The experiences of Nurse Managers navigating between two conceptual models of leadership in Aotearoa New Zealand.

A thesis presented in partial fulfilment for the degree of

Master of Philosophy

Massey University, Wellington,
New Zealand

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2020

Abstract

The Nurse Manager (NM) is critical in ensuring quality nursing care and health service delivery. However, the restructuring of organisations has dramatically altered the function, accountability, and responsibilities of the NM role. The NM is expected to juggle budgetary and managerial responsibilities whilst effectively leading nurses. The added complexity of the role requires the NM to navigate between two conceptual models: the Professional Practice Model (PPM) of nursing leadership and the Generic Management Model (GMM) of leadership. This can lead to a conflict of personal values, undermining role effectiveness in this key senior nursing position.

There is a large body of international research about the complexity, ambiguity, and dual role of the NM role, but limited qualitative research exists exploring the dual role of the NM role in the New Zealand context.

The aim of this qualitative, descriptive research was to explore the challenges that the NM experiences when trying to navigate between the PPM and the GMM. The purpose of undertaking this research was twofold: to inform the ongoing evolution of the NM role and provide a deeper understanding of the challenges that New Zealand NMs experience.

Five NMs within a New Zealand hospital were surveyed. Data were analysed using a general inductive approach. Four main themes—role confusion, level of expectation, support, and professional development—emerged.

Findings suggest that participants perceived their role to be predominantly generic management, but felt that clinical expertise, relational processes, and soft skills were the most important capabilities of the NM role. This suggests that the participants in this study favour and support the PPM rather than the GMM.

This small study highlighted the need for further analysis of the professional development and preparation requirements attached to the NM role in order better navigate the PPM and GMM. Recommendations include the need for succession planning and postgraduate education.

Acknowledgments

I would like to acknowledge my supervisor Dr. Kerri-ann Hughes, for the guidance she has given me throughout the research. I am thankful for my peers who were there encouraging and supporting me throughout my master's journey. I would especially like to acknowledge my dear friend Andrea Taylor, unconditionally supporting me emotionally and grammatically through my studies. I would like to acknowledge my nurse role models; Helen Costello and Anjana Naidu. Not only did they inspire and offer me knowledge, but they exemplified the integrity and professional dignity that comes with being a nurse. Finally, I would like to extend my appreciation to the Nurse Managers, past and present, who gave their time and offered me the opportunity to gaze into their world.

Dedication

I dedicate this thesis to Daniel, who has endured the long hours, days, and months of a partner immersed in and consumed by the intensity of studying and writing. I would also like to dedicate this thesis to my parents Sabin and Nicky Perkins who have always been supportive of me advancing my education. Included in this dedication are my family and friends who have provided encouragement, reassurance and have understood the reasons for my lack of attendance at family and social gatherings.

Contents

CHAPTER 1. INTRODUCTION

1.1 Background:

This thesis defines the project I began in November 2019 when I set out to explore the challenges that Nurse Managers (NMs) experience when trying to navigate between a Professional Practice Model (PPM) of nursing leadership and a Generic Management Model (GMM) of leadership within a New Zealand hospital. This exploration was achieved using principles of action; thus, the research was cyclic, qualitative, and participatory (DePoy & Gitlin, 2016). A general inductive approach enabled the researcher to undertake systematic reading of surveys, conceptualise the data, and produce a descriptive summary of a phenomenon. These summaries identified key themes within the data and have the potential to influence future nursing research.

My objective for undertaking this qualitative, descriptive research was twofold: to inform the ongoing evolution of the NM role, and to understand NMs experience with the cross-pressure in the role. The study would provide a deeper understanding of the challenges New Zealand NMs experience with the aim of optimising nursing leadership, support, and education. The New Zealand government health system reforms in the 1990s saw a change in the health service structure, including nursing leadership. Simply put, these reforms have dramatically altered the function, accountability, and responsibilities of the NM role (Jeffs et al., 2018). NMs are typically experts in their clinical area who demonstrate leadership qualities and can engage, motivate, and influence nurses. However, the NM must also juggle budgetary and managerial responsibilities while effectively leading nurses employed in their clinical area (Jeffs et al., 2018). The complexity of this role requires NMs to navigate between two conceptual models: the PPM of nursing leadership and the GMM of leadership. The PPM enables nurses in an organisation to provide patient-centred care and support a work environment that promotes high quality nursing practice (Hoffart & Woods, 1996; Slatyer et al., 2016). Conversely, the GMM values innovation, high motivation, and commitment to the goals of the organisation (Spehar et al., 2012).

Consequently, the NM is required to integrate both the PPM and the GMM into their daily activities and practice. This integration, however, can lead to personal conflicts as the NM is expected to support a work environment that promotes high quality nursing

practice whilst also balancing cost and resources, which might ultimately lead to discontent and a conflict of values (Hewison, 1999; Slatyer et al., 2016; Strandås et al., 2019). In fact, research states that nurses are becoming increasingly dissatisfied with their working environment because the clinical environments they work in now focus on service delivery— specifically efficiency and performance management—rather than patient-centred care (Ball & Pike, 2009). In turn, this dissatisfaction has had a negative impact on organisational culture with the belief that nurses, and managers have differing priorities and values regarding service delivery and patient outcomes (Ball & Pike, 2009). However, most organisations have a mission statement that outlines their priorities and values, and these are typically patient centred with a candour towards patients which aligns with nursing professional practice. Thus, it is, in fact, the way in which patient outcomes and service delivery are achieved that causes the negative impact, not the priorities or values themselves.

When an organisation fails to give sufficient priority to quality patient care over system-led targets and focus on finance, it results in a culture that is not conducive to ensuring patient safety and quality of care. This was evidenced in the Francis inquiry, the report into severe failings in care in Mid Staffordshire hospitals, which discovered that system-led targets and poor quality of leadership within the organisation was contributing to a poor quality of care (Francis, 2013; Lynas, 2015). It is well known that a top-down, performance-driven culture will not produce the climate that creates the conditions for success (Lynas, 2015). In fact, the Francis inquiry report referred to an atmosphere of fear of adverse repercussions and a forceful style of management contributing to tolerance of poor work conditions and a reluctance to engage with management (Francis, 2013; Lynas, 2015). This highlights how a lack of communication, poor leadership, and undue pressure to meet system-led targets can result in substantive and emotional conflict between nurses and management.

In turn, this conflict leads to a diminished level of trust, dissatisfaction, and poor interpersonal relations, which could in turn lead to a harmful organisational culture, poor patient outcomes, and decreased motivation in the workplace (Strandås et al., 2019). It is thought that a NM who can incorporate both the PPM and GMM conceptual models of leadership into an organisation could future-proof the nursing workforce by promoting efficient, high-quality nursing practice within fiscal constraints, which would

lead to positive experiences and improved organisational culture (Strandås et al., 2019). Therefore, it is imperative to explore the NM's experience when integrating the PPM and the GMM model of leadership, and the ideology of cross-pressure when balancing a dual role.

The remainder of this chapter includes the justification for the study and the aim of the research, the situational context; the setting and the New Zealand health system and its connection to the NM role are described. In addition, the practice, and professional domains in which the New Zealand NM functions are also described. The chapter concludes with an overview of the structure of the thesis.

1.2 Justification for the study:

I have commenced this research as a Clinical Nurse Educator. However, having previously worked as an Associate Charge Nurse Manager, I have an educational, leadership, and managerial perspective. These roles have provided me with the ability to observe the NM role at a superficial level, and recognise that the leadership and management of people, processes, and resources is complex and demanding. Anecdotally, this is a role that is becoming increasingly more complex, with the NM expending more time, resources, and energy than one can maintain or sustain. Little is known, though, about NMs' experience with the cross-pressure in the role, thus this research has the potential to inform, change and evaluate the NM role in New Zealand.

1.3 Aim of the research:

The aim of this study is to explore the challenges that NMs experience when trying to navigate between a PPM of nursing leadership and GMM of leadership. The findings from this research were predicted to provide an insight into NMs' experiences when balancing a dual role, with a view to optimising nursing leadership in New Zealand. It was hoped that the findings would result in a greater understanding of the barriers and enablers within the NM position and identify new ways to support the NM.

1.5 The New Zealand Health System

In March 2020, New Zealand reached an estimated resident population of five million. This was a milestone as it was New Zealand's fastest million, taking only 17 years to

climb from four million to five million (Medical Technology Association of New Zealand, n.d.). This is significant because the public funded New Zealand healthcare system provides health care to all, regardless of age, gender, or socioeconomic status (Ashton, 1996). However, a growing and ageing New Zealand population with multiple comorbidities inevitably puts the healthcare system under strain. The New Zealand healthcare system is a complex network of organisations and individuals who deliver health and disability services. This network is predominately publicly funded and raised through general taxation, representing 79.2 percent of total health expenditure while private healthcare is represented at 20.8 percent (Ashton, 1996).

Since the Social Security Act of 1938, independent funding of primary and hospital-based services has existed, with the objective of the Labour Government to provide a more equitable health care service to all New Zealanders (Social Security Act 1939; Upton, 1991). Although this general structure still largely remains, changes have evolved over several decades. As discussed above, because of New Zealand health reforms in 1990s, the health service structure has changed dramatically, consequently resulting in significant changes to the NM role, previously titled Nurse Matron (Surakka, 2008). The most momentous change in the 1990s was the introduction of a model of nursing leadership that incorporated clinical expertise and generic management. Whilst many NMs valued their clinical expertise, their role expanded to include increased management and financial responsibilities, and the title of NM was introduced (Surakka, 2008). This is significant to the New Zealand health system, specifically the leadership structures within the District Health Board (DHB), as the nursing services were directly impacted by the NM's ability to balance professional practice and managerial activities.

The DHBs are tasked with responding to the Minister of Health for providing or funding health and disability services in their geographical region. The Minister of Health develops national policy and holds full accountability for the performance of all 20 DHBs. All DHB activities are governed by a board of up to eleven individuals: seven elected by the public and four appointed by the Minister of Health (Gibbs et al., 1988; New Zealand Public Health and Disability Act, 2000; Quin, 2009). These DHB governing boards monitor performance, the strategic direction of the DHB, and compliance with the law and crown relating to finance and an achievement in health

service delivery for New Zealanders (Quin, 2009). The provision of publicly-funded health care services was adopted from the New Public Management ideology, and was introduced to New Zealand in the 1990s in an effort to reduce public spending, increase efficiency, improve access to care, and enhance the working environment for health professionals (Gibbs et al., 1988; Quin, 2009). Prior to the 1990s, parliament allocated money in bulk to public hospitals or area health boards; the prioritisation of healthcare funding was based on the decision-making of administrators, clinicians, and elected board members. This system was problematic because these individuals were acting as both purchasers and providers, which caused conflict and tension (Quin, 2009; Upton, 1991). In fact, this was the perfect opportunity for clinicians to influence decisions and funding prioritisation to their advantage, rather than that of the organisation (Gibbs et al., 1988).

In addition, these individuals had little management experience, which was problematic because the New Zealand hospital system was run by triumvirate management, where authority and responsibility is shared between three individuals rather than one. This management structure resulted in diluted accountability as no one person was willing to take responsibility, and so poor management resulted (Gibbs et al., 1988; Quin, 2009). An investigation in the late 1980s identified that a lack of management information and incentives to use the information was the root cause of this poor management. Shockingly, New Zealand's public hospitals had non-existent management accounting, no standards set for cost of services, and an absence of productivity measurement (Gibbs et al., 1988; Quin, 2009). Naturally, as there was no productivity measurement, there was no incentive to increase it, and a lack of management information meant that resources were not distributed to priority areas, which resulted in decreased efficiency and productivity in New Zealand's public hospitals (Gibbs et al., 1988; Quin, 2009).

In 1991, the National Government embarked on a comprehensive restructuring of the New Zealand health sector. A Ministerial Taskforce identified health sector problems and advised the government on potential solutions to address perceived deficiencies in the system (Quin, 2009; Upton, 1991). The Ministerial Taskforce conducting the investigation recommended the separation of the purchaser and provider roles of the boards and the establishment of a competitive, quasi-market approach to the provision of health services. This resulted in four Regional Health Authorities (RHAs) being

established to manage funding and contracting of health services from a range of providers throughout New Zealand (Quin, 2009; Upton, 1991). Public hospitals were established on a "for-profit" model as Crown Health Enterprises (CHEs), with appointed boards of directors now utilising their business and health sector expertise. This meant that public hospitals were paid in relation to both volume and quality of services according to contracts negotiated with RHAs. The Department of Health was replaced by the Ministry of Health which would monitor the performance of the RHAs against the funding agreements with the crown (Quin, 2009; Upton, 1991).

The provision of publicly funded health care services continued to go through a series of changes with the most recent reform in 2001. This reform resulted in the establishment of twenty DHBs who were responsible for the planning, purchasing and provision of health services (Quin, 2009). The Minister of Health became responsible for policy development, leadership, and monitoring of DHB performance, and is principally supported and advised by the Ministry of Health. The health system relies on DHBs, health crown entities and agents, the Minister of Health, and the Ministry of Health to work collaboratively to ensure quality health to New Zealanders (Quin, 2009). It is guided by the New Zealand health and disability system's statutory framework which includes three significant pieces of legislation: New Zealand Public Health and Disability Act, which establishes the structure for public sector funding and organisation of health and disability services; The Health Act 1956, which identifies the roles and responsibilities of individuals; and the Crown Entities Act 2004, which provides a statutory framework for the establishment, governance, and operation of health crown entities (Quin, 2009). Whilst hospitals have become less commercially focused, they still have an emphasis on preventive health services, national health goals and targets. Thus, DHBs have adopted a GMM as their focus is on advancing and safeguarding the health of New Zealanders—specifically by setting goals, monitoring resources, and measuring performance (Hewison, 1999; Strandås et al., 2019).

To meet the objectives of the New Zealand Public Health and Disability Act 2000, the New Zealand DHB has established governance with a board of directors. This board seeks advice regarding the needs of the region's resident population, funding priorities, and ways to provide the most effective and efficient delivery of health (Quin, 2009). The providers of services include healthcare workers who have direct contact with the

public. The NM role is a provider of services due to their regular, direct interaction with the public in both community and hospital settings. The NM has an obligation and duty to uphold the rights of consumers by ensuring that the nurses employed in their area comply with the New Zealand Public Health and Disability Act 2000. The NM plays a key role in helping the New Zealand DHB to deliver on government priorities due to their strong commitment to the provision of safe, sustainable quality health services and a passion for delivering equitable health outcomes for New Zealanders (Quin, 2009; Upton, 1991).

The New Zealand DHB where this research took place is responsible for ensuring the provision of health and disability to a region's population with government funding and Ministry of Health contract parameters. The NM has a responsibility to ensure the smooth running of a clinical area within the allocated resources set by the New Zealand DHB. The NM is a number of management layers away from the board of directors that govern the New Zealand DHB, the executive team, and general management. However, the NM is visible, recognisable, and accessible to patients and families during a hospital admission and thus the public often considers them answerable for the delivery of health services, with very few individuals even considering the wider DHB structure (Gardner, 2008)

1.6 Nurse Managers in New Zealand

The New Zealand Nurses Organisation (NZNO) is the leading professional body of nurses in New Zealand and represents approximately 500 NMs registered by the Nursing Council of New Zealand (Clendon & Walker, 2012). NMs anecdotally have one of the most challenging jobs in healthcare, and it is becoming increasingly more complex. These individuals play a crucial role in the maintenance of the clinical equilibrium, but changes in healthcare in the past twenty years have resulted in role instability. Clinical credibility and nursing expertise were considered a prerequisite of the role in the 1980s as the 'head nurse' provided patient care whilst managing the ward (Kramer et al., 2007). In the 1990s, with the advent of New Zealand health reforms, the role evolved from a 'head nurse' to a 'manager'; with the role embracing the GMM (Kramer et al., 2007). The NM's list of responsibilities expanded to include patient flow, budgetary oversights, performance measures and quality outcomes measures. Nurses who were perceived to be senior clinicians were suddenly expected to assume a

managerial role without appropriate training. As a result, this change of responsibilities created considerable tension between the humanism of nursing and managerialism (Bamford & Porter-O'Grady, 2000).

The New Zealand DHB involved in the research project for this thesis saw the negative effects of the implementation of an economic model of healthcare, as several professional nursing leadership positions were disestablished and middle management disappeared (Bamford & Porter-O'Grady, 2000). In fact, during the 1990s the New Zealand DHB went without a Director of Nursing for eight years. The lack of nursing leadership and shared governance resulted in nurses feeling disempowered as their organisational environment did not promote a PPM that celebrated their cognitive and clinical skill (Bamford & Porter-O'Grady, 2000). Research states that the introduction of a GMM created an environment where New Zealand NMs felt disheartened and confused. These feelings were generated by an underlying conflict between the nursing caring relationship and the want for efficiency and economy (Bamford & Porter-O'Grady, 2000). In New Zealand, the working environment has a culture of high nurse turnover and understaffing which echoes an accepted view of a nurse as a replaceable unit of labour (North et al., 2013). Consequently, this has had a detrimental impact on organisational culture with the belief that nurses, and managers have differing priorities and values regarding service delivery and patient outcomes.

Traditionally, the healthcare culture has held each tier of the organisation responsible for the performance of those below. However, in response to the feelings outlined above, the mid 1990s also saw more hospitals engaging in participative management, with an emphasis on empowering NMs to participate in organisational decision making by analysing problems, developing strategies, and implementing solutions in their clinical area (Duffield et al., 1993). Participative management was successful because it encouraged everyone to work together, with the NM being a pivotal force behind the successful implementation of new visions and ideas in a clinical area. Bennis and Nanus (1985) suggests that that leadership and management are different; a manager aims to take charge and responsibility for conduct whilst a leader influences and guides a course of action. Both of these aims continue to have a deep impact on the NM role.

Participative management is an organisational characteristic of Magnet hospitals and ensures patient care is collaborative, with NMs being included in decentralised decision-making (Kramer & Schmalenberg, 2004). Thus, in 2005, the New Zealand Ministry of Health published a document to support hospitals in integrating Magnet principles into their organisation the intention was that Magnet hospitals would promote and sustain professional nursing practice, organisational quality improvement, and encompass management and leadership principles (Magnet NZ, 2005). However, New Zealand has had only one hospital credentialed under the Magnet Hospital system; in 2007, Hutt Valley DHB was awarded Magnet status for its excellence in, and support of, nursing staff (Hutt Valley District Health Board, 2004; Vekony et al., 2007). Regrettably, the costs of continuing credentialing served as a deterrent for Hutt Valley DHB and it has since lost its Magnet status (Kelly et al., 2012). However, evidence suggests that during the period that Hutt Valley DHB was credentialed it might have addressed issues of culture and care present in non-magnet hospitals. Magnet-credentialed hospitals implement principles like the PPM of nursing leadership and GGM of leadership, so many healthcare organisations have chosen to apply these two conceptual models, but the success of this application relies heavily on the capability of the NM (American Nurses Credentialing Center, 2011; Vekony et al., 2007).

Under a traditional management system NMs had little opportunity to be heard, but nowadays they are considered a pivotal force behind the successful implementation of new visions and ideas in a clinical area. Thus, NMs play an active role in decision-making, strategy, and change in their clinical area; decisions that were traditionally of an authoritarian style but are now autonomous (Frankson, 2008). This autonomous decision-making is encouraged, rather than the past traditional hierarchical pattern of decision-making where outcomes were communicated down to frontline staff. Whilst this shift in decision making is an improvement, it also creates significant stress for the NM as the boundaries of structure, process, and responsibility become blurred. Additionally, this stress is exacerbated by expanded role responsibilities, such as advanced leadership and management skills (McCallin & Frankson, 2010).

In fact, McCallin and Frankson (2010) state that past organisational restructuring and ongoing changes to the NM role have resulted in role issues including role conflict and role ambiguity. The scope of the NM role is large with capabilities including clinical

expert, human resource authority, recruitment manager, quality specialist, policymaker, finance analyst, project manager, ward supervisor, administrator, teacher, and councillor. It is unrealistic to expect a senior nurse to take on these expanded capabilities and responsibilities without appropriate mentorship, coaching, education, and preparation. However, research suggests NMs are ill prepared for the role, with little succession planning or postgraduate education. In fact, many NMs have admitted to learning the role using trial and error methods, making role stress and fatigue inevitable (McCallin & Frankson, 2010).

Undoubtedly, the NM role has changed dramatically since the 1990s, and it is widely recognised that NMs are in a unique position to influence organisational culture, organisational success, and staff satisfaction because of their daily interactions with staff nurses (Loyens & Maesschalck, 2010). Therefore, these individuals often demonstrate leadership qualities and can engage, motivate, and influence staff nurses. In addition, the NM must juggle budgetary and managerial responsibilities while effectively leading staff nurses employed in their clinical area (Jeffs et al., 2018). The complexity of this role requires NM to navigate between two models: the PPM of nursing leadership and the GMM of leadership. A PPM enables nurses in an organisation to provide patient-centred care and support a work environment that promotes high quality nursing practice (Hoffart & Woods, 1996; Slatyer et al., 2016). Conversely, the GMM values innovation, high motivation, and commitment to the goals of the organisation (Spehar et al., 2012).

Consequently, the partnership of both the GMM and PPM has the potential to create personal conflicts as NMs are expected to support a work environment that promotes high quality nursing practice whilst also balancing cost and resources, which might ultimately lead to discontent (Tingvoll et al., 2016). Furthermore, the budgetary focus of the GMM requires NMs to employ bureaucratic strategies to best utilise resources, but these strategies can lead to tension with staff nurses who might feel their clinical care is undervalued (Brunetto, 2002; Tingvoll et al., 2016). This substantive and emotional conflict between staff nurses and their NM might result in a diminished level of trust, dissatisfaction, and poor interpersonal relations, which could in turn lead to a harmful organisational culture, poor patient outcomes, and decreased motivation in the workplace (Tingvoll et al., 2016). Therefore, it is imperative to consider how NMs

contribute to organisational culture and service delivery when faced with constant cross-pressure as they navigate between the PPM of nursing leadership and the GMM of leadership.

1.7 Structure:

This thesis consists of five chapters. Chapter one outlined the background that has shaped the NM role and the justification for the study. Chapter two defines the two conceptual models of leadership; the PPM and GMM and provides an overview of the current published literature relating to the NM role. It analyses the complexity of the role, and role ambiguity and cross-pressure are discussed. Chapter three discusses the methodology used to collect, interpret, and analyse the research data. Furthermore, it highlights the researcher's attempts to manage ethical issues. Chapter four presents the findings from the SurveyMonkey survey and identifies four main themes. Chapter five discusses and analyses the findings in relation to the literature. In addition, it outlines the limitations of this small study and recommendations for further research on the role of the NM, specifically in the New Zealand context.

CHAPTER 2. LITERATURE REVIEW

2.1 Review of literature:

There are several reasons for reviewing literature, but the primary reasons are to acquire an understanding of your topic, of what the possible gaps are, how it was researched, and what the issues were. This enables the researcher to analyse ideas, find common themes and determine what the main criticisms are within the existing literature, in turn illuminating the significance of further study (Hart, 2018). This chapter reviews the historical and contemporary research relating to the role of the NM. A NM is defined as a Registered Nurse with absolute accountability for the management and leadership of a ward, unit, or area within a healthcare institution (Gunawan et al., 2018; Kirchhoff & Karlsson, 2019). The term NM is synonymous with terms First Line Manager, Charge Nurse Manager or Ward Manager, which have been used in the literature (Ericsson & Augustinsson, 2015; Gunawan et al., 2018; Kirchhoff & Karlsson, 2019).

It is well documented that the NM role is critical in ensuring a safe patient journey and successful delivery of quality care in the hospital setting (Widman & Hewson, 2009). However, several studies have found the NM role to be complex; NMs are expected to be skilled in management, and have clinical expertise, all whilst inspiring and motivating the staff nurses within their clinical area (James-Sommer, 2008; McCallin & Frankson, 2010; Miltner et al., 2015; Udod et al., 2017; Warshawsky et al., 2020). These studies highlight the dual position of the NM and the role ambiguity NM's face. However, there is a paucity of research investigating the experiences of New Zealand NMs and it is this gap in the literature that highlights the need for further investigation. Relatively little is known about the dual position of the NM or the autonomy of the leadership position and the position's influence in organisational decision-making. Therefore, this literature review aims to contextualise available literature and provide insight into the types of experiences nurse have encountered whilst in the NM role.

To establish what literature has already been published, a search strategy was used, and the detail of this strategy will make up the first section of this chapter. A literature search was conducted using electronic databases— Cumulative Index to Nursing and Allied Health (CINAHL), Pubmed and Medline—using the following keywords: "Charge Nurse Manager", "Nurse Manager", "First Line Manager" and "Professional Practice Model". The researcher was not able to find a sufficient quantity of literature

searching the ‘Generic Management Model’ and instead worked under the assumption that ‘managerialism’/ ‘New Public Management’ is synonymous with generic management (Kirchhoff & Karlsson, 2019) Articles of all methodologies were included, such as original research studies, literature reviews, and thesis studies. Additionally, the search dates were not restricted due to the historical nature of the NM role, the Professional Practice Model, and the Generic Management Model, but the keywords outlined earlier were used to interrogate the data sources. This was important due to the vast variations in the definition of a NM, and so for this review the NM is required to be a Registered Nurse with direct oversight for the management and leadership of a clinical area (Gunawan et al., 2018; Kirchhoff & Karlsson, 2019). Consequently, nursing leadership without focus on the first line manager was excluded from this literature review. However, literature on the first line manager literature from other professional disciplines including medical imaging and medicine was used to inform this review. The online searches were limited to articles in English, with an emphasis on literature that was published primarily, but not exclusively, in New Zealand, Australia, and England. The application of the inclusion and exclusion criteria resulted in 57 relevant articles, and further literature was identified through cross-referencing reference lists. These reference lists enabled the researcher to trace and source articles of further relevance.

The literature review was vital in enabling the researcher to become acquainted with both the current research, the history of the subject, the common themes, and stimulate further investigation. The researcher aimed to understand the history of the NM role both internationally and domestically to acquire sufficient knowledge in the subject. An understanding of the history has provided the researcher with a new perspective, an understanding of the context of the topic, and has highlighted the significant work that has already been completed within this field of work. A familiarity with the history of the NM role has provided clarity around common themes, enhanced the subject vocabulary, identified the main methodologies that have been used and highlighted the significant work that has already been completed within this field of work (Hart, 2018).

The role of the NM has evolved significantly over the past 150 years. Wildman and Hewison (2009) state that the origins and development of nursing management were established in England in 1856, when the Anglican sisterhood of Saint John’s House

took control of the entire nursing and domestic workforce of King Hospital. This religious sisterhood reformed nursing by identifying a single, female nursing lead and thus introduced a management system. Subsequently, management of the nursing workforce at Charing Cross Hospital and the University College Hospital was claimed by more religious sisterhoods by 1866 (Wildman & Hewison, 2009). By the 1870s, the concept of a NM had started to gain popularity. This increase in popularity, was partly due to recommendations made by Florence Nightingale who believed a female lead should be in sole charge of the nursing staff and by the twentieth century the role of the matron was implemented (Nightingale, 2009).

The role of the matron included the authority and discipline of all nurses and domestic staff, overseeing all patient care and providing education. Nightingale advised that a woman appointed to a matron position should receive training, be a clinical expert and act as a leader (Nightingale, 2009; Wildman & Hewison, 2009). The matron was critical in managing nurses' work and the delivery of quality patient care. However, the position had no influence over the strategic running of the hospital, or even the decision-making processes in the clinical area (Kirchhoff & Karlsson, 2019). During this time, the matron had responsibility for housekeeping in a clinical area, and authority over the nurses and female servants. The matron had little responsibility, however, for the clinical care or treatment of patients as this was domain of the medical staff (Wildman & Hewison, 2009).

In 1917, a former Matron and Superintendent of Nursing at St Bartholomew's Hospital documented that the qualities of a NM included expert nursing knowledge, clinical expertise, and proven leadership ability (Wildman & Hewison, 2009). These qualities are still considered important today, but the role of the NM has undergone enormous change and become increasingly complex with an expectation that the NM also be proficient in people management, operational management, and clinical area performance. (Hyrkäs et al., 2005; McCallin & Frankston, 2008). Literature from the 1990s was the first to explore the intricacies of the NM role, an increase in the responsibilities and a need for graduate education in order to understand the health care system (Kleinman, 2003). This not only highlighted the complexity of the NM role, but also how the role had become increasingly demanding due to it being both management and leadership orientated (Hyrkas et al., 2005; Kitson, 2004). The NM is not only a

manager as their title implies; according to the organisation's job description, the NM provides visible clinical coordination and leadership, professional development, implementation of organisational initiatives, and clinical governance of all nursing areas. This highlights that the NM role functions using two models—the professional practice model of nursing leadership and the generic management model of leadership—resulting in an unusual degree of dissonance.

2.2 The Professional Practice Model (PPM)

The NM role is both central and critical to patient safety and the delivery of quality care in the hospital setting, but an ever changing health system has shaken employees' confidence and trust of management and has made the job of the NM challenging. Thus, the implementation of a PPM in a hospital nursing setting is perceived as valuable as it enables staff to have autonomy and control over their nursing practice while managing the realities of flattening organisational structures (Laschinger et al., 2001; Widman and Hewson, 2009). If a NM wants to regain the trust of nursing staff, they should be guided by the PPM as it is shown to support the positive working conditions that guarantee high-quality patient care and foster a genuine commitment to organisational goals (Aiken et al., 1997; Laschinger et al., 2001).

In 1982, an American Academy of Nursing study explored the characteristics that nurses felt were essential to quality care, and identified a selection of "magnet" hospitals (hospitals known for excellent nursing care) that were considered more desirable to work in and had higher levels of nurse retention Aiken et al., 1997; Kramer et al., 2008; Laschinger et al., 2001). This led to the development of the Magnet Recognition Program in 1991, which aimed to support nurses to provide patient-centred care by exercising their knowledge and clinical skills to support an organisation and promote high quality nursing practice (Hoffart & Woods, 1996; Slatyer et al., 2016). The PPM was developed to support the Magnet Recognition Program, and is best defined as a "conceptual framework of interrelated nursing care delivery structures, relational processes and values that that are meaningful to nurses in clinical practice and support their control over their practice and practice environment (Murphy et al., 2018, p. 264). The PPM incorporates five subsystems including: professional values, professional relationships, compensation, patient care delivery, and shared governance (Hoffart & Woods, 1996; Slatyer et al., 2016). Organisations that implement the Magnet

Recognition Program observe nurses, regardless of hierarchy, incorporate the PPM subsystems into their work and clinical care, which has been proven to improve patient outcomes (Aiken et al., 1997; Murphy et al., 2018).

The literature states that professional values such as respect, partnership, trust and integrity are vital tenets that form a foundation for other elements of the PPM subsystems (Ng'ang'a & Woods, 2015). In fact, these professional values underpin the Code of Conduct for nurses; an overarching document that guides the behaviour or conduct that nurses are expected to uphold (Hoffart & Woods, 1996; Nursing Council of New Zealand, 2012). Decentralised decision-making, effective professional relationships and the quality of patient care depend on the maintenance of professional values; without these the PPM will lack focus and cohesion (Hoffart & Woods, 1996).

The PPM incorporates decentralised decision-making which supports the NM to have accountability, responsibility, and authority over the delivery of clinical care and the nursing environment; therefore, autonomy is considered a vital element in the PPM and has a big influence on the ability to provide high-quality patient care (Kramer & Schmalenberg, 2004). Conversely, this might be challenging in organisations that are highly bureaucratic or have complex chains of command because there can be confusion as to what constitutes autonomous professional practice and what degree of autonomy is allowed. However, the ability to incorporate the PPM into an organisation is a distinct advantage for the NM as their decision-making and daily interactions with staff nurses will have more influence on organisational success, job satisfaction, and nurse retention (Loyens & Maesschalck, 2010).

Research shows many conflicting dualisms for staff nurses and managers, such as "us and them" and "care versus money", highlighting a strong disinclination for a bigger focus on service delivery and management, rather than high quality nursing practice (Ball & Pike, 2009; Hewison, 1999). However, the PPM encourages the NM to participate in governance and management, so by the late 1990's, hospitals had attempted to remove bureaucratic approaches by decreasing their organisational layers in favour of a shared governance approach which is more consistent with the PPM—especially the autonomy element (Hoffart & Woods, 1996). Consequently, shared governance has enabled the NM to be autonomous in professional practice and decision-

making at an organisational level; ultimately providing the NM with the ability to fully actualise their commitment to quality patient care delivery. Hoffart and Woods (1996) envision the PPM to have non-hierarchical multidisciplinary teams that have healthy professional relationships with a focus on teamwork, collaboration, and high-quality patient care. Therefore, the literature considers professional relationships to be of importance because nurses who respect others abilities have improved communication and are more likely to take a governance approach and engage in decentralised decision-making (Hoffart & Woods, 1996).

2.3 Generic Management Model (GMM)

Research shows that staff nurses are becoming increasingly dissatisfied in their working environment and this is directly related to a clinical environment with a bigger focus on service delivery; specifically, efficiency and performance management, rather than patient-focused care (Ball & Pike, 2009). In the 1980s the arrival of managerialist health reforms resulted in the New Zealand health system becoming a universal and comprehensive provision funded principally through general taxation. This resulted in all citizens and residents receiving free health care, regardless of age, gender, or socioeconomic status. However, due to a growing, ageing New Zealand population with multiple morbidities, the healthcare system is under financial constraint. As a result, New Zealand has adopted a New Public Management ideology in an effort to reduce public spending and increase efficiency (Minister of Health, 2016; Tingvoll et al., 2016).

As highlighted in the search strategy, the term ‘Generic Management Model’ does not feature regularly throughout literature, however the term ‘New Public Management’ (NPM) is synonymous with the GGM. Kirchhoff & Karlsson (2019) describes the NPM as being “general management”. This is interpreted as management using “general” tasks that are dissociated from the organisational context and thus prior knowledge of work processes is not required. This has been captured in previous studies, revealing that the NPM emphasised the need for effective leaders with managerial skills, but disregarded their professional experience in the clinical setting (Kirchhoff & Karlsson, 2019). Consequently, a nurse applying for a NM role with expert clinical skills or years of leadership experience in a specialty area might be less desirable than a nurse with proven organisational focus and business management competence. The integration of

nursing and management competence is challenging and often results in expert clinicians acting as management novices (McCallin & Frankson, 2008).

Research states that the NM is required to understand the GGM and its focus of improving organisational culture to achieve organisational success; specifically, by setting goals, utilisation reporting, reducing resources and the measurement of performance (Hewison, 1999; Strandås et al., 2019). The GGM aims to improve organisational culture and success by setting goals, monitoring resources, and measuring performance, so it is not surprising that the model's desired characteristics are innovativeness, high motivation, and commitment to the goals of the organisation (Spehar et al., 2012).

2.4 Role Ambiguity

Decentralising decision-making and expanding the NM's responsibilities has resulted in the role having a "generic manager" focus with literature signalling that NMs "have little, if any, connection with their professional training as a nurse" (Rosengran & Ottosson, 2008, p. 166). Consequently, the time associated with completing the managerial and administrative aspects of the NM role does not enable the NM to participate in clinical work which has an inherent problem that will lead to role ambiguity (Ericsson & Augustinsson, 2015). Role ambiguity is best defined as a lack of clarity or uncertainty of one's role, responsibilities, and/or what should be accomplished in the job (Kalkman, 2018; Zhou et al., 2016). A "lack of clarity" suggests an image has been formed, but the details of the image are ambiguous (Kalkman, 2018). For example, when the researcher googled the term 'Nurse Manager', the first image in the search engine was a woman in the clinical setting, donning a stethoscope and holding a clipboard. This image provides little insight into both the professional and operational requirements of the role and what should be accomplished in the job. Because the NM role is unclear and the practical reality is diverse, role ambiguity frequently occurs, leaving NMs struggling to understand the "professional practice "and "generic manager" components of their role and how to work within them (Cameron-Buccheri & Ogier, 1994; Kalkman, 2018).

There are a number of factors contributing to role ambiguity including a lack of quality information, inadequate feedback about performance, fast change in an organisation's

philosophy, a complex chain of command, or an information deficient pertaining to scope of practice, responsibilities and role expectations (Dasgupta, 2012). This is observed in a New Zealand study which investigated the experiences of NMs and discovered that many of the participants had difficulty integrating their clinical expertise with management responsibility. One participant indicated "the NM job description was generic and there were no clear guidelines on what to expect" (McCallin & Frankson, 2010). Another NM commented on an interchangeability of NM titles such as Charge Nurse Manager, Team Leader, and Service Leader, which caused confusion about the clinical and management responsibilities of the roles. These comments suggest a lack of clarity and ambiguous role expectations which can lead to detrimental consequences for both the individual and organisation, such as burnout, stress, job dissatisfaction, poor performance, and poor retention (Dasgupta, 2012).

Several literature articles that discuss role ambiguity have also cited the concept of role conflict, which is best described as the experience of incompatible demands placed upon the individual (Kirchhoff & Karlsson, 2019). This concept is important to note as the NM is expected to work within two incompatible roles: the "professional practice" and "generic manager". This will cause role conflict, anxiety, and stress because the incompatible roles have differing responsibilities and thus provide inconsistent information with regards to what should be accomplished in the job. This inconsistency of information from an organisation leads to feelings of being squeezed or pulled in various directions and illuminates the cross-pressure that NM's experience (Ericsson & Augustinsson, 2015).

2.5 Cross Pressure

Consequently, those experiencing cross-pressure from balancing a dual scope of practice might also experience role conflict because, while they are equipped for the professional practice component of their role, they might not be trained in generic management. The expansion and evolution of the NM role has resulted in work overload and potential for burnout (McConnell, 2002). An inability to cope with the managerial aspects of the NM role has led to frustration and a visible shift to professional practice being the focus, and thus an inability to effectively accomplish the NM role (Laschinger, & Finegan, 2008; McConnell, 2002). Burnout has been directly linked to both poor mental and physical health in the NM, and stressors such as role

conflict, role ambiguity, and cross-pressure, which have a negative effect and are universal catalysts (Dasgupta, 2012; Laschinger et al., 2004). Consequently, burnout is particularly prominent in the NM and is often associated with feelings of emotional exhaustion, depersonalisation, reduced personal accomplishment, and feelings of insufficiency (Dasgupta, 2012).

It is evident in the current New Zealand literature that when a NM experiences a lack of clarity to one's role and responsibilities, they will demarcate professional accountability from "management" accountability (Hughes & Carryer, 2011). This disparity can lead to frustration and tension when navigating between the PPM and GMM—specifically the professional ideals of a NM role versus the realities of the NM role. The NM role has evolved from a focus on professional practice to active participation in service delivery and organisational success. This has resulted in increased accountability in areas of budget, service planning, and human resources which might lead to a devaluation of the Registered Nurse role. In fact, the Royal College of Nursing Institute (2004) reported that the focus of the NM role was managerial rather than professional practice expertise, which in turn left individuals feeling that they lacked clinical credibility amongst their staff and colleagues.

According to Murphy et al. (2018), being a nurse contains as much a philosophical dimension as it does a practical one. This view is supported by Sellman's (2011) research by inferring that professional practice differs from generic management in the fact that it is more than just the ability to perform a task and requires something else. That something else is professional values such as respect, partnership, trust, and integrity that help guide nursing practice (Hoffart & Woods, 1996). It is incredibly challenging for the NM to uphold professional values in a patient-centred way and work within the GMM. This is because the GMM's focus is on achieving organisational success, through cost-efficient employees and the measurement of performance, which seek to control nurses rather than empower them (Cho et al., 2006). Furthermore, Pannowitz et al. (2009) suggest that professional values empower nurses to provide high quality nursing practice, but the discourses of generic management were found to disempower nurses.

The successful NM requires a specific set of skills: emotional intelligence, financial acumen and expert interpersonal skills. However, having exposure and the opportunity to develop these skills as a nurse in the clinical setting is limited (Titzer et al., 2013). Consequently, nurses are often promoted into a NM position based on their clinical expertise and leadership potential rather than formal education, proven organisational focus, or management competence (McCallin & Frankson, 2008). Lang and Thomas's (2013) research found that simple managerial skills such as interpersonal skills and organisational awareness had not been developed in 28 percent of internal leadership promotions, and that these internal leadership promotions failed to succeed in the role. This suggests that individuals who have been promoted to management positions without the appropriate managerial and communication skills will often not succeed, which might have a detrimental effect on organisational success.

The move into management is a critical transition which requires the NM to assemble an entirely new set of skills and often results in expert clinicians acting as management novices (McCallin & Frankson, 2008). The impact of learning managerial skills whilst working within nursing professional practice has resulted in an inability to psychologically adjust to the transition (James-Sommer, 2008). Subsequently, literature has noted the continued ill preparedness for nurses transitioning into the NM role; specifically the lack of training, education, and support has resulted in a number of nurses failing in first-time managerial roles (James-Sommer, 2008; McCallin & Frankson, 2010). Duffield et al (1993) reported that less experienced NMs often experience role ambiguity within the health care organisation—specifically the complexity and the diversity of skills required to accomplish the role. Thus, when considering a transition into the NM role, the minimum preparation should be an undergraduate nursing degree. Duffield et al (2001) states that 20 percent of nursing staff at a Midwest Hospital in the USA held either masters or doctorate qualifications and found that nurses with a higher level of education had greater critical reflection and were adept at decision-making skills. Those that are proficient at critical reflection are more eager to learn, introduce new skills and encourage improvement through shared governance (Yielder & Davis, 2009). Furthermore, those that had undertaken a higher level of education with an emphasis on leadership, management, and healthcare policy have greater success in a NM role (Duffield et al., 2001; Smith & Friedland, 1998).

In New Zealand there has been a shift in nurse education from hospital-training to polytechnic diploma to bachelor's degree, which has had positive benefits for the profession of nursing (Clendon, 2011). However, the nursing undergraduate degree still has an emphasis on clinical practice and little time is spent on developing the leadership, communication and delegation skills required in a managerial role (Clendon, 2011). When a new graduate nurse enters the workforce, they are expected to collaborate with the multidisciplinary team, provide clinical care to patients, advocate on behalf of patients, and delegate to healthcare workers. Therefore, leadership capabilities are critical as the new graduate nurse must be prepared to lead, act, and make decisions autonomously that fit within their professional aspirations and organisational goals (Hendricks, Cope & Harris, 2010). The importance of leadership, beginning at undergraduate level, has been recognised and the issue has been raised anecdotally through discussions with those in the sector, but there is little New Zealand research exploring the potential impact this may have on the future nursing workforce.

2.6 Conclusion

There is evidence in this literature review to indicate that while the GMM and PMM are not mutually exclusive, they both offer advantages and disadvantages for the NM, subsequently supporting the application of both models in healthcare organisations. The NM role has evolved dramatically over time, but still remains the centralising and stabilising structure to successful nursing leadership, management, and quality care in healthcare organisations (Wildman & Hewison, 2009). Though the GMM and PPM have two different approaches their ultimate aim is to provide quality health care and so the integration of both conceptual models is required in order to be successful in the NM role. While today we hold a different perspective on the NM role, understanding both the GMM and the PPM philosophies and motivations encourages us to excavate the relationship between professional practice and management. In an ever-changing New Zealand society, it is imperative that healthcare organisations understand the experiences and perspectives of the NM in order to strengthen and support the role. The literature is adequate enough to argue that there is currently a gap in the understanding of the dual scope of practice of the NM in New Zealand. This study was subsequently developed to explore the phenomenon of cross-pressure that NMs experience when navigating between the GMM and the PPM and how these experiences contribute to organisational culture and performance, with a view of optimising nursing leadership in

New Zealand. In the following chapter the research design and method will be presented.

CHAPTER 3. METHODOLOGY

3.1 Introduction:

By applying a qualitative mode of enquiry, the researcher has acquired an authentic insight of the NM and the phenomenon of cross-pressure when navigating between a PPM of nursing leadership and a GGM of leadership. This chapter will outline the qualitative descriptive methodology which underpins the research and present the methodology used to collect, interpret, and analyse the research data. Furthermore, this chapter will provide an overview of the recruitment and participant selection and provide an outline of the data collection. This chapter also discusses the researcher's attempts to ensure trustworthiness and manage ethical issues throughout the study.

3.2 Methodology:

When commencing a study, the researcher must consider which research methodology is most appropriate to get the best outcome. Research methodology encompasses the specific system of methods, phases, and qualitative or quantitative techniques used (Creswell, 2014; Polit & Beck, 2012). A qualitative technique was chosen to examine this study topic as it allows for a holistic investigation of a phenomenon and will obtain rich narrative data with a focus on human characteristics, insights, and experiences (Creswell, 2014; Polit & Beck, 2012). Therefore, the conceptual and contextual elements of professional cross-pressure in NMs, and the theme and message conveyed about the role expectations are well supported using a qualitative approach.

Quantitative methodology requires the measurement of a physiological problem such as a temperature. However, measuring a psychological problem can be more challenging as humans are inherently complex and diverse making them difficult to "measure" (Polit & Beck, 2012). The qualitative descriptive research design has become popular due to its ability to gain insight from participants regarding a poorly understood phenomenon (Kim et al., 2017). Consequently, for this study the researcher has chosen a qualitative descriptive research design within the interpretive paradigm. Whilst this methodology will not enable the researcher to attach precise numeric values to their research, it can provide a broad view of the human experience.

The following characteristics of qualitative description make it an appropriate research methodology choice for this study:

- It is flexible and changeable depending on what is discovered within the data collection.
- Knowledge of a topic can be enhanced through observation, analysis, and description.
- Benefits from ongoing data analysis that may provide suggestions of hypotheses for studies in the future.
- It encourages naturalistic inquiry.

Sandelowski (2000) states that qualitative descriptive studies are considered the crudest form of inquiry, likely because they are considered non-experimental and claim no particular disciplinary or methodological roots (Polit & Beck, 2012). However, an eclectic design and methodological approach based on constructivist inquiry is considered advantageous when the researcher is wanting to know the who, what, and where of events (Sandelowski, 2000). The use of a qualitative descriptive approach as a methodological tool to generate data and define a state of nature is valuable. Thus, the researcher felt it appropriate to apply this using a survey, which is a common method in qualitative descriptive studies (Koh & Owen, 2000). The purpose of this study was to gain authentic insight and a comprehensive understanding of the phenomenon from the perspective of NMs (Flick, 2014; Polit & Beck, 2012). The study required the participants to complete a survey, which was carried out in a naturalistic setting— a public hospital in New Zealand.

3.3 Ethical Issues:

Ethics is considered the cornerstone of conducting compelling and meaningful research; research ethics requires the researcher to apply a set of moral professional rules to planning, conducting, collecting, and reporting the research (Clark, 2019; Raykov, 2020). Therefore, prior to the commencement of this research study the researcher considered and addressed a range of ethical issues that could arise and how these would be addressed in order to protect the participants, data and potential readers (Massey University, 2010). Firstly, the researcher consulted with a Massey University academic supervisor and the Director of Nursing at a New Zealand hospital about the intentions of the research study. Secondly, the researcher was formally granted ethical approval (Appendix 1) by the Massey University Human Ethics Southern A Committee (SOA

19/56) to use human participants within the research study. Thirdly, the researcher obtained formal hospital ethical approval (Appendix 2) from the organisation's Research Office to conduct the study within the New Zealand hospital. Crucially, the research only began once ethical approval had been granted by both the Massey University and the New Zealand hospital; this ensured the research was meaningful and eliminated exploitation of the individuals being studied (Creswell, 2014). The primary ethical principles considered fundamental to ethical research—beneficence, respect for human dignity, avoidance of conflict of interest, justice, and privacy and confidentiality—will be addressed further.

3.4.1 Beneficence:

Beneficence is the first principle that determines if the research will protect the welfare of and maximise benefits to, the research participants (DePoy & Gitlin, 2016). Therefore, it was critical that the researcher identified, prepared, and managed risk by identifying a beneficial research problem to firstly ensure that the research was gainful, and secondly eliminate exploitation of the individuals being studied (Creswell, 2014). The researcher had an obligation to protect participants from harm and, therefore, ethical principles were incorporated into the survey design to safeguard participants from any physical or emotional harm. The researchers contact details were both visible and available to participants who wished to enquire about any aspect of the research.

3.4.2 Respect for Human Dignity

This second ethical principle of respect ensures that research participants have the right to self-determination and autonomy in their decision-making (DePoy & Gitlin, 2016). Therefore, the researcher recognised that the principle of respect should be adhered to, and offered individuals the option to consent voluntarily, without coercion or duress. To assist the individual in their decision-making, the researcher provided written material which included information about the research process, the participant's commitment, and their right to withdraw from the research study at any point. It was important that the information sheet was clear and understandable in order to provide transparency and full disclosure of the purpose of the study; this was important in establishing both trust and credibility with the participants (Creswell, 2014). Additionally, the researcher was able to avoid unnecessary deception by being honest and truthful with the participants,

the organisation's Research Office, and the Massey University Human Ethics Committee (MUHEC): Southern A

3.4.3 Avoidance of conflict of interest.

Any circumstance that creates risk to professional judgements or activity is considered a conflict of interest. Thus, in order to carry out a research study ethically and maintain trust it is important to minimise and manage conflicts of interest in two ways: first, the researcher's ethical conduction of the study and secondly, the influence of financial or career advancement for the researcher (Romain, 2015). Consequently, the researcher has been successful in avoiding any conflict of interest and maintaining integrity of the research. Qualitative enquiry draws on the importance of the researcher's ability to minimise the distance of the researcher- participant relationships and actively remove any potential power imbalance. Whilst the researcher works as a Clinical Nurse Educator within the New Zealand hospital, and was likely known to participants, there was no hierarchical relation of power. Furthermore, the use of SurveyMonkey was successful in providing an informal, anti-authoritive and egalitarian atmosphere which established power equality (Karnieli-Miller et al., 2009). Disclosure was not required as the researcher's findings were not influenced by any financial, career advancement or intrinsic incentives.

3.4.4 Justice

The third ethical principle is justice which is best described as the participants' right to fair treatment (Polit & Beck, 2012). Therefore, the researcher selected participants based on the requirements of the research; accepting all individuals that met the participant selection criteria. As discussed above, the participants were assured fair treatment by having the right to withdraw from the research study without penalty, and those who chose not to participate in the study were treated in a non-prejudicial manner.

3.4.5 Privacy and confidentiality

The researcher had an obligation to ensure the maintenance of justice and therefore identified that the anonymity and privacy of participants was paramount. This issue was of particular concern due to the small number of NMs within the New Zealand hospital, thus making them a vulnerable population due to an increased the risk of identification

within the research study. To minimise any risk to the researcher and provide further protection of anonymity for the participants the researcher had the General Administrator of Quality Improvement and Patient Safety publish the questions to the organisation's SurveyMonkey account independently in a private setting. SurveyMonkey is private by default, but the researcher was mindful that the demographic questions could likely identify the participants so did not include questions such as gender, ethnicity, or clinical area of work. In addition, to relieve any doubt, the researcher stated that the dissemination of the findings would be assiduously considered to further protect the anonymity of the participants. In accordance with Massey University protocol, all identifiable material will be stored on a password protected computer and only be accessible to the sole researcher; after five years all documents will then be deleted to ensure the participants anonymity in the long term.

3.5 Recruitment, sampling and participants

Whilst this study was mostly dependent on the participation of NMs, it was also developed in conjunction with the hospital's organisational leaders. Therefore, organisational permission was required to recruit and interview participants within the New Zealand hospital. Consequently, during the preparatory phase of this research study, the researcher was required to have discussions about the intention of study with the Director of Nursing, the Associate Director of Nursing- Practice Development and the Research Office Manager. These discussions resulted in the researcher being granted permission to undertake the research study.

Recruitment took place over two weeks and began immediately after the researcher obtained ethical approval from the organisation's Research Office and Massey University Human Ethics Committee (MUHEC): Southern. Recruitment was both verbal and written. Eligible participants were identified and recruited with the help of the Associate Director of Nursing- Practice Development who verbally informed NMs at a nursing leader meeting that this study was to take place. Additionally, a participant flyer (Appendix 3) was sent via email and displayed on the organisation's intranet. Interested and eligible individuals were informed of the general purpose of study, participant information (Appendix 4) and invited to follow a link to the SurveyMonkey (Appendix 5).

During this qualitative descriptive research study, the sole researcher employed purposive sampling to target and recruit a small, niche population. This was an appropriate method because it provided the researcher with the ability to deliberately select a sample based on their job title and usefulness (Polit & Beck, 2012). The researcher identified that the low levels of variability in the sample would reduce any risk of inadequately capturing purposeful results (Polit & Beck, 2012). Furthermore, to create a considerably homogenous sample, participants were only eligible for inclusion if they:

- were a Registered Nurse (RN) with a current practicing certificate *and;*
- were currently employed, at the time of the study, as a Nurse Manager (Charge Nurse Manager, Nurse Manager, Team Leader or Service Leader) in the New Zealand hospital or;
- had worked as a Nurse Manager in the past 12 months at the New Zealand hospital.

In the two-week period following the distribution of the email there were eight participants that responded to the research advertisement. However, only five participants completed the survey in its entirety. The participants had varying lengths of employment; some holding their position for less than two years and some more than ten years. All participants held a professional qualification, ranging from a Bachelor's Degree to Masters. The majority of NMs had undertaken further study and held a postgraduate qualification.

While a sample size of five participants could be considered small, it is typical of a qualitative descriptive study. These studies tend to be small due the fact that purposive sampling is often employed so the researcher can select 'information rich' data that is relevant to the research phenomenon (Vasileiou et al., 2018). The size of the sample in this research study was guided by data saturation; that is, the researcher was informed by the informational requirements and data quality. By using purposive sampling, the researcher was able to obtain adequate data about NMs' insights and perceptions. Thus, a sample size of five participants was considered sufficient saturation and would not threaten the validity or confirmability of the study's findings (Polit & Beck, 2012; Vasileiou, et al., 2018).

3.6 Data collection

According to Polit and Beck (2012), a scale is an instrument that gives a numeric score along a continuum; in methodology, scales permit the researcher to effectively measure the graduation of human feelings to computation of mathematical analysis. Consequently, the researcher has employed an ordinal social-psychological scaling technique, specifically the Likert scale to enable to the ability to assign numeric and verbal scores to the participants attitudes, perceptions and traits (Polit & Beck, 2012). The Likert scale is the most universal method for survey collection and are considered a psychometrically sound way to collect data. The researcher believed the use of a Likert scale was advantageous because its application is fast, cost effective, highly versatile and efficient (Forman, 2014).

Gunderman and Chan (2013) suggests that the Likert scale is useful when the researcher is intending on collecting profound information about attitudes and perceptions. Whilst it provides closed-ended questions participants are unable to select "yes" or "no" and are instead required to take a stance on the topic being presented. Furthermore, question answering is more accurate as responses are presented to accommodate neutral or undecided participants. The participants were asked to indicate how much they agree or disagree with the statements using a 5-point Likert scale, which highlighted the participants' degrees of opinion. Participants were asked to respond to a series of relevant and indirect statements that expressed a viewpoint on the phenomenon of cross-pressure that the NMs experience when navigating between the GMM and the PPM and how these experiences contribute to organisational culture and performance. The researcher recognised the difficulty associated with capturing data about concepts that are typically observable or described, such as opinions and attitudes. This influenced their decision to use a Likert scale as it provided response options that could illustrate the frequency, importance, and quality of a statement (Froman, 2014).

As discussed, originally there were eight participants but only five participants completed the SurveyMonkey in its entirety. All eight completed 'Section A: Demographics' but three failed to complete 'Section B: Nurse Manager Perceptions'. As a consequence, these three participants were removed from the sample and study. The information from the SurveyMonkey formed the basis for data analysis.

3.7 Data analysis

Nowell et al. (2017) state the instrument for data analysis is the researcher; they are required to gather detailed information from participants, contextualise data and create themes. These themes are then developed into theories or generalisations and will be compared with existing literature on the topic. Qualitative research is convoluted and requires rigorous and methodical methods to create useful results, therefore the researcher has used a form of thematic analysis called the general inductive approach to analyse the research data (Nowell et al., 2017; Thomas, 2003).

The application of Thomas' (2003) general inductive approach was considered appropriate because it provides systematic strategies to summarise raw data, establish clear links between the research aims and summary findings, and identify a theory based on the experiences derived from the raw data (Thomas, 2003; Thomas, 2006; Thorne, 2000). One of the advantages of the general inductive approach is it offers an accessible form of analysis for the novice researcher due to its simple and methodical approach to analysis. This approach has enabled the researcher to undertake a systematic reading of the SurveyMonkey data, conceptualise the data, and produce a descriptive summary of a phenomenon. These summaries identified key themes within the data which was a key advantage of using a general inductive approach in a qualitative descriptive research design (Neergaard et al., 2009).

One criticism of the qualitative descriptive research design is that the analytical process is typically subjective, with themes being developed from the interpretation of narrative data moulded by bias and experiences of the researcher (Neergaard et al., 2009). Consequently, suitable evaluative criteria are required in order to avoid prejudice and create a quality study. The researcher was guided by the Lincoln and Guba's (1985) trustworthiness criteria, and appraised the research rigour using credibility, transferability, dependability and confirmability.

3.8.1 Credibility

Credibility is considered an important criterion in establishing trustworthiness. Polit and Beck (2012) state that credibility requires two key features: 1) the application of study methodology that ensures confidence and believability of the study's data and findings and 2) demonstrating credibility to external readers. Credibility was achieved by

applying a purposive sampling method to select only NMs and allowed for the authentic exploration of experiences. Additionally, to ensure an accurate representation of NM's perceptions the SurveyMonkey questions were reviewed by the academic supervisor and the Massey University Human Ethics Committee (MUHEC): Southern, as well as the organisation's Research Office using a stakeholder checking technique (Thomas, 2006). Researcher credibility was considered to establish trustworthiness with external readers; the researcher included their professional credentials in the study and disclosed information about their role as a Nurse Educator within the New Zealand hospital. Furthermore, the researcher provides a detailed description of the data analysis which enables the reader to determine whether the process is credible (Nowell et al., 2017)

3.8.2 Transferability

The concept of transferability is the extent to which the study findings can be generalised or transferred from a representative sample to another setting or group (Polit & Beck, 2012). The researcher chose to use a purposeful sampling method, in which the researcher's knowledge about the sample was used to select the participants. Consequently, the researcher chose participants based on their role title because they were judged to be particularly knowledgeable about the topic being studied. Nevertheless, it is safe to assume that the findings within this study could be transferred to another hospital or organisation because it is thought that globally NMs are experiencing similar issues to the representative sample in this study. This assumption is underpinned by findings within the literature review earlier. However, generalisation of study findings would require careful consideration and transferability would require the approval of the NMs involved in the study.

3.8.3 Dependability

The concept of dependability is driven by the logical reasoning of the researcher, it refers to the stability, reliability and consistency of data over time and over conditions (Polit & Beck, 2012). Firstly, dependability was achieved with detailed and true documentation of the study's research question, qualitative descriptive methodology, data collection and interpretation of findings. Secondly, dependability was gained using an auditing process, whereby the researcher's academic supervisor contributed to thematic analysis, challenged the researcher's findings and confirmed the consistency of the hypotheses.

3.8.4 Confirmability

The confirmability of the research refers to its accuracy, validity, and genuineness. This criterion focuses on verifying that the study's findings represent the participants' narratives and viewpoint rather than potential researcher biases (Polit & Beck, 2012). In order to recognise personal biases and avoid misinterpretation of the findings, the researcher engaged in a personal reflection activity prior to beginning the research, which was useful in identifying pre-existing assumptions of the NM role. One quality-enhancement strategy used by the researcher to ensure confirmability was peer debriefing with their academic supervisor, allowing the researcher to receive feedback from an individual with impartial views and confirm connections between data and the results. The researcher achieved external validation by providing detailed documentation of the participant selection, the data collection process, and the analysis process, which provides the reader with transparency of the research process.

3.9 Conclusion:

This chapter has highlighted the qualitative descriptive methodology used in this study. The researcher has described the approval processes, ethical considerations and the consultation required to ensure a quality study. The researcher provides clarity and reasoning about the participant selection. Furthermore, the researcher justifies the use of a Likert scale and its appropriateness for this study, when used alongside thematic analysis. Consequently, Lincoln and Guba's (1985) trustworthiness criteria have been employed to establish and maintain rigour. Having discussed the methodology underpinning the research the findings, will be explored in the next chapter.

CHAPTER 4. FINDINGS

4.1 Introduction

This chapter presents the findings relating to the insights of the NM and the phenomenon of cross-pressure when navigating between a PPM of nursing leadership and a GMM of leadership. As indicated in the methods chapter, eight participants responded to a survey which consisted of 37 questions. Responses to the questions varied in numbers as outlined in table 4.1.

Table 4.1 – Survey Responses

Questions	**No. of Responses**
1-5	8
6,7,9	7
8	6
10,16	4
11-15, 17-37	5

As this survey was sent out just prior to the COVID-19 pandemic, it is noted that the stress and uncertainty associated with the pandemic has impacted on the numbers responding to the survey questionnaire and is therefore considered a limitation in the response rate.

4.1 Respondent profiling

Survey questions 1-10 profile the respondents in terms of experience and level of education.

In terms of the length of time respondents had been in the role as a NM, three participants (37.5%) indicated they had been a NM for less than two years, three (37.5%) indicated they had been in the role for over 10 years, and two (25%) responding they had been in the role for between two and five years. Question two asked whether respondents had worked in a previous role prior to being NM in their current setting, of which four (50%) indicated they had been working in the either the unit/service/ward prior to becoming the NM and four (50%) indicated they had not worked in that space.

Question three focused on educational qualifications and responses indicate that three participants (37.5%) have a Master's degree, three (37.5%) have a Postgraduate Diploma, one (12.5%) has a Postgraduate certificate, and one (12.5%) has their Bachelor's degree. Questions four, five, and six asked about the type of papers or courses the respondents had undertaken and whether these papers had covered healthcare management of leadership. Two (25%) participants indicated they had studied healthcare management at a postgraduate level, and only one participant (12.5%) had completed a paper on nursing leadership. When asked if they could indicate whether they had completed these papers before they had been offered the role as a NM, the response from seven participants was 'no', with the eighth participant not responding to the question.

Professional development in leadership and management was the focus of the profiling question seven, eight, nine, and ten, with seven of the original participants responding to these questions. Participants' responses to these questions were rather ambiguous and difficult to interpret. Only one participant indicated they had completed professional development in leadership, and yet two indicated they had undertaken leadership professional development before they had been employed as a NM. Four of the seven participants indicated they had completed professional development in management but only one of four participants had done so prior to being employed as a NM.

In summary, these responses highlight that, among the eight participants, higher education was predominant in their career pathways, with seven of eight participants going onto postgraduate and higher studies. However, leadership and management at both a higher education and professional development level was not seen as a precursor for entry into the role of NM. This highlights a potential lack of understanding of what is required in a leadership or management role within the health sector as a nurse and will be discussed further in the next chapter.

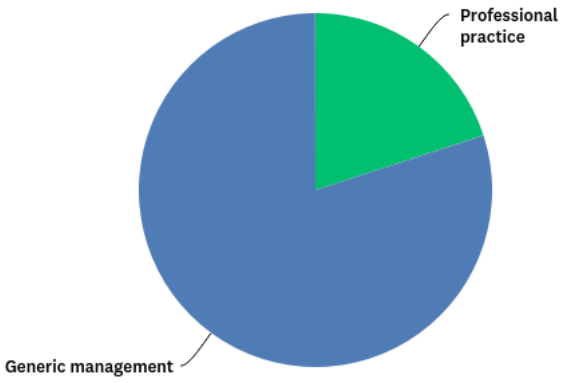
4.2 Professional practice models and Generic management models

Questions 11 to 37 focused on participants understanding of the PPM and GMM. In the information sheet both models were described to provide a context for respondents to understand the terms being used in the survey questionnaire. The PPM is developed

from the perspective that nurses are key to providing superior patient care, through leadership, professional growth and aims to support high quality nursing practice (Hoffart & Woods, 1996; Slatyer et al., 2016).The GMM aims to improve organisational culture and success by setting goals, monitoring resources and measuring performance (Spehar et al., 2012). With these two explanations in mind, the participants were asked to try and clarify how and what they thought of these models.

Question 11 focused on finding out what percentage of the NM role could be attributed to each of the two conceptual models of leadership. Four (80%) of the five participants who completed this section indicated that they felt over 50% of their role was defined by the generic management model. Based on the given understanding of the term, the majority of the participants therefore perceived that the role of the NM was primarily aimed at improving organisational culture and success by setting goals and monitoring and measuring performance. To a lesser extent, the participants agreed that some of their role was in viewing nurses as the key to providing superior patient care through leadership, professional growth, and high-quality nursing practice.

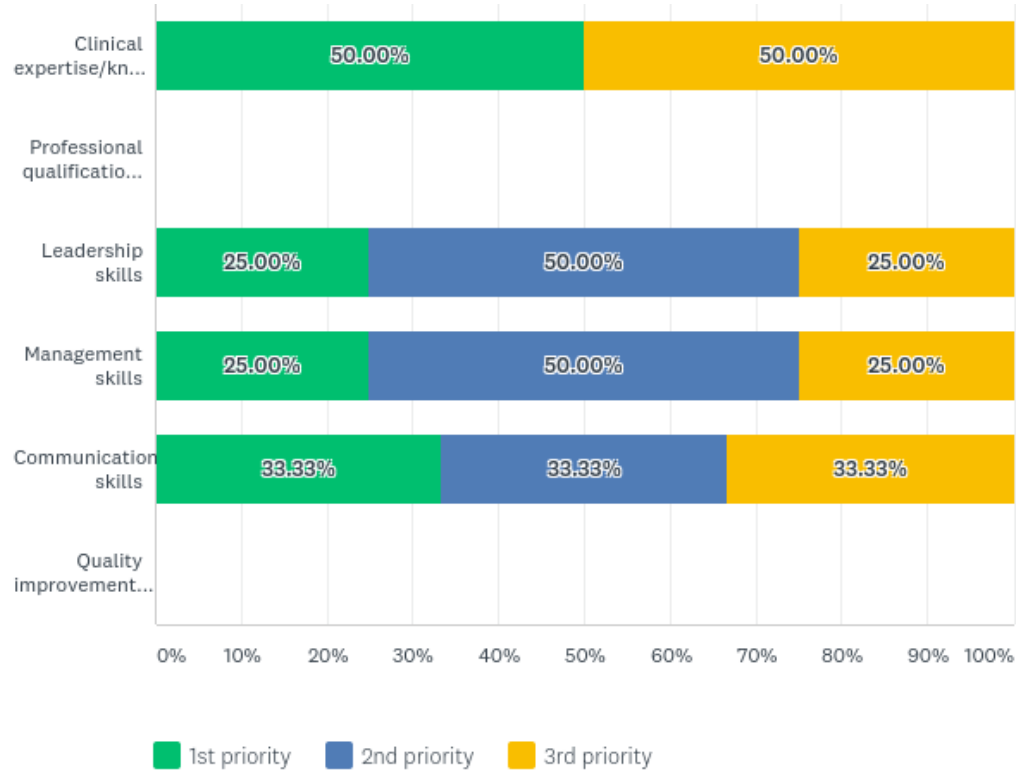
Figure 1. *The proportions of the NM role attributed to professional practice and generic management*



As part of identifying what the NM role looked like, participants were asked to prioritise the three most important skills. In question 12, two participants indicated that clinical expertise was ranked as the first priority, one participant indicated leadership, one management and another communication as the most important skill for role capability. Participants did not rank professional qualifications or accreditation as an important component for being in the role. The findings in this question begin to

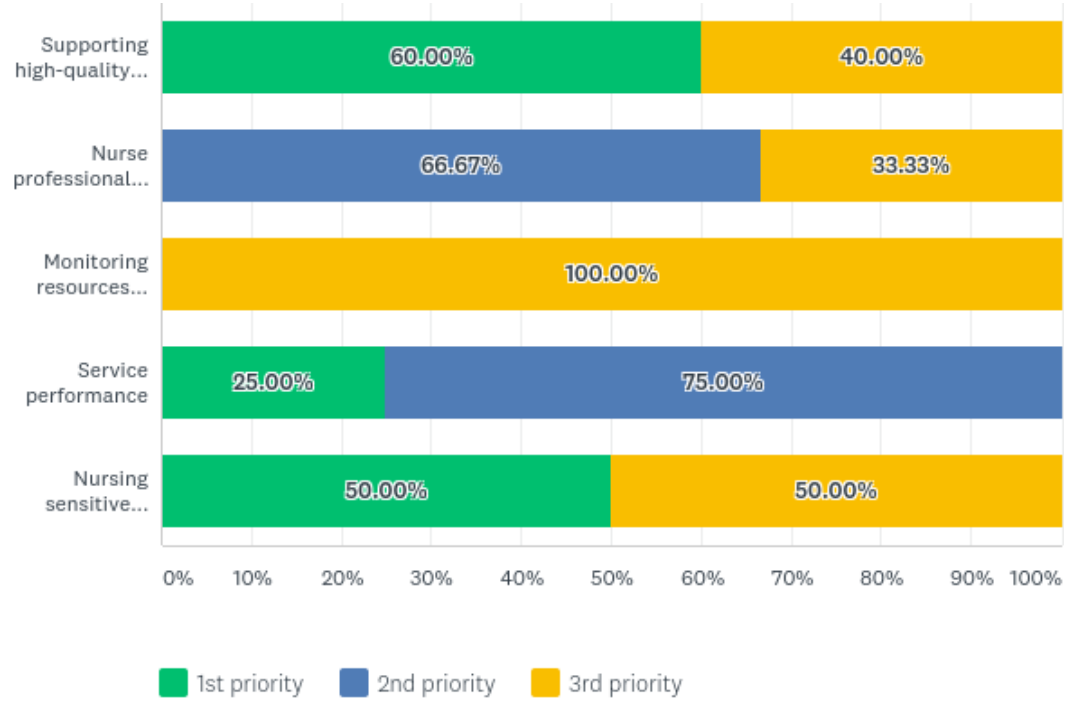
indicate a degree of confusion in the participants understanding of the NM role and the relationship of the role with the two models as they have been defined.

Figure 2. *Participants' prioritisation of the NM role capability essentials in response to the question: What do you believe are the capability essentials to the NM role?*



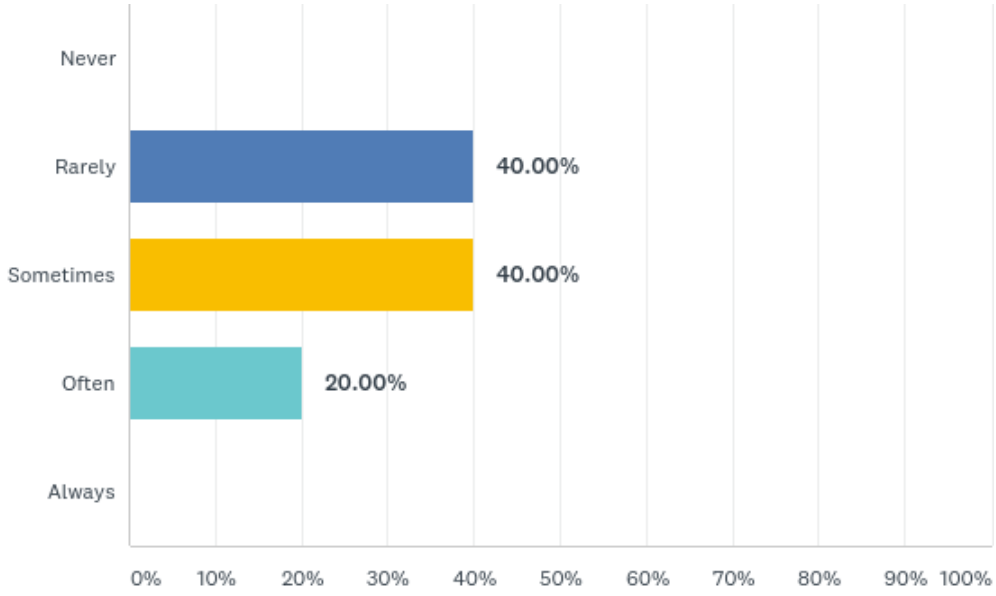
Question 13 focused on day-to-day management and leadership of the NM role. When asked which accountabilities are the most important to ensure a safe patient journey, three participants indicated that supporting high quality nursing practice was the most important priority to ensure a safe patient journey. One participant prioritised service performance and another indicated nurse sensitive indicators were the most important priorities to ensure a safe patient journey. None of the participants indicated that having nurse professional development and recognition or monitoring resources within a defined budget was the most important priority to ensure a safe patient journey. Again, we see evidence in the responses that there is a degree of confusion in the perception of the NM role; supporting high quality practice and being aware of nurse sensitive indicators are seen as high priorities, and monitoring resources within a defined budget is seen as a low priority in terms of the day-to-day management.

Figure 3. *Participants prioritisation of their three most important accountabilities in the NM role.*



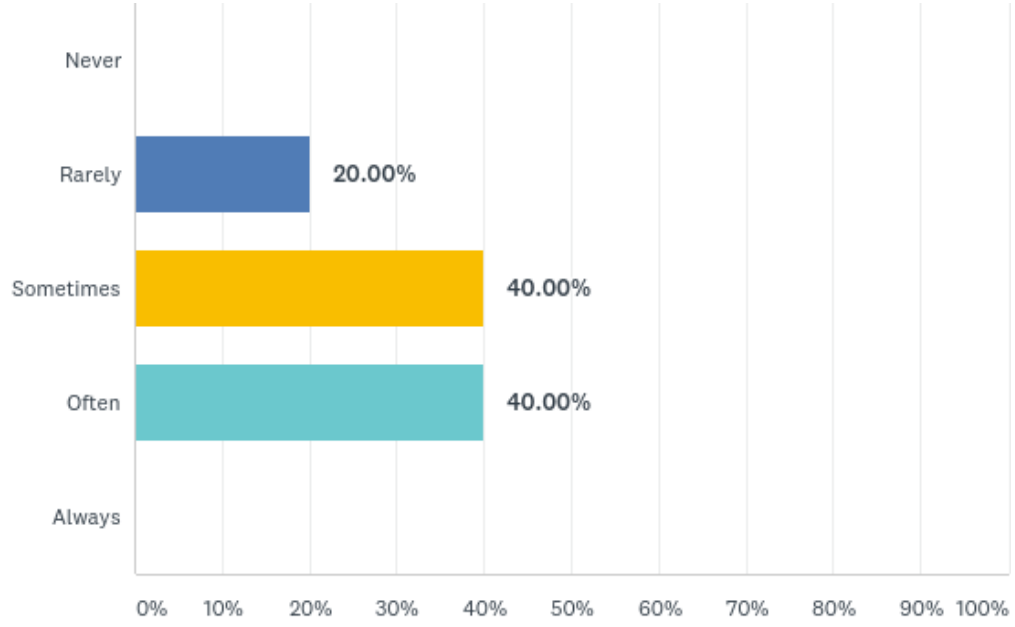
Following on from the role confusion we are starting to see exhibited in the responses from the participants, question 14 asked participants to indicate whether they have experienced ambiguity regarding the expectations of the NM role. Two (40%) of the participants indicated they rarely experience ambiguity, two participants (40%) indicated they sometimes experience ambiguity, and one participant (20%) indicated they often experience ambiguity with regards to the expectations of their NM role. None of the participants indicated they had never experienced ambiguity regarding the expectations of their role. Responses to this question indicate that at a number of levels NMs do experience a degree of ambiguity around the expectations of their role.

Figure 4. *Frequency with which ambiguity is experienced by participants in response to the question: Do you experience ambiguity regarding the expectations of your NM role?*



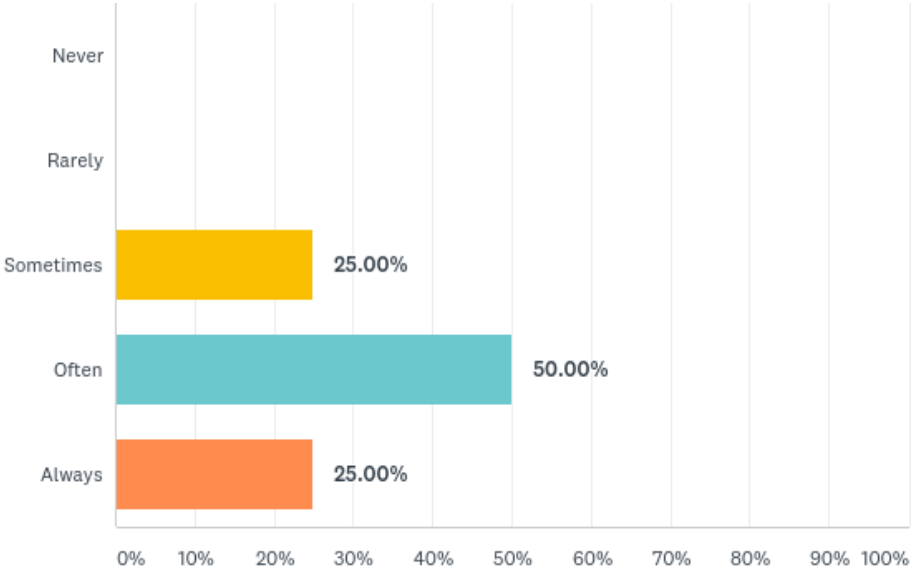
Regarding question 15 participants were asked if they believed they had received consistent information as to what is required to be accomplished in the role. One of the participants (20%) indicated that they rarely receive consistent information, two participants (40%) indicated they sometimes receive consistent information, and two participants (40%) indicated that they often receive consistent information as to what required to be accomplished in the role. None of the participants indicated they always receive consistent information regarding what is required to be accomplished in the role. We see evidence in these responses that indicates that the NM receives varying levels of consistent information around what is required to accomplish their NM role.

Figure 5. *Frequency with which consistent information is provided to participants to accomplish the NM role.*



Question 16 relates to visibility as a leader and NM. Participants were asked to rate whether they believe they are visible to the nurses in their unit/ward/service. Only one participant indicated they were always visible, and the other participants (three) indicated they believe they are often to sometimes visible to nurses in their unit/ward/service. One participant failed to answer this question, so the responses were from four participants.

Figure 6. *Frequency with which visibility is achieved by participants in response to the question: Do you believe you are visible to nurses in your unit/ward/service?*



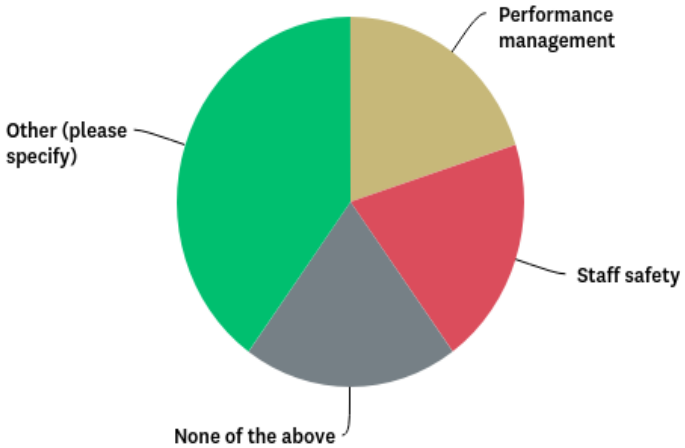
Question 17 focused on what the NMs perceived to be the most challenging whilst supporting the unit/ward/service to be clinically effective. There was a wide range of options including staff conflict resolution, monitoring resources within a defined budget, motivating staff, service performance/ nursing sensitive indicators, implementing organisation changes, supporting nurse professional development, and HR/ performance management. One participant (20%) indicated performance management, and another participant (20%) indicated staff safety. One participant (20%) indicated that they did not find any of the options listed to be the most challenging whilst supporting the unit/ward/service to be clinically effective. The remaining two (40%) chose to specify other challenges they experience whilst supporting the unit/ward/service to be clinically effective. These included:

"Being multi-jobbed. Too difficult to work clinically as part of your full-time FTE especially if shift work."

"An expectation to support and maintain staff safety/clinical practice when upper management and DNM (Duty Nurse Manager) cannot provide adequate staffing due to ailing and clinical requirements."

The findings in this question indicate a degree of cross-pressure in the participants' perception of what is most challenging whilst supporting the unit/ward/service to be clinically effective.

Figure 7. *Participants' perception of what is most challenging in response to the question: As a NM, what do you find most challenging whilst supporting the unit/ward/service to be clinically effective?*



Questions 18 and 19 focused on the participants' perception of peer support. One participant (20%) indicated they always receive peer support, three participants (60%) indicated that they often receive peer support, and one participant (20%) indicated they sometimes receive peer support to provide day-to-day management and leadership of the unit/ward/service. The group that the participants felt offered the most peer support was other NMs; this group was selected by 4 participants (80%). The remaining participant (20%) indicated that their Operational Line Manager offered the most peer support in their NM role. None of the participants indicated that Nursing Leadership or the nurses in their unit/ward/service offered the most peer support. We see evidence in the responses that indicates that the NM receives good levels of support and this is mainly from peers that are also employed as NMs.

Figure 8. *Frequency with which peer support is provided to participants in response to the question: Do you believe you receive peer support to provide day-to-day management and leadership of the unit/ward/service?*

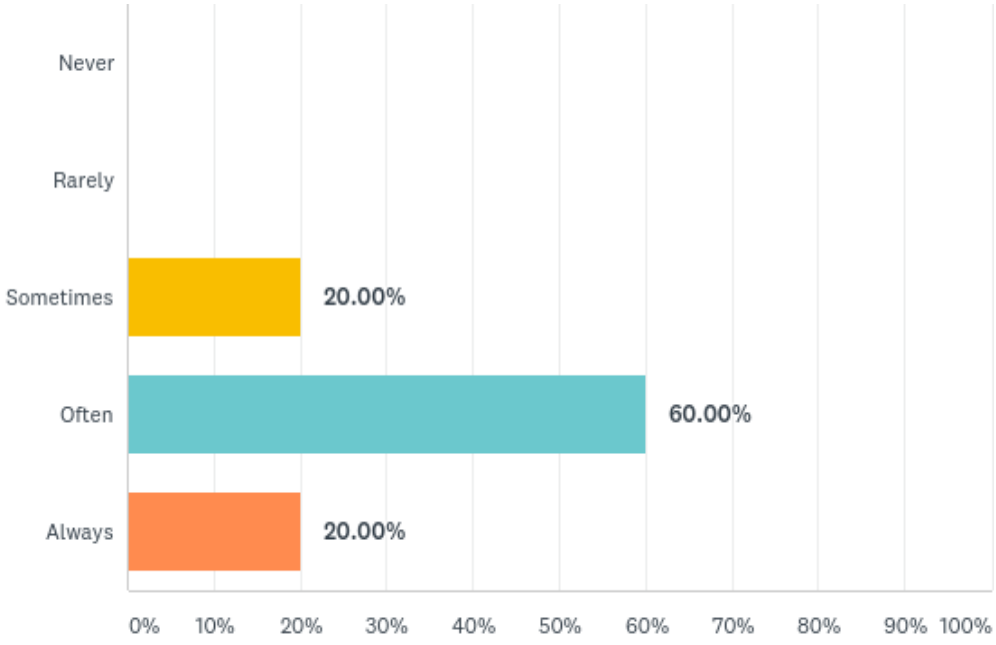
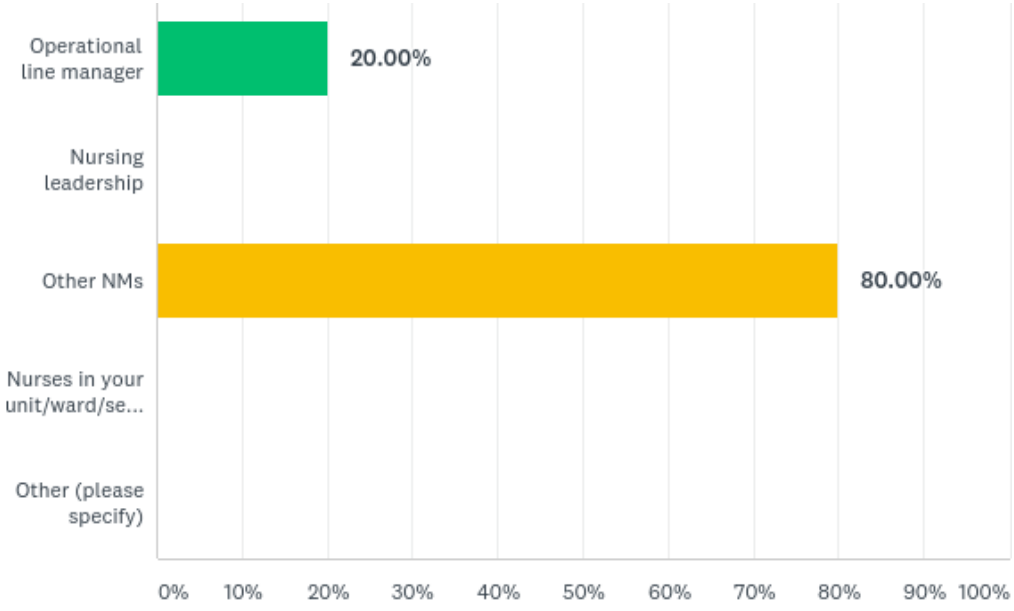


Figure 9. *Participants' perception of which group offers the most peer support in the NM role.*



Questions 20 to 27 focused on the key elements of the PPM. Participants' confidence in enabling the PPM key elements including nursing professional development, staff satisfaction, professional accountability, and nurse autonomy was the focus of question 20. Three participants (60%) indicated that they had moderate confidence in enabling the PPM elements, one participant (20%) indicated that they felt confident, and the remaining participant (20%) indicated they felt very confident in enabling the PPM elements. All participants ranked the PPM key elements as being important in providing high quality nursing practice within their unit/ward/service. In question 21, one participant (20%) indicated that the PPM key elements were moderately important, and the remaining four participants (80%) indicated the PPM key elements were important.

Figure 10. *Rating of confidence experienced by participants in response to the question: In your NM role, how would you rate your confidence in enabling the PPM key elements?*

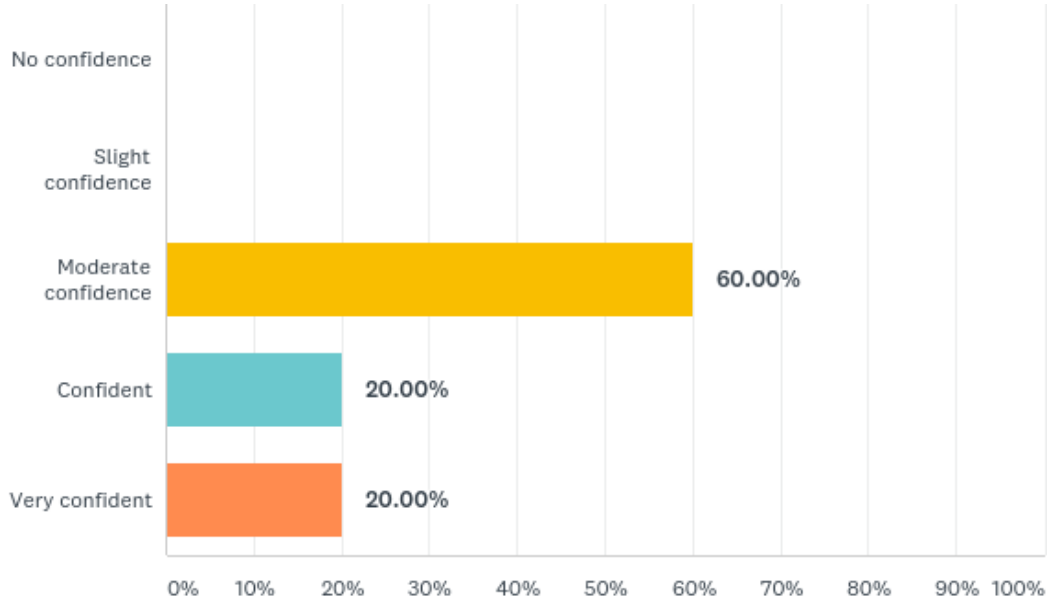
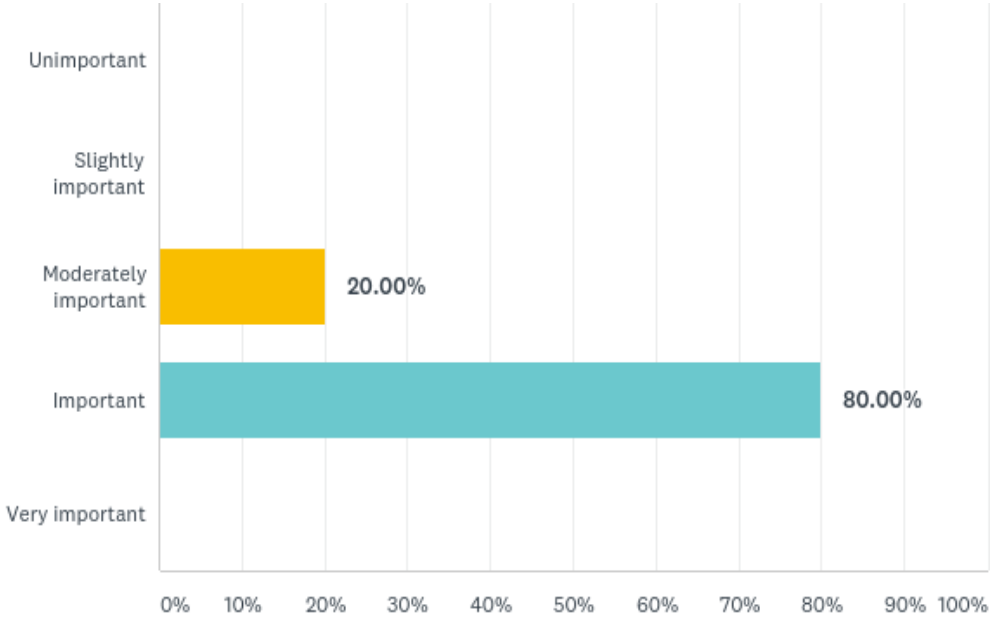
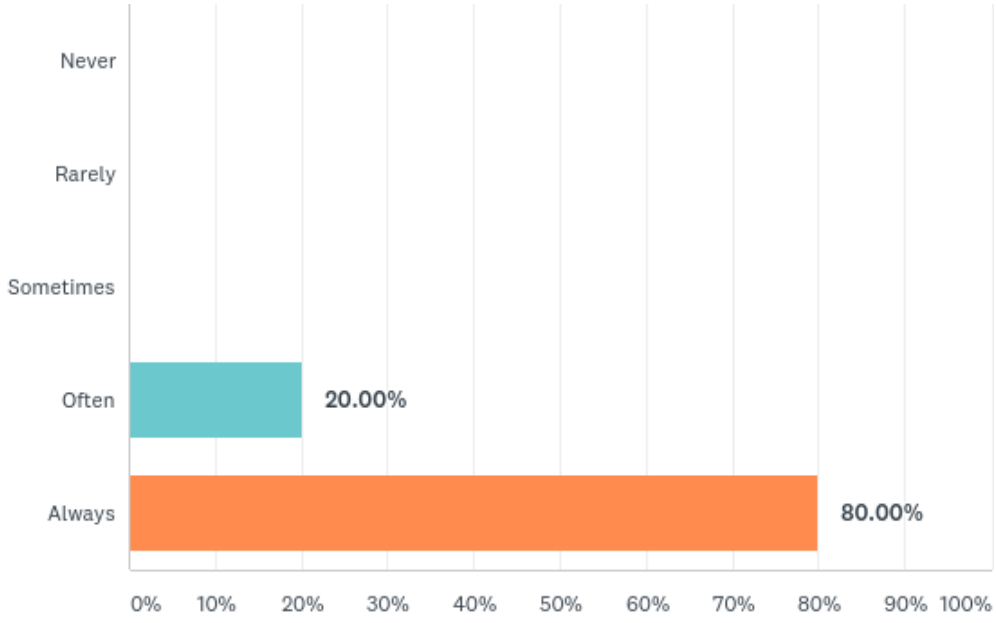


Figure 11. *Rating of importance perceived by participants in response to the question:. How important are the PPM key elements in your unit/ward/service in providing high quality nursing practice?*



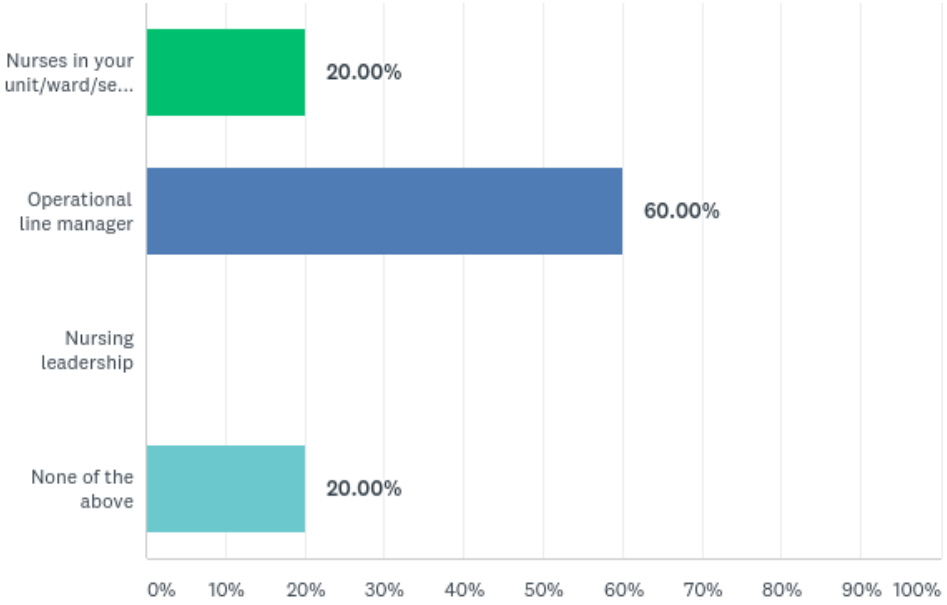
Regarding question 22, participants were asked if they feel professionally accountable for creating a unit/ward/service that provides high quality nursing practice. Four participants (80%) always felt accountable and one participant (20%) often felt accountable for creating a unit/ward/service that provides high quality nursing practice. The findings in this question indicate a degree of pressure felt by the participants to provide high quality nursing practice within their clinical setting.

Figure 12. *Frequency with which professional accountability is experienced by participants in response to the question**:** Do you feel professionally accountable for creating a unit/ward/service that provides high quality nursing practice?*



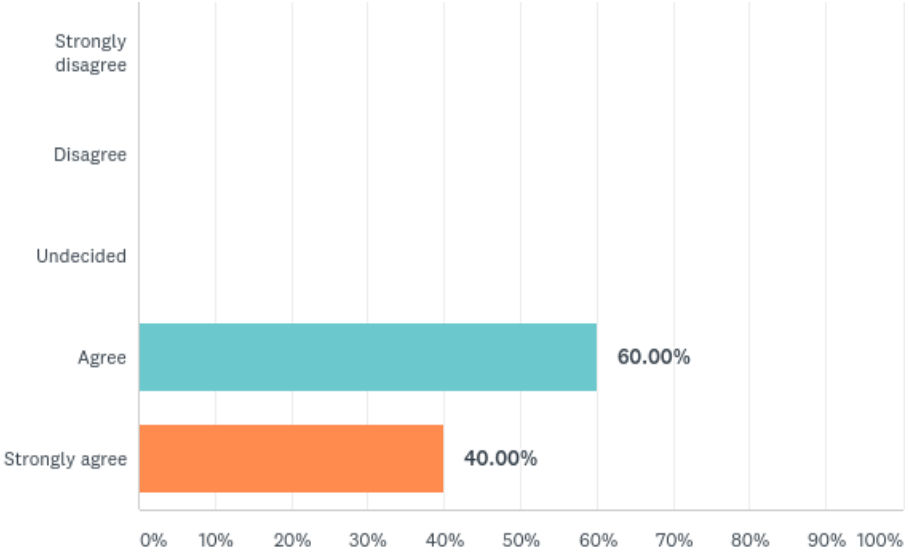
Following on from the feelings of professional accountability we are starting to see exhibited in participants' responses, question 23 asked the participants to indicate which roles place the highest expectations on them to provide high quality nursing practice. Three participants (60%) perceived their Operational Line Manager to place the highest expectation on them in the NM role, and one participant (20%) perceived the nurses in the unit/ward/service to place the highest expectations on them to provide high quality nursing practice. The remaining participant (20%) indicated that nothing listed placed high expectations on them to provide high quality nursing practice.

Figure 13. *Participants' perception of which role places the highest expectations on the NM to provide high quality nursing practice.*



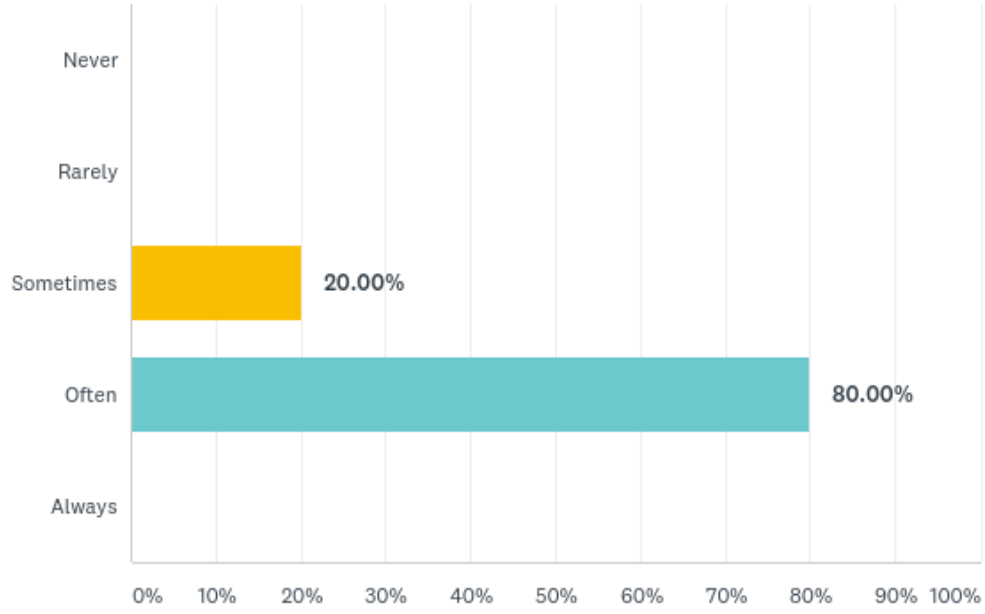
In question 24, the participants were asked if their professional autonomy enables day-to-day management and leadership of the unit/ward/service. Two participants (40%) strongly agreed with the statement and three participants (60%) agreed with the statement. The findings in this question indicate that all participants feel they have high levels of professional autonomy in their NM role.

Figure 14. *Participants' perception of whether the NMs professional autonomy enables the day-to-day management and leadership of the unit/ward/service.*



Question 25 relates to leadership; participants were asked if they believe their professional decision-making in the NM role has a positive influence on nursing team performance. Four participants (80%) felt their decision making often has a positive influence on nursing team performance, and one (20%) participant indicated sometimes. We see evidence in the responses that indicates that the participants perceive their decision-making to have a positive influence on nursing team performance. However, no participants indicated that their professional decision-making always has positive influence.

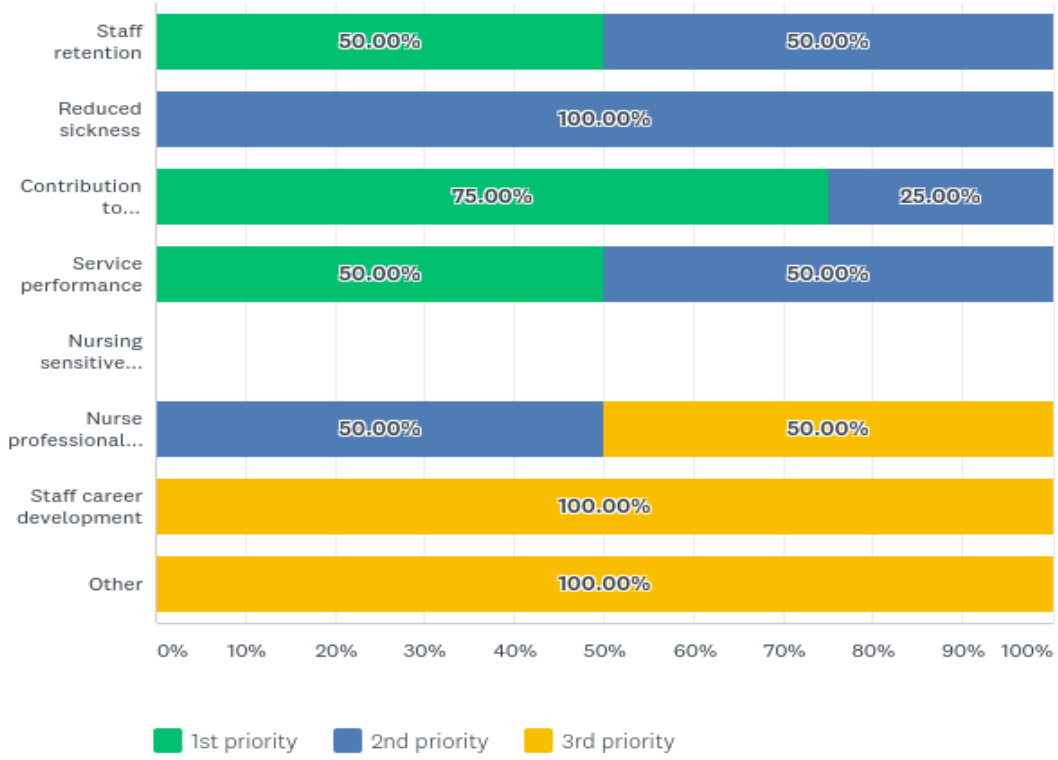
Figure 15. *Frequency with which professional decision-making is experienced by participants in response to the question: Do you believe your professional decision-making in the NM role has a positive influence on the nursing team performance?*



Question 26 relates to staff satisfaction factors, as perceived by the NM. As part of identifying what factors highlight staff satisfaction, participants were asked to prioritise the three most important factors. Three participants (60%) ranked contribution to workplace improvements as their first priority, one participant indicated staff retention, and another indicated service performance as the most important factors in highlighting staff satisfaction. Nurse professional development/education and career development were prioritised third, being perceived by the participants as a factor that was less important in highlighting staff satisfaction. Participants did not rank nursing sensitive indicators as a factor that highlights staff satisfaction. We see evidence in the responses that there is a degree of confusion in the perception of factors that highlight staff

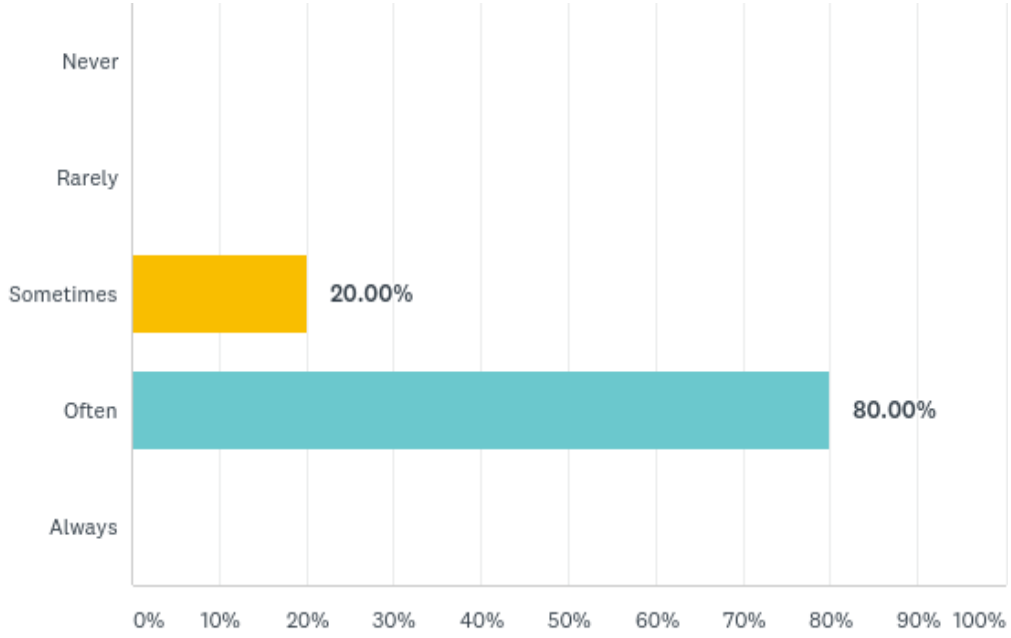
satisfaction with contribution to workplace improvements, staff retention, and service performance being high priorities, and nurse education, professional development, and career development being low priorities.

Figure 16. *Participants prioritisation of the three factors that highlight staff satisfaction.*



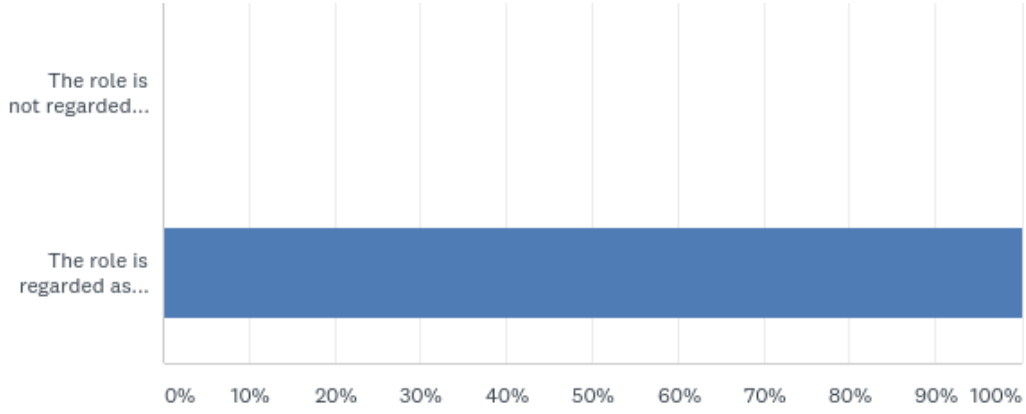
The responses regarding nurse development were interesting because, in question 27, the participants were asked how often they are involved in discussions where nurse development is the focus. Four participants (80%) indicated this happens often and one (20%) participant indicated this happens sometimes. None of the participants indicated that they were always involved in discussions where nurse development is the focus. Therefore, despite nurse education, professional development, and career development being ranked as low priorities, NMs report being involved in many conversations about such development.

Figure 17. *Frequency with which the participants are involved in discussions where nurse development is the focus.*



Question 28 asked the participants how they believe nurses in their unit/ward/service viewed their role in terms of leadership. All participants (100%) felt that their NM role was regarded as authentic in providing leadership.

Figure 18. *Participants' perception of how nurses in their unit/ward/service view their NM role in terms of leadership*



Questions 29 to 36 focused on the key elements of the GMM. Participant's confidence in enabling the GMM key elements including innovation, high motivation, and commitment to the goals of the organisation (i.e. operational focus) was the focus of question 29. Three participants (60%) indicated that they had moderate confidence in enabling the GMM elements, one participant (20%) indicated that they felt confident

and the remaining participant (20%) indicated they felt very confident in in enabling the GMM elements. Interestingly, these findings were the same as response to question 20, when participants were asked about their confidence in enabling the PPM key elements. All participants ranked the key elements of the GMM as being important in providing improved success and performance within their unit/ward/service. In question 30, Three participants (60%) indicated that the GMM key elements were moderately important, one (20%) participant indicated the GMM key elements were important, and one (20%) participant indicated the GMM key elements were very important. The findings in this question begin to indicate that the NM places a greater weighting on the key elements of the GMM than the PPM key elements.

Figure 19. *Rating of confidence experienced by participants in response to the question: In your NM role, how would you rate your confidence in enabling the GMM key elements?*

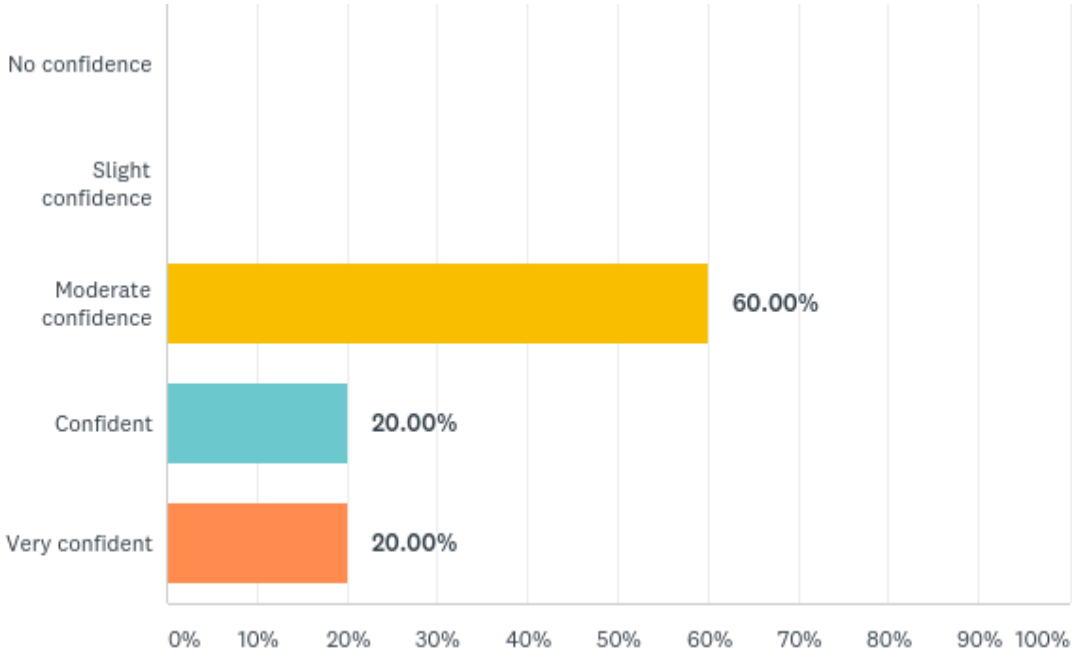
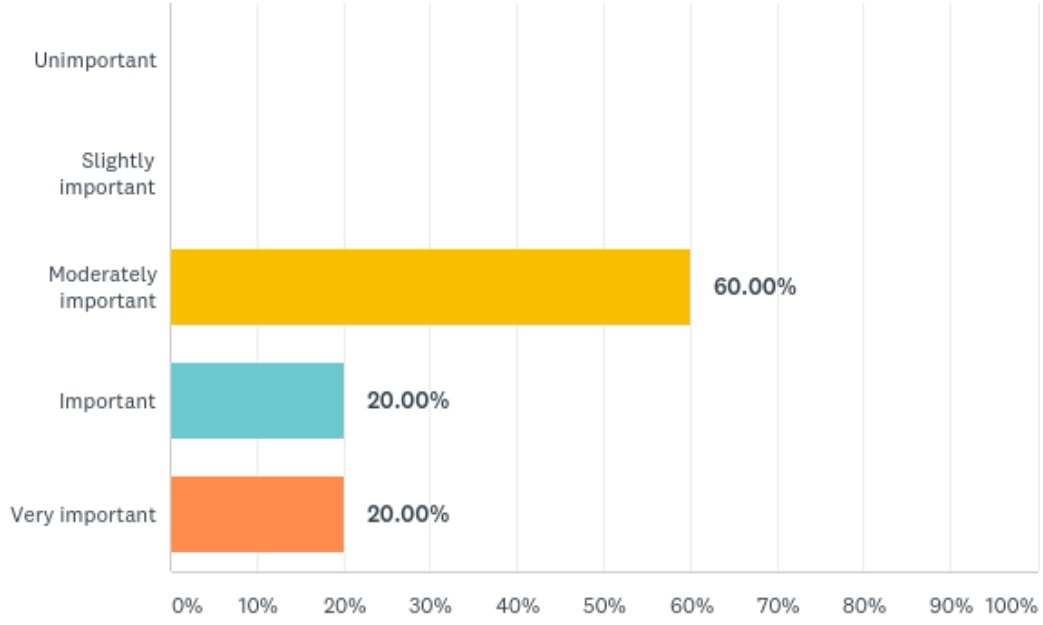
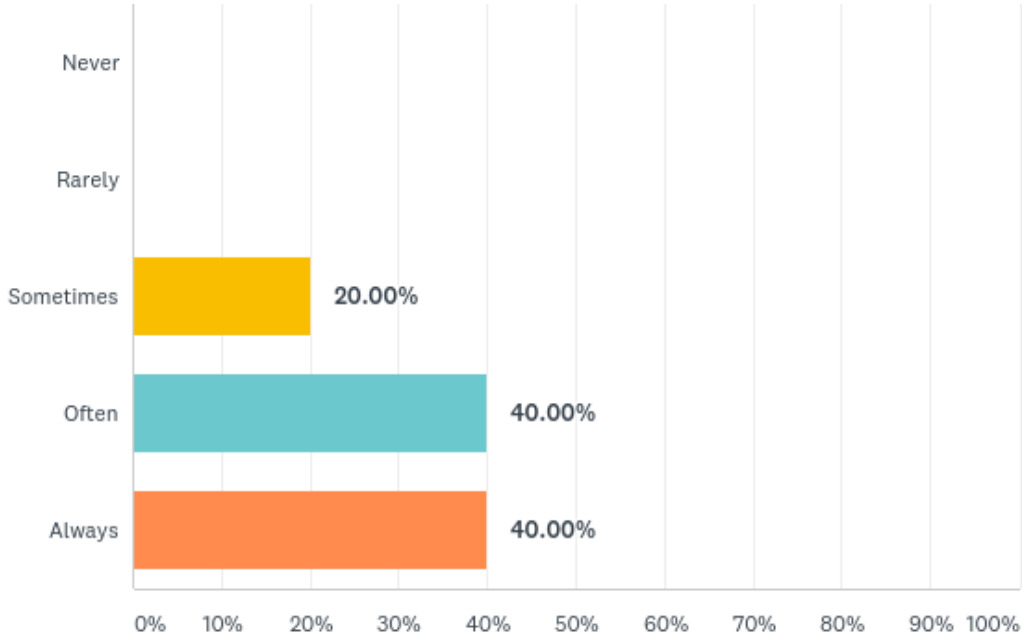


Figure 20. *Rating of importance perceived by participants in response to the question: How important are the GMM key elements in your unit/ward/service in providing improved success and performance.*



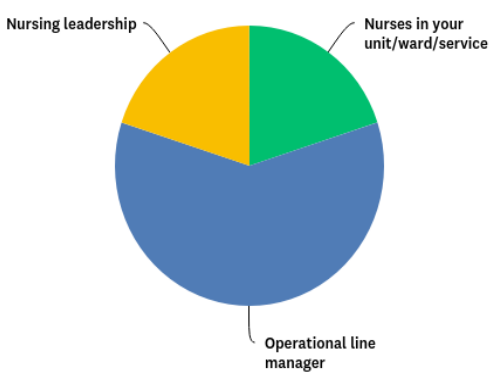
Regarding question 31 participants were asked if they feel professionally accountable for creating a unit/ward/service that provides improved organisational success and performance. Two participants (40%) always felt accountable, two participants (40%) often felt accountable, and one (20%) participant sometimes felt professionally accountable for creating a unit/ward/service that provides improved organisational success and performance. These findings suggest a degree of pressure is felt by the participants to provide improved organisational success and performance in the unit/ward/service.

Figure 21. *Frequency with which professional accountability is experienced by participants in response to the question: Do you feel professionally accountable for creating a unit/ward/service that provides organisational success and performance?*



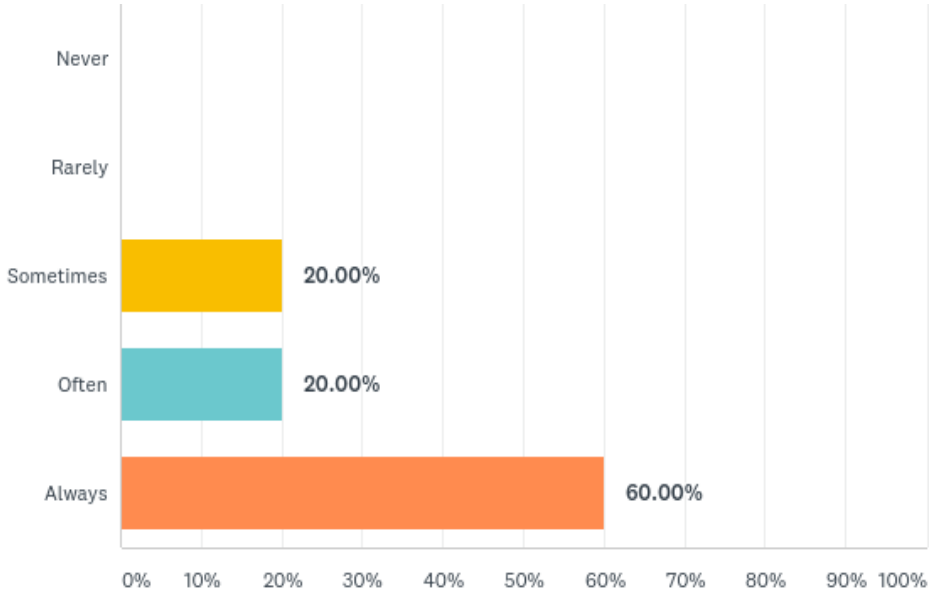
Again, following on from the feelings of professional accountability we are starting to see exhibited in the responses from the participants, question 32 asks the participants to indicate which roles place the highest expectations on them to enable organisational success and performance. Three participants (60%) perceived their Operational Line Manager to place the highest expectation on them in the NM role, one participant (20%) perceived nursing leadership, and another (20%) perceived the nurses in the unit/ward/service to place the highest expectations on them to enable organisational success and performance.

Figure 22. *Participants' perception of which role places the highest expectations on the NM to enable organisational success and performance.*



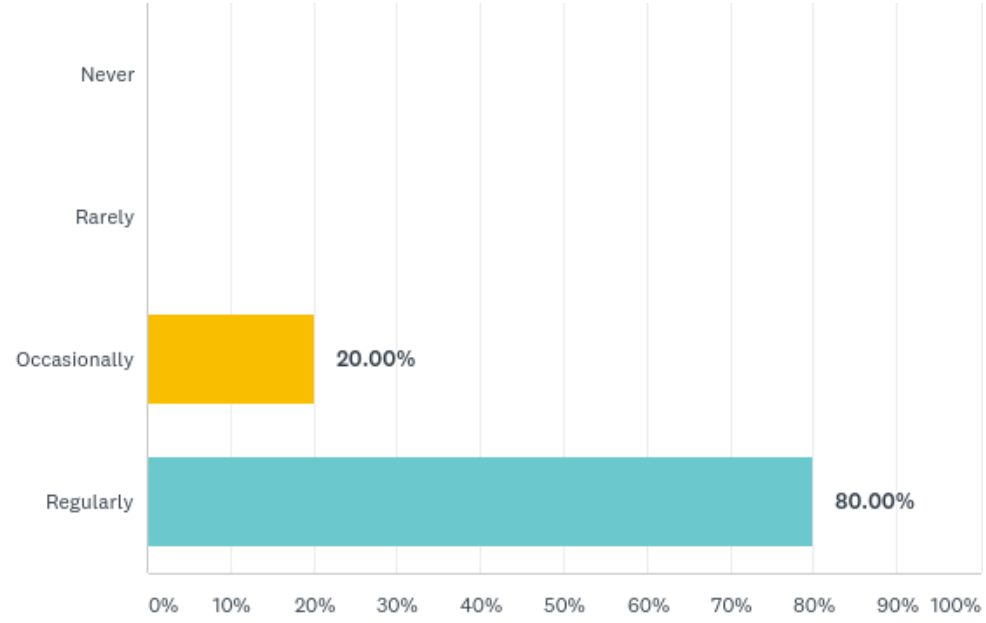
Question 33 relates to improved performance; participants were asked if they believe their management decision-making in the NM role has a positive influence on nursing team performance. Three participants (60%) felt their decision making always had a positive influence on nursing team performance, one participant (20%) indicated often, and one participant (20%) indicated sometimes. We see evidence in these responses that indicates that the participants have varying perceptions relating to management decision-making in the NM role.

Figure 23. *Frequency with which management decision-making is experienced by participants in response to the question: Do you believe your management decision-making in the NM role has a positive influence on the nursing team performance?*



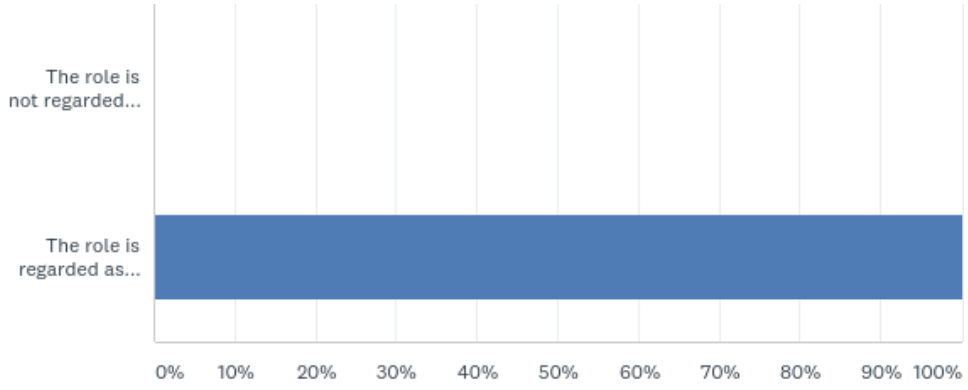
Following on from nursing team performance, question 34 asked participants how often they were involved in discussions where unit/ward/service performance is the focus. Four participants (80%) indicated this happens regularly and one (20%) participant indicated this happens occasionally. None of the participants indicated that they were never involved in discussions where unit/ward/service performance is the focus.

Figure 24. *Frequency with which the participants are involved in discussions where unit/ward/service performance is the focus.*



Question 35 asked the participants how the Operational Line Manager they report to viewed their role in terms of leadership. All participants (100%) felt that their NM role was regarded as authentic in providing leadership.

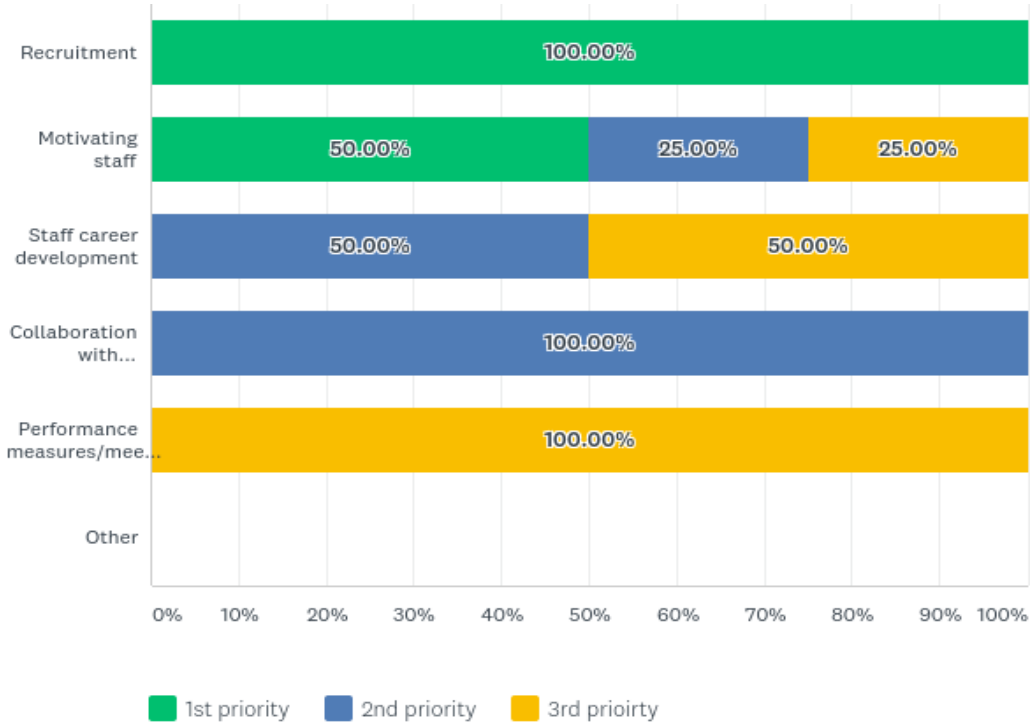
Figure 25. *Participants' perception of how the Operational Line Manager views their NM role in terms of leadership*



Question 36 relates to organisational culture and success; participants were asked to prioritise the three most important aspects of the NM role that enable them to improve organisational culture and success. Three participants (60%) indicated that recruitment was ranked as their first priority, and two participants (40%) indicated that the NM's ability to motivate staff was the most important aspect in enabling improved organisational culture and success. Motivating staff is a key element of the GMM and

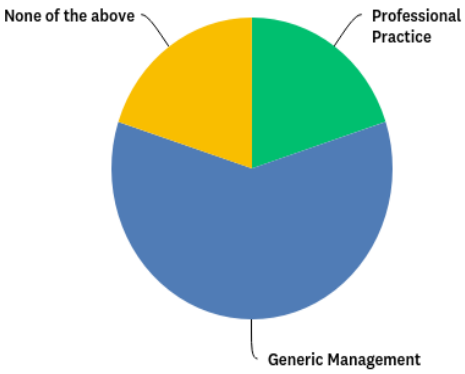
was ranked by four out of five participants at varying levels of priority. However, performance measures and meeting targets—another key element of the GMM—was prioritised third, being perceived by three participants as an aspect of the NM role that was less important in enabling improve organisational culture and success.

Figure 26. *Participants prioritisation of the three aspects that enable the NM to improve organisational culture and success.*



Professional development in professional practice or generic management was the focus of the question 37. Participants were asked if seeking professional development which type would they prioritise; professional practice or generic management. This question brought a rather mixed set of responses with three participants (60%) indicating that they would seek professional development in generic management, one participant (20%) indicating they would seek professional development in professional practice, and one participant (20%) indicating they would not seek professional development in either.

Figure 27. *Participants prioritisation of professional development in the PPM or GMM.*



This chapter presented the research findings of a study examining the insights of the NM and the phenomenon of cross-pressure when navigating between a PPM of nursing leadership and a GMM of leadership. The following chapter discusses these findings in relation to the literature and makes recommendations for the education, support and future development of the NM role.

CHAPTER. 5 DISCUSSION

5.1 Introduction

Following on from the findings chapter, four main themes emerged from the data captured from the questionnaire: (1) role confusion, (2) level of expectation, (3) support, and (4) professional development. These themes are thought to be significant because they replicate themes already identified in the existing literature, support the notion that there is tension inherent in the NM role, and influence how the NM perceives the PPM and GMM in terms of their role and what they are accountable for in their day-to-day work. These themes also support the premise indicated in the first chapter that NMs have a role that is evolving and is subject to cross pressure due to the different and often conflicting styles of managing in the clinical setting.

5.2 Role confusion

The first theme that was identified was role confusion. The role of the NM requires a complex set of interactions to occur, and at the heart of this triadic set of relationships is balance. The NM has to balance between "the use of self, use of staff and use of delivery systems" (Duffield, 1991, p. 1247). This complexity and need to balance the three different relationships have led to a broad interpretation of the NM role and function, and, in turn, a sense of role confusion. These ambiguities with the role emerged in the findings, specifically related to the NM role expectations. Question 14 asked participants if they experience ambiguity regarding the expectations of their NM role; all participants who responded to the questionnaire indicated they had experienced role ambiguity. In addition, question 15 inquired about the frequency with which consistent information was provided to participants to accomplish the NM role. None of the participants surveyed felt they always received consistent information as to what should be accomplished in the NM role. These findings suggest that all the participants have experienced a level, or levels, of role confusion at various times. Samson et al. (2012) discussed how role ambiguity can place stress on individuals in the workplace due to the different nuances that are inherent in a particular role. The ambiguity is illustrated by how the demands of the role, or the set of behaviours that are associated with the position, are unclear, and individuals become uncertain about what the expected behaviour might be. These findings highlight the perceived ambiguity associated with expectations of the role and how these expectations differ from what is accomplished within the parameters of the role.

Question 11 focused on establishing the percentage of the NM role that could be attributed to each of the two conceptual models of leadership. Participants were asked if they view their NM role to be mostly (more than 50%) professional practice or generic management. Eighty percent (4) of participants felt that their role was predominantly centred in generic management and twenty percent (1) felt it was mostly centred in professional practice. The fact that the NMs viewed their role to be mainly generic management was in direct contrast to what participants selected as being the three most important capability essentials of the NM role. Eighty percent of the participants selected clinical expertise as being important and forty percent selected clinical expertise as being the most important capability essential. These findings suggest that the participants felt they needed to be clinical experts and hold a certain level of clinical credibility prior to and after assuming the managerial role. However, the NM who is juggling the day-to-day management, leadership, and continual demands of a clinical area has very little time or energy to maintain a superior level of clinical skill and clinical credibility (Jeffs et al., 2018). This highlights a potential issue concerning capabilities essential to the NM role—should clinical expertise be considered an essential capability for the role given the conflicting requirements under the GMM?

Conversely, skills in leadership, communication, and management were also popular key capability essentials selected by participants. Leadership skills and management skills were the second most popular capability essentials, both being selected by forty percent of participants. None of the surveyed NMs viewed quality improvement as a first, second, or third choice when considering important capability essentials for the NM role. This was thought-provoking as the majority of participants perceived their role to have a generic management focus. However, with NMs not indicating that quality initiatives were important, there is a conflict of perception for the GMM as quality is a key component of the model which aims to improve organisational culture and success through quality improvement projects. Furthermore, the findings show that the majority of participants perceive the key capability essentials of the NM role to be nursing clinical expertise, relational processes and soft skills which would typically support the PPM rather than the GMM.

Furthermore, when participants were asked which three accountabilities they consider to be the most important to ensure a safe patient journey one hundred percent selected high-quality nursing practice as one of the three, and forty percent chose this as their number one priority. Eighty percent of NMs indicated that service performance was important, and sixty percent of the participants selected this as their number two priority. It is interesting to note that monitoring resources within a defined budget was not considered of major importance to the participants, being selected by twenty percent of participants and only as a third priority, although budgeting is a key skill of the GMM. With the majority of participants perceiving NM role as one of generic management but not viewing resourcing and budgetary processes as being important in ensuring a safe patient journey again there is a conflict in the perception around PPM and GMM. This highlights a disconnected perception of how the participants view the NM role and suggests that NMs prefer to exercise their previous nursing skills and clinical knowledge to promote a safe patient journey, even though they believe they are adapting generic management skills to do this. It also highlights how the NM can view the role as being that of one underpinned by GMM principles but struggle with the expectations of the role because they are applying PPM perceptions.

In general, the research findings resonate with the existing literature. It is widely recognised in the general literature that the NM role is pivotal to ensuring a safe patient journey and successful delivery of quality health care (Wildman & Hewison, 2009). Several international researchers have highlighted the complexity and dual-role of the NM but there is little known about the dual-role of the NM in a New Zealand context (McCallin & Frankson, 2010; Miltner et al., 2015; Udod et al., 2017). This research has highlighted that the New Zealand NM wears two hats: they deliver clinical care and serve as administrative leaders. The NM is expected to know the accurate standards of clinical competency and ensure that the highest quality of care is delivered as well as ensuring that the clinical area is aligned with the organisational goals of the hospital. Due to the variation of responsibilities within the NM role there is a broad interpretation of the role expectation and function leading to role confusion. There are several articles which support this finding with NMs indicating that they had experienced role ambiguity at varying levels and had difficulty integrating their nursing professional practice with their generic management responsibility (Cameron-Buccheri & Ogier, 1994; Ericsson & Augustinsson, 2015; Kalkman, 2018; Rosengran & Ottosson, 2008).

Dasgupta (2012) stated that a lack of quality information, or an information deficiency pertaining to NM scope of practice contributed to role ambiguity, and a New Zealand study highlighted that a lack of clarity and ambiguous role expectations meant that many of the participants had difficulty integrating professional practice with management responsibility (McCallin & Frankson, 2010). This is a true representation of reality as although most of the participants in this research indicated they felt they received consistent information, all reported experiencing role ambiguity at varying levels, signifying a degree of confusion or uncertainty within the NM role.

As the focus of the NM is divided between professional practice, with its associated professional values and, generic management with its associated organisational values, the present findings would suggest that the perceptions and understanding of the NMs of the two models has created a potential for confusion. Stanley (2006) states that it is not uncommon for the NM to experience a "confusion of identity", which can be associated with ineffective leadership and management, or even dysfunctional clinical care, and therefore poor quality care. Role confusion is likely due to preconceived, traditional ideas of what the NM role and responsibilities should be, or confusion between generic management and professional practice values (Stanley, 2006). This research also resonates with the existing literature, as the research findings revealed a mismatch between "professional practice" and "generic management". In this case the NM's considered their role to be predominately generic management. However, when asked what they would consider an important capability essential of the NM role all the participants selected clinical expertise before a generic management capability essential. Despite the NM belief that the role is predominantly generic management, it is clear from the research that the NM would prefer to use their clinical expertise, relational processes, and soft skills to promote quality care.

The "confusion of identity" is compounded by the NM's belief that an individual should hold a certain level of clinical expertise prior to and after assuming a managerial role. The importance of clinical credibility is evidenced in the literature with Spehar et al (2014) suggesting that there are institutional rules and norms within the hospital setting, including the perception that power lies in clinical expertise rather than formal position power. This is reflected in this study by the NM favouring clinical expertise to promote quality care. Clinical expertise is a hybrid of practical and theoretical knowledge that

enables the NM to have an intuitive grasp of the clinical environment, accurately diagnose and respond without wasteful consideration (Bennis & Nanus, 1985; McHugh & Lake, 2010). However, this clinical expertise can act as a restraint for action, specifically when the NM is attempting to gain strategic leverage upwards in the organisation. Clearly the NM must be aware of the accurate standards of clinical competency to ensure their clinical area provides quality care but it is important that the NM is able to differentiate between the PPM and GMM in order to recognise what influence strategies should be used in their dual role. In addition, because of the importance that the NM places on being perceived as a professional role model, a focus of the GMM can make them feel as though their clinical credibility is devalued, leading to role confusion, frustration and a shift to the PPM being the focus (Hughes & Carryer, 2011).

One of the factors that may be impacting on NM's and the need to focus on PPM is found in the profiling questions where it is noticeable that having management expertise and skills in either educational qualifications or experience is relatively lacking. NMs might be utilising their PPM skills as that is what they feel comfortable and able to do as they plan their day-to-day working. This is reflected in the lack of clarity and expectations of their role.

An unclear definition pertaining to the NM scope of practice, responsibilities and role expectation results in a lack of role clarity and serves as the basis for the phenomenon of role confusion (Dasgupta, 2012; Gray et al., 2013). McCallin and Frankston (2010) undertook a New Zealand study that suggested that the interchangeability of the NM title created confusion about the clinical and management responsibilities of the role. This was apparent when undertaking this research as there was a clear anomaly regarding the NM role titles within the New Zealand hospital, such as Charge Nurse Manager, Nurse Manager, Team Leader and Service Leader. An emphasis on role clarity for the NM is encouraged, and the NM role should be carefully designed and evaluated so that individuals can clearly identify and interpret the role expectations in order perform the NM role effectively, regardless of differing titles. In addition, consideration needs to be given to the level of managerial expertise the NM may have had or requirement to undertake the role which leads into the second theme, that of the level of expectation.

5.3 Level of Expectation

The NMs surveyed reported feeling that the professional autonomy within their role enables them to provide day-to-day management and leadership of the clinical area. The participants all agreed that they had the autonomy to make decisions within their clinical area and act in accordance with their professional judgement. However, when asked if their professional decision-making in the NM role had a positive influence on nursing team performance, none of the participants felt their decision-making always did; in-fact, twenty percent of participants felt their decision-making only sometimes had a positive influence on nursing team performance. This suggests that NMs feel that they are responsible for managing the clinical area and leading the frontline nursing workforce. However, they perceive that their decision-making does not always support the nursing team, or that their influence was not evident. Being able to influence as a manager is often seen as a positive attribute in developing and growing the team. Leadership literature indicates that transformational and servant leaders often produce high performing teams, resulting in the effective delivery of high-quality patient care (Alloubani et al., 2019; Eva et al., 2019). Stanley (2016) also outlines the benefits of authentic leadership where nurse's role model leadership and are influential through role modelling. The perception that the NMs reported not seeing consistent positive influence on their team could result in job-related stress as the NM is expected to create a clinical environment that promotes positive nursing care, and the NM's job performance and competence is benchmarked by the quality of care delivered by the nurses in the clinical area (Warshawsky et al., 2020).

Extensive experience in the NM role is a top predictor of NM competence and is considered a vital component in achieving enhanced NM performance. However, eighty percent of the participants in this study have less than five years of NM experience. This finding highlights the lack of experience currently prevalent in the nursing context in New Zealand, but also raises the question of who will fill the gaps when the current 'baby boomers' retire. The indications are that the gap would be filled by Millennials with only five or so years' experience in the clinical setting, raising the question of how DHBs will ensure future NMs receive the training they will need to fulfil the role (Warshawsky et al., 2020). This highlights an additional stress burden as the NM's job

performance is less likely to be influenced by their past NM experience and the competencies necessary for success in the role will need to be learned rapidly.

The role of the NM has become increasingly demanding with the requirement for a broader set of responsibilities in management, leadership, and professional practice. Challenges are intense, as the NM role demands multidimensional leadership and management skills. As noted in question 17, participants within the study did not agree on one common challenge; in-fact, sixty percent of the participants did not identify with any of the nine options listed, instead choosing to select "other". This highlights the size and complexity of the NM role, and the pressure these individuals are under when trying to navigate the PPM and GMM. Two participants commented on the most challenging aspects of their job whilst trying to support their area to be clinically effective. Participant one indicated that with the need to integrate both clinical and management tasks there were competing priorities, and that the issues with doing this were compounded by also being on shift work. The dual role with the combined expectations was challenging as there were multiple demands from a variety of sources that ranged from the patient and their whānau, nursing staff, and the wider organisation. So, the span of control within the NM remit was both wide and deep:

"Being multi-jobbed makes it too difficult to work clinically as part of your full-time FTE, especially if it is shift work". (Participant 1)

This begs the following questions: Is the NM role simply too big? Are the NMs' appointed spans of control too ill-defined and large for the actual role? Are the expectations of the role realistic?

This last question is echoed in the comment from participant three which raises the question of support for the role and the resourcing requirements for the workplace for which the NM has control:

"The expectation to support and maintain staff safety and clinical practice when upper management cannot provide adequate staffing due to ailing and clinical requirements". (Participant 3)

There is a conflicting dualism between the PPM and GMM that highlights how NMs want to provide high quality nursing practice whilst trying to work within the fiscal resource constraints of the clinical environment. This dualism has the potential to be a catalyst to role stress and overload and adds to the conflicting identity of the role itself.

As indicated in the findings for questions 22 and 23, NMs appeared to put a great deal of expectation and pressure on themselves, with eighty percent of NMs "always" feeling accountable for creating a clinical environment that provides high quality nursing practice. Some of the NMs also had additional expectation pressure from nursing staff, nursing leadership, and Operational Line Managers. However, Operational Line Managers were cited as the group that NMs perceived placed the highest expectation on them to provide high quality nursing practice, service delivery, and organisational success. In the chain of command in DHBs, NMs have dual reporting lines and professionally report through to the Director of Nursing and operationally to the Operational Line Managers (Hughes, 2013; Hughes et al., 2015). Therefore, expectations for performance will be higher from the operational line manager as the overseer of the budget and resources. It is in this space that the responses have indicated the conflict around expectations of the role, as the NMs see the driving force for effective patient outcomes as focussing on clinical practice and the operational line manager's expectations revolve around budgetary and resource constraints. The multidimensional aspects of the role, with the expectations of working in both PPM and GMM, therefore leads to feelings of being squeezed or pulled in different directions (Ericsson & Augustinsson, 2015).

Being able to manage and mitigate the stressors that are part of this dual performing role enable the NM to perform as both a professional and a manager and in turn enables the organisation to meets its expectations of providing effective patient outcomes and care (Bakker & Demerouti 2007; Goldsby et al., 2020). However, as indicated by question 17 there appeared to be a lack of consensus on what presented as common challenges for the NM. This may be occurring due to the different nature of the work in which the NMs were involved, or because wards/units/services were operating in silos. The inability to identify a common challenge contributes to the organisation not recognising clearly where support is needed, because the demands differ. Many DHBs have levels of bureaucracy that also create confusion and challenges in how the understanding of what is expected is portrayed down the line of reporting.

In some areas the removal of bureaucratic approaches in favour of a governance approach has resulted in the NM role having increased autonomy and ability to make decisions and act in accordance with their professional judgement (Van Bogaert et al.,

2015). This has resulted in the NM employing the GMM and the PPM as a means of installing organisational systems and granting them control of the delivery of patient care and the overall work environment. A healthy, and supportive clinical environment is a crucial in achieving and maintaining a stable, engaged, and productive nurse workforce, as well as favourable patient outcomes and positive organisational performance (Van Bogaert et al., 2015). The NMs in this study agreed that an increased autonomy provided them with the ability to control the delivery of patient care within their clinical environment, but the majority did not feel that their professional decision-making had an influence on nursing team performance.

These responses provide insight into the cross-pressure that the NM experiences when navigating the PPM and GMM where the NM feels pressure to empower nurses to provide both quality nursing care and positive organisational performance within a confined set of resources. Subsequently they feel the expectations and role demands exceed the necessary resources, both human and material, to support the nursing team performance and create a clinical environment that provides high quality nursing practice. This highlights the cross-pressure that the NM experiences and the conflicting dualism between the PPM and GMM. Whilst their professional practice values drive a desire to provide high quality nursing practice the generic management values push them to work within fiscal resource constraints. This has the potential to be a catalyst to role stress and overload.

An integration of nursing professional practice with generic management responsibility results in multiple demands from nursing staff, patients, and the wider organisation, all placing a heightened level of expectation on the NM. Therefore, the NM requires extensive experience to confidently and successfully integrate the PPM and the GMM, be innovators in health service delivery and increase production of health services (Warshawsky et al, 2020). However, if the NM is under-qualified, ill-prepared, poorly supported, or resource deprived, they may resign to a subordinate status that prevents them from fully influencing quality care (Ng'ang'a & Byrne, 2015). Eighty percent of the NMs in this study had less than five years of NM experience; this finding should be considered when the District Health Board is evaluating the NM's level of competence. An NM with little experience might feel a greater level of pressure as their job

performance is not influenced by their past NM experience and, therefore, the competencies necessary for success in the role need to be learned rapidly.

5.4 Support

The third theme that was identified from the findings was support. For NMs, this means providing support to a clinical area that enables nurses to achieve quality nursing care while, at the same time, ensuring departmental operational success. This cross-pressure has the potential to put the NM under considerable stress which, at times, might feel overwhelming. Whilst the NM sometimes works alongside nurses in a clinical area their role is unique, singular, and is often viewed as being superior, with the NM ultimately being responsible for the function of the clinical area. This superiority may lead to conflicting expectations from higher-ranking managers and nurses on the floor, resulting in the NM experiencing feelings of isolation and a lack of peer support in their workplace (Goodyear & Goodyear, 2018; Hyrkäs et al., 2003). Therefore, the NM requires support, mentoring, coaching, and guidance to achieve the fundamental skills required to be successful in the role. In question 18 of this study, the NMs indicated that they received high levels of support to provide day-to-day management and leadership of their service area.

5.4.1 Being Supported

As indicated in the findings for question 19, eighty percent of participants received the most support from other NMs, and this was likely through shared learning and peer supervision. Peer supervision is provided as a one-on-one conversation or in a group setting and is considered beneficial as the individuals are at the same level, share characteristics and experience similar challenges (Hyrkäs et al., 2003). Furthermore, NM's seeking support from each other provides the opportunity for NMs to reflect, and share knowledge and advice, which in turn provides support and reduces feelings of isolation. The remaining twenty percent of participants indicated that they receive the most support from their Operational/Line Manager. It is likely that participants looked to develop professionally and considered developing a relationship with a senior staff member as an opportunity to gain support and guidance. Research suggests that a mentoring relationship supports the NM in developing a leadership and management skill set (Goodyear & Goodyear, 2018).

The NMs surveyed felt they were part of a decentralised structure and were included in conversations at both a staff nursing level and an organisational level. Question 27 indicated that eighty percent of participants felt they were “often” involved in discussions where nurse development was the focus. Conversely, question 34 indicated that eighty percent of participants were “regularly” included in discussions where service performance was the focus. These results suggest that the NM plays a vital role in participative decision-making and is supported by both the PPM of nursing leadership and a GMM of leadership.

The NM is central to managing, leading and providing support to nurses that will enable quality nursing care, ensure departmental operational success and promote a healthy work environment so it is imperative that they understand the role behaviours that constitute as supportive and are consistent both the PPM and GMM. The participants had similar levels of confidence when asked if they could implement the PPM and the GMM into their clinical area. However, in question 21, eighty percent of participants identified that the use of the PPM was “important” when supporting nurses to provide high quality nursing practice. This was likely due to the fact that the PPM includes relational processes and values that that are meaningful to nurses in clinical practice and support their practice environment (Murphy et al., p. 264, 2018). With regards to improved success and performance, it is interesting to note that, in question 30, sixty percent of the NMs surveyed considered the GMM elements to be “moderately important”. This suggests a strong inclination towards providing high quality nursing practice over service delivery and management.

Professional values such as respect, partnership, trust, and integrity are vital tenets that form a foundation for other elements of the PPM subsystems (Ng’ang’a & Woods, 2015). All participants alluded to the ability to apply these values to ensure good levels of support to nurses in their clinical area. Additionally, all NMs aimed to provide a psychosocial safe environment by being visible to their nursing staff. However, question 16 indicated that there were differing degrees of visibility, with the majority of NMs feeling they were “often” visible to staff in their workplace. Visibility is an important characteristic of a NM, as it encourages approachability and creates a culture of compassionate care for staff (Ng’ang’a & Byrne, 2015). It is also consistent with the

concept of authentic leadership, which was considered important by all NMs surveyed; the NMs in this research indicated their role was regarded as authentic in providing leadership to the nurses in their workplace (Ng'ang'a & Byrne, 2015).

Anecdotally, many nurses find themselves in NM positions by default or in a nonlinear career pathway, and this is likely due to a combination of excellent clinical performance and appropriate qualifications (Kramer et al., 2007). However, merely encountering a challenging healthcare environment is not experience; rather, experience involves reflection to enable the NM to translate and apply previous leadership and management experience to larger-scale decisions (Bennis & Nanus, 1985). As part of gaining experience through supportive avenues, support is reflected as mentoring, peer group support, professional development; or it could be functional processes such as perception of adequate staffing and clinical autonomy (Kramer et al., 2007).

The American Organisation for Nursing Leadership (AONL) has recommended that organisations position themselves to provide the necessary support for NMs. An environment that facilitates the NMs' professional development stands to extend the commitment of NMs' to the organisation (Thompson et al., 2012). The nurse enters the NM role anticipating an organisation that will support them in their endeavours to provide high-quality care congruent with the fundamental values of nursing. However, the future of nursing management will affect the quality of patient care due to the context of the ever-changing and challenging healthcare environment. Therefore, a NM who is unprepared for the role, and untrained to meet the changing facets of healthcare and the needs of nursing staff will require guidance, nurturance, and support to be successful. In fact, the District Health Board has already identified the importance of support by providing regular NM forums. These forums provide NMs with the opportunity develop their leadership skills through learning and sharing experiences with peers. Shared learning complimented the research as majority of participants already felt they received the most support from other NMs'. Shared learning and self-reflection allows preconceived notions and expectations to be confirmed, refined, or disconfirmed using purposeful conversations that promotes a goal-oriented mentor–mentee relationship (McHugh & Lake, 2010). The literature highlights the importance of support for NMs and the findings from the survey also highlight that support is an

important aspect of the NM role with the NMs surveyed indicating that they tangibly felt supported.

5.4.2 Supporting Others

Professional values such as respect, partnership, trust, and integrity help shape professional nursing practice and are a central, stabilising element within the PPM. Hoffart and Woods (1996) state that the maintenance of professional values is key and without professional values elements, NMs are left without focus and coherence, which has a negative effect on professional relationships, patient care delivery and the management approach. This is consistent with the research with most participants choosing to incorporate these professional values when supporting nurses to provide high quality nursing practice. The findings suggested a strong inclination towards providing high quality nursing practice over management which was perhaps due to the PPM's focus on relational values; values that are favoured by nurses and support their clinical practice (Murphy et al., 2018).

As previously noted, eighty percent of the NMs' in this study had less than five years of NM experience highlighting a need to understand the workforce dynamics and tailor retention and recruitment strategies accordingly. Price and Reichert (2017) suggest that younger generations of nurses have lower levels of organisational commitment than baby boomers, and as a result, are more likely to consider leaving a position if they are dissatisfied with their work environment, schedule, or work to pursue a position more aligned with their expectations. This lower level of organisational commitment is identified as a characteristic of new nurses related to the nursing values within the PPM. A perceived reduction in ability to provide high quality patient care as part of job expectations might influence the long-term satisfaction of early-career nurses (Murphy et al., 2018).

Slatyer et al (2016) proposes that nurses adopt the healthcare organisational values to ensure that nursing is consistent with the organisational culture in which the nurses are employed, leading to great job satisfaction. The DHB values include respect, caring, autonomy, integrity and excellence, these compliment the professional values within the PPM, and also the GMM elements. It is widely recognised that the NM is central to managing, leading, and providing support to nurses to enable quality nursing care and

organisational success. With regards to nursing support, research has highlighted the pivotal nature of the role but also the importance of a decentralised structure where the NM is included in decision-making at both a staff nursing level and a governance level. This research revealed that the NM was involved in discussion that supported both the PPM of nursing leadership and a GMM of leadership but as suggested by the findings in question 34 the majority of participants claimed to be predominately involved in discussions where service performance was the focus. Whilst the research suggests that the NMs feel that GMM elements consume the bulk of their conversations they are participating in governance and decentralised decision-making which in turn ensures a nursing presence and the ability to articulate, specifically around quality nursing care, improved patient experience, and staff satisfaction. A decentralised structure is important for the NM as it assures that the professional values within the PPM and elements of the GMM are recognised and acted upon to ensure good levels of support to nurses in the clinical area (Hoffart & Woods, 1996).

5.5 Professional Development

The fourth theme that was identified in this study was professional development. This is defined as courses or activities that develop the NM's attributes, skills, knowledge, and expertise. Undertaking professional development is an expectation of the NM to keep abreast of nursing developments, improve patient outcomes, and meet current and future health care needs. Professional Development can be obtained by attending conferences, courses or study days. In question 7, eighty percent of the participants in this study had taken the opportunity to complete professional development in leadership. This result suggests that professional development was not perceived as important before progressing into a NM.

Generally, following the completion of a Bachelor of Nursing degree a graduate nurse can commence postgraduate study. This encompasses a range of qualifications including a postgraduate certificate, postgraduate diploma, Master's degree, and a PhD. It is thought that nurses, particularly NMs, should complete further training as they need to remain up to date with a rapidly changing knowledge base, technologies, and hospital systems to ensure a well-informed nursing workforce. Many new graduates apply for new entrant to practice programmes which enables them to be mentored in their first year of practice. As part of these programmes new graduates will consolidate their

training and undertake the postgraduate certificate in Nursing. Nurses that take advantage of completing postgraduate study often have a competitive edge when applying for NM roles as having completed postgraduate study is often mentioned in the NM role description. However, the current focus in postgraduate nursing programmes is predominantly aimed at clinical practice with limited opportunities or New Zealand workforce funding support for management and leadership. This lack of prioritising of funding to support management and leadership programmes in nursing highlights an overall lack of understanding of the dualism of the NM role.

Furthermore, this lack of understanding of what the role entails is also evident within the nursing profession as it became clear from the results, specifically question 6, that none of the participants had chosen to complete postgraduate papers specific to the NM role including healthcare management and nursing leadership before or after being employed as a NM.

While clinical expertise and knowledge was considered important, this was not necessarily specific to a unit, ward, or service. It became evident from the survey findings in question 2 that sixty percent of the participants had previously held a role in their area of work, therefore highlighting that clinical expertise and knowledge was likely "generic" nursing experience rather than specialty specific. Typically, the NM holds expert clinical knowledge and expertise but is required to learn generic management skills "on the job". This research highlighted a variation in the ways the NM gains generic management skills, including professional development opportunities and support from others. As discussed above, following employment some NM reflected on what knowledge would be beneficial to the role and completed a postgraduate paper in healthcare management. Very few nurses are equipped with the generic management skills and knowledge necessary for the role and this was apparent with sixty percent of participants expressing a desire to gain professional development in the Generic Management Model.

As mentioned in previous chapters, the NM role is complex and demanding and without the appropriate preparation and knowledge base it is challenging to effectively perform the role. This is evidenced in several studies that suggest that professional development is key to supporting the NM role. The NM role is unique due to it carrying both a

generic management focus and a professional practice focus but preparation for the role has been shown to be insufficient, causing tension (Cook & Leathard, 2004). The results from question 10 of the survey suggested the NM is ill prepared for the role with only twenty percent of participants completing professional development in leadership or management before transitioning into the role. These results should be taken into account when considering the suitability of professional development, as well as the content, timing and evaluation by the NM about what education is needed to support success in the role.

Regardless of the path, the goal of postgraduate study is to advance within the nursing profession and is likely why in response to question 3 of this survey, eighty percent of the NMs indicated that they had completed postgraduate qualifications. In addition, New Zealand workforce training needs are identified by each DHB and the boards allocate money for postgraduate education making study both accessible and free for Registered Nurses. However, nurse academia is considered out of touch with the realities of the clinical environment and as a result there is a perception among nurses that postgraduate study does not support "real-life" nursing (Brennan & Hutt, 2001). There was a clear correlation between the literature and the current research with most participants considering professional qualifications and professional development to be unessential before transitioning into the NM role. These findings are perhaps explained by eighty percent of participants considering clinical expertise to be of greater value than qualifications, whereby after assuming a managerial role the NM is worthy of trust from the staff about their decision-making. Conversely, Aiken et al., (2003) states that postgraduate education is associated with better critical thinking and decision-making. Thus, a sound educational foundation expedites the acquisition of skills through experience. Without knowledge and the ability to integrate theory, NMs risk using poor judgement and lack the tools necessary to install organisational systems and control the delivery of patient care. (Bennis & Nanus, 1985; Brennan & Hutt, 2001; Drummond, 2002).

5.6 Conclusion

This chapter presented the research findings of a study examining the insights of the NM and the phenomenon of cross-pressure when navigating between a PPM of nursing

leadership and a GMM of leadership. It is clear from the findings that the role of the NM is complex and diverse but what was described through the themes;—role confusion, level of expectation, support and professional development— made navigating between the PPM and GMM even more difficult for the NM. The findings in this study have raised issues suggesting that the NM role is not clearly defined. Ambiguities emerged relating to the NM's role expectations, making the NM role challenging. Challenges in the NM role were amplified by the high and differing perceptions of expectation on what the role does. The majority of participants felt their role was predominantly generic management, but it is apparent from the results that the NMs felt nursing clinical expertise, relational processes, and soft skills were most important. This highlights that the participants in this study favour and support the PPM rather than the GMM. It is evident from the results that the role requires professional practice competence and specialist management knowledge to function effectively as a NM. However, the findings suggest that both academic qualifications and professional development were not perceived as important before progressing into a NM role.

CHAPTER 6. CONCLUSION

6.1 Introduction

This Master's thesis has sought to examine how NMs perceive the PPM and the GMM within the course of their day-to-day work. The study used a qualitative descriptive approach to survey NMs within one District Health Board in New Zealand. A thirty-seven-question qualitative survey was split into ten questions profiling participants and 27 questions on how the participants perceived the PPM and GMM. The findings illustrated that four themes arose from the survey: role ambiguity, expectations, support, and professional development. The existing literature and the findings support the notion that there is tension inherent in the NM role caused by the craft of nursing professional practice being implemented against the backdrop of generic management in New Zealand.

6.2 Recommendations

Analysis of the survey data obtained in this research shows that NMs' do not have the appropriate preparation and knowledge base to navigate the PPM of nursing leadership and GMM of leadership. In order for the transitioning NM to be successful and recognise which skills should be used in their dual role, the potential candidates must be on a professional development and career plan, identified early, and supported within a succession planning programme (McCallin & Frankson, 2010). The nursing undergraduate degree is grounded in humanities and science, not business. The postgraduate nursing curriculum needs to prepare the nurse for the reality of the NM role and the DHBs' need to be involved in curriculum development, addressing specifically the two positions of generic management and nursing professional practice. Consequently, the NM would benefit from postgraduate study that deepens their understanding of health management, health economics, and the political processes that influence health care delivery. This includes the DHB as a crown agent, the DHB's responsibility to its population, and how this responsibility is translated via the PPM and GMM. Further analysis of the NM preparation and professional development attached to the dual role is recommended.

In addition, it would be valuable to conduct similar research on other sites across New Zealand to ascertain if NMs are experiencing parallel issues to the representative sample in this study. It may also be valuable for future research to take a richer approach to data

gathering by including the use of interviews or focus groups to obtain in-depth information regarding nurse's experiences and perceptions.

6.3 Ethics, Conflict of Interest and Acknowledgement

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 19/56. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A. telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz. In addition, when this project was reviewed and approved it was agreed there was no conflict of interest. The researcher would like to acknowledge the support of the New Zealand DHB that enabled this project to occur, and extend an appreciation to the NM's who took part in this project and have given selflessly of their time when life was already chaotic.

6.4 Limitations

Undertaking this research has been challenging due to the impact of the Coronavirus (COVID-19) not only on the scheduled timeline of the research but also on the participant recruitment rate. Although close to forty possible participants were identified in the NM area and the researcher had discussion through NM forums with potential candidates, the response rate was lower than anticipated as COVID-19 impacted on health care organisations. COVID-19 started to develop in New Zealand the week that the research was advertised meaning that priorities focused on preparedness for COVID-19. Even as the survey ran and the impact of the different alert levels occurred, there was a drop off of participants in the survey from eight down to five.

Whilst globally it is thought that NMs are experiencing similar issues to the representative sample in this study, a participant pool of five NM's from one hospital may have impacted transferability. Due to the siloed culture of hospital institutions, it could be challenging to transfer the findings within this study to another hospital or organisation.

I, as the principal researcher, was already employed in a nurse educator role before beginning this research. According to Coghlan & Casey (2001) undertaking research in

an organisation where you are employed is considered a limitation due to the position of being an “insider. An insider is perceived to have valuable information about the culture of their organisation and are at risk of being too close to the data (Coghan & Casey, 2001). However, I disagree with this view because I have not held a NM position and believe that by employing a Likert scale the participants were able to share their experiences in an honest and frank manner, whilst remaining anonymous. In addition, a Likert scale was an appropriate approach of data gathering due to the inability to assemble a focus group with the COVID-19 restrictions.

6.5 Final Reflection

As indicated in my recommendations and in my overall findings, there is a need for greater awareness of management and leadership understanding as nurses make career progressions through to NM. As has often been noted, there has been a tendency to assume that because nurses manage caseloads, they can then go on easily to manage people within an organisation and within an organisational context, and this is not easily the case. The area of nursing leadership is an important area and one that requires further study and intensive scrutiny around how management and clinical priorities can be aligned to a best possible solution to meet a set of clear expectations of the NM role.

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Appendix 1

Date: 20 December 2019

Dear Zoe Perkins

Re: Ethics Notification - **SOA 19/56** - **The experiences of Charge Nurse Managers navigating between two conceptual models of leadership in Aotearoa New Zealand**

Thank you for the above application that was considered by the Massey University Human Ethics

Committee: **Human Ethics Southern A Committee** at their meeting held on **Friday, 20 December,**

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)

Research Ethics Office, Research and Enterprise
Massey University, Private Bag 11 222, Palmerston North, 4442, New Zealand **T** 06 350 5573; 06 350 5575 **F** 06 355 7973
E humanethics@massey.ac.nz **W** http://humanethics.massey.ac.nz

Locality sign off for Hospital/Ethical Approval

Full project title:	**The experiences of Charge Nurse Managers navigating between two conceptual models of leadership in Aotearoa, New Zealand.**
Short project title:	The experiences of Charge Nurse Managers navigating between two conceptual models of leadership in Aotearoa, New Zealand.

1. Declaration by principal investigator

The information supplied in this application is, to the best of my knowledge and belief, accurate. I have considered the ethical issues involved in this research and believe that I have adequately addressed them in this application. I understand that if the protocol for this research changes in any way, I must inform the ethics committee. I have read and understood [redacted] research policy

Name of Principal Investigator (please print):	Zoe Perkins
Signature of Principal Investigator:	
Date:	13/ 01/2020

2. Declaration by Clinical Leader or CNM in which the Principal Investigator is located

I have read the application, and it is appropriate for this research to be conducted in this department. I give my consent for the application to be forwarded to the ethics committee.

Name (please print):	My employer is a CNM who will potentially be a participant. Therefor it is not appropriate for her to sign this.		
Signature:		Institution:	[redacted]
Date:		Designation:	

- Where the Clinical Leader is also one of the investigators, the Clinical Leader declaration must be signed by the Clinical Executive Director.

3. If the application is for a student project, the supervisor should sign the declaration.

If study conducted across several clinical areas, please have CL/CNM of appropriate clinical area to sign in this space.

I have read the application, and it is appropriate for this research to be conducted under my supervision. I give my consent for the application to be forwarded to the ethics committee.

Name (please print):			
Signature:		Institution:	
Date:		Designation:	

Version 2.0 dated 16th of September 2015

4. Declaration by Operations Manager/Executive Director in which the Principal Investigator is located

I have read the application, and it is appropriate for this research to be conducted in this department. I give my consent for the application to be forwarded to the ethics committee.

Name (please print): [redacted]

Signature: [signature] Institution: [redacted]

Date: 2/3/2020 Designation: [redacted]

Please include the flowing items with your application to the [redacted] Research Office:

1. Study Protocol with the outline of will be required from the [redacted] (with specific details such as Medical records will be requested, access to system will be required and so on)
2. Information and Consent Form
3. Evidence of Maori consultation
4. Ethics approval letter; if approved by the HDEC- request authorisation from [redacted] by using the following email address- Res-Research@[redacted]
5. Any other relevant paperwork such as financial arrangements, study contract etc.

PARTICIPANTS NEEDED!

FOR A MASSEY UNIVERSITY POSTGRADUATE RESEARCH PROJECT

Participants needed to explore the experiences of Nurse Managers navigating between two conceptual models of leadership in New Zealand.

The two models of leadership thought to be relevant are the Professional Practice Model and the Generic Management Model.

Nurse Managers are in a unique position to influence nurses' job satisfaction, as well as organisational culture and success because of their daily operational and professional interactions with their staff, Operational Line Manager and Nursing Leadership.

Your involvement will help to better understand how Nurse Manager's experiences influence organisational culture and performance, with a view to optimise nursing leadership in the [redacted]

WHAT WILL I BE ASKED TO DO?

Complete a 15-minute online survey, which includes demographic questions and a series of survey questions designed to understand your experiences.

YOU CAN PARTICIPATE IF YOU ARE:

- **A Registered Nurse (RN) with a current practicing certificate and;**
- **Are currently employed as a Nurse Manager (Charge Nurse Manager, Nurse Manager, Service Leader or Team Leader) in the [redacted]**
- **Have worked as a Nurse Manager in the past 12 months at [redacted]**

To participate, please visit

https://www.surveymonkey.com/r/HK5LVHV

If you have any questions about this project, either now or in the future please contact:
Zoe Perkins (RN, PGdip Nur, PGcert PeriOp) | Nurse Educator | zoe.perkins@[redacted]

Appendix 4

MASSEY UNIVERSITY

PARTICIPANT INFORMATION SHEET

The experiences of Nurse Managers navigating between two conceptual models of leadership in New Zealand

Thank you for showing an interest in this research. Please read this information carefully before deciding whether or not to participate. If you decide to participate, thank you.

What is the Aim of the Research Project?
This project is being carried out in order to explore the phenomenon of cross-pressure that Nurse Manager's (Charge Nurse Manager, Nurse Manager, Team Leader or Service Leader) experience navigating between between two conceptual models of leadership, and how these experiences contribute to organisational culture and performance, with a view to optimise nursing leadership in the [redacted].

Nurse Managers are in a unique position to influence nurses' job satisfaction, as well as organisational culture and success because of their daily operational and professional interactions with their staff, operational line manager and nursing leadership. Therefore, the role of the Nurse Manager requires the integration of two conceptual models; the Professional Practice Model (PPM) and the Generic Management Model (GMM).

The PPM aims to support high quality nursing practice through professional leadership supporting nurses' professional growth and practice development (i.e. professional focus). The GGM aims to improve organisational culture and success by setting goals, monitoring resources and measuring performance (i.e. operational focus)

Inclusion Criteria:
Registered Nurses (RN) with a current practicing certificate and;
Are currently employed as an Nurse Manager (Charge Nurse Manager, Nurse Manager, Team Leader or Service Leader) in the [redacted] or;
Have worked as a Nurse Manager in the past 12 months at [redacted]

What will I be asked to do?
If you agree to take part in this project, you will be asked to complete a 15-minute online survey, which includes:

Section A: Demographics
Section B: Nurse Manager Perceptions

Risks and Benefits:
There is a small number of Nurse Managers within the [redacted], thus they could be considered a vulnerable population due to an increased the risk of identification. To protect your anonymity:

The survey is anonymous and the researcher will not be able to identify the respondents from

the answers. A Likert scale will be used to eliminate the risk of language that could likely identify the participants or clinical areas. The researcher works as a Nurse Educator within the [redacted] but has mitigated conflict of interest as there is no power relationship between her and the group being surveyed. The researcher will independently read surveys in a private setting. Participants will be sent a link to any publications that arise from this research upon request.

What data or information will be collected and what use will be made of it?
The data collected will be securely stored in such a way that only the researcher mentioned below will be able to gain access to it. Data obtained as a result of the research will be retained for 5 years in secure storage.

Dissemination of results:
A summary of the findings will be presented at the [redacted] Nursing and Midwifery Leadership team (NAML) meeting. Furthermore, the findings of this research will be submitted for publication in an international nursing journal. In order to circulate the findings to a large population of nurses, a short report will be submitted to Kai Tiaki—a freely accessible New Zealand nursing journal. It is expected that the results will be presented at the annual NZNO Nurse Manager Conference.

If you choose to participate in the survey, a Likert scale will be used to better understand how your experiences. In the event that the questions make you feel hesitant or uncomfortable, you are reminded of your right to decline to answer any particular question(s).

If you have any questions about this project, either now or in the future, please do not hesitate to contact:

Zoe Perkins (RN, PGdip Nur, PGcert PeriOp)
Nurse Educator
[redacted]

Cell 027 44 86 7777 | zoe.perkins@[redacted].org.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 19/56. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 x 63363, email humanethicsoutha@massey.ac.nz

Beginning this survey indicates your consent to participate in this research.

Appendix 5

MASSEY UNIVERSITY

Participant Survey

Section A: Demographics

1. Length of time you have been a Nurse Manager (NM)?
◯ 1 month-23 months ◯ 2- 5 years ◯ 6- 10 years ◯ more than 10 years

2. Have you had a previous role in the unit/ward/service you are currently employed in as a NM?
◯ Yes ◯ No

3. What is your highest completed qualification?
◯ General Nursing (hospital trained) ◯ Diploma ◯ Bachelor's Degree ◯ Postgraduate Certificate ◯ Postgraduate Diploma ◯ Masters Degree ◯ PhD

4. Have you completed a postgraduate paper in healthcare management?
◯ Yes ◯ No

5. Have you completed a postgraduate paper in nursing leadership?
◯ Yes ◯ No

6. Did you complete this before you were employed as a Nurse Manager?
◯ Yes ◯ No

7. Have you completed other professional development in leadership?
◯ Yes ◯ No

8. Did you complete this leadership professional development before you were employed as a Nurse Manager?
◯ Yes ◯ No

9. Have you completed professional development in management?
◯ Yes ◯ No

10. Did you complete this management professional development programme before you were employed as a Nurse Manager?
◯ Yes ◯ No

Section B: Nurse Manager Perceptions

Nurse Managers are in a unique position to influence nurses' job satisfaction, as well as organisational culture and success because of their daily operational and professional interactions with their staff, higher operational management and nursing leadership.

Two relevant leadership conceptual models for Nurse Managers are the professional practice model (PPM) and the Generic Management Model (GMM):

- *The PPM aims to support high quality nursing practice through professional leadership supporting nurses' professional growth and practice development (i.e. professional focus).*
- *The GGM aims to improve organisational culture and success by setting goals, monitoring resources and measuring performance (i.e. operational focus)*

11. Do you view your NM role to be mostly (more than 50%) professional practice or generic management?
◯ professional practice ◯ generic management

12. What do you believe are the capability essentials for the NM role? (Enter <u>three</u> selections in order of priority)
◯ Clinical expertise/ knowledge ◯ professional qualifications/ accreditations ◯ leadership skills ◯ management skills ◯ communication skills ◯ quality improvement expertise

13. The NM role requires day-to-day management and leadership of all nursing areas (people, processes and resources) to ensure a safe patient journey. In your NM role, which three accountabilities do you consider most important? (Enter your selections in order of <u>priority</u>)
◯ high-quality nursing practice ◯ professional development ◯ monitoring resources within budget ◯ service performance ◯ nursing sensitive indicators

14. Do you experience ambiguity regarding the expectations of your NM role?
◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

15. Do you believe you receive consistent information as to what should be accomplished in your NM role?
◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

16. Do you believe you are you visible to nurses in your unit/ward/service?
◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

17. As a NM, what do you find most challenging whilst supporting the unit/ward/service to be clinically effective? (Select only <u>one</u>)
◯ staff conflict resolution ◯ monitoring resources within budget ◯ motivating staff ◯ service performance ◯ nursing sensitive indicators ◯ implementing organisation changes ◯ supporting nurse professional development ◯ performance management ◯ staff safety ◯ none of the above ◯ other_____please specify

18. Do you believe you receive peer support to provide day-to-day management and leadership of the unit/ward/service?
◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

19. Which group do you feel offers you the most peer support in your NM role?
◯ Operational line manager ◯ Nursing leadership ◯ other NMs ◯ Nurses in your unit/ward/service ◯ other_____please specify

*The following questions are focusing on the **professional practice model (PPM)***
- *The PPM aims to support high quality nursing practice through professional leadership supporting nurses' professional growth and practice development (i.e. professional focus).*
- ***Key elements in the PPM** include nursing professional development, staff satisfaction, professional accountability and nurse's autonomy*

20. In your NM role, how would you rate your confidence in enabling the PPM key elements?
◯ No confidence ◯ slight confidence ◯ moderate confidence ◯ confident ◯ very confident

21. How important are the PPM key elements in your unit/ward/service in providing high quality nursing practice?
◯ Unimportant ◯ slightly important ◯ moderately important ◯ important ◯ very important

22. Do you feel professionally accountable for creating a unit/ward/service that provides high quality nursing practice?
◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

23. In your NM role, which roles do you perceive place the highest expectations on you to provide high quality nursing practice?
◯ Nurses in your unit/ward/service ◯ operational line manager ◯ nursing leadership ◯ None of the above

24. In your NM role, your professional autonomy enables the day-to-day management and leadership of the unit/ward/service.
◯ Strongly disagree ◯ Disagree ◯ Undecided ◯ Agree ◯ Strongly Agree

25. Do you believe your professional decision-making in the NM role has a positive influence on the nursing team performance?
◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

26. In your NM role, what do you believe are the factors that highlight staff satisfaction? (Enter three selections in order of priority)
◯ staff retention ◯ reduced sickness ◯ contribution to workplace/ improvements
◯ service performance ◯ nursing sensitive indicators
◯ nurse professional development/education
◯ staff career development ◯ other

27. How often are you involved in discussions where nurse development is the focus?
◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

28. How do you believe nurses in your unit/ward/service view your NM role in terms of leadership?
◯ The role is not regarded as a leadership role ◯ The role is regarded as authentic in providing leadership

*The following questions are focusing on the **generic management model (GMM)***

- *The GMM aims to improve organisational culture and success by setting goals, monitoring resources and measuring performance.*
- ***Key elements in the GGM** include innovation, high motivation, and commitment to the goals of the organisation (i.e. operational focus)*

29. In your NM role, how would you rate your confidence in enabling the GMM key elements?
◯ No confidence ◯ slight confidence ◯ moderate confidence ◯ confident ◯ very confident

30. How important are the GMM key elements in your unit/ward/service in providing improved success and performance?
◯ Unimportant ◯ slightly important ◯ moderately important ◯ important ◯ very important

31. Do you feel professionally accountable for creating a unit/ward/service that provides organisational success and performance?
◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

32. In your NM role, which roles do you perceive place the highest expectations on you to enable organisational success and performance?
◯ Nurses in your unit/ward/service ◯ operational line manager ◯ Nursing leadership ◯ None of the above

33. Do you believe your management decision-making in the NM role has a positive influence on the nursing team performance?
◯ Never ◯ Rarely ◯ Sometimes ◯ Often ◯ Always

34. How often are you involved in discussions where unit/ward/service performance is the focus?
◯ Never ◯ Rarely ◯ Occasionally ◯ Regularly

35. How do you believe operational line manager views your NM role in terms of leadership?
◯ The role is not regarded as a leadership role ◯ The role is regarded as authentic in providing leadership

36. What aspect of your current role enables you to improve organisational culture and success (Enter three selections in order of priority)
◯ Recruitment ◯ Motivating staff ◯ staff career development ◯ collaboration with operational line manager ◯ Performance measures/ meeting targets ◯ other

37. If you were seeking professional development which would you prioritise?
◯ Professional Practice ◯ Generic Management ◯ none of the above

Please tick if you would like to be contacted to provide additional information to the questions above ◯

Thank you for your time.