of the three groups. There were different perceptions within the three groups of the effects of making a good professional relationship. For example; they talked about building a relationship to empower nurses, to maintain organization culture, and to network internally and externally with nursing professionals. According to a clear statement from one of the KI:

“Head Nurses should have strong relationships, and their

personality should be a personality that develops networking, because leaders cannot work in isolation. The networking [is] not only within the profession but it should go beyond the profession" (KI3).

A number of participants mentioned that a main inhibitor to leadership effectiveness is the lack of the skill that would enable a leader to connect with staff, as well as that leader's inability to read staff's emotions. This shortcoming is, at least in part, because HNs lack effective communication skills and networking abilities. According to the KIs interpretation this is because HNs are not emotionally connected with staff, a schism which can give rise to inconsistencies in their actions and lead to their staff frustration and burnout:

"The complaint about the Bahraini [HNs is] related to the 'soft' skills like communication, dealing with arguments and conflicts with patients. Therefore, HNs should have excellent communication skills and a personality that develops networking" (KI3).

4.5.2 Opening Dialogue with Policy Makers

Most of the participants in the interviews mentioned that opening a channel of communication with authorities is a key quality of the effective HN leaders. In the existing organization structure, there was an emphasis on maintaining negotiation, cooperation, clarification of roles and responsibilities and establishing effective relationships between leaders and representatives. As stated by one KI:

"The challenges that nurse leaders will face are the political atmosphere, how nurses are able to go into dialogue with politicians [i.e. Hospital Top-Management Board], and achieve quick success" (KI3).

4.5.3 Building and Strengthening Relationships

'Establishing a good relationship with staff' was a common response in the three groups to the question about how to develop an effective HN leader in CCSs. Participants talked about both the value of maintaining a strong professional relationship with staff, alongside social relationships outside of the work environment. In addition to that, establishing a line of communication with other

Findings

professions (i.e. media), as a powerful voice to familiarize people about the issues surrounding the nursing profession was recommended:

“I think improving your relationship [with other professions for example], working with the media to promote nursing, presenting nursing in a very professional way, advancing nurses’ education, and [sharpening] management skills, will all make nurses in a better position” (KI3).

Another HN talked about maintaining a healthy professional relationship. A professional relationship should not be based on what an HN likes or dislikes but it should be built on a solid foundation of equal sharing and mutual respect between managers and employees:

“What I like and what I dislike affects the relationship. We need a healthy relationship... it is really needed and actually it should be solid and at higher level” (HN8).

4.5.4 Building a Harmonious Team

Participants from the three groups also thought that building team confidence was an important factor to take into account for an effective HN working in CCSs. They thought that effective leaders should establish harmony with the team they are working with. One of the SSNs said:

“[Nurse Supervisors] have to build a team spirit in [their staff] by making them work as a team, [as well as] rewarding them for anything good they do” (SSN1).

Participants from the three groups suggested that HNs who build and encourage working as a team, set clear goals, and assign staff to tasks will avoid the confusion and the stress that might otherwise occur in the working environment:

“We work in a harmony and in [one] group. Once the task and people is assigned [then] there is no work ambiguity or no work conflict” (KI1)

Findings

A SSN added that it is a responsibility of an effective HN to collaborate with the team, to build trust within the groups, and to be accessible at work so as to know individual needs and concerns:

“ [Effective HNs] build a team spirit [through] working as a team, encouraging hard working, building trust with [other] supervisors and staff, and listening to [their staff’s] needs and concerns” (SSN4).

The need to build a harmonious team was a common finding through the three groups. It was interesting, in the group discussion of the findings, this was considered highly important by the groups. As one HNO said:

“We have to have a good relationship so we will not keep quiet about our rights, our dignity, and our staff’s rights” (HNO).

4.5.5 Open Style of Communication

Being easily available to staff, as a leader, was a common response to the question about how to develop effective HN leaders in the CCSs. Throughout my observation sessions it was evident that things which facilitate leadership effectiveness were to do with the idea of ease of access to the HN in the CCSs. In the interviews, it was interesting that the three groups of participants referred to the importance of HN visibility in clinical practice, in order to facilitate communication and to enable the HN to understand the difficulties facing their staff, and to allow easy access.

Participants stressed the need for understanding their staff, through allowing them to talk and valuing their physical presence:

“[HNs should] have an open communication atmosphere, open doors to listen to their staff and solve their problems together” (KI3).

Another SSN stated that:

“[The Head nurses who are] close to their nurses open doors for them to talk freely about their concerns” (SSN6).

4.5.6 Being Accessible

One participant talked about the HNs being accessible to staff to motivate them and to understand their needs. This is the HN who conveys messages of willingness by reaching out and inviting staff to maintain close contact with their team, and who also encourages them to talk and share their concerns and difficulties and build rapport:

“[To be an effective leader] I have to be fair, treat equally, respect, understand my-staff needs, work with them as a team, involve them in decision making, understand what motivates them, be close with them, and open a door for them to talk about their concerns” (SSN4).

Another KI mentioned that HNs should shape and establish the relationship with their staff, based on trust and transparency. They should be close to their staff in their working environment, as well as in social gatherings outside work:

“We [HNs] meet [frequently] with nurses, sometimes for an official meeting and sometimes as a social gathering. It is just to [build and] strengthen the relationship from both sides” (KI1).

4.6 Education and Development

The third theme emerging from the data was about the education and development of effective HN leaders in CCSs. The participants were asked about the factors that contribute to a HN’s leadership development. There was a strong emphasis on the issue of cultivating a learning organization, as it is important to facilitate the continuous expansion of HN leaders’ capacity to create the results they truly desire. This could be effectively shaped through creating an environment where people are continuously learning, supported and appreciated. From the participants’ point of view, there was a need in the organization to develop and prepare leaders for their role before engaging in that role. Therefore, there was high stress on the need for HN leaders to develop creative thinking, where there is a continuous investigation, questioning and analysis of any existing problem as it is crucial to come up with new ideas. Therefore, participants from all three groups encouraged healthcare organizations to develop ‘role model’ skills, as such development is an important factor in the facilitation of HN leadership effectiveness in CCSs in Bahrain.

Findings

4.6.1 Cultivating a ‘Learning Organization’

Head nurse participants considered developing a learning environment to be an important factor in developing HNs’ leadership effectiveness. A participant from the HNs group talked about the role of a HN leader in providing and maintaining an environment that facilitates and supports a HN to take an active role in the need to identify organization; the environment that contains qualified, highly educated and trained nurses, supported by clinical mentors and with all parties working as a team.

“My role as a leader is to have an environment where there are qualified nurses who are experienced and competent in working in such critical care areas. The [critical care nurses] are supported by a training educator or preceptor and work as a team” (HN7).

Whereas, another HN stressed developing a culture which facilitates better education and training for HN leaders, as well as a need for sustaining a collaborative atmosphere where they can grow and develop as effective leaders:

“The main factors which empower HN [leaders are] more education and [training], trust and support in their capabilities, and close team-working” (HN6).

4.6.2 Developing and Preparing Leaders for their Role

According to participants from the three groups, involving HNs in leadership programmes to prepare them for the role was one of the requirements for developing HNs’ leadership effectiveness. It was said that it is necessary to prepare HN leaders through a formal leadership programme, with clinical attachment before nomination. As one KI said:

“From my viewpoint, HNs should be allocated with senior productive supervisors and they should attend special courses before assigning them to a position” (KI2).

Another participant from KIs’ group highlighted the issue of a leadership programme and said the programme should include different concepts from both schools of leadership and management.

Findings

This will help HNs to gain concepts of leadership and management which will facilitate the HN leader to be supportive to nurses and effective in developing nursing as a profession:

“[We should] involve HNs in leadership programmes which focus on the thinking process and management style. [The programme should] include issues about HNs working with media [for example,] how to promote nursing in the media, and how to present nursing roles in a professional approach” (KI3).

When asked about the leadership programme details, one HN stressed the issue of self- development, as it is a core to the development of an effective HN leader in CCSs. For example, one said HNs should not stop identifying their strengths and weaknesses because the learning process is long and their knowledge about leadership will always need to be advanced:

“I have to assess myself to develop [my knowledge]...we should not at any time stop developing ourselves. There are so many [new] things HN leaders can learn” (HN7).

Another HN said that, to develop effective HN leaders, the one responsibility of an organization should be to provide opportunities for the HN leaders to evaluate their emotional behaviour and to provide them with courses to overcome their deficiencies:

“To be an effective leader, I think [I should] give myself a chance for self- development. You have to develop yourself [by taking] special courses” (KI2)

On the other hand, the analysis of the interview data showed that participants from the three groups believed that one of the barriers to HN leadership effectiveness, as one participant from KIs group said, is appointing HN leaders to the HN positions without prior preparation through attending formal leadership programmes:

“HN leaders [were] not prepared....for the position. [Nursing authorities] should prepare HN leaders before they put them in their post” (KI2).

Findings

One more SSN supported the above argument and the suggestion made by KI. The SSN's thought was in-line with KI; to prepare HN leaders before promoting them to HN positions:

“I think it will be very helpful... if [nursing Top-management] prepare nurse supervisors and put them in [HN positions] rather than assigning them without preparation” (SSN3).

In the three Phases' interviews, there was a common agreement about developing and preparing a leader for their role. Although this had been agreed on in the reference group discussion of the findings, one N.O. offered the following suggestion. HN should always acknowledge areas of self-weaknesses and should work hard seeking more knowledge and development:

“I am against the [HN who says] I know everything, which totally kills the leaders [ambition]. However, when HNs admit that they do not know [certain issues], they will be able to develop themselves” (N.O.).

4.6.3 Developing a Creative Thinking Environment

Developing a creative thinking environment was one of the sub-themes raised through participant interviews. It was interesting that the analysis showed that one member of the KIs group talked about the prime attributes of effective HN leaders in CCSs. It was said that the ability of a HN leader to manipulate information and ideas, so that he or she might discover new meanings and understandings, is highly appreciated by effective leaders in CCSs. Therefore, it is important to create an environment that permits HN leaders to have the opportunities to engage in such a high level of thinking:

“We provided opportunities to identify people who have those skills, who can manage small groups, who are creative or innovative and have higher level of thinking” (KI3).

According to the participant from HNs group, one of the barriers to HNs leadership effectiveness is the difficulties they encounter with their Head Nursing Officers (HNOs), who are not open to new ideas. The HNOs often show little or no interest in their staff's suggestions. The HNOs believe that only whatever they know is true. The problem, as one HN said, is the mindset of HNOs who are committed to employ rules and regulation, and follow procedures through repetitive routines. This lower

level thinking of the HNOs is a barrier to HN effectiveness:

“The barrier to [HN effectiveness is the] resistance to change due to old generation [thinking] and the mentality and knowledge gap between HNOs and their supervisors” (HN5).

Another participant from HNs group considered that a barrier to leadership effectiveness is the lack of initiative within HNs themselves. It was said that HNs lack the courage to develop themselves. An additional barrier was that there was no reinforcement from the organization to develop HNs to a level of specialization in the field of Critical Care Nursing. Therefore, it was suggested it would be of great benefit to have a visionary HN leader, who has the initiative to develop self and others through being actively open minded:

“I believe this narrow thinking of [HNs] will not help in [developing] the future of the cardiac care unit. We need better visionary Head nurses through sending Head nurses for higher studies [to specialize] as cardiac nurses or consultant [critical care HNs]” (HN8).

4.6.4 Developing Role Model Skills

The participants from the three groups emphasized the importance of effective HN leaders developing role model skills. As one HN mentioned, in the quote below, the role model leader should have certain characteristics, such as self-confidence, good judgment and the ability to make decision:

“She should be a role model [for example, have] confidence in whatsoever she does, have good judgment and decision making, and listen to the staff’s problems and solve them” (HN3).

Participant from the KIs group considered the qualities of a role model leader should include self-confidence and self-belief, which would make them visible and open to their staff:

“Effective HNs should have personal presence. [For example,] When they are in the room you [should] feel that they are leaders, they [should] shine, and they [should] be the people who can stand and have good presentation skills. [This is because] they have strong persuasive skills” (KI3).

Findings

The same KI acknowledged the necessity of self-belief. It was said that HNs who believe in themselves, and in their profession, will be the right people to lead and inspire others:

“If the [Head] nurses showed their knowledge [and] their skills they could lead. [Therefore,] how I present myself will reflect on how others treat me. So if you believe in yourself, in your profession, and you have the right skills, no matter what happens you are going to [lead effectively]” (KI3).

There was a strong feeling from one HN, who said that an effective HN leader is one who trusts his knowledge and experience, and who listens to the small voice inside himself, which always gives him courage to take a step forward and to be confident:

“I [trust] my knowledge and my experience as a senior staff nurse [and this helps me] to be an effective manager” (HN6).

Participants from the three groups added more attributes to the concept of an effective HN leader being a role model. For example, one SSN and one KI talked about an effective leader who should have an influential personality in order to be able to convey a leader's voice, the ability to take a decision, the willingness to take risks, and the personal characteristic of being honest:

“She should have a strong personality... for example, in [a certain] situation the leader should be strong to face the situation and deliver the message she wants and take a decision....” (SSN3).

The KI added that the organization requires a role model leader who should be empathetic, trustworthy, and accountable for the decisions they make in managing their practice and their staff:

“I already have many [senior nurses who] have the leadership but unfortunately they are very weak and they cannot control... we need people who are good decision makers, assertive, and honest....” (KI1).

A leader as role model was frequently felt to be an important issue, as expressed in the interviews across the three groups. Within the reference group discussion of the findings, this was confirmed as a really significant feature by the group.

The following quotes show how they presented their feelings:

- “A role model HN should be a good listener” (SSN).
- “A role model leader is one who listens more and talks less” (N.O). “A role model leader is proactive and not reactive” (HN).
- “She has interest in developing herself” (N.O).

4.7 Developing a Healthy Working Environment (HWE)

The Healthy Working Environment (HWE) was one of the major themes emerging from the data analysis. Participants from the three groups raised issues, in the interviews, when asked about how can a healthcare organization create and maintain a healthy working environment for HN leaders? The participants highlighted that the healthcare organization should have a facilitative organizational structure which is considered highly important because organizational structure deals primarily with the setup of the work culture, how management works, and how effective communication is between various parts of the organization. Participants mentioned that healthcare organization should develop a culture where the HN leader is ‘authorized and empowered’ to take decisions and introduce changes in services. Such a culture is also one which would ‘value and acknowledge’ HN leadership effectiveness. This is because empowered leaders are those individuals with the ability to use their expertise, knowledge and skills in clinical care, and are ‘clearly aware of leadership roles’. Participants from the three groups considered the ‘availability of resources’ to be one of the key factors which facilitates HN leadership effectiveness. On the other hand, participants stressed the barriers of healthcare organization facilitating HWE are the ‘impact of the economic downturn’ which has had a major negative influence on HN leadership effectiveness.

4.7.1 Having a Facilitative Organizational Structure

During the observation sessions it was evident that the different levels in the organization inhibited leadership effectiveness. For example, there was continuous argument between HNs with different healthcare providers due to delays in responses to certain situations. In the interviews, participants clarified and emphasised this problem when they talked about the organizational structure and the delay in the flow of communication due to hierarchical structure:

“The problem is our [organization] structure, it is centralized and it has a lot of channels. For example, if you want to do a project it is a big barrier [and you need time] to reach to the [top] levels in the organization” (HN5).

Findings

One SSN said the main barrier to leadership effectiveness is the existing organizational structure, because it delays the responses from other levels or authorities, such delays ending with ineffectiveness in communication between staff working in those levels:

“There are always different levels in the hospital and the main problem is the communication channel between these levels” (SSN6).

Another HN participant said the problem with the existing organizational structure is that the different levels in an organization do not integrate their vision and mission with the larger organizational vision. This might lead to waste in resources and potentials:

“If we think strategically [then] there should be one vision, and one mission. Yes, our objectives and the strategies [are different] but it will go parallel with the vision and the mission of [the organization]. We should not waste resources, energy, our thinking or our materials, and we should not waste all these things by making sub-missions. The mission and the vision should be one for the [whole organization], and yes, objectives and the strategies [could be changed] but it should go parallel with the [organization’s] vision and mission” (HN8).

4.7.2 Creating an Empowering Working Environment

Participants frequently emphasized the necessity of having authority to empower their staff. To these respondents authority means support, the power to lead, the power of position, the power of trust and working in a team, and the power of capabilities. The power to empower was considered important for the development of a healthy working environment. In the interviews, one KI talked about giving HNs certain authority for some aspects of the nurse role. During the observation sessions it was evident to the researcher that HNs were not given full authority to manage and facilitate their organization. There were many obstacles and much interference from higher management:

“[When] my superior supports me and gives me the authority I will be able to empower my staff. [As I mentioned earlier] I have the authority to promote staff but sometimes there is [an] influence from administration....” (KI2).

Findings

An HN talked about her experience of managing one of the CCSs. It was said that the authority of a HN leader is composed of two types of power: one power of systemic the position and the second is the power of professional and personal qualities, such as the power of respect, and the power of working in a team. These are all factors facilitating HNs effectiveness and helping to build a healthy working environment:

“I have the power of authority because of leading this unit and because of having the current position. [So,] the power is the power of the position, quality, and the power of trusting staff. When I have respect and competency I will be considered and I will be working for my team” (HN8).

Creating a HWE, where the HN leader is empowered and authorised to take a decision, was commonly felt to be important as expressed in the interviews across the three groups. Within the group discussion of the findings, decision making was confirmed as a subject of real interest by the group. For example, one said:

“The main problem is that we have responsibility without authority. Nursing administration gives team leaders and nurse supervisors more responsibilities without authority. The authority is very.....very...very limited. They should expand the role of the supervisor and they should give her more power and authority in all aspects” (HN).

4.7.3 Being Valued and Lack of Acknowledgement

According to participants from the three groups, effective HN leaders play a key role in developing a HWE through recognizing the professional contribution of nurses and by involving them in decision-making and developing their needs:

“[Effective HNs] allow nurses to share ideas and take their suggestions, share them in their plans, solve their problems, and develop their knowledge by assessing their weaknesses” (HN7).

Another participant from the HNs group, when asked about the role of the HN in developing and sustaining a HWE, said that in a HWE effective HN leaders have the ability to inspire nurses, specifically in CCSs, where such nurses are alienated by working in a discouraging environment, where they experience a high workload, yet

with little appreciation for their efforts:

“The nurse supervisor has to be competent in problem solving, and in encouraging and motivating the staff especially in critical care settings where the place is depressing for some of the staff [because of] high workload, and lack of rewards” (HN6).

4.7.4 Being Clear about Leadership Role

Participants from the three groups mentioned that nursing managers are loaded with non-nursing responsibilities, such as doing the cleaning and writing materials inventories. These responsibilities created a negative effect on HN leaders and served to them when considering their role as professional managers, as mentioned in the following quotes:

“Due to the shortage of hospital attendants and cleaners, [HNs] are forced to do the [extra work] of cleaning and this is certainly disappointing” (SSN4).

Similarly, another HN talked about HNs doing book-keeping duties:

“We [HNs] are checking the store, [writing requests for] surgical dressing, disposal, stationery, and four or five type of indents” (HN2).

4.7.5 Related Factors

Participants from the three groups raised their frustrations regarding the unavailability of resources; for example, the lack of qualified trained staff, lack of equipment, and lack of beds and shortage of space. The availability of these resources is considered to facilitate an effective HN leadership role in CCSs and, in turn, sustain a healthy working environment:

“Things that facilitate my work [as a HN] is having enough manpower, enough space to receive patients, enough beds, and enough equipment” (HN3).

Findings

Another HN had a different view, when it was said that CCSs require nurses who are highly prepared, who have enough experience in caring for critically sick patients and who are able to work in a stressful environment:

“The new [critical care] unit will be with 22 beds so it will be double of the existing bed. Therefore, we need human resources, we need competent well trained nurses practicing at advanced levels to deliver a high standard of care for in and out patients” (HN7).

4.7.6 The Impact of the Economic Downturn

The impact of the economic recession was highlighted when one KI said the economic crunches affected the nursing profession. For example, cutting the health budget and downsizing the nursing workforce, act as barriers to HNs effectiveness:

“In many organizations when they have economic crises in the hospital, the first group they think of terminating is nurses, because they are the largest group and they take on quarter of the budget of any organization.....” (KI3).

While I was in a clinical area doing the observation, I noted a nurse leader talking with nurses, physicians, and the nurse officer regarding the shortages of facilities (i.e. capital equipment). In the interview, the HN said shortages in the budget are one of the difficulties they are facing in CCS:

“Due to budget constraints, we [are not able to] replace some of the important equipment so we can deliver the best care to the patients” (HN7).

Findings

4.7.7 Conclusion

This chapter presented the integrated data analysis from three research Phases of in-depth interviews and observations. The thematic analysis of the interviews and other data revealed content relating to the importance of leadership style and its relationship to leadership effectiveness. In addition, the respondents emphasised the importance of networking and communication to keep HN leaders connected with people from inside and outside the organization. Participants highlighted the value of the continuous education and development of HN leaders as the foundation for HN leadership. Furthermore, the findings showed the importance of establishing a healthy working environment for the HN leaders in order to empower those leaders. Participants were concerned about certain qualities that prepare an effective HN for a leadership role. For example, the ability to network and build a rapport with nursing teams, to open dialogue with politicians, to build a strong relationship with other healthcare teams, to be visible and very close with their employees team members, to be able to intervene in different situations using different leadership styles, to be able to build a strong group of nurses who are effective, and search for the best in the individuals they work with. There were high emphases on having role model leaders who have self-confidence and self-efficiency. The data analysis revealed that effective HN leaders create a positive culture which engages employees at all levels to explore their abilities to produce effective changes in the organization. Effective leaders should have the work strategy of using open-door approaches as well as building a strong network with other professionals. The research findings clarified certain barriers to leadership effectiveness such as close minded thinking, a lack of preparation for the post, a lack of role model leaders, obedient leaders, and leaders lacking soft skills associated with leadership. However, it also illustrated certain qualities that were required for leadership effectiveness such as: inspiration, effective communication, vision and creativity in Critical Care Settings. The analysis focused on the future education and development of effective HN leaders which included self-development, investments in nursing, the accreditation of health services, and prior preparation for leaders assigned to a post. Finally, a healthy work environment was one of the strong themes which immerged from the data analysis, where participants stressed issues which hinder leadership effectiveness, such as a leader's disengagement with the meaning of work, and a lack of clarity about a HN's leadership role. The presentation and interpretation of the findings from this research were verified with a group of participants from SSNs, HNs, and N.Os to authenticate the findings.

CHAPTER 5 Discussion

5.1 Introduction

This chapter presents and discusses how the findings outlined in Chapter Four contribute to the body of knowledge regarding the factors that facilitate or hinder leadership effectiveness in Critical Care Settings (CCSs). This focus will therefore address the research questions and fulfil the research aims. The chapter begins with an overview of the research to this point as an underpinning for the discussion. The chapter presents the discussion of and reflection on the research findings about the factors that facilitate or inhibit effective leadership in CCSs in Bahrain and locates them in the wider context of leadership.

5.2 Overview of the Research

This case study research was conducted over a year in one Government hospital in Bahrain. The research aims to make recommendations for developing leadership roles in health care. Sixteen participants from different levels in the hospital consented to be a part of the research. The study was conducted in three Phases. The first Phase was interviews with three key informants (KIs). The findings from this Phase were used to develop the interview questions in Phase Two. Phase Two involved a combination of interviews and observations on four Head Nurses (HNs) and three Senior Staff Nurses (SSNs). The final phase, Phase Three, took issues raised in Phases One and Two in order to focus on specific issues related to HN leaders' roles in order to gain more details about those roles. The findings from the three Phases revealed themes relating to leadership style, networking and communication, education and development, and creating a healthy working environment.

5.3 Discussion of the Findings

The findings chapter highlighted issues that were relevant to answering the research questions which were related to:

- The factors that facilitate or inhibit effective leadership in Bahrain,
- The characteristics of a HN who is considered to be effective,
- The abilities of effective HN leaders.

Analysis of the data revealed four major issues that were important for and impacted upon the Head Nurse role:

- Leadership style,
- Networking and communication,

- Education and development,
- Healthy working environment.

Each of these has its own subthemes (see Table 4.3, page 58). My intention is to take each of the research questions and draw upon those findings and the literature in order to reach my conclusions. The factors facilitating or inhibiting HN leadership effectiveness are classified into three groups. Firstly, the individual HN initiatives, secondly, organization drives. The third group is a combination of both individual HN and organization drivers.

5.4 Factors Facilitating or Inhibiting Effective Leadership

5.4.1 The Individual Head Nurse Initiatives

5.4.1.1 Building and Strengthening Relationships

The findings of the research highlighted the necessity for effective HN leaders to build and strengthen relationships with their staff, and other healthcare professionals as illustrated in chapter four, section 4.5.3. The respondents mentioned that effective HN leaders should have the ability to establish a culture that builds a strong relationship with all professionals, and specifically with their own staff. The literature in chapter two, (section 2.4.1) illustrated the strategic direction of top management in the MoH that focuses on building and strengthening relationships at top management levels at the six GCC countries and within the MoH at Bahrain. From the data analysis, responses showed that participants desired to establish and to strengthen relationships at all levels with all professionals in the MoH. Participants' focus was directed towards the lower level staff nurses who provide direct care of patients in order to motivate, establish and maintain close relationships, and build a healthy environment based on trust. Respondents mentioned that unavailability of the role model leaders who have the relevant qualifications and skills, may be one of the causes of leadership ineffectiveness.

In wider literature reviews, the study by Avolio and Gardner (2005) reported that authentic leadership encourages transparent relationships that build trust, and promote a positive healthy environment. Cowden et al's (2011) findings suggest that the development of supportive working environments facilitate staff nurses' intent to remain at work. These findings are consistent with my research findings which support leadership styles that exhibit effective leadership behaviours such as the ability to establish and build a healthy professional relationship, open communication, trust, and the building of confidence.

5.4.1.2 Networking and Rapport

This present study findings suggested the importance of effective HN leaders having the skills of networking and rapport. Respondents talked about effective leaders who are acting together and connecting with employees as presented in chapter four (section 4.5.1). The respondents stated that the main barrier to leadership effectiveness is a leader's lack of emotional intelligence skills that enable them to connect and engage with their employees. In the literature review chapter two (section 2.4.1 and 2.4. 2) several studies emphasised the importance of the leadership skills of networking and rapport in clinical practice, for example Al-Gasseer et al (2003), Fradd (2004), Goleman et al (2004) and Marquis and Huston (2009). In a recent study, Boomer and McCormack (2010) mentioned that well-trained leaders have a significant effect on other leaders' attitudes when interacting with staff. Participants mentioned that rapport and communication foster good working relationships amongst staff, encourage communication, and improve morale and a sense of working as a team. The findings from these studies aligned with my study findings.

According to the literature in chapter two, (section, 2.4.1) the nature of the ideas used in the MoH in Bahrain and Al-Gasseer et al (2003) suggested introducing a strategic plan and vision at higher levels where the focus was introducing nursing into the agenda within Bahrain as well as at the national and international level. The focus was to develop leadership at a higher level in order to facilitate in goal directness, cost-effective and high-quality healthcare services, effective and efficient nursing care, and budget control. The aforementioned action plan seemed to be aligned in a very managerial way of thinking. On the other hand, respondents' dialectical style seemed to be centred on humanistic aspects such as leaders being open and honest, being optimistic, building and strengthening relationships, and networking and rapport. This shows that there is a potential tension between the vision of the higher management and the expectations of lower level managers in clinical practice.

5.4.2 The Organization Drivers

5.4.2.1 Developing Organization Culture

According to the findings in my research, the factors that act as an influence on developing organization culture include creating an empowering working environment, being valued and acknowledged, and the availability of qualified nurses and equipment needed). However, the findings also showed that the barriers to the application of those factors were lack of resources, an overly bureaucratic

system, and lack of vision alignment. The literature in chapter two (section 2.4.1) presented the factors that facilitate organization culture and included providing opportunities for leaders to practice in autonomous and participative decision making; continuous professional development and learning, and supportive relationships and networking with their staff and other professionals (Marquis and Huston 2009; Ellis and Hartley 2009). In reality, as discussed in chapter one (section 1.1), the application of the above-mentioned facilitator factors might be difficult, this is because of the existing system which focuses on communicating and developing policies at the top management level with minimal involvement of HNs. This system lays importance on power and domination, and does not encourage autonomy. In addition, the American Association of Critical Care Nurse (AACN 2005), as illustrated in the literature review in chapter two, (section, 2.4.2), listed six guidelines for a healthy working environment which contribute to a positive working situations: skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful employee recognition, and authentic leadership. The current system of the MoH in Bahrain is a long chain system which consists of different layers. This type of system has delays in communication between those layers. The system itself does not encourage collaboration and motivation between different staff.

5.4.2.2 Organization Structure

The findings in the current research indicate that a facilitative organization culture and structure has an influence on the HN leaders' working role in Bahrain. Respondents in this research talked about the classical management hierarchical organizational structure, the disturbance in the flow of communication, and the lack of collaboration between the different levels in the organization, all of which lead to deviation from the main organization strategies, vision and mission. The respondents mentioned in chapter four (section 4.7.1) that the MoH organization structure acts as a barrier to leadership effectiveness. This is because of the delay in communication between HN leaders and other professionals, the inability of HN leaders to fulfil organization vision and mission due to different levels in hierarchical structure with each level having their own vision and mission.

According to literature in chapter one (section 1.1), the MoH in Bahrain has a hierarchical organization structure. This type of structure has its own advantages and disadvantages. It creates an imbalance of power and authority between the top management level and the lower levels and this affects the HNs performance. In the MoH in Bahrain, the HN leaders are not empowered. As discussed in chapter one (section 1.1) a flattened organization structure facilitates staff empowerment. Davis et al (2009) found that a less structured organization provides HNs with more

control on human and material resources, but at the same time it increases overall organizational productivity. On the other hand, more structure enables more control and it offers more opportunities for promotion. Moreover, efficiency and flexibility are less when structure is high, and will be more efficient and prompt when structure is low. Haghaghery et al (2004) clarified the factors affecting nurses' clinical decision-making, including internal and external factors. The internal factors are nurses' self-confidence and nurses being competent. The external factors included organizational support, continuous development, and the structure of the organization.

It can be seen from the literature in chapters one and two (sections 1.1, 2.4.1, and 2.4.2) that there were diverse opinions with regards to the development of an organization culture between the top management of the MoH and the lower HN leaders. According to the top managers, organization culture can be developed with the existing structure and through exercising power and by domination. On the other hand, HN managers at a lower level think differently through autonomous practicing, involvement and empowerment. This is also emphasised and clarified by the existing gap between the thinking of HN managers and their superiors.

5.4.3 The Combined Factors of Individual HN Initiation and Organizational Drives

5.4.3.1 A Learning Organization

The findings from the research indicated that cultivating a learning culture should be the responsibility of both the individual HN leaders as well as the organization. Cultivating a learning organization is considered by the participants to be one of the critical elements for the development of HN leaders' effectiveness. As presented in chapter four, (section 4.6.1), developing effective HN leaders facilitates the establishment of an organization that has balance. This can be achieved by having a highly educated workforce qualified in their fields, the availability of opportunities to grow and to improve, and having easy access to resources. The literature in chapter two, (section 2.4.1) illustrated that the strategic plan of the MoH in Bahrain is to develop nursing education through establishing a supportive working environment, and sending more nurses for higher studies. In reality, the literature showed that there was less encouragement for higher education, the HN leaders are appointed without preparation for the post, and there is less involvement of HN leaders in the future of development plans relating to the position of HN leader. HN leaders are unable to cultivate a learning culture due to the type of organization system, constraints from shortage of resources, and the instability of the management and leadership within the MoH.

The literature has identified the elements that give rise to a learning organization. For example, Vollers et al (2009) considered that an organization that can develop and maintain a healthy work environment is one that encourages learning through acknowledging the importance of skilled communication as a two-way dialogue. Thus, employees are encouraged and rewarded to enhance their communication skills and to share their positive stories to improve their professional practices. The organizations that inspire work collaboration do so through working in partnership with others at different levels, and respecting and empowering each and every individual through recognition of their efforts. Charlotte and Sheenu (2001) stated that an organization that provides support, education, and development for nurse managers equips them with necessary tools and resources to achieve success.

5.4.3.2 Strengthening the Quality of Education and Training of the Future HN Leaders

It appears from the findings and the literature that the development of education for HN leaders is vital to meet the current and future challenges in healthcare services. The findings in the current research showed four major issues concerning the education and development of HN leaders. These were: cultivating a learning organization, developing and preparing leaders for the role, developing a creative thinking environment, and being a role model that exhibits in a highly positive manner those factors that facilitate HN leadership role. As outlined in chapter one (section 1.1), there are challenges facing nursing which act as a constraint to strengthening the quality of HN leader education and training. According to AACN (2005), Nichols et al (2011), and WHO (2009), the challenges are inadequate leadership capacity in policy analysis and strategic planning, inappropriate staffing, and shortages of specialised highly trained leaders. In Bahrain, according to Al-Gasseeer et al (2003), the MoH in Bahrain pays attention to the cost-effective and high-quality healthcare services. This is because the MoH in Bahrain faces challenges such as the increase of healthcare service costs, threats to patient care and to the safety of nurses, and lack of specialised nurses in critical care settings.

The concepts of education and training are extensively discussed in the latest literature. For example, the authors of the Commission on Education of Health Professionals Frenk et al (2010) issued a very important report which aims to have a positive impact on the effectiveness of health care systems, on health outcomes of patients, and on populations globally. The authors of this report call for a major reform in the education and training of healthcare professionals in order to equip health professionals for the 21st century. They articulated a number of

recommendations in their report “Health Professionals for a New Century: Transforming Education for Health Systems in an Independent World”. The authors mentioned that the existing professional educational strategies employed across different countries have not kept pace with the current health service challenges. They claim it is mainly because the traditional way of teaching is fragmented, outdated, and uses a fixed curriculum that does not prepare graduates to have the necessary skills or capabilities to manage in a continuously changing environment. Therefore, Frenk et al (2010) suggests that change is needed, to establish strategies in response to these challenges through strengthening health professionals’ education and training. They propose the following steps to strengthen education and training: implementing the competency-based curricula (such as knowledge, skills and attitudes); adapting the competencies to the local settings; developing a framework that considers linking the education with the health systems; involving all concerned participants in the reform process; developing global collaboration and networks for collective strengthening; and broadening health education to reach schools and primary care hospitals based in the communities (Frenk et al 2010).

The Institute of Medicine released an important report for United States nurses on ‘the future of nursing’ (Nichols et al 2010). The report called for an increase in the number of baccalaureate graduate nurses from 50% to 80%, as well as the doubling the nurse graduates with doctoral degrees by the year 2020. The Institute of Medicine’s Committee developed a vision for a transformed health care system. The committee visualized a future system that creates quality care accessible to the different citizens of the United States, purposely encourages wellness and disease prevention, constantly improves health outcomes, and provides empathetic care. As a result of the Institute of Medicine Committee’s debates, the Committee came up with four key messages for the future: nurses should practice to the full extent of their education and training; they should attain higher levels of education and training through a developed educational structure that links the education with the contexts; nurses should collaborate with physicians and other health professionals to redesign healthcare; and effective labour force planning and policy making necessitates better data gathering and developed information infrastructure. These important recommendations will help to address the problem raised by respondents in relation to the healthy working environment section (4.7.1, 4.7.2, and 4.7.4). In reality, the existing organization system and structure in Bahrain is dominated by physicians who have more power and authority than nurses as discussed in chapter one (section 1.1). In such a system, it is difficult to introduce changes or implement

the latest recommendations made by such authorities as Frenk et al (2010) and Nichols et al mentioned (2010).

5.4.3.3 Head Nurse Leaders Role Preparation

In the current research, the findings showed that participants emphasized the need to develop HN leaders for the role, as reflected by the research participants, was due to the HN leaders' lack of interest in developing themselves, there is a limited budget for training, nurses are not updating their professional knowledge, senior nurses were appointed to their positions without formal preparation, there is a lack of HN leaders who have future vision, and lack of motivation and encouragement from the higher level management board.

It is evident from the literature in chapter two, (section 2.4.1) that there is little attention devoted to nursing education in the MoH in Bahrain. Literature shows a strategic plan by Al-Gasseer et al (2003) to reform nursing education and nursing services. Yet there was no specific programme to develop HN leaders and prepare them for the position. However, in viewing the healthcare system in the UK, the RCN (2005) proposed a programme to develop leaders' qualities. The RCN (2005) clinical leadership programme and the Welsh assembly government's final report 'Free to Lead, Free to Care' (NHS 2008) were designed to prepare effective charge nurse leaders for future healthcare in the NHS. These two essential documents were designed to emphasise the preparation of ward sisters and charge nurses with capabilities to ensure that ward sisters and charge nurses have the requisite authority, knowledge, and skills and are empowered to improve the environment of care and patient practice. The theme of the NHS programmes and the profession's view of leadership have centred around an understanding of leadership based on the dominance of transformational leadership theory.

The RCN (2005) and the Welsh assembly government (NHS 2008) programmes are well designed with different learning and development concepts. The programme includes core components and clinical skills from both leadership and management theories such as:

- Action learning to explore existing challenges in organization;
- Mentoring to help nurse leaders to provide valuable networking and learning culture;
- Shadowing to assist nurse leaders to develop their leadership capacities;
- Team building to help nurse leaders to work in a team to establish how group of leaders work together;

- Observation of care and practice to introduce the two strategies of observation as an outsider and an insider to enhance their engagement in clinical dialogue about what they have observed and the areas for development to reflect on what action is needed;
- Collecting patient stories through audio-taped interviews about patient experience to help identify areas for quality development;
- Networking to encourage both communication internally and externally to their organization to develop their confidence and learn different ways of working;
- Political awareness capacity and capability to develop their influence within their organization.

The programmes are structured to strengthen and empower the charge nurses to have authority, to make their own decisions, to accept the responsibility for those decisions, and to justify the decisions they have made.

In my research the participants showed the need for a more relevant leadership programme to facilitate effective HN leadership in Bahrain. Participants identified different concepts considered to be important in the leadership programme, as discussed in chapter four sections 4.6 and 4.6.2. This will help to address the problems raised by participants in relation to appointing HN leaders to the position without formal preparation. Research studies show that nurse leaders who are prepared with advanced education (e.g. Consultant Nurses) are considered more prepared for the role and more effective in that role (Volk and Lucas 1991, Cartledge 2001, Duffield et al 2010).

A recently published document 'The Future of Nursing: Leading Change, Advancing Health' (Nichols et al 2011) released by the Institution of Medicine of the National Academies (IOM) in partnership with Robert Wood Johnson Foundation (a private foundation dedicated to improve health and healthcare for Americans) was referred to as a landmark report by the joint committees. In their report, they have proposed four key recommendations in order to transform nursing. The four points are: the importance of authorizing nurses to practice to the full extent of their knowledge, training and capabilities; encouraging nurses to achieve the highest level in education and training; inspiring nurses fully engagement in the transformational process of the health care in the United States; facilitating effective efficient access to information system. The supporting recommendations included: emphasis on developing leadership at all levels, a plea that organizations should seriously value the training and the process of selection of their leaders and should focus on

Discussion

certain issues such as nursing leadership qualities; the importance of engagement and networking, and consideration of the introduction of emotional intelligence as it is a core component of all organization practices.

5.4.3.4 Level of Thinking and 'Cognitive Development' in Critical Care Settings

In the current study, participants considered there to be a relationship between having a higher qualification and the ability to apply creative thinking. It was evident from observing and talking to the respondents that the nurse managers who have a higher qualification in nursing were able to introduce a different level of thinking in their clinical practice and had the confidence to build their skills. Nurses who were more highly qualified were considered to be open minded, seeking new information and opportunities and applying a certain level of creative thinking in practice. The findings strongly suggest that having highly qualified HN leaders enable those leaders to be equipped with different abilities that facilitate them during their work.

According to Simpson and Courtney (2002), the ability of critical thinking in nursing is necessary in clinical practice where there is a rapid advancement in technology and change in healthcare approaches. It is important because it encompasses making assumptions and generalizations and the skills of being able to consider carefully the judgement and accuracy of evidence. This is in-line with the findings from my research which suggest nurses working in critical care settings should exhibit critical thinking skills, to provide effective care, and cope with the challenges of an expansion in role associated with the complexities of the current and future healthcare system in Bahrain. In reality, nursing in Bahrain follows rules, policies and written procedures as discussed in the literature in chapter one (section 1.1). This type of system does not encourage higher thinking and is dependent on existing procedures which hinder HN leaders from applying critical thinking in their role.

Purvis (2009) undertook a study to find-out the factors that influence the development of critical thinking in nursing. The findings showed that critical thinking was influenced by three factors. First, curriculum design is a key factor. Second, personal characteristics promote the development of critical thinking. Finally, reinforcement promotes the development of critical thinking. Although the study sample was small the results were positive. The findings from the current research resonate with three factors recommended by Purvis's (2009) study. For example, sections 4.6.2, 4.6.3, and 4.6.4 describe where respondents mentioned that the organization should develop a programme that focuses on critical thinking.

develop HN leader characteristics which facilitate critical thinking and create a climate which encourages higher level thinking.

In another study, Chabeli (2010) recommended that critical thinking should be one of the core components in nursing education; it should focus on skills such as creativity, reflection, and conceptualisation which are considered as higher order thinking which will activate self-confidence, truth seeking, and keep leaders open-minded. Thus, HN leaders should be qualified and prepared with critical thinking skills to be able to see the 'big picture' and to be able to incorporate critical thinking into real life.

5.5 Characteristics of Effective Head Nurse Leaders

5.5.1 Being Empathetic

The findings from the current research showed the value of empathy as a concept within the effective NH leaders' role. Respondents said that the effective leader is concerned with building good relationships with the employee, based on understanding their problems and taking an active interest in their feelings and emotions. It is also the ability of a HN leader to control his/her emotions specifically in critical situations where they need to be calm and focused. But in reality (see chapter four, section 4.4.1) it is difficult for the HNs because they lack: certain qualities of being open and being concerned in some situations; the ability to establish a good relationship with their employees; the skills of effective communication; the ability to control their emotions; and they are unaware of how to develop the professional knowledge and the training skills needed for themselves and other staff.

In essence, emotional intelligence is about recognizing and managing your emotions and those of others. In the field of emotional intelligence, there are four key components: self-awareness, self-management, social-awareness, and relationship management. Empathy falls under social-awareness (Goleman 1995). Empathy is one of the skills of emotional intelligence as discussed in the literature review (in chapter two, section 2.5). This skill reflects a leader's ability to connect with others and to relate to them, which is considered an essential skill in building healthy professional relationships with staff. According to Goleman et al (2002) leaders who lack the skill of empathy are not able to communicate or understand the emotional needs or feelings of employees. In reality, as discussed in chapter one (section 1.1) the organization of MoH in Bahrain follows a hierarchical system which has rules and control but little emphasis on trust. The findings showed that

this type of system does not encourage good relationships or even motivate and support staff.

Research has shown that empathy is a major influencing factor in leadership effectiveness. Skinner and Spurgeon (2005) examined the relationship between health managers' self-assessed empathy, their behaviour as rated by their staff, and staff's personal ratings on a range of work satisfaction and related outcome measures. The outcome of this study was that there is a significant relationship between empathy and outcome and it is positively related to transformational behaviour (e.g. motivating followers to achieve expected results). During research an attempt to understand how leaders can be effective in their jobs, Gentry et al (2010), from the Center for Creative Leadership (CCL), conducted a study within 38 countries, involving 6,731 managers from different levels, to address two key issues. Firstly, they considered whether empathy is needed to be successful in a leader's job. Secondly, they asked whether empathy influences success in different cultures. The findings showed that empathy is positively related to job performance. Also when they compared empathy across cultures the findings showed that empathy is tied to performance of the managers. The findings from this study suggest an effective HN leader should have the characteristic of being empathetic as it is a key element of an effective HN leader working in a leadership role. Participants in the current study stressed the importance of the HN building good relationships to understand employee needs, feelings and emotions (see chapter four, section 4.4.1). In reality, in the setting of the research this cannot be applied because HNs are not prepared with the knowledge and skills to be empathetic and demonstrate emotional intelligence skills.

5.5.2 Being Open and Honest

In addition to empathy, the findings in the research indicated that establishing a culture that promoted open and honest communication was considered to be a challenge. Data analysis showed that respondents emphasize the necessity of HN leaders being equipped with qualities such as being open and honest with their staff and developing a healthy professional culture that supports openness and honesty in working together as a team. According to the participants the lack of confidence and lack of trust between HN leaders and their superiors (see chapter four, section, 4.4.2) are serious obstacles to HN leadership effectiveness.

Several authors have highlighted that honesty and openness are significant factors in successful leadership. For example Avolio and Gardner (2005), Pearson et al (2007) and NHS (2008) have argued that honesty is important in leadership. The

NHS (2008) policy on openness and honesty discusses the key elements of being open and honest in any healthcare organization. Nurse leaders have to create a culture of open and honest communication where employees share ideas and opinions. A culture is required where there is trust, openness, and acknowledging, apologising and explaining when things go wrong.

Gerling (2000) said that the problem of employees not speaking openly and honestly with their leaders is caused by the employee fearing getting into real trouble. This suggests a system of closed communication where authority and decision-making are organized in a hierarchy ruled by a strict chain of command. Avolio et al (2004) considered openness and honesty as the root component of effective leadership. Leaders are required to build trust and to establish a healthier working environment that fosters patient safety, excellent care, and which recruits and retains staff. Similar findings have been reported by Wrong (2010) who stated that leaders who are authentic and who create a culture of trust will positively influence staff trust, encourage work engagement, openly express their views at work, and that their intention is to improve the quality of care. Therefore, in order to promote openness, honesty and work engagement Wrong et al (2010) suggest it may be useful for nurse leaders to lay emphasis on authentic leadership concepts such as sharing information, being open and being truthful when dealing with staff, asking staff for feedback, involving staff in decision-making, and highlighting the moral and ethical standards behind decision processes and outcomes. From the data analysis in section 4.4.2, it was evident that the respondents raised similar issues that show a relationship with the findings from Avolio et al (2004) and Wrong et al (2010); particularly that effective HN leaders are able to create a culture that fosters trust, honesty, and encourages openness to talk about care and other unsettled issues. However, this model is difficult to apply in the MoH in Bahrain because of the existing top down managerial system. According to the literature from MoH, the organization structure of MoH in Bahrain is a hierarchical structure of management. This type of structure is seen as closed, fragmented, ruled and regulated, bureaucratic, and the flow of communication is downward. This type of organization does not foster an effective culture to cultivate open and honest communication.

5.5.3 Being Optimistic

The value of having skillful optimistic leaders in critical care settings as respondents mentioned is to motivate nurses and to keep them confident, and to increase their productivity and engagement with the work which facilitates organizational development. The research findings showed that the HN leaders felt demoralized,

stressed, and overburdened. They wanted to create an optimistic working environment but, in reality, it is very hard to do because of shortages in manpower, lack of support from the management level directly above them and work overload.

In the literature, McColl-Kennedy and Anderson (2002) stated that leaders in clinical practice are exposed to difficult situations that result in producing emotions that can possibly influence their feelings, attitudes and behaviours. The findings which indicated the importance of the emotions in the work place (see chapter four, sections, 4.4.1, 4.5.1, and 4.6.2). In this study, the respondents felt that the effective HN leaders need to be equipped with the skills of emotional intelligence and the ability to be confident. My study findings aligned with the claim made by McColl-Kennedy and Anderson (2002), Greenberg and Arakawa (2006), Al-Gasseer et al's (2003), and Shirey (2006) about the importance of establishing an environment that encourages optimism through working collaboratively with employees and fostering positive feelings. In reality, it is difficult in an organization such as the MoH in Bahrain because of lack of a role model leader who is optimistic, confident, trustworthy, and who has the knowledge and skills of emotional intelligence.

5.5.4 Being a Visionary

Being a visionary is one of the contemporary competencies required by the effective HN leaders in the current challenging healthcare organization. In my research, the findings showed that the respondents desires for effective HN leaders who have the abilities of envisioning the present and future situation in nursing so enabling them to plan to introduce change in nursing services (see chapter four, section, 4.4.4). Discussed in the literature from the USA, UK and Canada, for example, Huston (2008), NHS (2010), and Gordon and Melrose (2011) is the importance of preparing leaders with the skill of being a visionary in today's continuously changing healthcare. The current MoH management system does not encourage, engage and empower nurse managers to practice the skill of being a visionary. In addition, nurse managers are not prepared or even given the opportunity to practice the skill of being a visionary. They are not given the opportunity to share their vision to plan and improve their healthcare services.

5.5.5 Being Accessible

The findings from the current research showed the importance of accessibility of effective HN leaders in clinical practice. Respondents said that the effective leader is responsible for facilitating staff with easy access and allows them to express their concerns and desires (see chapter four, section, 4.5.6). As discussed in chapter one,

(section 1.1) the bureaucratic management system focuses on rules and regulations and avoids the flexibility of being accessible, open, and visible to employees. In addition to that, emotional intelligence is a core component of an effective leader as mentioned in chapter two, sections 2.6. An emotionally intelligent leader is one who is able to create a healthy working environment that facilitates communication and collaboration through being open and reachable to employees. According to the AACN (2005) the invisibility of a leader is a major barrier to leadership effectiveness. The leader will be undervalued, unmotivated and disrespected. In the current MoH hierarchical structure leaders are not motivated to be visible and this affects their morale and their productivity.

5.6 Abilities of Effective Head Nurse Leaders

5.6.1 Developer

In the current research, the findings showed that participants highlighted the need to develop certain competencies of HN leaders. From the respondents' perspectives, HN leaders should be developers as discussed in chapter four (section, 4.6.1, 4.6.2, 4.6.3). It was clearly mentioned that the barriers to HN leader effectiveness are the low level of thinking of the above level management, and lack of initiative and courage within HN leaders to develop self and other nurses. In the literature, Vollers et al (2009) clearly mentioned that in healthy working environments managers are supported and empowered, working collaboratively, provided with support of education and development, and are encouraged to establish and maintain an effective communication atmosphere. In reality, in the setting of the research these characteristics of managers cannot be implemented because of the unavailability of a healthy working environment due to the lack of support and encouragement from top-level-management to initiate and sustain such an environment.

5.6.2 Creator

It is evident from the findings in chapter four, (section 4.4.2, 4.4.4, 4.4.5) that there is a high emphasis from participants that effective HN leaders must be prepared to be future oriented; able to set a clear vision; visualize the bigger picture while creating a new initiative; encourage staff to introduce change rather than change by using their position and authority; and establishing and maintaining communication bridges with other professionals. According to the literature from the UK, the clinical leadership programme (RCN 2005) and the Welsh assembly government programme (NHS 2008) are designed to prepare nurse leaders with certain capacities such as being creative. The programmes focus on developing nursing leaders up to a professional calibre who are equipped with knowledge and skills to

initiate or create change. This is in order to change the traditional experience of nurses leaders which no longer fits with the existing advances in the healthcare services. The programmes prepare leaders with the knowledge and skills needed to provide opportunities for change; the ability to be creative and innovative; the ability to retain a big-picture while articulating a new vision; the ability to be open-minded and receptive to change and view change as a challenge and opportunity for growth. In reality, in the MoH in Bahrain, there is yet to be a specific leadership and management programme preparing HN leaders with such abilities. HN leaders are not optimistic about introducing change in nursing practice due to work overload, increasing paper work, and lack of authority and power. This contradicts the MoH in Bahrain and the WHO strategic plan, which focuses on preparing nurse leaders with abilities to be able to cope with the escalating cost in healthcare organization, so enabling the provision of healthcare with first class services.

5.6.3 Communicator

The findings in chapter four, (section 4.5) showed that having highly qualified HN leaders with the abilities of communication skills facilitates the establishment of a healthy working environment. Respondents stressed the building of professional relationships; an open style of communication; networking and communication with concerned professionals; and keeping a link with policy makers to clarify nursing related issues. Participants reported that HN leaders who are incompetent in practicing communication skills effectively will not be able to emotionally connect with other employees. A communicating effective leader is one of the characteristics of emotionally intelligent and authentic leadership which concentrates on facilitating communication and collaboration as discussed in the literature review in chapter two, (section 2.6, 2.10). This communicating skill reflects a leader's ability to connect with others and to relate to them which is considered an essential skill in building a healthy working environment and professional relationships with staff. The existing management system in the MoH in Bahrain exists as an obstacle to leadership effective communication. In addition, the literature review in chapter one (section, 1.1) clarified that the different management levels within an organization system hinder the effectiveness of leadership communication.

5.7 Special considerations regarding leadership in a critical care setting

This case study research was conducted in a Critical Care Setting (CCS) in Bahrain. However many of the findings resonate with the literature which is about effective leadership in general. Therefore, it is possible to conclude that there are generic issues surrounding leadership in healthcare settings. Nevertheless, looking at the findings and from my own knowledge, it is apparent that some findings were specifically related to the context of critical care. For example, the nature of the work in a CCS is more dependent on speedier decision-making because of lack of time for decisions in life and death situations. There are time pressures because leaders have to understand and translate information quickly, promptly, and accurately, and there is more dependence on advances in technology which require leaders to be skilled experts about the latest aspects of critical care. The HN has to work in a situation where dealing with emergencies is common place. Thus they have to cultivate a high level of critical thinking skills, using more intuitive decision-making supported with creative reflection on practice. The environment within which they work is one of rapid change.

The findings from this research and the literature revealed that an effective HN leadership role is essential not only in CCSs but for leaders in different positions in the healthcare organization. Participants in this study talked about the effectiveness of the HN leadership role in general. Therefore, some qualities were considered important such as the ability to use different styles of leadership like empathy, optimism, openness and honesty, and being a visionary. Leadership visibility and the continuity of building bridges with all professionals are important to the HN leadership role.

5.8 Summary

In the current study the leadership literature relates to leadership in a number of different organizations some of which are healthcare organizations, but not in relation to a specific setting. On the other hand, the data collected from this research was only obtained from participants who are working in Critical Care Settings in Bahrain. Therefore, from my point view the data collected cannot be said to be necessarily generalised to other settings. However, if one looks in the literature and how one relates findings to the literature there is remarkable evidence that supports the findings from this research. The literature and the findings from this research suggest that leadership effectiveness is about how effectiveness is defined, and how HN leaders are prepared with the necessary qualities to be effective leaders. The dynamic healthcare situation requires a healthcare organization that values and prepares HN leaders not only in critical care settings but in different leadership positions to enable them to interact in different situations. The factors that facilitate or inhibit leadership effectiveness are grouped into three main categories which include individual HN initiatives, organizational drivers, and the combination of factors which include both individual HN initiatives and organizational drivers. Included in each of these factors are key capabilities that make HN leaders effective.

In order to have effective HN leaders, there has to be a healthy work environment that encourages learning and development, empowers HN leaders, and does not have a hierarchical structure. This makes it difficult to communicate effectively such as in Bahrain where it does not necessarily help to empower leaders at the level of head nurses. There are specific findings from this study that help in developing evidence such as: although this study was conducted in Critical Care Settings many of the findings resonate with findings located in and sourced from the relevant literature. The participants involved in the study tended to talk about leadership in general. There are specific requirements of HN leaders in Critical Care Settings that require leaders with explicit characteristics.

CHAPTER 6 Conclusions and Recommendations

6.1 Introduction

This final chapter draws the conclusions of this research; it presents the recommendations for the sponsor of this study (Ministry of Health MoH), as well as to the Hospital Management Board in Bahrain. The chapter satisfies research aims by making appropriate recommendations based on the research findings in chapter four and conclusions in chapter five. The researcher considered the challenges of conducting this research in the organization where he / the researcher was employed. It presents a reflection on my study; it identifies opportunities for future research, and discusses the implications and limitations of this research.

6.2 Conclusions

Although the study was undertaken in critical care settings there was considerable evidence that many of these findings were generic. However, the findings from this research and from the literature revealed that an effective HN leadership role was considered important not only in the critical care settings but also within different levels of healthcare organizations. The findings from the current research showed that organizational culture was the major factor that facilitated or hindered HN leadership effectiveness. The research findings clarified that there is a disjunction between the culture the participants want to create and the current culture, which is a highly structured, managerial dominated culture.

The findings from current research showed that effective HN leaders who are equipped with core competencies are needed at all levels in the organization. It is clearly evident from the findings presented that there is a lack of leaders who have such qualities and this primarily relates to personal and organizational influences. In regards to the characteristics of the HN leader who is considered to be effective in their/his/her leadership role, it depends on how the word 'effective' is defined and from whose perspective. It seems effectiveness is defined differently by different people. Effectiveness from a patient's perspective is, according to the literature, related to a healthy working environment, authenticity, and emotional intelligence. On the other hand, effectiveness from the perspective of managers has a different set of characteristics for example, managers look for the employees who have the ability to: be self-aware, be empathetic, handle emotions and control self, build relations and network, motivate and inspire, introduce change, communicate effectively, think at a high level, have courage, and be creative.

The findings also illustrated the abilities HN leaders perceive as important for effective day to day practice. Effective HN leaders need both sets of abilities, the leadership abilities as well as the managerial. This depends on the HN and where he/she is on this continuum of emotional intelligence, authenticity, and healthy working environment. For example, the HN leader who is rooted in that culture should have the abilities which match that culture and the way of working within it. Whereas, the HN who is completely following a managerial list way of working needs a different set of abilities. This means that the HN leaders need a different style of leadership to cope with a variety of demands in different cultures.

The findings and the literature review indicate that recruitment and retentions of nurse leaders, learning and development for the HN leaders, and undervaluing of a supportive organizational culture are substantial to effective leadership. The findings from the current study illustrated that there is limited evidence that supports the existence of a learning organization culture in relation to leadership effectiveness in the context of the study meaning within Bahrain. On the other hand, the evidence from the literature emphasised the cultivation of a learning organization culture: one that encourages work collaboration, rewards, enhances two way communications and focuses on achievement rather than looking at weakness. Understanding the characteristics of effective leaders working in a context such as critical care settings could assist future HN leaders' in recruitment and selection.

As discussed in the findings and in the literature, HN leaders often carry the responsibility of leadership without possessing the needed competencies and skills. They are selected for the HN leadership role without adequate preparation, only a few HN leaders having attended a formal, structured leadership programme. Therefore, cultivating a learning organization at a unit or ward level is important, where action learning is an effective method to develop HN leaders' potential. Effective HN leaders bring employees together in a small group known as a 'learning set' and reflect positively on the ideas in a supporting and non-threatening environment. The role of an effective leader in this focus group will be as a supporter and guide. According to Wallis and Long (2002), action learning is considered as an effective way of development, it focuses on current challenges rather than the traditional way of teaching which draws attention to the past problems. Therefore, action learning will facilitate turning potential into positive power. It encourages employees and inspires them to voice their ideas, empowers nurses through giving them the space to think creatively and make their own decisions (Whitney et al 2010).

Conclusion

At the organization level, the Ministry of Health in Bahrain is responsible for encouraging the maintenance of a facilitative organizational culture which supports the building and sustaining of healthy working environment. A HWE is one that recruits and develops effective HN leaders, more importantly retains staff, values the significant contribution of HN leaders, and empowers HN leaders through involving leaders in policy making, and decision-making. The ideal HWE also encourages and supports new advancement in a nurse leader's role (e.g. developing leaders at consultant level, having specialised clinical leaders) as well as shaping leadership programmes that focus on developing effective leaders at the local level of the country, region (GCC countries), and international level. This could be arranged through collaboration and networking with local, regional and international government bodies (e.g. UK and USA) to share extensive experiences of developing effective leadership programmes in healthcare organizations.

6.3 Recommendations

The following recommendation will be implemented in practice through negotiating with the Chief Nursing Officer of nursing services at SMC in Bahrain. A committee comprising SNOs, HNs, and SSNs will be established to set-up criteria for developing nursing services and to apply the recommendations from this study as follows:

- Staff recruitment plans should define and include effective qualities necessary in the process of selecting the HN leaders and in evaluating their leadership potential.

The committee will be asked to evaluate the existing recruitment process and come with the plan to develop it. I will present to the committee members the qualities and the characteristics of the effective HN leader and utilize the findings from my study in developing a standard of qualities of effective HN leaders. I will introduce the new concepts in leadership and management to the committee members and arrange a workshop to introduce the latest issues in leadership and management.

- Leadership development plans should take account of new concepts from leadership and management schools particularly in relation to emotional intelligence, authentic leadership, organizational culture, and human resource management in the curriculum of undergraduate nursing programmes and in the life-long learning programmes. This provides the foundation for nurse managers to take a higher education course in nursing (e.g. MSc and PhD level).

Conclusion

I will negotiate with the Chief Executive Nursing Officer to formulate a multidisciplinary team included members from the nursing services and education hospital administration to look into advances in teaching and encourage applying the research process in investigating the existing challenges.

- Developing a learning environment at ward/unit level which applies action learning and reflection on practice.

I will meet with all HNOs from different levels to discuss my recommendation of standardizing criteria for promoting and recruiting nurses. Then we will work on developing a tool to evaluate HN leadership role and work with the team to create new opportunities for advancement.

- Introduce new approaches to promote or recruit senior nurses to the role of HN leader through assessing the knowledge base and educational needs of new leaders and develop a new mechanism to continuously evaluate the HN leader role to enhance successful performance.

The multidisciplinary team will be asked to evaluate the existing leadership programmes. The HN leaders who attended the programmes will be invited into a group discussion to discuss the strengths and weaknesses of the programmes.

- Designing and implementing a formalized leadership and management training programme using the leadership qualities and characteristics emerging from this research and from the literature as a foundation to create competency based job descriptions for HN leaders.

Negotiate with the nursing chief executive about the advances in nursing services in developed countries like UK and USA where they have introduced new roles in nursing which facilitate the development and empowerment of nursing as a profession.

- Developing new clinical roles in nursing at a level of 'clinical consultant nurse', specialist nurse leader, and clinical nurse specialist. The role of the clinical consultant nurse is to be a highly motivated professional to play a key role in developing nursing services, act as role model for clinical managers and staff, be able to critically analyse clinical situations and provide guidance and appropriate plans for improvement of nursing care to

Conclusion

patients, educate nurses, and introduce research in practice, and be involved with the direct care of patients.

- Developing an organization culture that empower HNs and facilitate for leadership effectiveness.

6.4 Opportunities for Future Research

Interesting issues surfaced throughout the different stages of the research. In literature reviews for example, the issue of establishing a Healthy Working Environment (HWE) in Critical Care Settings is considered one of the central issues to achieve efficiencies and high quality patient care. It might be useful to examine the elements of a healthy working environment in CCSs in Bahrain. This could be done through utilizing the six elements from the American Association of Critical-Care Nurses (AACN 2005) as a model. The second research opportunity is that the findings from this case study research can be taken further by developing questionnaires to undertake a larger study survey on a bigger sample from different levels in nursing in Bahrain. The third issue lends itself from the discussion about further research and concentrates on exploring the factors that encourage developing critical thinking in CCSs through action research involving a small group of nurses. Further research is also required to examine the relationship between organizational culture and leadership styles.

6.5 Reflections Relating to Conducting the Study

6.5.1 Nature of the Study

The nature of this research was an in-depth study which enabled me to address the specific research questions. It is an applicable design for this specific study because the advantages of the in-depth study provided much more detailed information than what is available through other data collection methods, such as surveys. The in-depth methods employed in this study offered a more complete picture of what factors were facilitating and inhibiting the effectiveness of the HN leadership role. This type of approach to date gathering provides a friendlier relaxing atmosphere in which participants felt comfortable and they talked openly with me as a researcher about their concerns regarding the research subject. The broader scope covered by these designs ensures that some useful data is always generated. The in-depth approach enabled participants to provide details about their personal experience, views, and behaviour. Although the sample size was small, the in-depth design was able to generate meaningful results. However, there are certain limitations and drawbacks generated when using an in-depth study design. For example, in-depth

Conclusion

studies such as this current research, generate enormous amounts of data and it was time consuming when conducting interviews which then needed transcribing, and data analysing. In this study I have conducted interviews and observations to obtain as many different perspectives not only from the HN leaders but from other people who manage and work closest to the HNs. Thus, it requires a lot of careful thought and planning, to ensure that the results obtained are as accurate as possible. As an insider researcher I have the accountability to increase the credibility of data collection due to the added richness, honesty, and authenticity of the information obtained. Therefore, I was careful with my method, analysis, and my interpretation of the data I obtained from participants. I frequently returned to the data to check if my interpretations of the data were accurate through introducing the findings to head nurse leader from different managerial levels, and that such interpretations were it is not a result of me being affected by the academic literature or manipulated because of my experiences or insights but that my conclusions were based on information received from the research participants.

6.5.2 The implications of being an insider researcher

I faced challenges because I was familiar with the environment and the participants who I had already established relationships with from previous acquaintances. Nevertheless, I still had to maintain a position from which I could understand the views of participants and not to be biased by my own preconceptions because I have an adequate knowledge and experience working in the same environment as the research group. I took extensive precautions to ensure that there was a balance between my personal and professional relationships and my researcher role as an insider. This helped in selecting my participants who were enthusiastic to tell their stories and who have a vast store of experience in the study context. The selection of participants was based on me making contacts with concerned people. Thus, having prior established relationships provided me with the opportunity to gain participants easily.

6.6 Implications for Practice

There is increasing evidence from nursing literature that shows improvements in patients' care, nurse recruitment and retention, and financial stability are all linked to the effective leader establishing and sustaining a healthy working environment. Effective leadership is important in all nursing roles whether the nurse practices in the field of education developing future leaders, as a researcher who mentors new researchers, as a manager who provides support and guidance to employees, or as a consultant who provides exemplary care and shares specialized knowledge. For effective HN leaders who are at the bed-side, the advantage of having effective

Conclusion

leaders linked with achieving high quality patient care is through creating a work environment that encourages professional accountability, allowing nurses to have the flexibility to practice in accordance to their expert judgment when dealing with patient care issues, encouraging an autonomous practice climate, empowering nurses to take control over their work environment, and improving recruitment and retention of nursing staff (Aiken et al 2000, NHS 2010). The benefit of having effective HN leaders in clinical practice is to build relationships and trust, to create an atmosphere that supports and empowers nurses, to promote an environment that supports learning and development, and introduce and sustain changes in clinical practice. Therefore, recruiting effective HN leaders with the necessary capabilities within healthcare in Bahrain or specifically in critical care settings will facilitate a in reduction of absenteeism due to illness and work injury, will enhance nurses' productivity in the workplace and reduce costs to the health system (Anthony et al 2005, Kramer et al 2010). According to Smith (2011) effective leaders with transformational skills are able to promote teamwork amongst staff, encourage positive self-esteem, motivate staff to function at a high level of performance, and empower staff to become more involved in the development and implementation of policy and procedures. Effective leaders are able to create a positive working environment where employees are interested and satisfied with the managers who lead in a positive encouraging manner and this correlates with reduction in staff turnover and improvement in retention, as well as patient satisfaction (Robbins and Davidhizar 2007).

References

References

References

Accreditation Canada International (2011). Accredited Organizations. (Retrieved From:

<http://www.internationalaccreditation.ca/accreditation/AccreditedOrganizations.aspx> Accessed on 22nd Oct 2011).

Aiken, L.H., Havens, D.S., and Sloane, D.M. (2000) The magnet nursing services recognition program: A comparison of two groups of magnet hospitals. *American Journal of Nursing*, 100, 3, 26-35

Aiken, L.H. and Buchan, J. et al (2004) Trends in International Nurse Migration: The world's wealthy countries must be aware of how the "pull" of nurses from developing countries affects global health. *Health Affairs*, 23(3), 69-77. (Retrieved from: <http://content.healthaffairs.org/cgi/content/full/23/3/69>. Accessed on 3 May 10).

Al-Darazi, F. A. (1991) A Proposed Plan for Bahrainization of the Nursing Positions at the Ministry of Health -Bahrain. Ministry of Health, Manama, Bahrain.

Al-Gasseeer, N. and Al-Darazi F. et al (2003) Achievement and challenges of formulating a strategic plan for nursing development at the national level in Bahrain. *International Nursing Review*, 50(3): 148-155.

American Association of critical Care Nursing (AACN 2005). Standards for establishing and sustaining healthy work environments: a journey to excellence. (Retrieved from: <http://ajcc.aacnjournals.org/cgi/reprint/14/3/187>. Accessed February 3, 2010).

Anthony, M. K., Standing, T.S., Glick, J. et al (2005) Leadership and nurse retentions: the pivotal role on nurse managers. *The Journal of Nursing Administration*, 35, 3, 146-155.

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

Appleton, V. J. (2002). Critiquing approaches to case study design for a constructivist inquiry. *Qualitative Research Journal*, 2(2), 80-97.

Avis, M. (2005) 'Is there an epistemology for qualitative research?', in Holloway, I. (eds.). *Qualitative Research in Health Care*. Open University Press, U.K.

Avolio, B.J., Gardner, W. L., Walumbwa, F.O. et al. (2004). Unlocking the mask: a look at the process by which authentic leaders impact follower attitudes and behaviours. *The Leadership Quarterly*, 15, 801-823.

Avolio, B.J. and Gardner, W.L. (2005). Authentic leadership development: getting to the root of positive forms of leadership. *The Leadership Quarterly*, 16(3), 315-338.

AWahed, F (2005). Current & Projected Nursing Workforce Ratios in Kingdom of Bahrain. MoH, Bahrain.

Baggott, R. (1994). *Health and Health Care in Britain*, The MacMiLLan, Press LTD Great Britain.

Benner, P. and Tanner, A. C. (1987) Clinical judgment: how expert nurses use intuition. *American Journal of Nursing*, 87, 23-31.

Bassett, C. (2004). *Qualitative research in Health Care*. Whurr Publishers Lts, United Kingdom.

References

Begley, P. T. (2006). Self-knowledge, capacity and sensitivity: Prerequisites to authentic leadership by school principals. *Journal of Educational Administration*, 44(6), 570-589.

Bhindi, N. and Duignan, P. (1997). Leadership for a New Century: Authenticity, Intentionality, Spirituality, and Sensibility. *Educational Management & Leadership*, 25(2), 117-132.

Blakemore, K. and Griggs, E. (2007). *Social Policy: an introduction*. Open University Press, England

Boomer, A.C. and McCormack, B. (2010). Creating the conditions for growth: a collaborative practice development programme for clinical nurse leaders. *Journal of Nursing Management*, 18, 6, 633-644.

Bowling, A. (2002). *Research Methods in Health: Investigating health and health services*, 2nd Edition. Open University Press, United Kingdom.

Buchan, J. (2000). *Health Sector reform and human resources: lessons from the United Kingdom*. *Health Policy and Planning*, 15(3): 319-325. (Retrieved from: <http://heapol.oxfordjournals.org/content/15/3/319.full.pdf> Accessed on: 2nd December 2010).

Burnard, P. (1997). *Know Yourself: Self-awareness Activities for Nurses and other Health Professionals*. Whirr Publishers Ltd. London.

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

Cartledge, S. (2001) Factors influencing the turnover of intensive care nurses. *Intensive and Critical Care Nursing*. 17, 348-355.

Carr, T (2003). *Authentic Leadership: the competencies senior women need in order to be successful*. (Retrieved from: <http://www.bawp.org/assets/file/Authentic%20Leadership.pdf> Accessed on: 10th July 2010).

Chabeli, M. M. (2010). Concept-Maping as a Thinking Method to Facilitate Critical Thinking in Nursing Education: A Review of the Literature. *Journal of Interdisciplinary Health Sciences*. 15(1), 432-437. (Retrieved From: <http://www.ajol.info/index.php/hsa/article/viewFile/58195/46556> Accessed on: 25th Oct 2011).

Charlotte and Sheenu (2001) Cultivating Careers: Professional Development for Campus IT. (Retrieved from: <http://www.educause.edu/cultivatingcareers> Accessed on: 29th Oct 2011).

Cherniss, C. and Goleman, D. (2001) *The Emotionally Intelligent Workplace: How to Select for, Measure, and Improve Emotional Intelligence in Individuals, Groups, and Organizations*. Jossey-Bass, U.S.A.

Cherniss, C. and Adler, M. (2000). *Promoting Emotional Intelligence in Organizations*. ASTD Press, USA.

Choi, J. (2006). *A motivational theory of charismatic leadership: envisioning, empathy, and empowerment*. *Journal of Leadership and Organizational Studies*, Fall, (Retrieved from: http://findarticles.com/p/articles/mi_m0NXD/is_1_13/ai_n24993403/ Accessed on: 6th December 2010).

Ciarrochi, J. V., Chan, A. Y. C., and Bajgar, J. (2001). Measuring emotional intelligence in adolescents. *Personality and Individual Differences*, 31, 1105-1119.

Clifford, C. (1997). *Qualitative Research Methodology in Nursing and Healthcare*. Churchill Livingstone, New York.

References

Cooperrider, D., Whitney, D. (2005). *Appreciative Inquiry A Positive Revolution in Change*. BerrettKoehler Publishers, Inc, USA.

Corbin, J and Strauss, A. (2008) *Basics of Qualitative Research*. Third Edition, SAGE Publication, United kingdom.

Cowden, T., Cummings, G., and Profetto-Mcgrath, J. (2011) Leadership practices and staff nurses' intent to stay: a systematic review. *Journal of Nursing Management*, 19, 461-477.

Darzi, A. (2009) *Darzi calls on nurses to lead NHS innovation*. NursingTime.Net (Retrieved from: <http://www.nursingtimes.net/whats-new-in-nursing/management/darzi-calls-on-nurses-to-lead-nhs-innovation/5000803.article> Accessed on: 10th May 2009).

Davis et al (2009). Optimal structure, Market dynamism, and the strategy of simple rules. *Administrative Science Quarterly*, 54, 3, 413-452. (Retrieved from: <http://asq.sagepub.com/content/54/3/413.short> Accessed on 2nd Nov 2011).

Department of Health (DH 2010). “*Equity and excellence: Liberating the NHS*”. (Retrieved from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf Accessed on 10th December 2010).

Department of Health (DH 2009a). “*Inspiring leaders: leadership for quality*” (Retrieved from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093395 Accessed on: 20th May 2009).

Department of Health (DH 2009b). “*Implementing the Next Stage Review Vision: the Quality and Productivity challenges*” (Retrieved from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_104255.pdf Accessed on: 23rd Oct 2010).

Department of Health (DH 2004). *Speech by Sarah Mullally, Chief Nursing Officer, to the NHS Leadership Center Annual Conference, on 12th April 2002*. (Retrieved from: http://www.dh.gov.uk/en/News/Speeches/Speecheslist/DH_4015310 Accessed on: 20th May 2009).

Department of Health (DH 2000). *National Leadership Council: Championing the transformation of leadership across the NHS*. (Retrieved from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093342 Accessed on: 22nd May 2009).

Department of Health (DH 1998). *Data Protection Act*. (Retrieved from: http://www.dh.gov.uk/en/Managingyourorganisation/Informationpolicy/Recordsmanagement/DH_400489 Accessed on: 24th Nov 2008).

Dorothy, C. F., Jane, G. S., and Vicki, Z. L. (2010). Factors That Influence Pediatric Intensive Care Unit Nurses to Leave Their Jobs. *Critical Care Nursing Quarterly*, Oct/Dec, 33, 4, 302-316

Douglass, L. M. (1996). *The effective nurse: leader and manger (fifth edition)*. St. Louis, Mo. London, Mosby.

Duffield, M.C, Roche, A.M., Baly, N. and Stasa, H. (2010). Nursing unit managers, staff retention and the work environment. *Journal of Clinical Nursing*, 20, 23-33.

Eagly, H. A., Johannesen-Schmidt, C. M., Van, E., and Marloes, L. (2003) Transformational, Transactional, and Laissez-faire Leadership styles: A meta-analysis comparing women and men. *Psychological Bulletin*, 129(4), 569-591.

References

Elliott, D., Aitken, L. and Chaboyer, W. (2007). ACCN's Critical Care Nursing. Mosby, Elsevier, Australia.

Ellis, R. J. and Hartley, L. C. (2009). Managing and Coordinating Nursing Care, Fifth Edition, Lippincott Williams & Wilkins, USA.

Exworthy, M., Macfarlane, F. and Willmott, M. (2009). 60 Years of Transition: A research project funded by the Nuffield Trust. (Retrieved from: <http://www.rhul.ac.uk/Management/cpso/research/2009/Transitions-summary.pdf> Accessed on: 24th October 2010).

Fontaine, D.K. and Gerardi, D. (2005) Healthier Hospital? Nursing Management, 36, 10, 34-44.

Fradd, L. (2004). Political leadership in action. Journal of Nursing Management, 12, 242-245.

Frankel, A. (2008). What leadership styles should senior nurses develop? Nursing Time, 104, 35, 23-24. (Retrieved From: <http://www.nursingtimes.net/nursing-practice/1811643.article> Accessed on: 13th October 2011).

Frenk, J., Chen, L., Bhutta, Z. A., et al. (2010). Health Professionals for a new century: transforming education to strengthen health systems in an interdependent world. The Lancet, 376 (9756), 1923-1958. (Retrieved From: <http://www.healthprofessionals21.org/docs/HealthProfNewCent.pdf> Accessed on: 13th October 2011).

Fyffe, T. (2009). Nursing Shaping and Influencing Health and Social Care Policy. Journal of Nursing Management, 17, 698-706.

Gardner, L. W., Avolio, J. B., and Walumbwa, O. F. (2005). Authentic Leadership Theory and Practice: Origins, Effects, and Development, Volume 3, Elsevier Ltd, USA.

Gedney, R. C. (1999). Leadership Effectiveness and Gender. A Research Report Submitted to the Faculty in Partial Fulfilment of the Graduation Requirements. (Retrieved From: <http://www.au.af.mil/au/awc/awcgate/acsc/99-061.pdf> Accessed on: 12th Oct 2011).

Gentry, A. W., Weber, J. T., and Sadri, G. (2010). Empathy in the workplace: A tool for effective leadership. (Retrieved From: <http://www.ccl.org/leadership/pdf/research/EmpathyintheWorkplace.pdf> Accessed on: 18th October 2011).

George, B. and Sims, P. (2007) True North: Discover your Authentic Leadership. John Wiley & Sons, Inc. USA.

George, W.W. (2003). Authentic Leadership: Rediscovering the Secrets to Creating Lasting Value. Jossey-bass, USA.

Gerling, P. K. (2000) Achieving Open and Honest Communication Throughout the Organization. The Spinal Column, NMHS, Nelson, New Zealand, October 1999 (Retrieved from: <http://www.leadershipproject.net/clientarea/openhonestarticle.html> Accessed on: 29th October 2011).

Goethals, R. G., Sorenson, L. G., and Burns, M. J. (2004). Encyclopedia of Leadership, Volume 1, Sage Publications, Inc. USA. (Retrieved from:

References

http://books.google.co.uk/books?id=kjLspnsZS4UC&printsec=frontcover&source=gb_ge_summary_r&cad=0#v=onepage&q&f=false Accessed on: 2nd December 2010).

Goleman, D.; Boyatzis, R. and McKee, A. (2002). *Primal Leadership*. The Harvard Business School Press, USA.

Goleman, D., Boyatzis, R. and McKEEA, A. (2004). *Primal Leadership: Realizing the Power of Emotional Intelligence*. Harvard Business School Press, Boston, MA.

Goleman, D. (1995). *Emotional Intelligence: Why it Can Matter More Than IQ*. New York: Bantam Books, USA.

Goffee, R. and Jones, G. (2006). *Why Should Anyone Be Led by YOU? What It Takes to Be an Authentic Leader*. Harvard Business School Press, USA.

Gordon, K. and Melrose, S (2011) LPN to BN Nurses: Introducing a New Group of Potential Health Care Leaders. *E-Journal of Organizational Learning and Leadership*, 9(1): 121-128. (Retrieved from: <http://www.leadingtoday.org/weleadinlearning/Spring2011/Article%2010%20-%20V9N1%20-%20Gordon%20and%20Melrose.pdf> Accessed on 12th March 2012).

Govier, I and Nash, S. (2009). Examining transformational approaches to effective leadership in healthcare settings. *Nursing Times*, 105: 18, (Retrieved from: <http://www.nursingtimes.net/nursing-practice-clinical-research/examining-transformational-approaches-to-effective-leadership-in-healthcare-settings/5001102.article> Accessed on: 18th May 2010).

Greenberg, H.M. and Arakawa, D. (2006). Optimistic Manager & Their Influence on Productivity & Employee Engagement in a Technology Organization. (Retrieved from: http://repository.upenn.edu/mapp_capstone/3/ Accessed on 30th Oct 2011).

Grint, K. (2010). *Leadership: A Very Short Introduction*. Oxford University Press, USA.

Hagbaghery, A. M., Salsali, M. and Ahmadi, F. (2004). Factors facilitating and inhibiting effective clinical decision-making in nursing: a qualitative study. *BioMed Central Nursing*, 3:2, 1-11(Retrieved from: <http://www.biomedcentral.com/1472-6955/3/2> Accessed on 2nd Nov 2011).

Hamm R. M. (1988) 'Clinical intuition and clinical analysis: expertise and the cognitive continuum', In Dowie, J. and Elstein, A. (eds.), *Professional Judgement: A Reader in Clinical Decision Making* Cambridge University Press, Cambridge, 78-109.

Hammond, K. R., Hamm, R. M., Grassia, J., & Pearson, T. (1987). Direct comparison of the efficacy of intuitive and analytical cognition in expert judgment. *IEEE Transactions on Systems, Man, and Cybernetics*, 17, 753-770.

Hammond, K. R. (1996). *Human judgment and social policy: Irreducible uncertainty, inevitable error, unavoidable injustice*. New York: Oxford University Press.

Harrison, S. and Pollitt, C. (1994) *Controlling Health Professionals: The Future of Work and Organization in the NHS*. Open University Press, USA.

Hay Group (2006) *Nurse Leadership: Being Nice is Not Enough*. London: Hay Group. (Retrieved from: <http://www.haygroup.com/Downloads/uk/misc/Frontlineleaders.pdf> Accessed on: 16th June 2009).

References

Heath, J, Johanson, W, and Blake, N. (2004). Healthy work environments: a validation of the literature. *Journal of Nursing Administration*, 34(11), 524-530.

Higgs, J. and Jones, M. (2000) Clinical Reasoning in the Health Professions. Second edition. Butterworth Heinemann, Oxford.

Holloway, I. and Wheeler, S. (2002) Research in Nursing. Second edition, Blackwell Science, UK.

Huston, C. (2008). Preparing nurse leaders for 2020. *Journal of Nursing Management*, 16, 905-911.

Johnson, B. R. (1997). Examining the validity structure of qualitative research. *Education*, 118(3), 282-292.

Jorgensen, L. D. (1989). Participant Observation: A Methodology for Human Studied, Applied Social research Methods Series Vol. 15. The International Professional Publishers, SAGE, UK.

Keith, J. M (1996) Flattening the hierarchy. A hospital streamlines managerial layers to meet market demands. *Health Progress*, July-August, 77(4): 60-62.

Kerfoot, K. (2006a). Authentic Leadership. *Medsurg Nursing*, 15(5), 319-320.

Kerfoot, K. (2006b). Authentic Leadership. *Dermatology Nursing*, 18(6), 595-596.

King's Fund (2008). High Quality Care For All. Briefing Paper. (Retrieved from: <http://www.google.co.uk/url?sa=t&source=web&cd=1&sqi=2&ved=0CBYQFjAA&url=http%3A%2F%2FError! Hyperlink reference not valid.%20quality%20care%20for%20all%20lord%20darzi%20and%20leadership&ei=p44bTaqAMceHhQeW9Z23Dg&usg=AFQjCNHKvqA8PxP1VcllaQx88yLykpzeNg&cad=rjt> Accessed at: 29th December 2010).

Klenke, K. (2007). Authentic Leadership: A Self, Leader, and Spiritual Identity Perspective. *International Journal of Leadership Studies*, Vol. 3 Issue 1, pp. 68-97.

Kramer, M., Schmalenberg, C., and Maguire, P. (2010) Nine structures and best leadership practices essential for a magnetic healthy work environment. *Nursing Administration Quarterly*, 33, 4, 4-17.

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

Le Grand, J., Mays, N., and Mulligan, and Jo-Ann. (1998). Learning from the NHS internal Market: A review of the evidence. King Fund, UK.

Linton, J. and Farrell, M. (2009). Nurses' perceptions of leadership in an adult intensive care unit: A phenomenology study. *Intensive and Critical Care Nursing*, 25, 64-71.

Lippincott, Williams & Wilkins (LWW 2008). *Critical Care Nursing Made Incredibly Easy*, 2nd Edition, Lippincott Williams & Wilkins, U.S.A.

LoBiondo-Wood, G. and Haber, J. (2006). *Nursing Research: Methods and Critical Appraisal for Evidence-Based Practice*, 6th Edition, Mosby, U.S.A.

Marquis, L. B. and Huston, J. C. (2009). *Leadership role and Management functions in Nursing: Theory and practice*, 6th Edition, Lippincott Williams & Wilkins, U.S.A.

References

Mays, N. and Pope, C. (1996). Qualitative Research in Health Care. BMJ Published Group, UK.

McColl-Kennedy, R.J. and Anderson, D.R. (2002). Impact of leadership style and emotions on subordinate performance. *The Leadership Quarterly*, 13, 545-559.

McLennan, M. (2005). Nurses' view on work enabling factors. *Journal of Nursing Administration*, 35, 6, 311-318.

Mcsherry, R. and Haddock J. (1999). Evidence based healthcare: its place within clinical governance. *British Journal of Nursing*, 8(2), 113-117

Ministry, of Health (MoH 2009) Health Statistics. MINISTRY OF HEALTH (Retrieved from:
http://www.moh.gov.bh/PDF/Publications/Statistics/HS2009/PDF/CH09%20smc_2009.pdf Accessed on: 8th December 2010).

Ministry of Health (MoH 2006) Ministry of Health Directorate: Annual Report. Patient Advocate Office, Ministry of Health, Bahrain.

Ministry of Health (MoH 2005). Vision & Strategic Directions for Nursing Services at MoH. April, Nursing Services.

Munro, L. C. and Savel, H. R. (2011). Critical Care and the Future of Nursing. *The American Journal of Critical Care*, 20,3, 187-199 (Retrieved from:
<http://ajcc.aacnjournals.org/content/20/3/188.full.pdf+html?sid=00577087-8454-4c6d-bf67-f27c5b6e2c7b> Cited on 12th Sept 2011).

Nichols, L. B., Davis, R. C., and Richardson, R. D. (2010). The Future of Nursing: Leading Change, Advancing Health. (Retrieved From:
http://www.rwjf.org/files/research/Future%20of%20Nursing_Leading%20Change%20Advancing%20Health.pdf Accessed on: 15th October 2011).

NHS (2008) Being open & honest policy: Policy on openness and honesty following patient safety incidents. Primary Care Trust. (Retrieved from:
<http://www.bolton.nhs.uk/Library/policies/RM008.pdf> Accessed on 29th Oct 2011).

NHS Confederation (2009) Reforming leadership development...again. Future of Leadership, Part 1(Retrieved from:
<http://www.nhsconfed.org/Publications/Documents/Debate%20paper%20-%20Future%20of%20leadership.pdf> Accessed on: 29th December 2010).

NHS (2010) The Clinical Leadership Work stream aims to. (Retrieved from:
<http://www.nhsleadership.org.uk/workstreams-clinical-reports.asp> Accessed on: 29th December 2010).

NHS (2010) Equity and excellence: Liberating the NHS. (Retrieved from:
<http://www.official-documents.gov.uk/document/cm78/7881/7881.pdf> Accessed on 15th Nov 2011).

Nicolson, P., Rowland, E., Lokman, P. et al (2011). Leadership and Better Patient Care: Managing in the NHS. Final report, NIHR Service Delivery and Organisation Programme, NHS National for Health Research (Retrieved From:
http://www.sdo.nihr.ac.uk/files/project/SDO_ES_08-1601-137_V01.pdf Accessed on 13th Sept 2011).

Northouse, P. G. (2001). Leadership: Theory and practice, 2nd Ed, Thousand Oaks, CA: Sage.

References

Norwood, L. S. (2000) Research strategies for advanced practice nurses. Prentice Hall, New Jersey.

O'Neill, E. S., Dluhy, N. C. and Chun, E. (2005) Modelling novice clinical reasoning for a computerised decision support system. *Journal of Advanced Nursing*, 49, 68-77.

Patton, M.Q. (2002). Qualitative evaluation and research methods, third edition. Thousand Oaks, CA: sage Publications, Inc.

Pierre, St. M., Hofinger, G., and Buerschaper, C. (2008) Crisis Management in Acute Care Settings: Human factors and Team Psychology in a High Stakes Environment. Springer-Verlag Berlin Heidelberg, New York

Polit, D.F., Hungler, B.P. (1999). *Nursing Research: Principles and Methods*, sixth edition. J.B. Lippincott Company, Philadelphia, New York, Baltimore.

Polit F. D. and Beck T. C. (2006). *Essentials of Nursing Research: Methods, Appraisal, and Utilization*. Sixth Edition, Lippincott Williams & Wilkins, USA.

Powell, N. G. (1990). One More Time: Do Female and Male Managers Differ? *Academy of Management Executive*, 4(3), 68-75.

Prescott, B. (2007). Grassroots efforts promote image of nursing. *Health Publications*, Oct-Dec (Retrieved from: http://findarticles.com/p/articles/mi_6876/is_4_44/ai_n28474593/ Accessed on: 18th Nov 2010).

Purvis, A. C. (2009). Factors that influence the development of critical thinking skills in Associate degree nursing students. (Retrieved From: https://getd.libs.uga.edu/pdfs/purvis_carol_a_200912_edd/purvis_carol_a_200912_edd.pdf Accessed on: 16th October 2011).

Ulrich, T.B., Lavandero, R., Hart, A.K. and et al. (2009). Critical care Nurses' Work Environments 2008: A follow-up Report. *Critical Care Nurse*, 29, 93-102.

Robbins, B. and Davidhizar, R. (2007) Transformational leadership in health care today. *Health care Management*, 26, 3, 234-239.

Royal College of Nursing (RCN 2003). Defining Nursing. (Retrieved from: http://www.rcn.org.uk/_data/assets/pdf_file/0008/78569/001998.pdf Accessed on: 10th Jan 2010).

Royal College of Nursing (RCN 2009). Breaking down barriers, driving up standards: The role of the ward sister and charge nurse. RCN, London

Royal College of Nursing (RCN 2005) RCN Clinical Leadership Programme: Transforming Clinical Leaders to Become Agents of Positive Change. Executive Summary, (Retrieved from: http://www.rcn.org.uk/_data/assets/pdf_file/0009/78651/002524.pdf Accessed on: 20th November2010).

Salovey, P., Mayer, D.J., and Caruso, R. D. (2004). Emotional Intelligence: Theory, Findings, and Implications. *Psychological Inquiry*, 15, 3, 197-215

References

Schaufeli, W. and Bakker, A. (2004). Job demands, job resources, and their relationship with burnout and engagement: a multi-sample study. *Journal of Organizational Behavior*, 25, 293-315. (Retrieved from: http://igitur-archive.library.uu.nl/fss/2006-0807-200738/schaufeli_04_jobdemands.pdf Accessed at: 6th Sept 2011).

Shamir, B. and Ellam, G. (2005). What's your story? A life-stories approach to authentic leadership development. *The Leadership Quarterly*, 16, 395-417.

Sherman, R. and Pross, E. (2010). Growing Future Nurse Leaders to Build and Sustain Healthy Work Environment at the Unit Level. *The Online Journal of Issues in Nursing*, 15(1), 1-4. (Retrieved from: <http://www.medscape.com/viewarticle/723409> Accessed on 13th Jan 2011).

Shirey, R. M. (2006) Authentic Leaders Creating Healthy Work Environments for Nursing Practice. *American Journal of critical Care*, 15(3), 256-276

Shirey, R.M. and Fisher, L.M. (2008). Leadership Agenda for Change Toward Healthy Work Environments in Acute and Critical Care. *Critical care Nurse*, 28: 66-78.

Simpson, E. and Courtney, M. (2002). Critical thinking in nursing education: literature review. *International Journal of Nursing Practice*, 8, 89-98.

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

Smith, R., Grabham, A. S., and Chantler, C. (1989). Doctors Becoming Managers. *British Medical Journal*, 298, 311-314.

Smith, A.M. (2011) Are you a transformational leader? *Nursing Management*, 42, 9, 44-50.

Sperry L. (2002) Effective Leadership: strategies for Maximizing Executive Productivity and Health. Psychology press, London.

Speziale, S. H. and Carpenter, R. D. (2007) Qualitative research in Nursing: Advancing the Humanistic Imperative. Fourth Edition, Lippincott Williams & Wilkins, USA.

Storr, L. (2004). Leading with integrity: a qualitative research study. *Journal of Health Organization and Management*, 18(6), 415-434.

Sullivan, J. E. and Decker, J. P. (2009) Effective Leadership and Management in Nursing. Seventh Edition, Pearson Prentice Hall, U.S.A.

Taylor-Powell, E. and Renner, M. (2003). Analysing Qualitative Data. The BOARD OF Regents of the University of Wisconsin System. (Retrieved from <http://www.google.co.uk/url?sa=t&source=web&cd=1&sqi=2&ved=0CB0QFjAA&url=http%3A%2F%2Flearningstore.uwex.edu%2Fpdf%2Fg3658-12.pdf&rct=j&q=Analyzing%20qualitative%20data&ei=OYxLTvvyNc6ChQee3OD6Bw&usg=AFQjCNFF724GqJwtDvPjqcDx0lTf8YORg> Accessed on 30th April 2011).

The Cognitive Fitness Consultancy (CFC 2009). Authentic Leadership, Do the right whilst being yourself. An e-book for Authentic Leaders, UK (Retrieved from: <http://www.cognitivefitness.co.uk/documents/Authentic%20Leadership%20e-book%20for%20RAF.pdf> Accessed on: 6th December 2009).

References

Thompson, C. and Dowding, D. (2002). Clinical Decision Making and Judgment in Nursing. Churchill Livingstone, UK.

Tribal (2010) System transformation in the NHS, Quality, Innovation, Productivity and Prevention (QIPP): the Tribal approach. (Retrieved from: http://www.tribalgroup.com/Documents/Health/7308_QIPP_Brochure_web.pdf Accessed on: 23rd Oct 2010).

Vaill, P. (1996). Learning as a Way of Being: Strategies for Survival in a World of Permanent White Water. San Francisco: Jossey-Bass USA.

Volk, M. and Lucas, M. (1991). Relationship of management style and anticipated turnover. Dimensions of Critical Care Nursing. 10 (1), 35-40.

Vollers, D., Hill, E., Roberts, C., and et al. (2009). AACN's Healthy Work Environment Standards and an Empowering Nurse Advancement System. Critical Care Nurse, 29, 20-27.

Wallis, B. and Long, T. (2002) 'Exploring the barriers to practice development', in McSherry, R. and Bassett, C. (eds.). Practice Development in the Clinical Setting: A Guide to Implementation, Ashford colour Press, UK.

Watson, H., and Whyte, R. (2006) 'Using Observation', in Gerrish, K. and Lacey, A. (eds.). The research Process in Nursing, fifth edition, Blackwell Publishing Ltd, UK.

Watson, L. (2004) Self-leadership: becoming an exceptional leader. Radiologic Technology, 75 (6), 457-470. (Retrieved from: http://www.accessmylibrary.com/coms2/summary_0286-12906031_ITM Accessed on: 6th October, 2010).

Welsh Assembly Government (DH 2008) Free to Lead, Free to Care: Empowering ward sisters/charge nurses. Ministerial Task and Finish Group. Crown Copyright (Retrieved from: <http://wales.gov.uk/docs/phhs/publications/empowering/090427empowering.pdf> Accessed on 28th Oct 2011).

Whitney, D., Trosten-Bloom, A. and Rader, K. (2010). Appreciative Leadership: Focus on What Works to Drive Winning Performance and Build a Thriving Organization. McGraw-Hill, USA.

Williams, M. D. (1991). Policy at the grassroots: Community-based participation in health care policy. Journal of Professional Nursing, 7(5), 271-276. (Retrieved from: http://www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6WKV-4C7W5W3-9X&_user=126770&_coverDate=10%2F31%2F1991&_rdoc=1&_fmt=high&_orig=search&_origin=search&_sort=d&_docanchor=&view=c&_searchStrId=1548014165&_rerunOrigin=google&_acct=C000010399&_version=1&_urlVersion=0&_userid=126770&_md5=34e8810674dcd3113d1768f8b9d276f4&searchtype=a Accessed on:19th November 2010).

Woods L.P. (1997) Designing and conducting case study research in nursing, Nursing Times Research 2(1), pp.48-56.

Wong, C. and Cummings, G. (2009) Authentic leadership: a new theory for nursing or back to basics? Journal of Health organization and Management, 23(5), 522-538.

World Health Organization (WHO 2009). The Work of WHO in the Eastern Mediterranean Region: Annual Report of the Regional Director 1 January-31 December 2009. (Retrieved

References

from:http://www.emro.who.int/rd/annualreports/2009/pdf/annualreport_09.pdf
Accessed on: 18th November 2010).

World Health Organization (WHO 2007a). Health System Profile Bahrain. (Retrieved from:
<http://gis.emro.who.int/HealthSystemObservatory/PDF/Bahrain/Full%20Profile.pdf>
Accessed On: 10th May 2009).

World Health Organization (WHO 2007b). Country Cooperation Strategy at a glance. (Retrieved from:
http://www.who.int/countryfocus/cooperation_strategy/ccsbrief_bhr_en.pdf
Accessed on: 3rd May 2010).

World Health Organization (WHO 2001). Assessing Performance Management of Human Resources for Health in South-East Asian Countries: Aspects of Quality and Outcome. (Retrieved from: http://www.who.int/hrh/en/Assessing_performance.pdf
Accessed on:15th June 2008).

World Health Organization (WHO 1998a), "Health for all in the 21st century - an executive summary of the WHO's draft policy", Health for the Millions, Vol. 24 No.1, pp.5-7.

Wrong, A.C., Spence Laschinger, K.H. and Cummings, G. G. (2010). Authentic Leadership and nurses' voice behaviour and perceptions of care quality. *Journal of Nursing Management*, 18, 889-900.

Yin, R. K. (2009). Case study research: design and methods, Fourth edition, Vol 5, Sage Publication, London.

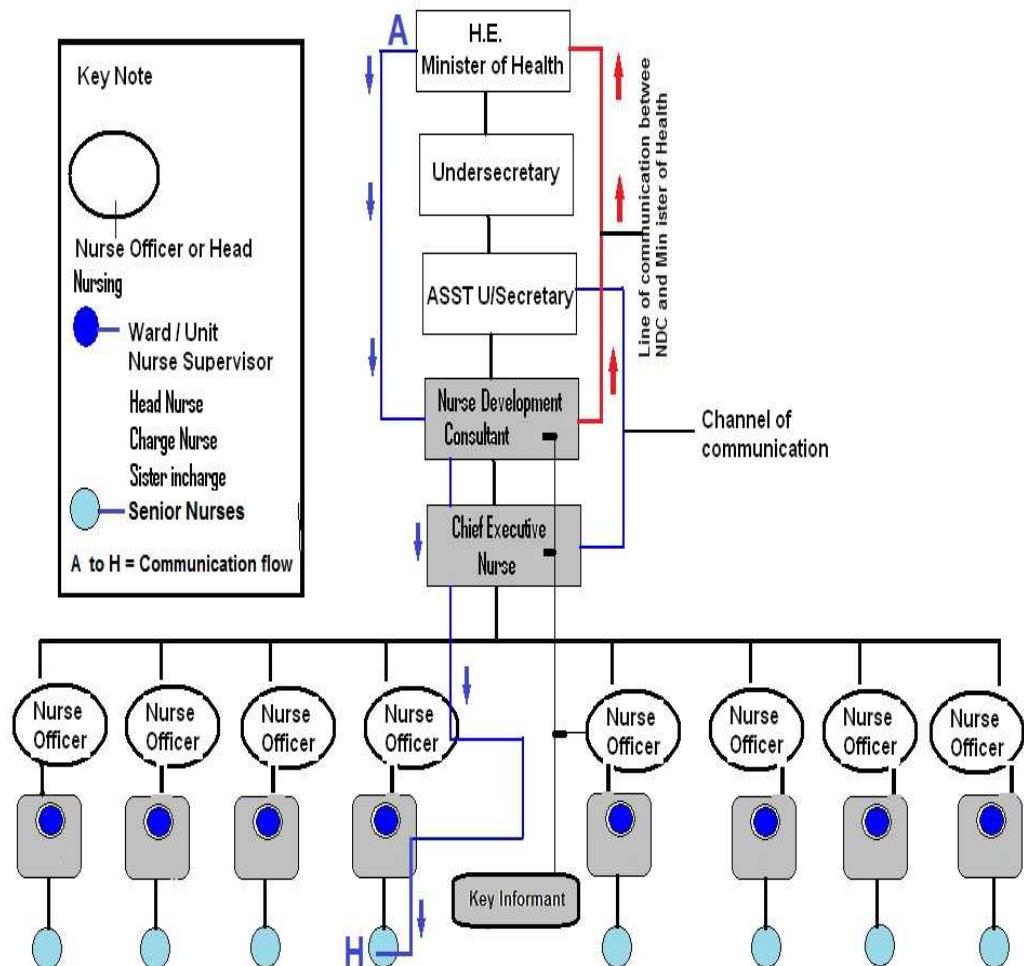
Yin, R.K. (1994) Case Study Research: Design and Methods. Vol 5 (2nd edition), Thousand Oaks, CA: Sage Publications.

Yin, R. K. (1989). Case study research: design and methods, Sage Publication, London.

Appendices

Appendices

Appendix 1 Ministry of Health Organization Layers



Appendix 2 Literature Search Approach**Steps of the Literature Search**

1. Set the criteria for inclusion and exclusion Table2.
2. The search by subject using: database and indexes through CINAHL, MEDLINE, SCOPUS, and COCHRANE by a login page via Authentication.
3. I defined terms (Key word) and concepts Table.2.
4. The articles were scanned and selected according to the criteria.

Table.1 Key word search

Key Word	Results
Emotional Intelligence leader	View Results (118)
Leading in critical care	View Results (7)
Barriers to leadership	View Results (16)
Factors facilitating leadership	View Results (3140)
Critical care leadership	View Results (20)
Future leadership	View Results (138)
Effective nurse role	View Results (8)
Effective nurse leader	View Results (5)
Leadership and clinical judgment	View Results (7)
Effective leadership style	View Results (4)
Leadership and organization culture	View Results (25)
Work engagement	View Results (124)

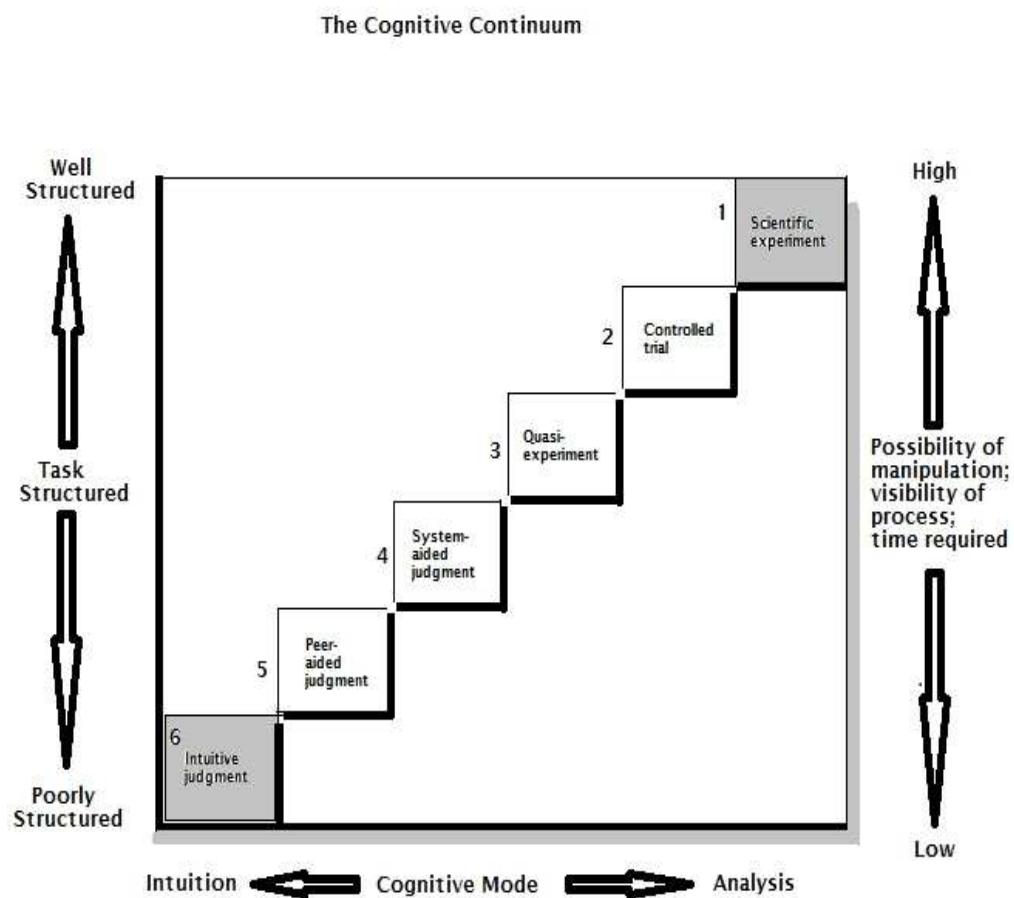
Table. 2 Exclusion and Inclusion criteria

Inclusion criteria	Exclusion criteria
<p>1- Studies published in English between 1996-2011 in UK, USA, and Canada</p> <p>2- Research studies including Randomized Controlled Trail Studies (RCTs) and non RCTs</p> <p>3- Research studies used appropriate instrument and showed consideration to validity and reliability of their tool</p> <p>4- Research studies used a valid design to address the research question</p> <p>5- Research studies that used appropriate analytic techniques appropriate to the research question</p> <p>6- Research studies that have a research question that appropriately answers this research questions</p>	<p>1- Studies not published in English</p> <p>2- Unpublished dissertations and theses</p>

Appendix 3 Leadership Style and Associated Competencies

Author	Leadership Style	Personal Competencies
Burns (1978)	Transformational	<ul style="list-style-type: none"> Identify common values Committed Inspires and motivates others with vision Has long term vision Look at effects Empowers others Encourage development Have the ability to raise others Establish a healthy work environment
David Cooperrider (1980)	Appreciative Inquiry	<ul style="list-style-type: none"> Open for new potentials and possibilities Committed Empowers others Set a dialogue It is about strengths, successes, values, hopes and dreams It is a journey for new ideas and images Open minded thinking Encourage engagement, networking, communication
Goleman et al. 2004)	Primal Leadership	<ul style="list-style-type: none"> Move people toward shared dreams Provides the space for freedom innovation Take risks Set individual development plans with organization's goals Improve performance through building long-term capabilities Build bridges between individual and organization Highly effective in crisis and emergency situations

Appendix 4 Cognitive Continuum



Based on Hamm (1988) taken from Thompson and Dowding (2002, p. 13)

Appendix 5 Invitation letters for participating in the study

Date: 30th June 2009

Mr. Shawqi A. Isa
University of Southampton
School of Health Sciences
Post graduate office
Southampton
United Kingdom.

Dear participant: _____

On behalf of the School of Health Science, University of Southampton, I am pleased to invite you to be a participant in this research for a period starting from (July 2009 to December 2011).

You will be interviewed by myself about your experience and insights of leadership competencies in the Critical Care Settings. We look forward for your participation in this study.

Sincerely,

S Isa

Students of DCLinP
School of Health Sciences
University of Southampton

Appendix 6 In-Depth Interview Guide

Skilled Attended

Interview Schedule
Interview Comments:

Interview Code: _____
Date: ____/____/09
Location: _____
Time: from ____ to ____

IN-DEPTH INTERVIEW WITH INDIVIDUAL SKILLED ATTENDANT

Participant Code:	Name:
	Age: Years Gender: M/F
Area of Practice:	Qualification:
Number of years in practice:	Number of years as supervisor

Research Objectives:
<p>Overall Objectives:</p> <p>A- To identify factors which facilitates or inhibits effective HNs' leadership in their leadership role .</p> <p>B- To make a recommendations of how to prepare future leaders with effective leadership competencies.</p>
<p>Specific Objectives:</p> <p>C- To better understand the qualities of the effective HNs in relationship to the leadership.</p> <p>D- To better understand the context of day-to-day practice of HNs to look at the problems, obstacles and frustrations about leadership. E- To identify the educational needs for developing future HNs leadership roles.</p>

Key Notes: This is a part of a study to identify factors which facilitate or inhibit effective Head Nurses Leadership in their leadership role. I want to ask you as a Nurse Supervisors about effective HNs leadership roles.

Effective Leadership Competencies

Notes for the Interviewer

Key Ideas to Explore:

- What competencies do HNs perceive as important for effective day-to day nursing practice?

Question to ask:

- 1- What do leaders usually do?
- 2- What competencies does effective Nurse Supervisor have?
- 3- As a healthcare provider, what do you do to be an effective leader?
- 4- What do you think could be done to help HNs to be better prepared for the position?
- 5- Why do nurse leader follow order or being obedience?
- 6- How can we change others from imposing the stigma of obedience on nurses?

Characteristics of Effective Nurse Supervisor

Notes for the Interviewer

Key Ideas to Explore:

- What are the characteristics of the NS who is considered to be effective in their leadership role?

Question to ask:

- 1- What characteristics should HNs have to be effective leader?
- 2- From your experience, what are the most six effective characteristics HNs have that satisfied nurses in clinical practice?
- 3- What behaviours do effective leaders exhibit?

Current and Future challenges

Notes for the Interviewer

Key Ideas to Explore:

- What are the challenges for the current and future leadership?

Question to ask:

- 1- In your opinion, what are the current problems do HNs face in clinical practice?
- 2- What create those problems worse?
- 3- From your experience, what are the future HNs leadership challenges?

Empowering Nurse Supervisors**Notes for the Interviewer****Key Ideas to Explore:**

- Does empowering HNs by acquiring more competencies decrease nurse turnover and improve working condition?

Question to ask:

- 1- What types of power do effective leaders acquire and use?
- 2- If leaders influence people, how can they do so more effectively?
- 3- What are the factors that contribute nursing empowerment?
- 4- What are the effects of nursing empowerment?

Factors that facilitate or Inhibit Nurse Supervisor Leadership**Notes for the Interviewer****Key Ideas to Explore:**

- What are the factors that facilitate or inhibit HNs from being effective Leaders in the Critical Care Settings?

Question to ask:

- 1- What are the facilitators and barriers to effective HNs leadership competencies?

Developing Nurse Supervisors Leadership Competencies**Notes for the Interviewer****Key Ideas to Explore:**

- What are the factors that contribute to HNs leadership development?

Question to ask:

- 1- How should we develop the skills, competencies, and behaviour needed by current and future leaders?
- 2- What training techniques are needed for effective leader?
- 3- How can we create and maintain the type of organization culture that will support and facilitate increased leadership development?
- 4- How can we create and maintain a healthy work environment?
- 5- What do we mean by self-development?
- 6- What is your leadership journey?

Thank you for answering all our questions about factors facilitates or inhibits effective HNs leadership. Your answers have been helpful. Maybe you have thought of something that we have left out. Is there anything that you can think of that we need to know but has not come out?

THANK YOU VERY MUCH FOR TAKING THE TIME TO TALK TO ME.

Appendix

Appendix 7 Research Information Sheet

Title: Leading and Following: An exploration of the Factors that Facilitate or Inhibit Effective Leadership in the Critical Care Settings.

Sponsor: The research is financially supported by Ministry of Health in Bahrain.

About the Study: The purpose of this research project is to explore the factors that facilitate or inhibit HNs effective leadership Competencies in the Critical Care Settings, with a view to make recommendations as to their future development. Specifically this research project will meet the following objectives:

- To better understand the qualities of effective HNs in relationship to leadership.
- To better understand the context of day-to-day practice of HNs by looking at the problems, obstacles and frustrations about leadership.
- To identify factors which facilitate or inhibit effective HNs in their leadership role.
- To identify the educational needs for developing future HNs leadership roles.
- To make recommendations regarding how to prepare future leaders for effective leadership roles.

The study definition of effective leadership is the capability to establish direction and to influence and align others toward a common goal, motivating and committing them to action and making them responsible for their performance.

About the Interview: I am interested in interviewing you as one of our key informants on this research, as you are known for your expertise in leadership competencies. I would need about thirty to sixty minutes of your time in order for me to conduct this interview regarding your insights into leadership competencies, and the factors that facilitate and inhibit effective leadership competencies in Critical Care Settings. I will also be interviewing other key informants.

In the interview, we will ask you open-ended questions about your experiences and insights regarding leadership competencies. I am interested in hearing your thoughts expressed in your own words, and encourage you to be honest in what you tell us. I expect the interview to last for about a 30-60 minutes.

With your permission, I will tape record the interview so that I have an accurate record of it and can refer back to your comments during the data synthesis and analyses. Tapes and transcripts of the interview will be kept in a locked location, accessible only by the researcher and the advisory team. If you do not want a portion of your comments to be recorded, I will turn off the tape recorder as soon as you indicate this.

Your responses will be held entirely confidential. Your responses will be used for research purposes only. When information is summarized into a research report, your comments (quotes) will be attributed anonymously. I will not reveal your name or detailed information that could be used to identify you personally as study participants.

Your participation in the study is entirely voluntary. You may leave off from discussion anything that you do not wish to talk about, and you may withdraw from the interview at any time.

About the Research: This study is being supervised by Professor. Judith Lathlean, Head of Postgraduate Research Students at School of Health Sciences, University of Southampton, United Kingdom, and Dr. Sue Colley, Director of Employer Engagement and Enterprise, School of Health Sciences, University of Southampton, United Kingdom.

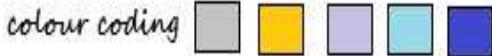
Risks and Discomforts: There is no potential risk of participating in this study. However, participants will be providing their time for the interviews. The time required for the interview may represent a small burden in the context of a large workload or schedule. I anticipate the interviews to last from 30-60 minutes and they will be conducted at the convenience of the participants.

If you have any further questions concerning matters related to this research, please contact:

- 1- Mr. Shawqi A. Isa Skinner (Skinnery2k@gmail.com) or Call on: 07775805480
- 2- Prof. Judith Lathlean (J.Lathlean@soton.ac.uk) or Call on: +44 (0)23 80598226
- 3- Dr. Sue Colley (S.M.Colley@soton.ac.uk) or Call on: +44 (0)23 8059 8226

Appendix 8 An Extract of Observation Notes

Observation Code: **An Extract of Observation Notes**

colour coding: 

Themes

Things Observed

Activities

I was greeted by nurses and the charge nurse on arrival. The Charge Nurse was working with the staff close to patients. The Charge Nurse spends most of XXX time with nurses' and other staff.

Charge Nurses are very close with nurses, physicians, and patients' relatives. XXX discuss all issues with the nurses before taking decisions. XXX report issues to N.O and give feedback to XXX nurses'.

XXX listens and gathers information before XXX discusses and takes decision.

XXX took a responsibility of N.O as an extended role for three weeks. Therefore, I was able to listen to the report XXX handed to XXX N.O. XXX listed the responsibilities and the further plans for the area XXX covers.

There was no regular departmental meeting. Last meeting with XXX staff was on August 2008. The arranged daily short meeting in the morning with the staff on duty to discuss any further issues or changes related to nurses' and nursing as a profession.

XXX encourage nurses to work in group while XXX work very close with nurse doing care.

Last meeting agenda included the following points:

- Maintains patient quality services
- Training new nurses.
- Journal club presentation

Settings

The area was crowded with nurses', patients' relative, doctors, and other health professional and cleaner supervisors.

In general the unit atmosphere was friendly.

Nurses used to sit in the nursing station to answer the telephone and collect laboratory results. Most of the time nurses talk together and surf the internet searching for advances in patient care.

People

Charge Nurse maintained good relationship and XXX socialize with other staff nurses, physicians, and patients' relative. XXX maintains a close relationship with all staff.

There is no control of patient visiting times in the unit. There is always a crowd of relatives waiting in the unit to see doctors or nurses.

Themes

Empowering staff (grey arrow)

Close relationship (yellow arrow)

Extended Role (light blue arrow)

Nursing Training (purple arrow)

Friendly Clinical Practice (grey arrow)

Stressful Clinical Practice (yellow arrow)

Hospital Regulation (green arrow)

Appendix 9 An Excerpt of an Interview Transcript

Phase 1

An Excerpt of an Interview Transcript

of Key Informant

Themes

R: Ok sister thank you very much..... What competencies do you think effective nurse supervisors or leaders have to have? What competencies should they have?

I: Well, the supervisors should have a... should be a decision maker aah... good decision makers.....

R- Yes...

I- We lack sometime this one...yah...and the supervisor should have the ability also to say yes or no and stand in front of different categories of hospital people. They should not be in other words a follower.....

R- What do you mean by that....

I- They should have assertiveness and power. They should have the assertiveness and power to say yes and say no when there is something wrong going on and not just to accept any order that's come to them without discussion....this is very important.

R- How to build ...how to build this?

I- Well of course there are two or three things related.... First, training has a good impact on this ...yeah...leadership and management programs. Second thing, you feel this is staff personality, something inside you makes you a good decision maker or makes you a good manager or a good leader... hah ...this is something that is built in the leadership program that sometimes enhances what is inside the person and what you have... yah...yah.. Third thing, maybe we need to follow up with the nurses when they have the leadership training, and when they have managerial programmes. We should go hand by hand to help them apply what they studied and to apply it in the clinical area...

Decision-maker

Assertiveness and Power

Obedient

Training Programmes
e.g Leadership and Management Programmes

Strong personality

Leader born or made

colour coding



Appendix 10 Personnel Letter to the Chief Nurse Executive of Nursing

Personnel Letter to the Chief Nurse Executive of Nursing Requesting For Permission to Conduct the Study

Mr. Shawqi Ali Isa Skinner
Doctorate of Nursing Clinical Practice (DCLinp)
University of Southampton
School of Health science
School of Nursing & Midwifery
United Kingdom
Sali3@health.gov.bh
Tel. 044 07775805480

To:
Chief Nurse Executive
Ministry of Health
Nursing Services
Manama
Kingdom of Bahrain

Dear Sir / Madam
RE: PERMISSION TO CONDUCT RESEARCH FOR DCLINP STUDY

I am writing to seek your permission in regard to the subject above. I am sponsored by the Ministry of Health to do a Doctorate in Clinical Nursing Practice in the University of Southampton, United Kingdom. The study title is "Leading and Following: An exploration of the Factors that Facilitate or Inhibit Effective Leadership in the Critical Care Settings".

This study is proposed to be conducted in one Government Hospital, specifically in Critical Care Settings, involving Chief Nurse Executive, Nursing Supervisors, and Senior Staff Nurses.

Prior to conducting the study, I would like to request for your Office kind permission for me to proceed with the study on the Nursing supervisors in your hospital. The permission letter will facilitate in obtaining ethical approval from the Scientific Research Ethical Committee in hospital. I have enclosed with this letter a copy of research proposal

I look forward for you reply and I would like to thank you for your kind attention and consideration of the above matter.

Yours Sincerely
Shawki Skinner

Appendix

Appendix 11 Cover letter to the Head of Research Committee

Cover letter to the Head of Research Sub Committee at Government Hospital
June 30th, 2009

Head of Research Sub - Committee
Ministry of Health

Dear

Please find the enclosed protocol and consent form for the study, "Leading and Following: An exploration of the Factors that Facilitate or Inhibit Effective Leadership in the Critical Care Settings." I will also enclose a copy of University of Southampton Peer Review approval to your committee soon.

Thank You

Yours sincerely

Appendix 12 Informed Consent Form

Participant Identification Number:

Title of Project:

Case Study Leading and Following: An exploration of the Factors that Facilitate or Inhibit Effective Leadership in the Critical Care Settings (CCS).

Name of Researcher: SHAWQI ALI ISA

I understand that I am being asked to participate in a research study at one General Government Hospital. This research study will explore: the factors that facilitate or inhibit HNs from applying effective leadership competencies in the Critical Care Settings (CCS). If I agree to participate in the study, I will be both interviewed and clinically observed. The interview will take approximately 30 to 60 minutes about my experience as a nurse supervisor. The interview will be tape-recorded and taken place in a private office. No identifying information will be included when the interview is transcribed. There are no known risks associated with this study.

- 1- I confirm that I have read and understand the information sheet Dated ___/___/09 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactory.
- 2- I understand that my participation is voluntary and that I am Free withdraw at any time, without giving any reason, without my legal right being affected.
- 3- I understand that relevant sections of any of my data collected during the study, maybe looked at by responsible individuals from University of Southampton, from the research supervisory team, where it is relevant to my taking part in this research. I gave permission for researcher of this study to have access to all information required.
- 4- I understand that all study data will be kept confidential. However this information may be used in nursing publications or presentations.
- 5- If I need to, I can contact Prof. Judith Lathlean, University of Southampton, School of Nursing, anytime during the study.
- 6- I agree to take part in the above study,

Signature of Participant

Date

Signature of Supervisor

Date

Signature of Researcher

Date