National Nursing and Midwifery Clinical Leadership Development Needs Analysis

HSE Executive Report

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Foreword

Clinical leaders in nursing and midwifery enable excellent patient experiences, high standards of clinical outcomes and safe care for all patients/clients in their scope and area of responsibility. The importance of developing clinical leaders in nursing and midwifery has been brought to the fore by reports such as Commission on Patient Safety and Quality Assurance (2008), The Lourdes Hospital Enquiry 2006 and the Health Service Executive’s Framework for Integrated Quality, Safety and Risk Management.

To this end, the Health Service Executive, Office for the Nursing Services Director has commenced a national clinical leadership development project which aims to implement a national approach to the development of clinical leaders in nursing and midwifery. To inform this project, The School of Nursing, Midwifery and Health Systems, University College Dublin (UCD) completed this comprehensive national clinical leadership development needs analysis. The findings clearly indicate that to be an effective clinical leader at all levels in nursing and midwifery in Ireland, a range of competencies are required which will give the nurse and midwife both the confidence and skills to lead on the provision of excellent clinical care in all settings.

This report is the first step in identifying the clinical leadership needs of nurses and midwives and supporting them in developing their skill and ability to be effective clinical leaders. I wish to thank the School of Nursing, Midwifery and Health Systems, UCD for undertaking this study. Funding support by the National Council for the Professional Development of Nursing and Midwifery is also gratefully acknowledged.

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Nursing Services Director
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Executive Summary

Clinical Leadership in Nursing and Midwifery

Nursing and Midwifery clinical leadership involves influencing and motivating others to deliver clinically effective care by demonstrating clinical excellence, and providing support, and guidance to colleagues through mentorship, supervision and inspiration. It is also concerned with demonstrating the distinct Nursing or Midwifery contribution within multidisciplinary contexts. Clinical leaders in Nursing and Midwifery not only contribute to effective patient care, but they also give a voice to their disciplines by participating in policy development and collaborating with other members of the interdisciplinary team.

Leadership development refers to the process of developing both the intrapersonal and interpersonal leadership competencies of the individual, while also developing the organisation. Clinical leadership development is itself a complex process and there are a number of distinct approaches that focus on leader development, leadership development, or more usually combinations of both.

To develop clinical leadership within the Republic of Ireland, it is essential to understand the needs of Nurses and Midwives. To this end a National Clinical Leadership Needs Analysis was commissioned by the Health Service Executive (HSE), Nursing and Midwifery Planning and Development Units; funded by the National Council for the Professional Development of Nursing and Midwifery; and undertaken by University College Dublin (UCD).

The National Clinical Leadership Needs Analysis Study

The aim of this needs analysis was to describe the clinical leadership development needs of a national sample of Nurses and Midwives in Ireland. A mixed methods approach to data collection and analysis was developed and successfully deployed. The major components of the study design were a national survey using the CLAN-Q questionnaire, which was designed specifically for the purpose of the study and a series of focus group interviews among all grades of Nurses and Midwives from each of the four administrative regions of the Health Service Executive in Ireland.

The study design generated more than 900 completed questionnaires from a national survey of Nurses and Midwives and a body of rich and detailed qualitative data from 22 focus groups. The response rate to the national survey was 48% and the rate of usable responses was 30.9%. These rates compare favourably with other similar national surveys.

The 22 focus groups were conducted at 14 different centres in the four major HSE administrative regions in Ireland and comprised of a total of 184 participants. The focus groups contained representation of Nurses and Midwives from across all grades and all disciplines, and each region was represented.

The demographic profile of the respondents to the national survey was generally similar to that of the total population of interest, indicating that the sampling strategy generated a representative sample of Nurses and Midwives nationally. The majority of the sample was female. Two-thirds worked in a public or public voluntary hospital setting and approximately two-thirds of the sample had been working in current area of practice for up to 10 years. Less than one-third of the sample had a Bachelor’s degree and the majority of those at Clinical Specialist and Advanced Practitioner grade held a Postgraduate degree.
The key findings of the summary include:

- Less than half of the national survey sample reported receiving no education and training for their leadership role in the course of undergraduate Studies, and just over two-thirds received education and training for their leadership role as part of in-service education and training. The majority of those who participated in education and training for their leadership role found it useful.

- Self-reported data from the national survey indicated that Nurses' and Midwives' leadership development needs can be described in distinct dimensions of clinical leadership, ranging from the intrapersonal to the departmental, and from the organisational to the wider interdisciplinary dimension.

- Factor analysis of survey data indicated five dimensions of clinical leadership development that give rise to particular types of leadership development need. These dimensions were managing clinical area, managing patient care, development of the individual, development of the profession and skills for leadership.

- Leadership development need was greater with reference to those dimensions of the professional role which concerned organisational and interdisciplinary working, interactions with other healthcare professionals and influencing clinical decision making and health policy more generally. Conversely, leadership development need was perceived as lower with reference to those aspects of the professional role associated with the management of care and with the micro-system of care within which the Nurse or Midwife operates. Certain grades differed in their self-perceived clinical leadership development needs, with Staff Nurse and Staff Midwife grades having significantly higher self-reported needs. These differences were found to be statistically significant with reference to the dimensions of clinical leadership associated with organisational and interdisciplinary working.

- Focus group data confirmed the major findings from the national survey and suggested that as Nurses and Midwives move further away from their locus of direct care, they are less assured of their roles and hence their clinical leadership development need is greater.

- Four distinct dimensions of barriers to leadership development emerged from factor analysis of the data. These were quality care factors, recognition, interdisciplinary relationships and influence. Self-perceived barriers were seen as greater with the organisational dimensions of the professional role and with interdisciplinary working. Certain grades differed in their self-perceived barriers to their clinical leadership development. These differences were found to be statistically significant with reference to organisational and interdisciplinary working dimensions of the professional role.

- Differences in self-reported leadership development need and in perceived barriers to leadership development were evident across higher and lower grades and related to the relative influence which each grade perceives that it has in effecting quality care and in influencing clinical decision making and wider policy.

- Qualitative data suggest that where Nurses and Midwives have a direct impact on care they perceive they have more influence. The principal means through which Nurses and Midwives impact on patient care is through such activities as patient advocacy, attending to issues of safety, dignity and privacy. Crucially, their influence is also through the co-ordination and orchestration of activities in the care environment. However, this type of co-ordinating activity can impact on their ability to give effective
care, since they are constantly acting to compensate for deficiencies and gaps in service and care provision. In this compensatory mode, they are frequently in need of having to keep up-to-date and this can impact on their ability to demonstrate and articulate the Nursing or Midwifery contribution to care.

- Combined quantitative and qualitative data from the study may be interpreted as suggesting that Nurses’ and Midwives’ leadership development needs are related to their spheres of influence in regard to their professional practice and their organisations. At the micro level of their professional role where they manage direct care, they are more self-confident in their ability to influence care. However, as they move further away from the micro level to the meso (departmental/organisational) and the macro (policy) levels their influence becomes somewhat more diffuse and dissipated. These spheres of influence give rise to particular areas of development need and to particular barriers to clinical leadership development, which are associated with organisational and interprofessional domains of leadership.

**Key Recommendations**

On the basis of the evidence from this national needs analysis study the following recommendations are offered:

- The development of a national clinical leadership framework should take cognisance of the clinical leadership development needs of Nurses and Midwives identified in this report in conjunction with best evidence from the literature.

- Leadership development should include strategies to assist Nurses and Midwives to articulate their distinct contribution to care in the practice setting.

- Clinical leadership development should emphasise the development of Nurses and Midwives as clinical leaders both in the context of organisations and the wider health care systems.

- Both clinical leader development (individual and intrapersonal) and leadership development (interpersonal and organisational) must be considered as part of the spectrum of clinical leadership development.

- Different clinical leadership strategies will be required for different clinical grades that have varying contextual needs.

- Clinical leadership development must target the levels of the individual, the team, the unit/department and the organisation.

- Investment in clinical leadership development should be part of ongoing professional and organisational development and not considered a once-off activity.

- Clinical leadership development should enhance the development of the profession, with a particular focus on participating in professional Nursing and/or Midwifery forums; considering the effect of current issues, trends, and policies on practice and on the profession; networking across organisational and professional boundaries; understanding the impact of internal organisational politics on the work of the profession; and representing the interest of the profession at the national policy-making level.
• Nursing and Midwifery clinical leadership programme development should be led by the profession and combine theory, interdisciplinary learning and learning experiences that are based in practice settings and with an orientation towards collective and individual development.

• Clinical leadership programme design for Staff Nurses and Staff Midwives should take cognisance of the various dimensions of clinical leadership development need identified in this report, including the development of the individual, the development of the profession and skills for leadership development.

• Clinical leadership development strategies should take cognisance of the perceived barriers to clinical leadership development as identified in this report, including barriers associated with influence in the work setting and interdisciplinary relationships.

• Graduate courses aimed at developing specialist clinical knowledge and skills should broaden their remit to include explicit content on the fundamentals of clinical leadership.

• Clinical leadership development programmes should be developed within the context of a partnership approach between the healthcare and academic sectors.

• The use of demonstration projects at one or more pilot sites would permit an evaluation of the effectiveness of different programme designs.
CHAPTER 1

Introduction And Background

Introduction
Leadership is a complex phenomenon that takes place in social contexts in which groups of people work towards the attainment of a particular goal or set of goals. The phenomenon has been the subject of academic study since the latter half of the 20th century, resulting in a myriad of theories about leadership style and approaches, and about effective leadership and its development.

Clinical Leadership in Nursing and Midwifery
Clinical leadership in Nursing and Midwifery is about influencing and motivating others to deliver effective care. Clinical leaders support colleagues and demonstrate clinical excellence, mentorship, supervision and inspiration (Davidson, Elliot and Daly 2006). They are practitioners who are patient-centred and capable of ensuring the delivery of high-quality client-focused care through the development and maintenance of effective team relationships (Large, Macleod, Cunningham and Kitson 2005). Clinical leadership is also about driving improvements in service and effectively managing care teams to provide excellence in care (NHS Scotland 2004). It promotes the integration of research and other evidence into practice and advocates for transformation of healthcare systems.

Clinical Leadership Competencies
Clinical leadership in Nursing and Midwifery is a function of the clinical leader’s ability to ensure effective clinical care and to do this in the face of situational challenges such as competing demands on resources, interdisciplinary rivalries and wider health reforms. Domains of competence for clinical leadership can be described in relation to four levels of complexity: the individual, the care team, the departmental group and the organisation (Large, Macleod, Cunningham and Kitson 2005), Stanley et al. (2008), Tornabeni and Miller (2008) and Sorensen et al. (2008). At the level of the individual, effective clinical leadership requires self-awareness and openness to criticism, and being able to challenge others, to enlist support when warranted, and to anticipate risks and search for opportunities to minimise them. At the care team level, clinical leaders function as resource persons, strengthening others and fostering collaboration by supporting and educating staff. As effective team leaders they manage change processes, build good working relationships and assume accountability for the care outcomes of clients within a specific setting.

At the departmental level, clinical leaders are willing and able to challenge suboptimal practices and to champion best practice based on sound evidence. They contribute to wider policy and practice agendas within their units, departments and organisations. At the organisational level, clinical leaders are able to conduct both clinical and organisational analysis and comprehend health system reform and its impact on structures, process and outcomes at all levels. By forging organisational, regional, national and international networks, clinical leaders in Nursing and Midwifery can form effective professional partnerships and contribute to health planning and policy development through advocacy and lobbying skills.

Common challenges in modern health systems in developed countries include changes in workforce, an ageing population, high patient acuity, increasing complexity of care and resource constraints. All of these challenges require effective leadership if care is to be effective. Leadership development needs can be considered with reference to not just the individual, but also the team, the clinical department and the organisation in which the Nurse and Midwife works (Rashford & Coghlan 1994, McAuliffe, Coghlan, Pathe 2002).
In Nursing and Midwifery in Ireland, there is recognition of the growing knowledge and skills deficit in areas such as leadership, policy development, health economics and management skills (Government of Ireland 1998, Meehan et al. 2005). This knowledge and skills deficit is particularly apparent and further exacerbated as often ill-prepared staff are expected ‘to shift from operational engagement to a more strategic and clinical leadership role for their service’ (Treacy & Hyde 2003).

A review of a number of programmes for clinical leadership development (Large et al. 2005, Stanley et al. 2008, Posner & Kouzes 1988, 1993) indicates a tendency to focus on personal development through experiential learning, with an emphasis on action learning and structured reflection, where personal development needs are linked to the needs of the workplace. The content of programmes targeted at Nurses and Midwives tends to focus on the discrete areas of care delivery, healthy workplaces, the business of healthcare, and personal, professional and team development.

Objectives of the Needs Analysis Study

The overall aim of the study was to generate valid and reliable data with which to describe the needs and the views of a national sample of Staff Nurses, Staff Midwives and Nursing and Midwifery Managers in relation to clinical leadership development in Ireland. This data would provide robust information with which to inform policy for developing a national clinical leadership framework for Nursing and Midwifery in Ireland. The study objectives were:

- To identify and critically examine clinical leadership development from published work in the literature.
- To identify the needs of Nurses and Midwives with regard to clinical leadership development in relation to their role in improving patient/client care.
- To examine and describe key Nursing and Midwifery stakeholders’ views in relation to clinical leadership development.

This national needs analysis study, commissioned by the Nursing and Midwifery Planning and Development Units of the Health Service Executive (HSE), adopted a mixed methods approach to data collection and analysis. It consisted of a national postal survey of Nurses and Midwives regarding their clinical leadership development needs and a series of focus group interviews among Nurses and Midwives across all grades to elicit their views and needs on clinical leadership development. With the aim of adding scope, quality and comprehensiveness to the study, data collection was carefully planned to elicit meaningful and representative data on clinical leadership development that would inform policy. This was achieved by using a sampling strategy that ensured representativeness and by deploying qualitative and quantitative data collection methods that generated valid, reliable and rich data on stakeholders’ needs and views regarding clinical leadership development.

Project Management

The School of Nursing, Midwifery & Health Systems, University College Dublin research team was recruited in late 2008. The research team comprised experts in both quantitative and qualitative research methods, including the methods of survey design and focus groups. The team consisted of researchers with previous experience in conducting national survey research among Nurses and Midwives in Ireland. It also contained two international advisors with expertise in similar large-scale studies and in the topic of concern to the study. In addition statistical experts were available to the research team.
The research team was made up of a project team from the UCD School of Nursing, Midwifery & Health Systems including: Gerard Fealy (Principal Investigator); Martin McNamara (Project Manager); Mary Casey, Ruth Geraghty (Research Assistants) and Michelle Butler, Jonathan Drennan, Phil Halligan, Pearl Treacy, Maree Johnson (Project Team Members).

Gerry Conyngham and Corina Naughton were statistical advisors. Other collaborators included Eileen Bohan, Maria Brenner, Margaret Kilkenny, Declan Patton.

A National Clinical Leadership Steering Committee comprising representatives of the Health Service Executive, patient(s) representative group, trade unions, international expertise and third level institutions, provides ongoing guidance and support to the national project. The Committee is chaired by an independent facilitator. The Office for Nursing Services Director Project Team (Joan Phelan, Michael Shannon, Jim Brown-Retired 2009, Pat Harvey, Cora Lunn, Eithna Coen, and Bernadette Toolan) advised on the study topic and monitoring aspects of the research process as and when required.
Summary Of Literature Review

Introduction
This summary of the literature examines approaches to leadership development in general and leadership development in Nursing and Midwifery in particular. A number of key questions pertaining to clinical leadership and its development in Nursing and Midwifery are addressed:

- What is leadership?
- What is leadership in Nursing and Midwifery?
- What is clinical leadership in Nursing and Midwifery?
- What are the enablers and barriers to effective clinical leadership?
- How may clinical leadership skills and capabilities be developed?

Review Methods
The aim of the review was to collect, collate, analyse and provide a critical appraisal of the literature concerned with clinical leadership, its development and its effectiveness in Nursing and Midwifery practice. A planned systematic review of literature was conducted in accordance with best practice guidelines for accessing, retrieving, extracting and synthesising data from the literature.

For the purpose of the review, ‘clinical leadership’ was operationally defined as ‘a multifaceted process, involving influencing and motivating others to act, in a group context’ and which involves the achievement of mutually-negotiated goals (Davidson et al. 2006, Northouse 2007). Development needs were defined as all or any of the supports, training, education, skills, knowledge, information and resources that Nurses or Midwives require to function more effectively as clinical leaders.

Leaders and Leadership
As a concept, leadership is rarely critiqued (Jackson & Watson 2009). Leadership is regarded as a process that involves influence, occurs in a group context and is goal oriented (Rafferty 1993, Shortell & Kaluzny 1994, Northouse 2004). While many individuals are leaders by virtue of an assigned role or position, it does not necessarily follow that they have leadership capabilities or that they give leadership, since leadership is also a function of the way that others respond to, support and accept an individual’s ideas and behaviours. Accordingly, both leaders and followers are involved in an interdependent relationship (Burns 1978).

Leadership is one of the most observed but least understood phenomena (Burns 1978), giving rise to a considerable body of literature into areas such as organisational management and change management. Definitions of leadership abound and the myriad of definitions relate to the leader’s qualities, group processes and the interpersonal dimension and the context or setting. Typical of these definitions is that offered by Davidson et al. (2006) who define leadership as a ‘multifaceted process of identifying a goal or target, motivating other people to act and providing support and motivation to achieve mutually negotiated goals’. Bowles and Bowles (2000) emphasise the leader’s personal qualities, defining leadership as ‘an interpersonal relationship of influence, the product of personal characteristics rather than mere occupation of a managerial position’. Gopee and Galloway (2009) point to four possible meanings in leadership, namely the ‘the activity of leading, the body of people who lead a group, the status of the leader and the ability to lead’.
Leadership Versus Management

Although there is a tendency to consider leadership and management as interchangeable, the literature is replete with efforts to highlight the distinction between these terms (Jackson & Watson 2009). The essential distinctions are generally described with reference to aspects of leader function and role performance in each. It is recognised that management is just as important a function as leadership if organisations are to succeed (McCrimmon 2006) and that over emphasis on either one at the expense of the other can have undesired consequences for an organisation (Yukl & Lepsinger 2005).

Clinical Leadership in Nursing and Midwifery

Given the milieu of constant change in healthcare, Nurses and Midwives are required to be proficient in leading and negotiating change and motivating colleagues to participate effectively in a changing environment. High-quality healthcare and innovation in practice depend on effective teamwork, for which clear leadership is essential (Borrill et al. 2002). The way that a leader’s skills and leadership style are exercised determines leadership effectiveness (Gopee & Galloway 2009) and effective leadership in Nursing and Midwifery empowers individuals and groups to engage in change (Casey 2006). In assuming a leadership role, a Nurse or Midwife is required to become many things, including a stakeholder ‘fixer’, a reflective planner, a craftserson, a strategy ‘fitter’ and a provider of continuous quality service (Jumaa & Marrow 2008). Despite calls for Nursing and Midwifery involvement in clinical leadership, the term ‘clinical nursing leadership’ is not well defined, leading to a poor understanding of the concept, the clinical leader role and the core competencies involved.

In general, the literature fails to satisfactorily investigate the clinical leadership dimension integral to the role of experienced Nurses and Midwives, regardless of their designated title, hierarchical status or area of practice (Stanley 2008). Nevertheless, there is evidence of some attempts to define and describe clinical leadership for the disciplines of Nursing and Midwifery, with particular reference to processes and leadership attributes. For example, in its Leadership Development Framework discussion document, the National Health Service in Scotland declared that clinical leadership was concerned with ‘driving service improvement and [with] the effective management of teams to provide excellence in patient/client care’ (NHS Scotland 2004). On that view, clinical leadership is essentially about delivering effective care by care teams acting through the agency of key individuals. The American Association of Colleges of Nursing (AACN) defines a clinical nurse leader as someone who supports innovations that improve outcomes of care, ensures quality care, reduces healthcare costs, integrates research evidence into practice, leads efforts to improve patient care, is recognised as a leader in all settings and is an advocate for transforming the health system and implementing best practice. (Smith and Dabbs 2007).

Clinical Leadership Role

Leadership in healthcare systems involves leadership at both the micro level and the organisational and departmental levels and generally concerns setting the direction for the broader health system or within an organisation and with creating possibilities for success and helping people to achieve goals (Milward & Bryan 2005). A major component of the Clinical Nurse leader’s role is to provide a leader at the centre of the micro system to promote quality outcomes (Hix, McKeon and Walters 2009). In Nursing and Midwifery, leadership involves taking responsibility for direct care and its outcomes and being responsible for monitoring service more generally (Davidson et al. 2006) and it involves both leading and developing clinical practice and taking responsibility for service and its development (Carrey et al. 2007). Clinical leadership concerns leadership at the level of clinical care and is about facilitating evidence-based and effective local care and improved patient outcomes (Milward & Bryan 2005).
Providing leadership to individuals, groups and teams is an inherent component in the management of care and is generally seen as being one of the essential functions of care managers. Traditionally, there has been a tendency to associate clinical leadership with medical personnel who hold a management function associated with clinical care. This is hardly surprising since it is widely recognised that having clinicians involved in leadership positions is essential to successfully managing clinical care. However, it is generally accepted that clinical leadership is not the preserve of any one single disciplinary group in healthcare and hence Nurses and Midwives are seen as having a definite role in giving clinical leadership.

Grades and Leadership

There is emerging consensus that clinical leadership in Nursing and Midwifery is not the sole preserve of those occupying formal leadership or management roles (NHS Scotland 2004); any clinician can be a clinical leader (Faughier & Woolnough 2002). Moreover, those with formal management responsibilities may not always be best placed to provide clinical leadership (Stanley 2008) and this highlights the importance of developing leadership capacities at all levels within the healthcare setting.

There is a substantial body of literature describing the role that the clinical leader in Nursing and Midwifery performs. A clinical leader is an expert clinician involved in providing direct clinical care and someone who influences others to improve the care that they provide (Cook 2001a, 2001b, Cook 1999). The role incorporates facilitation of the process of care delivery and managing relationships between other professionals, team members, the organisation and service users (Milward & Bryan 2005). Ultimately, clinical leadership concerns ensuring the provision of high-quality care (Large et al. 2005). In an examination of the clinical leader role in Nursing and Midwifery development units in UK, Christian and Norman (1998) reported that the clinical leader’s ability to fulfill the role was contingent on the leader’s position in the organisational hierarchy. Cook (2004) found that the clinical leader was not always the most senior Nurse but could emerge from across the spectrum of clinical and managerial grades. However, despite much commentary on the importance of clinical leadership in direct care, the impact of leadership on the process of care remains elusive and difficult to describe and the impact of nursing leadership on patient outcomes also remains unclear (Vance & Larson 2002, Wong & Cummings 2007). Davidson et al. (2006) wrote that the Nurse’s greatest power base lies in the practice domain and that Nurses have the power to influence and direct patient care by exemplary leadership and excellence in their clinical practice. This is the essence of clinical leadership.

Domains for Competence for Clinical Leadership Development

Clinical leadership development needs can be categorised with reference to capabilities for effective performance, usually termed ‘competence’. In the broadest sense, competence is the individual’s ability to apply knowledge, skills and attitudes or dispositions to a particular standard in the effective performance of a particular role or task. The context in which the role or task is being performed can mediate performance. The competence of the clinical leader resides in the two principal elements of leadership development, namely the intrapersonal and the interpersonal. The literature points to emerging consensus around the core domains of competence required of clinical leaders. These domains can be broadly mapped to each of the four levels of organisational complexity already discussed.
Table 2.1 indicates the core domains of competence in relation to clinical leadership. It is based on the work of Large, Macleod, Cunningham and Kitson (2005), Stanley et al. (2008), Tornabeni and Miller (2008) and Sorensen et al. (2008).

Table 2.1 Indicators of Core Domains of Competence of Clinical Leaders

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<tr>
<th>Level</th>
<th>Core Domain of Competence</th>
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<tr>
<td>1. Individual</td>
<td>Self-awareness, commitment to personal development linked to workplace learning</td>
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<tr>
<td>2. Face-to-face team</td>
<td>Acts as a resource and role model, educates, mentors, coaches, initiates change</td>
</tr>
<tr>
<td>3. Interdepartmental group</td>
<td>Professional and patient advocacy, cross boundary working, information management, change management</td>
</tr>
<tr>
<td>4. Organisation</td>
<td>Analyses organisational issues and considers their impact on clinical care, forges partnership and networks and contributes to policy development</td>
</tr>
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Competent clinical leaders are able to conduct both clinical and organisational analysis and can comprehend health system reform and its impact on structures, processes and outcomes at all levels. They can systematically consider the implications of change and reform for patient care. By forging organisational, regional, national and international networks, clinical leaders form effective partnerships that enable them to contribute to health planning and policy development collectively through advocacy and lobbying.

Leadership Development Approaches

Leadership development is not a single activity, but a set of activities, often taking place over many years (Hartley & Hinksman 2003). It concerns the resources and processes for developing leadership in individuals and work settings and is influenced by the explicit or implicit model of leadership which underlies work practices.

Leadership development is the subject of considerable attention in leadership literature. In a critique of reports on leadership development, Proctor-Thomson (2008) observes that reports emphasise the need for planned and systematic approaches to defining leadership development needs and the types of strategies needed for enhancement within specific contexts. The majority of reports also stress development that fits individual skill and capability requirements.

Models and their Effectiveness

A number of effective reviews have been undertaken in the field of leadership development. Most learning from leadership development takes place in the work setting as opposed to formal training programmes and participants tend to prefer process-rich, experiential learning over content-driven learning (Glatter 2008). Experiential approaches, such as mentoring, reflection, coaching and 360 degree feedback have also received widespread support in the literature (Proctor-Thompson 2008). (Bush, Glover, and Harris 2007) concluded that mentoring was an effective method of leadership development but that it required considerable training in its proper use. This supports the idea that leadership is a craft best learned on the job through effective role modelling, mentoring and coaching in the real-life situation (Lewis & Murphy 2008).
Leadership development strategies must align with organisational characteristics such as the dominant leadership concept, the corporate culture and cultural context in which leadership development is taking place (Proctor-Thompson 2008, Williams 2005). Hence, leadership development for professional groups can be effective in driving organisational change but it needs to be of the appropriate kind, to be both work-based and programme-based and to take into account organisational culture (Williams 2005). In a review of the evidence of the contribution of leadership development programmes for professional groups, Williams (2005) characterised leadership development as consisting of two main kinds: one with a focus on a local context in which change is needed and the other with a focus on more general overall development needed for a particular professional group. It was concluded that the former appears to be more effective than the latter in achieving organisational change.

Leadership development that emphasises team development is underpinned by ‘dispersed leadership’ or ‘distributed leadership’ theories in which it is assumed that leadership takes place at all levels of an organisation and with a greater emphasis on teamwork (Glatter 2008, Proctor-Thompson 2008). It is argued that providing leadership development that focuses more on work-based learning, on the individual and the work team and on processes as opposed to content will result in more effective and sustainable leadership learning, i.e. learning will be more likely to be transferred into leadership practice (Lewis & Murphy 2008, Bush et al. 2007).

However, Proctor-Thompson (2008) points to the tension in leadership development literature between the idea that leadership is a constellation of components, of which the individual leader is just one unit and the idea that leadership development necessarily involves the personal and professional development of individual leaders.

Leadership Development in Nursing and Midwifery

Particular sets of circumstances demand particular sorts of leaders and particular types of leadership (Jackson & Watson 2009). Since leadership is also context-dependent, the work setting is influenced by leadership and its development; however, leadership and development are influenced by any given work context (Dierckx de Casterle et al. 2008). There is evidence that both the quality of care and the work environment are enhanced by improving the leadership skills of bed-side Nurses and Midwives. Leadership enhancement programmes that focus on Nurses and Midwives across all grades and that are tailored to the needs of Nurses and Midwives at each individual grade have better results (Harvath et al. 2008).

In any strategic development plan designed to help Nurses and Midwives to be more effective in their role in improving patient care, two dimensions need to be considered: leader development and leadership development. The former concerns personal attributes in the leader and the latter relates to the context in which leadership takes place, including the interpersonal relationships among team members. The key components of both leader and leadership development are summarised in Table 2.2.
Table 2.2 Key Aspects of Leader and Leadership Development (Day 2001)

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<tr>
<th>Aspects of Leader Development</th>
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<tr>
<td>Building intrapersonal competence</td>
<td>Building interpersonal competence</td>
</tr>
<tr>
<td>Focus on human capital – developing individual knowledge, skills and abilities</td>
<td>Focus on social capital; building network relationships through interpersonal exchange</td>
</tr>
<tr>
<td>Self awareness (emotional awareness, self confidence)</td>
<td>Social awareness (empathy, service orientation and enabling others)</td>
</tr>
<tr>
<td>Self regulation (self control, trustworthiness, ability to cope with change)</td>
<td>Social skills (collaboration, partnership, cooperation, conflict management)</td>
</tr>
<tr>
<td>Self motivation (commitment, take initiative, positive outlook)</td>
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</table>

Identifying and Meeting Leadership Development Needs

On the subject of leadership development in Nursing and healthcare, Jackson and Watson (2009: 1961) take the view that effective leadership is a combination of personal qualities and skills learned over time and argue that ‘in the absence of key personal qualities, no amount of formal classroom teaching can create a leader’. Identifying needs of clinical leaders in Nursing and Midwifery requires analysis and identification of the core components of knowledge, skills and dispositions and awareness of the contextual conditions in which leadership actions take place. Hence, leadership is context-specific and Jackson and Watson (2009) observed that particular sets of circumstances demand particular sorts of leaders and particular types of leadership. Given the complexity of modern health systems, leadership is about negotiating these complex systems, including facilitating transformational reform (NHS Scotland 2004). Leadership development needs must also be considered with reference to individual and team needs and needs at the level of the clinical department and the wider healthcare organisation.

Since clinical leadership involves intrapersonal and interpersonal competencies and dispositions that are expressed in context, then it follows that leadership development needs in Nursing and Midwifery can be assessed with reference to the intrapersonal and the interpersonal, as well as with reference to different contexts in which leadership is expressed, such as the grade at which the Nurse or Midwife operates in the practice setting. Leadership needs can be assessed with reference to four levels of complexity: the individual, team, departmental and organizational level Large et al. (2005), Stanley et al. (2008), Tornabeni and Miller (2008) and Sorensen et al. (2008). (See Table 2.3).
Table 2.3 Tasks at each of the Four Organisational Levels (Coghlan & McAuliffe 2003)

<table>
<thead>
<tr>
<th>Level</th>
<th>Task</th>
<th>Examples of Potential Development Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>Bonding</td>
<td>Personal development needs – involves meeting conditions to self-improve. Feel supported and listened to by peers, colleagues and those more senior.</td>
</tr>
<tr>
<td>Face-to-face team</td>
<td>Creating a functioning team</td>
<td>Be appreciated and valued for level of clinical expertise. Need to be included in decision-making and given constructive feedback on performance. Become an effective communicator</td>
</tr>
<tr>
<td>Interdepartmental group</td>
<td>Co-ordination</td>
<td>Need to develop skills in partnership and collaborative activities in Nursing and Midwifery. Manage conflict as it arises and have political awareness of influences on clinical practice</td>
</tr>
<tr>
<td>Organisation</td>
<td>Adaptation</td>
<td>Be consulted and included in broader policy-making decisions pertaining to clinical practice and education.</td>
</tr>
</tbody>
</table>

Summary of Findings
The literature reveals a myriad of books, articles and commentary pieces on leadership and clinical leadership. The following key findings emerge from the literature concerning leadership, clinical leadership and its development:

- There is a distinction between the intrapersonal and the interpersonal competencies of leadership development.
- The need to match leadership styles to specific contexts has been consistently highlighted.
- Effective clinical leadership is seen as essential for optimising the environment of care and improving patient outcomes.
- Clinical leadership is best developed by paying attention to the competencies that are deemed essential for effective leadership.
- It is important to develop clinical leadership capacities at all levels within the healthcare setting.
- Leadership development is best facilitated through action and experiential learning that occurs in the practicum.
- Clinical leadership is not the sole preserve of those occupying formal leadership or management roles, but can be demonstrated by Nurses and Midwives across all clinical grades.
- Clinical expertise and credibility are viewed as essential to effective clinical leadership and such expertise provides the foundation upon which specific leadership capacities are built.
- There is little evidence of the long-term effectiveness of clinical leadership development initiatives and no evidence of any large-scale analysis of leadership development needs in Ireland.
CHAPTER 3

Study Design

The study design was a mixed methods approach combining quantitative and qualitative methods of data collection and data analysis (see Figure 3.1). The quantitative element consisted of a Clinical Leadership Development Needs Analysis Survey among a national random sample of Nurses and Midwives across all grades representing hospital and community Nursing and Midwifery. The qualitative element involved a series of focus group interviews among a purposive sample of all grades of Nurses and Midwives working in hospital settings from each HSE administrative region. The quantitative and qualitative methods of data collection occurred concurrently.

Fig. 3.1 Study Design

The National Postal Survey of Nurses and Midwives

The purpose of the survey was to generate valid and reliable data with which to describe the needs of Nurses and Midwives in regard to clinical leadership development and the enablers and barriers to clinical leadership development. For the purpose of this survey, it was determined that a study-specific instrument was required. The Clinical Leadership Analysis of Need Questionnaire (CLAN-Q) was developed (Appendix 1). The CLAN-Q instrument is a self-reported, self-administered needs analysis instrument developed to measure the self-perceived needs of a national sample of Nurses and Midwives in Ireland. The instrument measures two critical elements: clinical leadership development need and enablers and barriers to clinical leadership development. The instrument comprised 89 items, which were presented with a number of simple rating scales and under three major category headings based on the literature concerned with clinical leadership in Nursing and Midwifery and with leadership development needs. These three category headings included:

- My development needs: improving the environment of care delivery
- My development needs: personal and professional development; and
- My development needs: skills for clinical leadership.
The CLAN-Q instrument also contained a 17-item demographic questionnaire, which sought information on respondents’ discipline, current grade, current employment, and level of education and training. It also contained items that measured variables on respondents’ education and training for the clinical leadership role. The instrument was subjected to rigorous testing at the level of the research team acting as subject experts.

Sample and Sampling Strategy
The eligibility criteria for inclusion in the survey were that respondents should be currently on the Active Register of the Register of Nurses maintained by An Bord Altranais, be employed directly by the Health Service Executive or by a public voluntary body and be employed at one of the following grades: Staff Nurse, Staff Midwife, Clinical Nurse Manager, Clinical Midwife Manager, Director of Nursing or Director of Midwifery. The sampling criteria also permitted the random selection of Nurses and Midwives at the Specialist and Advanced Practitioner grades.

The size of the sample was determined by the degree of accuracy required for the sample and the extent of variation in the population in regard to the key characteristics of interest. Based on the most recent figures available to the research team at the time of sampling, the total sampling frame from which the sample was drawn exceeded 68,000 Nurses and Midwives listed on the Active Register (An Bord Altranais 2008). This did not include the total number of qualifications registered on the Active Register, which were almost 92,000. With a precision of ±3% at a 95% confidence interval, it was considered that a sample size of 1,100 would be required. To allow for non-responses and the potential problem of over representation of the largest subset and under representation of the smaller subsets, it was determined that an actual sample of 3,000 Nurses and Midwives would be randomly generated from the Active Register.

A pilot study was conducted among a convenience sample of Nurses and Midwives employed in different settings and representing both junior and senior grades. Pilot testing indicated that the instrument took approximately 20 minutes to complete. Following pilot testing some changes were made to the instrument.

Data Collection
The instrument was mailed to a sample of 3,000 Nurses and Midwives. A commercial mailing and postal service was employed to facilitate printing, packaging and mailing of the questionnaire. The Dillman method of multiple contacts was deployed to enhance response rates, with a target response rate threshold of between 48 to 55%. (Dillman 2000). A tracking mechanism ensured that only those who failed to return the questionnaire after round one would be contacted at round two. Contact at round two involved a personalised letter and the insertion of the questionnaire and a stamped-addressed envelope.

Quantitative Data Analysis
Prior to analysis, rigorous data screening and cleansing was performed. Data handling and analysis were undertaken using the Statistical Package for the Social Sciences® (SPSS Version 15.0) software. A range of descriptive and inferential statistical tests were deployed to handle and analyse the data. Descriptive variables related to sample characteristics, including age, discipline, grade, current employment and level of education and training attained, were calculated and summarised using frequency distributions and cross-tabulations. Sample characteristics related to registration status were compared with those of the total population from which the sample was drawn and displayed using frequency distribution tables.
Focus Groups Interviews

The aim of the focus group recruitment strategy was to select participants who were best positioned to provide valid and reliable information on their views, needs and the factors that either enabled or constrained clinical leadership and its development in Nursing and Midwifery. Data collection involved conducting 22 focus groups interviews with Nurses and Midwives over a three-month period. The Nurses and Midwives worked in purposive sample of healthcare provider sites across the Health Service Executive and represented all grades, all five divisions of the Register and the four administrative Health Service Executive (HSE) regions in Ireland.

Recruitment Procedures

The target number of participants in each focus group was 12. Recruitment was facilitated through the Director of Nursing and Midwifery in the chosen site. Recruitment of Specialist (CNS and CMS) and Advanced Practitioner (ANP and AMP) grades was facilitated through the National Council for the Professional Development of Nursing and Midwifery (NCNM). Recruitment of Directors of Nursing and Directors of Midwifery was facilitated through the Irish Association of Directors of Nursing and Midwifery.

Data Collection

Each focus group comprised up to 12 informants and took place over a period of approximately one hour. At least one Moderator and one Assistant Moderator attended each group and had agreed roles. A topic guide based on the current literature was prepared in advance and structured using the same broad categories that were developed for the national postal survey instrument, which were: the care environment, professional development needs, professional skills and factors that enable or constrain ability to deliver care effectively (see Appendix 2). The topic guide was subjected to pilot testing initially at the level of the research team and minor modifications were made following the first two focus group interviews.

A mix of question styles and formats, including follow-up and targeted questions, paraphrase, summary, and openness to and exploration of disagreements proved successful in encouraging participation and stimulating interaction (Puchta & Potter 2004). All participants were assured of anonymity and advised that the names of healthcare organisations were not recorded for the purpose of reporting findings from the focus groups.

Qualitative Data Handling and Analysis

Demographic data for focus group participants were entered into SPSS for ease of handling and presentation. Qualitative data generated from the focus groups were transcribed after each focus group was completed and imported into the computer-assisted qualitative data analysis software package, NVivo 7. Analysis followed the well-known stages of data reduction, exploration and synthesis common to most qualitative research designs, regardless of their specific methodological commitments (Attride-Stirling 2001). Each transcript was read closely and tentative themes noted. These themes were labelled as free nodes in NVivo 7. Free nodes represent themes or categories that stand in no particular relationship to each other.
As significant relationships between these free nodes were identified and further explored in the existing and incoming data, a tree node structure was devised. Tree nodes can be organised and arranged in various ways and can display hierarchical relationships between themes, enabling underlying patterns and relationships in the data to be explored. The tree node structure was constantly modified as data from the free nodes was ‘coded on’ to its constituent nodes. At this stage, the literature was revisited and a tentative reading frame or coding framework was devised to help filter and organise the data.

As exploration of the data deepened, the coding framework was modified and used to refine the tree node structure until the research team was satisfied that the maximum amount of data was accounted for in a concise way,

**Ethical Approval**

An application for ethical approval to conduct the study was submitted to the University College Dublin (UCD) Human Research Ethics Committee (HREC). Both the national postal survey and the focus group elements of the study were exempt from full ethical review and ethical exemption was thereby granted by the Committee through a standard procedure of notification to the Committee.\(^1\) All focus group participants were asked to give written informed consent prior to participating in the focus group. No names of individuals or their organisation were recorded during the focus group or identified in the report and all data were stored securely as indicated in the information sheet. The return of completed questionnaires was taken to indicate consent to participate in the national survey.

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\(^1\) HREC reference: LS-E-09-37-Fealy
Summary Of Findings

Focus Groups

Introduction
A total of 22 focus groups were conducted comprising 184 participants from all grades including Staff Nurse to Director of Nursing or Midwifery, and from five divisions of the Register: Midwife, General, Psychiatric, Intellectual Disability and Children’s Nurse. The focus groups were conducted in locations across all four Health Service Executive administrative regions. The mean number of participants per group was 8 and the range was 3 to 12. Of the 184 participants in the 22 focus groups, 169 (92%) were female and 15 (8%) were male.

Summary of Findings
The 22 focus groups yielded a large amount of rich data concerning clinical leaders, clinical leadership, the expressed personal and professional development needs of participants themselves and their views on the needs of Nursing and Midwifery in relation to developing a critical mass of clinical leadership capacity in the professions. There was considerable variation in the views expressed according to grade and area of work; however, the major issues arising were similar across the groups. Analysis of the data yielded five major themes as follows:

- **Theme 1 - Clinical leadership and leaders from a Nursing and Midwifery perspective**
- **Theme 2 - Quality service from a Nursing and Midwifery perspective**
- **Theme 3 - Clinical leaders’ roles and functions**
- **Theme 4 - Competencies for clinical leaders and leadership**
- **Theme 5 - The context of clinical leadership.**

**Theme 1 - Nurses’ and Midwives’ Views on Clinical Leaders and Leadership**
This section provides an overview of focus group participants’ views of clinical leadership and of themselves and their colleagues as clinical leaders. There is consensus that clinical leaders are the ‘guardians’ of patient care and are expected to advance Nursing and Midwifery practice by advocating for patients’ interests and by maintaining and improving standards.

The diffuse and underappreciated role of Clinical Managers is a recurring theme in the Clinical Manager groups. Despite the variation in the data, there is agreement that clinical leadership is founded on clinical expertise, experience and credibility. It is identified that clinical leaders need to be team players, working within multidisciplinary teams in the interests of patient care. Clinical leadership is considered to be more a distributed, collective property and should be inherent in all nursing and midwifery practice.

It is seen that a clinical leader leads by example and acts as an approachable and trustworthy resource person and role model, supporting, guiding, motivating and challenging staff to advance Nursing and Midwifery practice. At the director level, the focus must be on leading Nursing and Midwifery rather than managing Nurses and Midwives.
Summary
Clinical leadership involves establishing, maintaining and improving standards of patient care to ensure safe and cost-effective practice. Clinical leaders act as patient advocates and role models for other staff within the overall multidisciplinary team in which they are central to the efficient co-ordination of care. Clinical leaders need to be self-aware, critical and reflective practitioners, recognising their own limitations and those of their staff and being open to criticism, challenges to the status quo and suggestions for innovation and change. They hold themselves responsible and accountable for their actions and attempt to create an environment in which colleagues assume equal responsibility and accountability for their practice in the context of support for their continuing professional development. Above all, clinical leadership is seen as everyone’s business and is therefore a collective responsibility distributed throughout the healthcare setting.

Theme 2 - Quality Service from a Nursing and Midwifery Perspective
Three dimensions of quality service from the Nursing and Midwifery perspective were identified:

- Advocacy
- Safety, dignity and privacy
- Co-ordination and compensatory action.

Quality Nursing and Midwifery services are, or should be, an outcome of effective clinical leadership. One of the strongest findings of the study was participants’ demonstration of a very strong orientation and commitment to the delivery of a quality service and a particular focus on patient advocacy, standard setting, risk reduction and their role in co-ordinating care to deliver a service that ensures client safety, dignity and privacy.

Summary
Focus group participants are clear about the relationship between the existence of a critical mass of clinical leadership across the Nursing and Midwifery resource and quality patient services. All Nurses and Midwives consider themselves to be strong advocates for a patient-focused, quality service, understood as protecting patient safety, privacy and dignity. Establishing, maintaining and improving standards through monitoring and formal audit are seen as the specific remit of more senior grades. These grades are also more conscious of the need for cost-effectiveness and containment. The co-ordinating role of Nurses and Midwives is emphasised. They see themselves as integrating diverse disciplinary inputs in the interests of patient care, and in fact, they regard themselves as the only group to which this crucial responsibility falls. This can mean that Nurses’ and Midwives’ specific, specialist expertise is marginalised and their efforts thwarted in a health system that treats them as a generic, infinitely flexible and mutually interchangeable resource to be deployed when and where needed to compensate for gaps and deficiencies in organisational structures, systems and processes.
Theme 3 - Clinical Leaders’ Roles and Functions

Four key clinical leader interpersonal competencies, roles and leadership functions that directly impact on the quality of Nursing and Midwifery services emerged including:

- Representing Nursing and Midwifery
- Team building
- Challenging and changing
- Managing conflict.

Summary

Clinical leadership in Nursing and Midwifery entails representing the professions at both an intra- and interprofessional level within the organisation. The ability to credibly and convincingly articulate verbally and in writing Nurses’ and Midwives’ contribution to patient outcomes is critical to their roles as boundary-spanning agents, which underscores their ability to act as effective team players and team builders, capable of initiating and driving change and handling conflict. The key role of clinical leaders in Nursing and Midwifery is to protect the patient by facilitating evidence-based practice and improved patient outcomes through direct care and by advocating for the changes necessary to implement best practice and build clinical leadership capacity within the health system. This requires that the relationships, roles and functions between Nursing and Midwifery and other professions within the organisation are strengthened. However, the ability of Nurses and Midwives to perform the leadership roles and functions they regard as critical to the protection of patient care are compromised by organisational hierarchies and their relatively subordinate and often marginalised position in the organisations in which they work.

Theme 4 - Competencies for Clinical Leaders and Leadership

Three key clinical leader intrapersonal competencies, roles and leadership functions that directly impact on the quality of Nursing and Midwifery services emerged including:

- Self-regulation – personal and professional autonomy, responsibility and accountability
- Self-awareness – self-image and others’ images of Nursing and Midwifery
- Self-motivation – initiative, commitment and hope for the future.

Summary

Nursing and Midwifery practice has become more independent in recent years, partly as a result of new legislation and regulations. However, this autonomy is unevenly exercised across divisions of the Register, grade and location. Unsurprisingly, autonomy appears greatest in the specialist roles, while managerial grades in particular express concern at their increasing marginalisation within organisations and their exclusion from budgetary and other decision-making processes. Professional and personal accountability is acknowledged as an important attribute of clinical leaders but there is a reluctance on the part of some staff to assume wider responsibilities beyond their immediate sphere of patient care. Some participants felt that this may be due to lack of confidence, encouragement, poor delegation or poor morale.

Most groups discussed the importance of reflection on and in practice and the need to assess one’s own strengths and weaknesses. Formal appraisal systems, more structured support and supervision would greatly enhance self-awareness and professional development. Participants were acutely conscious of the images of nursing held by medical colleagues and senior management, and believed them to be outdated.
and inaccurate, saying that these images contributed to the erosion of professional status and the exclusion from strategic decision-making. Initiative and commitment are key attributes of the clinical leader, with many instances of outstanding examples of both; however, participants believe that Nursing and Midwifery initiatives are frequently blocked and their commitment is susceptible to exploitation, including by more senior members of their own professions.

**Theme 5 - The Context of Clinical Leadership**

The structural dimension refers to an individual’s location in relation to others in a structured organisational network. Organisational charts of most healthcare structures depict a pyramidal hierarchical structure, usually with the patient at the base rather than the centre and the Chief Executive at the apex. The location of Staff Nurse and Staff Midwife is commonly placed in close proximity to the patient – at the base.

**Facilitators of Clinical Leadership Development**

Identified facilitators of clinical leadership development included:

- Proper induction and orientation, effective teamwork, continual professional development and networking opportunities were the most frequently mentioned facilitators of clinical leadership.

- Structured development plans for new staff were considered very important.

- Formal appraisal systems were also viewed as an important element of clinical leadership development.

- Mentorship was mentioned by some groups as central to leadership development.

- Learning experiences in multidisciplinary environments are valued by those who have experienced them.

- Equally important are opportunities to network within the organisation. This is considered to be an important and under-utilised potential source of support for leadership development.

- Specialists in particular praised the opportunities provided for their role development and the increasing autonomy of their practice and presented as a somewhat more empowered group. They availed of professional networking opportunities and also mentioned clinical supervision as a key facilitator of their clinical leadership.

- Specific skills and knowledge identified by more senior staff as important to their role as clinical leaders included financial and human resource management, industrial relations, and communication and ‘people’ skills. Once again, the core theme of representing the professions predominated and was regarded as an essential prerequisite to the acquisition of more specific leadership knowledge and skills.

- The ability to establish and sustain networks of peer support was considered crucial. Where peer support groups were established, these were considered to be very helpful. However, in general, these need to be integrated into existing support structures and could be strengthened by work shadowing and through internal and external placements or secondments.
Barriers to Clinical Leadership Development
Identified barriers to clinical leadership development included:

- Orientation and induction of new staff was often found wanting.
- Support for new staff, where it existed, had been curtailed in some areas.
- Implementation of staff appraisal was considered by some clinical managers to be little more than a cosmetic exercise on the part of the organisation.
- Many participants were unrelenting in their criticism of the lack of development opportunities, inadequate career guidance and poor succession planning.
- Much criticism was directed at Nurse or Midwife Managers for being unapproachable and lacking visibility and influence.
- Both Staff Grades and Clinical Managers recognised Managers’ lack of authority and influence within the organisation. This was seen as a major barrier to clinical leadership development in Nursing and Midwifery.
- The lack of status and influence of directors and clinical managers was a cause for concern, as it inhibits the development of clinical leadership capacity in the professions through a kind of cascade of disempowerment.

Discussion of barriers to clinical leadership development focused on staff shortages; inadequate skill mix; non-replacement of staff on sick leave, study leave or maternity leave; the 37.5-hour week; too few beds; too little space; lack of time; financial constraints; non-replacement of staff on short-term contracts; and threats of bed, ward and unit closures. These issues provided a gloomy backdrop to attempts to pinpoint more specific impediments to leadership development.

Summary
The economic context, and its impact on the health system, forms the backdrop to discussions of how the organisation affects and effects clinical leadership development. Nurses and Midwives in management positions require more structured preparation prior to promotion that focuses on their development and formation as leaders. Participants believe that a more structured progression to formal leadership positions would prevent burnout, underperformance and break the insidious cycle of disempowerment and poor morale in the professions. This would aid succession planning and the development of a critical mass of adequately prepared leaders capable of building leadership capacity at all levels of Nursing and Midwifery. The context in which leaders operate will impact on the extent to which they are able to build teams, effect change and manage conflict. The ability to represent Nursing and Midwifery throughout the organisation is a prerequisite to the acquisition of more specific leadership knowledge and skills that could be developed and strengthened through programmes involving peer support, networking opportunities, clinical supervision and mentoring.
Conclusions

- There is consensus that clinical leadership is distributed or collective property of healthcare organisations directed at improving services provided to patients.

- At the bedside, ward or unit level, closest to patients, Nurses and Midwives act as clinical leaders through advocacy, ensuring patient safety, dignity, privacy and by co-ordinating the activities of the multidisciplinary team.

- In order to function as clinical leaders at a wider level, Nurses and Midwives need to better represent the specific contribution of their respective professions to patient and organisational outcomes. This capacity is critical to their ability to engage fully in multidisciplinary care and managerial teams, to initiate change and to resolve conflict as it arises. These roles and functions require excellent social and political skills and a high degree of social and political awareness.

- The key roles and functions of a clinical leader identified by participants are underpinned by sets of interpersonal and intrapersonal competences that need to be acquired and enhanced in order to build clinical leadership capacity in the professions and organisations.

- In the specific case of Nursing and Midwifery, clinical leaders require a high degree of personal and professional autonomy and must be willing to assume increasing levels of responsibility and accountability for judgments and decisions that impact on the standard of care and service provided to patients. This requires a high level of self-confidence and assertiveness and the ability to challenge outdated or ill-informed perceptions of Nurses and Midwives, their scopes of practice, their educational attainments and their distinct specialist expertise.

- Participants highlight the importance of initiative and commitment to clinical leadership development and while they recognise these attributes in themselves and their colleagues, they are pessimistic about the extent to which their initiative can be harnessed to drive wider changes and believe that their commitment is often exploited.

- The needs of Nurses and Midwives in relation to clinical leadership development fall into three broad areas: their needs as professional clinicians, their needs as leaders and their needs for clinical leadership.

- Clinical leadership development activities must address all three sets of needs in order to build the human and social capital required to support the range of intrapersonal and interpersonal competencies needed to enact key leader roles and functions in Nursing and Midwifery.

- Leadership development approaches, by definition, must target the organisational aspects that impact on the ability of Nurses and Midwives to act as effective clinical leaders.
Summary of findings from the National Survey

Introduction

The aim of the quantitative component of the National Clinical Leadership Needs Analysis study was to conduct an analysis of need among a national, random sample of Nurses and Midwives in Ireland. Based on a critical review of literature, a needs analysis questionnaire (CLAN-Q) was developed for the study and administered. The CLAN-Q questionnaire was a self-reported, self-administered needs analysis instrument containing a 17-item demographic questionnaire and a series of 89 items set out in a number of simple rating scales to elicit self-perceived needs by measuring two constructs: clinical leadership development need and perceived barriers to clinical leadership development.

Response Rate

The CLAN-Q instrument was mailed to a national sample of 3,000 Nurses and Midwives, randomly generated from the Active Register of the Register of Nurses. This resulted in a usable sample of 911 completed questionnaires, representing a cumulative usable response rate of 30.92% for the purpose of data analysis.

Sample Profile

The CLAN-Q instrument sought demographic data on respondents’ discipline, divisions in which registered, length of time since first registration, current grade and division in which currently employed, level of education and training attained, and education and training for the clinical leadership role received. For the purpose of analysis and presentation of findings, the Clinical Manager grade 3 was included with the Director of Nursing and Director of Midwifery grade.

Gender, Age and Nationality

Of the sample, 92% (n=836) were female and just over 7% (n=70) were male. The mean age of the sample was 41.7 years (SD =10.14) and ranged from 22 to 70 years, with the majority in the 30 to 39 years age category (35.4%). The smallest proportion of the sample was in the 22 to 29 years age category (10.8%). Of the sample, the majority (84.2%, n=746) reported their nationality as Irish, 3.1% (n=28) reported it as ‘other EU’, and 12.7% (n=115) reported it as ‘Non-EU’.

Years of Experience since First Registration

The number of years’ experience working in Nursing or Midwifery since first registration represented in the sample ranged from under five years to 55 years. The average number of years’ experience since obtaining first registration was just under 18 years (mean =17.84, SD =9.85) (see Table 5.1).

Table 5.1 Years of Experience since First Registration

<table>
<thead>
<tr>
<th>Years</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>≤5 years</td>
<td>11</td>
<td>98</td>
</tr>
<tr>
<td>6–20 years</td>
<td>52</td>
<td>465</td>
</tr>
<tr>
<td>21–55 years</td>
<td>37</td>
<td>330</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
<td>893</td>
</tr>
</tbody>
</table>
Years Working in Current Area of Practice

The number of years working in current area of practice in Nursing or Midwifery ranged from under one year to 47 years (see Table 5.2). The average number of years spent working in the current area was just under 10 years (M = 9.89, SD = 8.3). Two years working in current area of practice was most commonly reported (9%, n=84).

Table 5.2 Years Working in Current Area of Practice

<table>
<thead>
<tr>
<th>Years</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; years</td>
<td>3.4</td>
<td>31</td>
</tr>
<tr>
<td>1–5 years</td>
<td>35</td>
<td>316</td>
</tr>
<tr>
<td>6–10 years</td>
<td>29.3</td>
<td>264</td>
</tr>
<tr>
<td>11–20 years</td>
<td>19.6</td>
<td>177</td>
</tr>
<tr>
<td>&gt;20 years</td>
<td>12.6</td>
<td>114</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
<td>902</td>
</tr>
</tbody>
</table>

Health Setting in which Currently Employed

All of the study respondents indicated that they currently worked in the public or public voluntary sector of the Irish health services with the largest proportion (66.3%, n=584) working in a public or public voluntary hospital. Just over one-fifth (20.4%, n=180) worked in public health or community and 5.2% (n=46) worked in a nursing home.

Grade

The majority of the respondents in the national sample were at Staff Nurse grade (66.6%, n=599) (see Figure 5.1). Grades of Clinical Nurse Manager 1, 2 and 3 were 18% (n=72), of which the Clinical Nurse Manager 2 grade comprised 10.6% (n=95) of all respondents. The proportion of Midwifery respondents was 5.9% (n=53) and the breakdown of Midwives by grade is indicated in Figure 5.1. In total 19.5% (n=175) of the total sample worked at the Clinical Manager grade.

Figure 5.1: Grade at which currently employed

<table>
<thead>
<tr>
<th>Grade at currently employed</th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Nurse</td>
<td>66.6% (n=599)</td>
</tr>
<tr>
<td>CNM:</td>
<td>6.3% (n=57)</td>
</tr>
<tr>
<td>CNM2:</td>
<td>10.6% (n=95)</td>
</tr>
<tr>
<td>CNM3:</td>
<td>1.1% (n=10)</td>
</tr>
<tr>
<td>CNS:</td>
<td>5.1% (n=46)</td>
</tr>
<tr>
<td>ANP:</td>
<td>0.4% (n=4)</td>
</tr>
<tr>
<td>ADoN:</td>
<td>3.1% (n=28)</td>
</tr>
<tr>
<td>DoN:</td>
<td>0.8% (n=7)</td>
</tr>
<tr>
<td>Staff Midwife:</td>
<td>3.9% (n=35)</td>
</tr>
<tr>
<td>CNMM1:</td>
<td>0.2% (n=2)</td>
</tr>
<tr>
<td>CNM2:</td>
<td>0.8% (n=7)</td>
</tr>
<tr>
<td>CNM3:</td>
<td>0.4% (n=4)</td>
</tr>
<tr>
<td>CMS:</td>
<td>0.2% (n=2)</td>
</tr>
<tr>
<td>AMP:</td>
<td>0.1% (n=1)</td>
</tr>
<tr>
<td>ADoM:</td>
<td>0.2% (n=2)</td>
</tr>
<tr>
<td>DoM:</td>
<td>0% (n=0)</td>
</tr>
</tbody>
</table>
Educational Level Attained

Table 5.3 summarises four main categories of level of education attained.

Table 5.3 Highest Level of Education by Category

<table>
<thead>
<tr>
<th>Education Level Category</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital certificate (pre-registration and specialist</td>
<td>25.9</td>
<td>230</td>
</tr>
<tr>
<td>clinical training)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>18.1</td>
<td>161</td>
</tr>
<tr>
<td>Degree</td>
<td>30.4</td>
<td>270</td>
</tr>
<tr>
<td>Postgraduate (Higher Diploma, Graduate Diploma and Master's</td>
<td>25.6</td>
<td>228</td>
</tr>
<tr>
<td>Degree)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
<td>889</td>
</tr>
</tbody>
</table>

Further analysis of the data indicate that the highest proportion of those educated to degree level were at the Staff Nurses and Staff Midwife grade (34.9%, n=216).

Educational Preparation for the Leadership Role

Of the total sample, 36% (n=319) indicated that they had participated in in-service education and training for the leadership role, while 64% (n=568) indicated that they had not participated in such training. There was considerable variation in both the reported types of in-service training that had been received and the duration of in-service courses attended, with respondents indicating a wide variation in the way in which leadership training in the clinical setting was understood by respondents. Additionally, more than one-quarter of respondents (26.1%, n=77) reported attending the Leading an Empowered Organisation (LEO) programme, which was reported as typically of two to three days in duration.

Participation in in-service education varied according to grade, with 59.6% (n=93) of Clinical Manager grades reporting having participated in in-service education and training for the leadership role, and just one-quarter (24.8% (n=154) of the Staff grade having participated. Approximately half (49.1% n=26) of respondents in the Specialists and Advanced grades and 83.3% (n=40) of those at Director of Nursing and Directors of Midwifery grade participated in in-service education and training for the leadership role (see Table 5.4).

Table 5.4 Participation in In-Service Education and Training by Grade

<table>
<thead>
<tr>
<th>Grade</th>
<th>In-Service Training</th>
<th>Staff Nurse &amp; Staff Midwife</th>
<th>Clinical Nurse &amp; Clinical Midwife Manager</th>
<th>Specialist &amp; Advanced Practitioner</th>
<th>Director of Nursing/ Director of Midwifery</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL N</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>N</td>
<td>620</td>
<td>156</td>
<td>53</td>
<td>48</td>
<td></td>
</tr>
</tbody>
</table>
Education and training for the leadership role undertaken in the course of academic studies also varied by grade, with 36.1% (n=210) of the staff grade and 63.8% (n=97) of Clinical Manager grade reporting preparation for the leadership role in the course of academic studies. Approximately two-thirds (66% n=33) of respondents at the Specialist grade and 84% (n=42) of those at Director of Nursing or Director of Midwifery grade participated in education and training for the role in the course of academic studies (see Table 5.5).

Table 5.5 Participation in Academic Studies by Grade

<table>
<thead>
<tr>
<th>Grade</th>
<th>Academic Studies</th>
<th>Staff Nurse &amp; Staff Midwife</th>
<th>Clinical Nurse &amp; Clinical Midwife Manager</th>
<th>Specialist &amp; Advanced Practitioner</th>
<th>Director of Nursing/ Director of Midwifery</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td></td>
<td>36.1%</td>
<td>63.8%</td>
<td>66%</td>
<td>84%</td>
</tr>
<tr>
<td>NO</td>
<td></td>
<td>371</td>
<td>63.9%</td>
<td>34%</td>
<td>16%</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Of those who participated in some form of in-service education and training in relation to their leadership role, 78.7% (n=244) reported that the education and training that they received was ‘useful’ or ‘very useful’. Of those who attended preparation for the clinical leadership role in the course of academic studies, 74.1% (n=284) reported that the education and training received was ‘useful’ or ‘very useful’ (see Table 5.6).

Table 5.6 Perceived Usefulness of Previous Education and Training for Clinical Leadership Role

<table>
<thead>
<tr>
<th>Training type</th>
<th>Not useful</th>
<th>Somewhat Useful</th>
<th>Useful</th>
<th>Very useful</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-service training % (n)</td>
<td>2.3% (7)</td>
<td>19% (59)</td>
<td>33.5% (104)</td>
<td>45.2% (140)</td>
<td>100% (310)</td>
</tr>
<tr>
<td>Academic studies % (n)</td>
<td>2.9% (11)</td>
<td>23% (88)</td>
<td>34.2% (131)</td>
<td>39.9% (153)</td>
<td>100% (383)</td>
</tr>
</tbody>
</table>

Survey Findings
The CLAN-Q questionnaire measured the two main constructs: clinical leadership development need-enablers and perceived barriers to clinical leadership development.

Factor Analysis
Following data collection, factor analysis was performed to identify and explain patterns of correlations between the 89 items measured in the CLAN-Q questionnaire. Factor analysis resulted in the identification of nine subscales: five subscales called dimensions for Construct 1 - clinical leadership development need-enablers and four subscales called dimensions for the Construct 2 - barriers to clinical leadership development. (For further information see Appendix 3). Cronbach’s alpha levels were used to measure the internal consistency and reliability of the dimensions, as listed in Tables 5.7 and 5.8.
Table 5.7 Five dimensions for Clinical Leadership Development Need

<table>
<thead>
<tr>
<th>Dimensions of Clinical Leadership Development Need Construct</th>
<th>Alpha (α) Level</th>
<th>Number of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing clinical area</td>
<td>0.91</td>
<td>6</td>
</tr>
<tr>
<td>Managing patient care</td>
<td>0.98</td>
<td>25</td>
</tr>
<tr>
<td>Development of the individual</td>
<td>0.95</td>
<td>9</td>
</tr>
<tr>
<td>Development of the profession</td>
<td>0.91</td>
<td>5</td>
</tr>
<tr>
<td>Skills for clinical leadership</td>
<td>0.98</td>
<td>22</td>
</tr>
</tbody>
</table>

Table 5.8 Four Dimensions for Barriers to Clinical Leadership Development

<table>
<thead>
<tr>
<th>Dimensions of Barriers to Clinical Leadership Development</th>
<th>Alpha (α) Level</th>
<th>Number of Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality care factors</td>
<td>0.86</td>
<td>11</td>
</tr>
<tr>
<td>Interdisciplinary relationships *</td>
<td>0.62</td>
<td>2</td>
</tr>
<tr>
<td>Recognition**</td>
<td>0.58</td>
<td>3</td>
</tr>
<tr>
<td>Influence</td>
<td>0.69</td>
<td>5</td>
</tr>
</tbody>
</table>

* r = 0.5, p<0.005; ** r = 0.3, p<0.005

The optimal level for Cronbach’s Alpha is at 0.7 or above.

Construct 1 - Clinical Leadership Development Needs

The mean overall scores for each of these individual five dimensions indicate that self-reported clinical leadership development need was highest for the subscale ‘development of the profession’, which yielded a mean score of 3.22 (SD=0.99) on the five point Likert scale of 1 to 5 (Table 5.9). The Likert scale which is commonly used in questionnaires, where respondents specify their level of agreement to a statement.

This dimension was composed of five items that addressed development need in regard to participating in Nursing/Midwifery forums, effects of current issues, trends, policies on the professions, networking across organisational and professional boundaries, understanding the impact of organisational politics on the work of the profession and representing the interest of the profession at national policy making.

Relative to the other dimensions of need, the lowest level of self-reported need was for the dimension ‘managing patient care’ which yielded a mean score of 2.92 (SD =1.1).
Table 5.9 Self-Reported Clinical Leadership Development Need

<table>
<thead>
<tr>
<th>Dimensions of Clinical Leadership Development Need</th>
<th>Managing Clinical Area</th>
<th>Managing Patient Care</th>
<th>Development of the Individual</th>
<th>Development of the Profession</th>
<th>Skills for Clinical Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>3.07</td>
<td>2.92</td>
<td>3.04</td>
<td>3.22</td>
<td>3.07</td>
</tr>
<tr>
<td>SD</td>
<td>1</td>
<td>1.1</td>
<td>1</td>
<td>0.99</td>
<td>1</td>
</tr>
<tr>
<td>N</td>
<td>880</td>
<td>834</td>
<td>863</td>
<td>872</td>
<td>834</td>
</tr>
</tbody>
</table>

Group Differences for Clinical Leadership Development Need

For the dimension ‘development of the individual’ the highest level was reported by those at Staff Nurse and Staff Midwife grade (M=3.09, SD=1.03) and the lowest level of need was reported by the Directors of Nursing and Directors of Midwifery grade (M=2.87, SD=1.03). Differences between the various grades were marginal. The ‘development of the individual’ (personal development) dimension subscale contained nine items that included: commitment to lifelong learning, participating in Continuing Professional Development, recognising own strengths and weaknesses, getting and giving feedback, coping effectively with pressure, acting as a mentor to colleagues, contributing to the professional development of others and recognising and acknowledging the contributions of others.

For the dimension ‘skills for clinical leadership’ the highest level of need was reported by the Staff Nurse and Staff Midwife grade (M=3.14, SD=1.03) and the lowest level of need for this dimension was reported by the Clinical Manager grade (M=2.85, SD=0.94). A significant difference was observed between Staff and Clinical Manager grades for the ‘skills for leadership development’ dimension (p=0.015). The Specialist or Advanced Practitioner grade also reported a high level of need in this same dimension (M=3.06, SD=0.94) (see Table 5.10). The dimension ‘skills for clinical leadership’ contained 23 items (see Appendix 3) concerned with effective working relationships with the interdisciplinary team, motivating others, accepting accountability and initiating change to ensure optimal care.

Table 5.10 Dimension ‘skills for clinical leadership’ and Grade

<table>
<thead>
<tr>
<th>Grade*</th>
<th>Skills for Clinical Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
</tr>
<tr>
<td>Staff Nurse and Staff Midwife</td>
<td>581</td>
</tr>
<tr>
<td>Clinical Nurse and Clinical Midwife Manager</td>
<td>146</td>
</tr>
<tr>
<td>Specialist or Advanced Practitioner</td>
<td>48</td>
</tr>
<tr>
<td>Director of Nursing and Director of Midwifery</td>
<td>48</td>
</tr>
</tbody>
</table>
Construct 2 - Perceived Barriers to Clinical Leadership Development

The CLAN-Q presented respondents with a series of statements relating to conditions in the practice setting that may enable or hinder their development as clinical leaders. Following factor analysis the following four subscales called dimensions emerged: quality care factors, interdisciplinary relationships, recognition and influence (See Appendix 3). Table 5.11 summarises the main findings from respondents concerning self-reported barriers to clinical leadership development.

Table 5.11 Self-Reported Perceived Barriers to Clinical Leadership Development

<table>
<thead>
<tr>
<th>Dimensions of perceived barriers</th>
<th>Quality Care Factors</th>
<th>Interdisciplinary Relationships</th>
<th>Recognition</th>
<th>Influence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>2.86</td>
<td>3.41</td>
<td>3.15</td>
<td>3.51</td>
</tr>
<tr>
<td>SD</td>
<td>0.69</td>
<td>0.84</td>
<td>0.85</td>
<td>0.74</td>
</tr>
<tr>
<td>N</td>
<td>856</td>
<td>886</td>
<td>884</td>
<td>878</td>
</tr>
</tbody>
</table>

The mean scores for the four barriers subscales indicate that respondents perceived a lower level of barriers to clinical leadership development within the dimension ‘quality care factors’ (M = 2.86, SD = 0.69) when compared with the dimensions ‘interdisciplinary relationships’ (M = 3.41, SD = 0.84), ‘recognition’ (M = 3.15, SD = 0.85) and ‘influence’ (M = 3.51, SD = 0.74) (Table 5.19). The ‘quality care factors’ subscale included items such as ‘organisational support for nursing and midwifery clinical decision making’, ‘existing skill mix ensures optimal care’, and ‘care and treatment plans are negotiated by all members of the multidisciplinary team’. The ‘recognition’ subscale contained three items: ‘nurses or midwives often have little say in decisions about patient care and treatment’, ‘there is little support for nurses’ or midwives’ continuing professional development’ and ‘there are few opportunities for nurses or midwives to progress along clinical career pathways’.

Respondents perceived barriers to be higher within the ‘interdisciplinary relationships’ subscale (M = 3.41, SD = 0.84) and the ‘influence’ subscale (M = 3.51, SD = 0.74). The ‘interdisciplinary relationships’ subscale contained the two items: ‘there are professional tensions among members of the interdisciplinary team’ and ‘interdisciplinary clinical care is fragmented’. The ‘influence’ subscale contained five items, including ineffective communication in the workplace, managers’ lack of authority at the organisational level, and a lack of representation of nursing or midwifery interests at the organisational level.

Group Differences for Perceived Barriers to Clinical Leadership Development

Staff grade and Clinical Manager grade reported a higher perceived barrier in the dimension ‘influence’ (M = 3.53 versus M = 3.22). Staff had a higher perceived need with the dimension ‘interdisciplinary relationships’ (M = 3.47 versus M = 3.26 and M = 3.32) and with the dimension ‘recognition’ (M = 3.25), versus (M = 3.07 and M = 2.58) relative to the other grades.

Education Profile

A significant difference was found in respondents’ scores in regard to the dimension ‘recognition’ for those who had received some leadership education and training as part of academic studies (M = 3.05, SD = 0.87) and those who had not (M = 3.21, SD = 0.83); t(819) = -2.74, p = 0.006. In addition, there was a significant difference in scores in regard to the dimension ‘managing clinical area’ for those who had received some leadership education and training as part of academic studies (M = 2.98, SD = 0.96) and those who had not (M = 3.13, SD = 1.02); t(818) = -2.15, p = 0.032.
Summary of Findings and Discussion Points

Study Design

- The response rate was 48% and the unusable response rate was 30.9%. A response rate of 35% was reported in a national study entitled the Review of Nurses and Midwives in the Prescribing and Administration of Medicinal Products study (An Bord Altranais 2005). A similar response rate was achieved from a training needs analysis study of Family Planning Nurses in England and Wales. In that study Tyler and Hicks (2002) reported a response rate of 34% from a national postal survey mailed to a sample of over 1,100 Nurses.

- In the present study, a survey sought data on self-reported need and hence the burden of interpretation with reference to predicting need may be considered lower than that demanded in intervention and inter-relationship studies.

- The fact that more than 50 respondents names taken from the Active Register were either not employed in Nursing or Midwifery in Ireland or were not available at the postal address, calls into question the use of the Active Register as a reliable sampling frame from which to draw samples of Nurses and Midwives currently working in practice in Ireland. Nor was it possible to target Nurses and Midwives employed specifically in the public and public voluntary sectors of the Irish health services using the Active Register.

- The survey was administered at a time of considerable uncertainty and pessimism in Ireland due to national and global economic crises.

Profile of Study Respondents

- More than 70% of the study sample was aged over 30 years and more than 46% was aged 40 years and over. Clinical leadership a relatively new concept would not have been part of these Nurse and Midwives’ initial formal Nursing and Midwifery education.

- The age profile of the study sample indicates a much larger proportion of Nurses and Midwives (26%) in late career than the proportion (10.8%) in early career.

- The majority of the sample was female and all grades were represented.

- Two-thirds worked in a public or public voluntary hospital setting and approximately two-thirds of the sample had been working in current area of practice for up to 10 years.

- Less than one-third of the sample had a Bachelor’s Degree and the majority of those at Clinical Specialist and Advanced Practitioner grade held a Postgraduate Degree. This upward trend towards having a higher academic level is consistent with the widespread provision and uptake of Degree and Postgraduate Degree education for Nurses and Midwives in Ireland in the intervening years since (Scott, Mathews and Corbally 2003) conducted the Experiences of Empowerment study.

- Fewer than half of the sample reported receiving any education and training for the leadership role in the course of undergraduate studies.

- A total of 64% of Nurses and Midwives indicated that they had not participated in in-service education and training for their leadership role.
The majority of those who participated in education and training for the leadership role found it useful. These positive evaluations of leadership training development are consistent with reports of studies that have specifically evaluated leadership development programmes (Dierckx de Casterlé et al. 2008, Lunn, MacCurtain, and McMahon 2008, Faughier & Woolnough 2002). However, it is still an unknown how this leadership development and training impacts on care given to patients.

A total of 59.6% (n=93) of Clinical Manager grades reported having participated in in-service education and training for the leadership role.

More than one-quarter of respondents (26.1%, n=77) reported attending the Leading an Empowered Organisation (LEO) programme and this was reported as typically two to three days in duration.

Defining Clinical Leadership

Overall when the data were reduced, explored in detail and re-integrated, themes, patterns and concepts were identified that resonated with the wider literature on leaders, leadership and clinical leadership. In particular, there was a consensus that clinical leadership is directed at ensuring quality patient services and that at the level closest to the patient, Nurses and Midwives consider themselves well-positioned to make a difference.

The principal mechanisms through which Nurses and Midwives impact on patient care are patient advocacy, attention to issues of safety, dignity, privacy, and crucially, through the co-ordination and orchestration of the care environment. The management of relationships between patients, multidisciplinary team members and the wider organisation is widely acknowledged to be a key function of clinical leaders (Milward & Bryan 2005).
CHAPTER 6

Conclusion

Clinical leadership is essential for achieving quality care and improving care outcomes. It is therefore not the sole preserve of those occupying formal leadership or management roles, but can be demonstrated by Nurses and Midwives across all clinical grades. Since effective care requires effective clinical leadership, then clinical leadership concerns all Nurses and Midwives and affording them the opportunity to develop their clinical leadership skills and capabilities will help them to give more effective care. This national study on clinical leadership development involved a mixed methods approach to data collection and analysis and provided complementary data with which to describe Nurses’ and Midwives’ clinical leadership development needs.

Overall, when the data was examined, there was a consensus among respondents of all grades that clinical leadership is directed at ensuring quality patient services and that, at the level closest to the patient, Nurses and Midwives consider themselves well-positioned to make a difference. From the national survey 64% of Nurses and Midwives indicated that they had not participated in in-service education and training for their leadership role. Therefore, a need for clinical leadership development clearly exists.

The ‘development of the profession’ dimension was found to be the greatest clinical leadership development need identified in the national survey. The dimension ‘development of the individual’ and the dimension ‘skills for clinical leadership’ were reported by those at Staff Nurse and Staff Midwife grade at the highest level for this group.

Respondents to the national survey perceived barriers to be higher within the ‘interdisciplinary relationships’ dimension and the ‘influence’ dimension. Staff grades in particular reported a higher perceived barrier in the dimension ‘influence’, with and the dimensions ‘interdisciplinary relationships’ and ‘recognition’ relative to the other grades.

The focus group data suggests the needs of Nurses and Midwives in relation to clinical leadership development fall into three broad areas: their needs as professional clinicians, their needs as leaders and their needs for clinical leadership. It also suggests at the bedside, ward or unit level closest to patients, Nurses and Midwives act as clinical leaders through advocacy, ensuring patient safety, dignity, and privacy and by co-ordinating the activities of the multidisciplinary team.

Throughout the qualitative data, Nurses and Midwives suggest that in order to function as clinical leaders at a wider level, they need to better represent the specific contribution of their respective professions to patient and organisational outcomes. This capacity is critical to their ability to engage fully in multidisciplinary care and managerial teams, to initiate change and to resolve conflict as it arises. These roles and functions require excellent social and political skills and a high degree of social and political awareness.
Clinical leadership development needs from the focus group data suggest that clinical leaders require a high degree of personal and professional autonomy and must be willing to assume increasing levels of responsibility and accountability for judgements and decisions that impact on the standard of care and service provided to patients. This requires a high level of self-confidence and assertiveness and the ability to challenge outdated or ill-informed perceptions of Nurses and Midwives, their scopes of practice, their educational attainments and their distinct specialist expertise. Participants highlight the importance of initiative and commitment for clinical leadership. While they recognise these attributes in themselves and their colleagues, they are pessimistic about the extent to which their initiative can be harnessed to drive wider changes and believe that their commitment is often exploited.

Both leader development (individual intrapersonal development) and leadership development (interpersonal organisational context) must be considered as part of the spectrum of clinical leadership development. Clinical leadership development approaches must target the individual, team, unit or departmental and organisational levels. Those in formal management positions in Nursing and Midwifery – Clinical Managers and Directors – are actual and potential clinical leaders. Clinical leadership development approaches must identify their needs as leaders in the context of their location in the wider organisation and take into account the systemic, structural and cultural aspects of healthcare organisations that either facilitate or inhibit the exercise of leadership from within Nursing and Midwifery. It must also address the sense of marginalisation and powerlessness that many in senior Nursing and Midwifery positions in Ireland can experience (Hogan 2006, O’Shea 2008, Treacy & Hyde 2003). Early identification and development of the clinical leaders of the future through structured development programmes will ensure succession planning and the building of clinical leadership capacity in the professions. Identification of potential leaders is important because, as Cook (2004) points out, clinical leaders are not always the most senior Nurses or Midwives, but can emerge from across the spectrum of clinical and managerial grades.

This study suggests that clinical leadership is everybody’s business and that actual and potential clinical leaders are those involved in ensuring the delivery of quality Nursing and Midwifery services at all levels in the system. Equally, clinical leadership development is a shared responsibility and Nurses and Midwives in leadership positions in clinical care, management and education must work together and across professional boundaries to ensure that Nursing and Midwifery secure the recognition and influence they need to make a difference to patient services.
References


Dear Colleague,

Your name has been randomly chosen from the list of names on the Register of Nurses maintained by An Bord Altranais to participate in this national survey on Nurses’ and Midwives’ clinical leadership development needs. The questionnaire is designed for Nurses and Midwives currently employed in the public sector of the health system (e.g. public or voluntary hospitals or local health offices, or other HSE settings). If you are not employed in the public sector of the health services there is no need to proceed and you may return the blank questionnaire in the prepaid envelope.

The questionnaire is presented in a number of scales, and requires you to tick the response that is most relevant to you. By completing the questionnaire you are providing valuable information to help identify Nurses’ and Midwives’ development needs in relation to providing clinical leadership to improve patient/client care. For convenience and brevity the term ‘patient’ is used throughout to refer to recipients of nursing or midwifery care.

Please take your time and ensure that you complete all questions. The questionnaire will take approximately 15 to 20 minutes to complete.

The information that you provide in this questionnaire is confidential. No individual names will be used in the study report. Therefore it is not necessary to include your name on the questionnaire.

Thank you for taking the time to complete the questionnaire.

What is clinical leadership?
For the purpose of this national survey, we define a clinical leader as someone who supports innovations that improve patient outcomes, ensures quality care and reduces health care costs. A clinical leader integrates research evidence into practice, leads efforts to improve patient care, is recognised as a leader in all settings and is an advocate for transforming the health system and implementing best practice.

What are development needs?
Development needs refer to all or any of the supports, training, education, skills, knowledge, information and resources that nurses or midwives require to function more effectively as clinical leaders.

Please return the questionnaire in the prepaid envelope provided on or before **** date to:
National Clinical Leadership Study,
UCD School of Nursing, Midwifery & Health Systems,
UCD Health Sciences Centre
Belfield,
Dublin 4.
SECTION 1: SECTOR OF HEALTH SERVICE IN WHICH EMPLOYED

1.1 Employment sector
Are you currently employed in the public sector of the Irish health care system (e.g., public or voluntary hospital, local health office, or other HSE settings)?

Please place a tick ‘✓’ in the space provided

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

If ‘YES’, please proceed to SECTION 2

If ‘NO’, there is no need to proceed further.

Please return the incomplete questionnaire ➔

SECTION 2: DEMOGRAPHIC INFORMATION Please answer all questions

2.1 Gender
Please tick ‘✓’

<table>
<thead>
<tr>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
</table>

2.2 Age at last birthday

__________ years

2.3 Nationality
Tick ONE box only

<table>
<thead>
<tr>
<th>Irish</th>
<th>Other EU</th>
<th>Non-EU</th>
</tr>
</thead>
</table>

Please specify ______________________________

Please specify ______________________________

2.4 Registration
Tick ALL that apply

<table>
<thead>
<tr>
<th>General (RGN)</th>
<th>Intellectual disability (RNID)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwife (RM)</td>
<td>Children’s (RCN)</td>
</tr>
<tr>
<td>Psychiatric (RPN)</td>
<td>Public health nurse (RPHN)</td>
</tr>
<tr>
<td>Tutor (RNT)</td>
<td>Registered nurse prescriber (RNP)</td>
</tr>
</tbody>
</table>

2.5 Division of the Register in which currently employed

Tick ONE box only

<table>
<thead>
<tr>
<th>General nursing</th>
<th>Midwifery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric nursing</td>
<td>Intellectual disability nursing</td>
</tr>
<tr>
<td>Children’s nursing</td>
<td>Public health nursing</td>
</tr>
<tr>
<td>Tutor</td>
<td></td>
</tr>
</tbody>
</table>
2.6 Type of health setting in the PUBLIC sector in which currently employed

<table>
<thead>
<tr>
<th>Tick ONE box only</th>
<th>Office use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public/voluntary hospital</td>
<td></td>
</tr>
<tr>
<td>Public health/community</td>
<td></td>
</tr>
<tr>
<td>Nursing home (HSE)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Please specify ______________________________</td>
</tr>
</tbody>
</table>

2.7 Grade at which currently employed

<table>
<thead>
<tr>
<th>Tick ONE box only</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff nurse</td>
<td>1</td>
</tr>
<tr>
<td>CNM 1</td>
<td>2</td>
</tr>
<tr>
<td>CNM 2</td>
<td>3</td>
</tr>
<tr>
<td>CNM 3</td>
<td>4</td>
</tr>
<tr>
<td>CNS</td>
<td>5</td>
</tr>
<tr>
<td>ANP</td>
<td>6</td>
</tr>
<tr>
<td>Assist. Director of Nursing</td>
<td>7</td>
</tr>
<tr>
<td>Director of Nursing</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>Please specify ______________________________</td>
</tr>
</tbody>
</table>

2.8 Number of years of nursing and/or midwifery experience since first registration

___________ years

2.9 Length of time working in current area of nursing or midwifery

___________ years

2.10 Highest educational level attained

<table>
<thead>
<tr>
<th>Tick ONE box only for highest level attained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital certificate (pre-registration training)</td>
</tr>
<tr>
<td>Diploma</td>
</tr>
<tr>
<td>Bachelors degree</td>
</tr>
<tr>
<td>Masters degree</td>
</tr>
</tbody>
</table>
### SECTION 3a: PREVIOUS PREPARATION FOR LEADERSHIP ROLE: In-service education and training

#### 3.1 Have you participated in any in-service education and training in relation to your leadership role in the clinical setting?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

If 'YES', please state [ ]

If 'NO', please continue [ ]

to SECTION 3b [ ]

#### 3.2 The title of the course:

______________________________

#### 3.3 The approximate duration of the course in either:

Write NUMBER in space provided

______ days / or ______ weeks / or ______ months

#### 3.4 How useful was the course in meeting your clinical leadership development needs?

<table>
<thead>
<tr>
<th>Not useful</th>
<th>Somewhat useful</th>
<th>Useful</th>
<th>Very useful</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### SECTION 3b: PREVIOUS PREPARATION FOR LEADERSHIP ROLE: Academic module(s) or course(s) taken

#### 3.5 Have you participated in any leadership education and training module(s) or course(s) as part of an academic programme?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

If 'YES', please state [ ]

If 'NO', please continue [ ]

to SECTION 4 [ ]

#### 3.6 The level of the programme (e.g. diploma, bachelors, masters etc)

______________________________

#### 3.7 In general, how useful were the module(s) or course(s) in meeting your clinical leadership development needs?

<table>
<thead>
<tr>
<th>Not useful</th>
<th>Somewhat useful</th>
<th>Useful</th>
<th>Very useful</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
### SECTION 4: MY DEVELOPMENT NEEDS: IMPROVING THE ENVIRONMENT FOR CARE DELIVERY

Sections 4 to 6 contain a list of clinical leadership skills and capabilities that Nurses and Midwives may demonstrate in their clinical practice. Each statement relates to aspects of knowledge, skills, and professional approach when working as a member of the care team or as an individual practitioner.

**Instruction:** Please read each item on the list. Using **SCALE A**, please indicate how important you consider each skill or capability to be for your effective performance as a clinical leader in your practice, using the five-point scale: 1 (‘not important’), 2 (‘of little importance’), 3 (‘moderately important’), 4 (‘important’), and 5 (‘very important’).

**Then,** using **SCALE B**, indicate your development needs for each leadership skill or capability, using the five-point scale: 1 (‘I have no need’), 2 (‘I have low need’), 3 (‘I have moderate need’), 4 (‘I have high need’), and 5 (‘I have very high need’). Development needs refer to all or any of the supports, training, education, skills, knowledge, information and resources that nurses or midwives require to function more effectively as clinical leaders.

The items in this section relate to the care environment. Please do remember to complete **SCALE A** and **SCALE B** for each item in the list.

| 4.1 | Coordinating care in the work setting to ensure optimum patient outcomes | 1 2 3 4 5 | 1 2 3 4 5 |
| 4.2 | Assessing the capacity of work colleagues to provide optimum patient care | 1 2 3 4 5 | 1 2 3 4 5 |
| 4.3 | Ensuring that adequate resources are available to provide optimum patient care | 1 2 3 4 5 | 1 2 3 4 5 |
| 4.4 | Identifying priorities for service improvement | 1 2 3 4 5 | 1 2 3 4 5 |
| 4.5 | Ensuring that team members carry out duties appropriate to their grade | 1 2 3 4 5 | 1 2 3 4 5 |
| 4.6 | Ensuring that the most appropriate team member provides direct patient care | 1 2 3 4 5 | 1 2 3 4 5 |
| 4.7 | Protecting the dignity, privacy and confidentiality of patients | 1 2 3 4 5 | 1 2 3 4 5 |
| 4.8 | Involving patients in their care and treatment plans | 1 2 3 4 5 | 1 2 3 4 5 |
| 4.9 | Involving families, relatives and significant others in planning patient care | 1 2 3 4 5 | 1 2 3 4 5 |
| 4.10 | Treating others with compassion, tact and sensitivity | 1 2 3 4 5 | 1 2 3 4 5 |
### SECTION 4: MY DEVELOPMENT NEEDS: IMPROVING THE ENVIRONMENT FOR CARE DELIVERY

The items in this section relate to the care environment.

Please do remember to complete **SCALE A** and **SCALE B** for each item in the list.

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
<th>SCALE A</th>
<th>SCALE B</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.11</td>
<td>Creating a culture of trust and ethical behaviour</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.12</td>
<td>Monitoring patient satisfaction with standards of care</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.13</td>
<td>Orientating new employees to the work setting</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.14</td>
<td>Orientating learners to the work setting</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.15</td>
<td>Encouraging staff to communicate concerns about standards of care</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.16</td>
<td>Creating a non-blame climate in which staff can report errors</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.17</td>
<td>Reporting critical incidents to line manager as appropriate</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.18</td>
<td>Contributing to the development of clinical practice guidelines</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.19</td>
<td>Ensuring that the outcomes of care and other interventions are documented</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.20</td>
<td>Ensuring patient care is based on current, evidence-based best practice</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.21</td>
<td>Working within own scope of practice</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.22</td>
<td>Making patients aware of their rights and relevant policies and procedures</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.23</td>
<td>Acting to uphold patients' rights</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.24</td>
<td>Challenging processes and practices that compromise patient safety</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>4.25</td>
<td>Participating in multidisciplinary decision making</td>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
### SECTION 4: MY DEVELOPMENT NEEDS: IMPROVING THE ENVIRONMENT FOR CARE DELIVERY

The items in this section relate to the care environment.

Please do remember to complete SCALE A and SCALE B for each item in the list.

<table>
<thead>
<tr>
<th>Item</th>
<th>SCALE A IMPORTANCE</th>
<th>SCALE B MY DEVELOPMENT NEED</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.26 Providing clear and concise instructions to others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.27 Representing the nursing or midwifery perspective at discussions and meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.28 Preparing concise and accurate written documents and reports using appropriate professional language</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.29 Considering social and cultural backgrounds when interacting with others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.30 Stating priorities with an appropriate sense of urgency and importance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.31 Respecting colleagues’ needs and feelings</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### SECTION 5: MY DEVELOPMENT NEEDS: PERSONAL AND PROFESSIONAL DEVELOPMENT

The items in this section relate to your personal and professional development.

Please do remember to complete SCALE A and SCALE B for each item in the list.

<table>
<thead>
<tr>
<th></th>
<th>SCALE A IMPORTANCE</th>
<th>SCALE B MY DEVELOPMENT NEED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not important</td>
<td>Of little importance</td>
</tr>
<tr>
<td>5.1</td>
<td>Demonstrating commitment to lifelong learning</td>
<td>1</td>
</tr>
<tr>
<td>5.2</td>
<td>Participating in continuing professional development</td>
<td>1</td>
</tr>
<tr>
<td>5.3</td>
<td>Constructively receiving criticism and suggestions from others</td>
<td>1</td>
</tr>
<tr>
<td>5.4</td>
<td>Recognising own strengths and weaknesses</td>
<td>1</td>
</tr>
<tr>
<td>5.5</td>
<td>Coping effectively with pressure</td>
<td>1</td>
</tr>
<tr>
<td>5.6</td>
<td>Contributing to the professional development of colleagues</td>
<td>1</td>
</tr>
<tr>
<td>5.7</td>
<td>Recognising and acknowledging the contributions of others</td>
<td>1</td>
</tr>
<tr>
<td>5.8</td>
<td>Acting as a mentor to colleagues</td>
<td>1</td>
</tr>
<tr>
<td>5.9</td>
<td>Offering constructive criticism to others</td>
<td>1</td>
</tr>
<tr>
<td>5.10</td>
<td>Participating in professional nursing and/or midwifery forums</td>
<td>1</td>
</tr>
<tr>
<td>5.11</td>
<td>Considering the effect of current issues, trends and policies on the profession</td>
<td>1</td>
</tr>
<tr>
<td>5.12</td>
<td>Networking across organisational and professional boundaries</td>
<td>1</td>
</tr>
<tr>
<td>5.13</td>
<td>Understanding the impact of internal organisational politics on the work of the profession</td>
<td>1</td>
</tr>
<tr>
<td>5.14</td>
<td>Representing the interest of the profession at the national policy-making level</td>
<td>1</td>
</tr>
</tbody>
</table>
The items in this section relate to skills for clinical leadership.

Please do remember to complete SCALE A and SCALE B for each item in the list.

<table>
<thead>
<tr>
<th></th>
<th>SCALE A IMPORTANCE</th>
<th>SCALE B MY DEVELOPMENT NEED</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Developing effective working relationships with the interdisciplinary team</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.2</td>
<td>Motivating others to provide optimal patient care</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.3</td>
<td>Fostering the development of a shared vision within the nursing or midwifery team</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.4</td>
<td>Building integrated interdisciplinary teams to ensure optimal care</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.5</td>
<td>Managing and resolving conflicts effectively</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.6</td>
<td>Accepting accountability for own actions</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.7</td>
<td>Enabling team members to be responsible and accountable for their actions</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.8</td>
<td>Acting appropriately when professional standards are compromised</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.9</td>
<td>Understanding the roles of others in the work setting</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.10</td>
<td>Understanding the financial aspects of healthcare delivery</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.11</td>
<td>Being accountable for the resource implications (e.g. costs) of one’s practice</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.12</td>
<td>Initiating change to ensure optimal care</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.13</td>
<td>Implementing change to achieve desired goals</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.14</td>
<td>Influencing key stakeholders within the organisation</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
<tr>
<td>6.15</td>
<td>Responding effectively to changes in internal environment</td>
<td><img src="scale_a.png" alt="Importance Scale" /></td>
</tr>
</tbody>
</table>
### SECTION 6: MY DEVELOPMENT NEEDS: SKILLS FOR CLINICAL LEADERSHIP (CONT/...)

The items in this section relate to skills for clinical leadership.

Please do remember to complete **SCALE A** and **SCALE B** for each item in the list.

<table>
<thead>
<tr>
<th></th>
<th><strong>SCALE A</strong> IMPORTANCE</th>
<th></th>
<th><strong>SCALE B</strong> MY DEVELOPMENT NEED</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not important</td>
<td>Of little importance</td>
<td>Moderately important</td>
</tr>
<tr>
<td>6.16</td>
<td>Identifying and addressing the underlying causes of problems</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.17</td>
<td>Contributing to the resolution of individual and organisational problems</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.18</td>
<td>Anticipating unexpected obstacles to problem resolution</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.19</td>
<td>Knowing when to seek advice and support to deal with problems</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.20</td>
<td>Creating alternative solutions to address problems</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.21</td>
<td>Anticipating potential problems</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.22</td>
<td>Basing decision making on the best available information</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>6.23</td>
<td>Evaluating the impact of one's decisions</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
### SECTION 7: THE CONTEXT OF MY PROFESSIONAL PRACTICE

Nurses or midwives may encounter factors in the work setting, which either enable or hinder their development as clinical leaders. This section contains a list of statements that reflect the experiences of nurses or midwives in the practice setting.

**Instruction:** With reference to your experiences of conditions affecting your development as a clinical leader, please indicate the extent to which you agree or disagree with each statement on the list, using the scale 1 (‘strongly disagree’), 2 (‘disagree’), 3 (‘uncertain’), 4 (‘agree’), and 5 (‘strongly agree’).

Please do remember to complete the scale for each item in the list. (Where an item reads ‘nurses or midwives’, please respond with reference to either nurses or midwives.)

<table>
<thead>
<tr>
<th>Statement</th>
<th>AGREE/DISAGREE</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 There is organisational support for nurses’ or midwives’ participation in clinical decision making</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.2 Nurses or midwives often have little say in decisions about patient care and treatment</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.3 Existing skill mix ensures that optimum care is possible</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.4 There is little support for nurses’ or midwives’ continuing professional development</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.5 There is effective collaboration between clinical and academic settings</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.6 There is high regard for the status of clinical nursing or clinical midwifery</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.7 There are few opportunities for nurses or midwives to progress along clinical career pathways</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.8 Clinical decision-making is systematic, routine, transparent and evidence-based</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.9 Nurses or midwives are viewed as equal members of the interdisciplinary team</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.10 There are professional tensions among members of the interdisciplinary team</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.11 Interdisciplinary clinical care is fragmented</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.12 Nursing or midwifery patient assessments are clearly expressed and documented</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.13 There are effective collaborative working relationships between members of the interdisciplinary team</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>7.14 There is ineffective communication between administrators and nurses or midwives providing direct patient care</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>
### SECTION 7: THE CONTEXT OF MY PROFESSIONAL PRACTICE (Cont/...)

Please remember to complete the scale for each item in the list

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.15</td>
<td>There is poor communication in the workplace</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>7.16</td>
<td>Nursing or midwifery interests are not well represented at the organisational level</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>7.17</td>
<td>Care and treatment plans for patients are negotiated by all members of the interdisciplinary team</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>7.18</td>
<td>Nurse or Midwife managers lack authority at the organisational level</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>7.19</td>
<td>Shortages of nurses or midwives compromise the provision of optimum care in my workplace</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>7.20</td>
<td>There is a shared ethos of clinical care within the organisation</td>
<td>1  2  3  4  5</td>
</tr>
<tr>
<td>7.21</td>
<td>The expertise of nurses or midwives is recognised and valued by other health professionals</td>
<td>1  2  3  4  5</td>
</tr>
</tbody>
</table>

Thank you for taking the time to complete this questionnaire

Please do remember to return your completed questionnaire
Introduction
Welcome to you all. Thank you for agreeing to take part in this focus group discussion. We are part of a team of researchers from the UCD School of Nursing, Midwifery & Health Systems and we are conducting this national study on behalf of the Nursing & Midwifery Planning and Development Unit, HSE West. This is one of a total of 22 focus groups that will be taking place throughout the country. The other main element of the study is a national postal survey of a sample of 3000 Nurses and Midwives.

We are studying the topic of clinical leadership and the main purpose of the focus groups is to gather information from clinical Nurses and Midwives across all grades about their views on clinical leadership and their development needs in relation to clinical leadership. Clinicians can be better assisted in developing their clinical leadership role if we know their clinical leadership development needs.

At the start, I would like to clarify what we mean by clinical leadership. For the purpose of this study, we define a clinical leader as someone who supports innovations that improve patient outcomes, ensures quality care and reduces health care costs. A clinical leader integrates research evidence into practice, leads efforts to improve patient care, is recognised as a leader in all settings and is an advocate for transforming the health system and implementing best practice.

Development needs refer to all or any of the supports, training, education, skills, knowledge, information and resources that nurses or midwives require to function more effectively as clinical leaders.

(Supplemental if clarification needed: Clinical leadership is a group process in which individuals influence and motivate other group members to achieve shared goals. It is concerned with clinical teams acting through key individuals to achieve better quality of care and better patient/client outcomes. It is therefore about achieving effective care and about influencing and motivating others to deliver effective care. On this basis, clinical leadership concerns all Nurses and Midwives and is not just the concern of senior Nurses and Midwives).

Ground rules
All of you have been asked to sign a consent form –thank you. In accordance with standard practice, we will record the focus group, so that we capture all of the ideas and views of the group members. A written transcript of the recording will be prepared and this will be analysed along with the transcripts from other focus groups and will be used in preparing the final report.

No names of individuals and no names of health care organisations will be identified in reporting the findings from the focus groups.
We would like all members of the focus group to contribute.
Content of discussion
In our discussion, I will suggest some particular topic areas for discussion that will be concerned either directly or indirectly with clinical leadership. For this discussion, I would like you to discuss four particular areas:

1. The care environment in which you work
2. Your professional development needs
3. Your professional skills
4. Some of the factors that either enable or constrain your ability to deliver care effectively.

Begin by asking each member to state their first name and the clinical department in which they work.

Part 1: The care environment: care delivery
I would like us to begin by discussing your own particular experiences in relation to care delivery.

1.1 How do you coordinate care delivery in your own clinical situation?

1.2 On the ground in the clinical area, who takes responsibility for decisions regarding skill mix, allocation of staff to particular duties, planning resources, and so forth?

(Supplemental: As individuals, do you have a particular role in this?).

1.3 In your experience, is there much emphasis on involving patients and relatives in their care? Do you take a particular role in this? (Supplemental: In what ways?)

1.4 In general, how is patients’ dignity and rights to make decisions about their own care addressed in day-to-day practice? (Supplemental: Do you take a particular role in this?)

1.5 Do you have mechanisms for ensuring that patients’ concerns and wishes are addressed? (Supplemental: As individuals, do you have a particular role in this?).

1.6 Do you take part in orientating new employees and students in training?

1.7 If you had a concern about a particular patient’s treatment or about standards of care in general, how would you respond? (Supplemental: Would you feel comfortable in highlighting this concern? Would you feel comfortable in addressing another colleague about their standards of care? Would you feel comfortable in addressing another colleague if they were stepping outside the boundary of the scope of their practice?)

1.8 Finally, in this aspect of the discussion about the care environment in which you work, I would like you to briefly discuss documentation of care. What are the systems for documenting care especially care outcomes?

Can you indicate the typical type of language that you might use to record a patient outcome?
Part 2: Personal and professional development

Now I would like us to discuss aspects of your own professional and personal development

2.1 What have been your experiences in relation to opportunities for continuing professional development?

Do you seek out opportunities, or are you more likely to pursue continuing professional development on the basis of what your line manager requires of you?

2.2 In your work, are you good at accepting criticism from others?

How well do you cope under pressure?

Are you good at recognizing your own strengths and weaknesses?

2.3 Do you participate in professional associations?

Do you get opportunities to network with other professional bodies outside of nursing?

2.4 Do you get/take the opportunity to participate in national debates around nursing policy and practice?

(Supplemental: Would any of you consider that your contribution to national nursing/midwifery policy has been reflected in that policy?)

Part 3 Your professional skills

In this third area, I would like you to discuss aspects of your professional skills.

3.1 I would like you to now discuss the work of nurses/midwives with other members of the multidisciplinary team. Do you take opportunities to foster interdisciplinary collaboration in the clinical area?

3.2 Do you have a role in making decisions about the patients’ treatment and care? Is that role always only about nursing/midwifery specific aspects or do you take opportunities to contribute to decisions about medical and other treatments? (Supplemental: Do nurses and other healthcare professionals generally?)

3.3 Do you understand the roles of other members of the care team?

3.4 Do you have a role in budgeting and finance?

3.5 What are your experiences of managing change? Would you see yourselves in your current role as agents of change?

3.6 If a problem arises in the clinical area, e.g. regarding a patient, how do you address the problem? Do you seek solutions from within yourselves, from within the nursing team or would you go to others? What would make you decide whether to deal with it yourself or to seek advice?

3.7 What do you base your decisions on and how do you know your decisions are the correct ones to achieve your goals?
Part 4: Barriers and facilitators to development of your clinical leadership role

Finally, I would like you to talk about the factors that impact on your ability to develop your clinical role, in particular your clinical leadership role.

4.1 Can you discuss anything in your work situation that impedes your ability to give effective care? (Think about factors in yourself, your immediate work environment and the wider organisation).

4.2 Can you discuss factors that help you to deliver effective care?

4.3 If there is one factor that you think would help you in developing your clinical leadership role, what would that be?

Close by thanking all participants.
A factor analysis was performed following the data collection to identify and explain patterns of correlations between the 89 items measured in the CLAN-Q questionnaire. Factor analysis resulted in the identification of nine subscales: five subscales called dimensions for Construct 1 - clinical leadership development need and four subscales called dimensions for the Construct 2 - barriers to clinical leadership development.

**Construct 1: Clinical leadership development need**

**Managing clinical area**
4.1 Coordinating care in the work setting to ensure optimum patient outcomes
4.2 Assessing the capacity of work colleagues to provide optimum patient care
4.3 Ensuring that adequate resources are available to provide optimum patient care
4.4 Identifying priorities for service improvement
4.5 Ensuring that team members carry out duties appropriate to their grade
4.6 Ensuring that the most appropriate team member provides direct patient care

**Managing patient care**
4.7 Protecting the dignity, privacy and confidentiality of patients
4.8 Involving patients in their care and treatment plans
4.9 Involving families, relatives and significant others in planning patient care
4.10 Treating others with compassion, tact and sensitivity
4.11 Creating a culture of trust and ethical behaviour
4.12 Monitoring patient satisfaction with standards of care
4.13 Orientating new employees to the work setting
4.14 Orientating learners to the work setting
4.15 Encouraging staff to communicate concerns about standards of care
4.16 Creating a non-blame climate in which staff can report errors
4.17 Reporting critical incidents to line manager as appropriate
4.18 Contributing to the development of clinical practice guidelines
4.19 Ensuring that the outcomes of care and other interventions are documented
4.20 Ensuring patient care is based on current, evidence-based best practice
4.21 Working within own scope of practice
4.22 Making patients aware of their rights and relevant policies and procedures
4.23 Acting to uphold patients' rights
4.24 Challenging processes and practices that compromise patient safety
4.25 Participating in multidisciplinary decision making
4.26 Representing the nursing or midwifery perspective at discussions and meetings
4.27 Providing clear and concise instructions to others
4.28 Preparing concise and accurate written documents and reports using appropriate professional language
4.29 Considering social and cultural backgrounds when interacting with others
4.30 Stating priorities with an appropriate sense of urgency and importance
4.31 Respecting colleagues' needs and feelings

**Development of the Individual**

5.1 Demonstrating commitment to lifelong learning
5.2 Participating in continuing professional development
5.3 Constructively receiving criticism and suggestions from others
5.4 Recognising own strengths and weaknesses
5.5 Coping effectively with pressure
5.6 Contributing to the professional development of colleagues
5.7 Recognising and acknowledging the contributions of others
5.8 Acting as a mentor to colleagues
5.9 Offering constructive criticism to others

**Development of the profession**

5.10 Participating in professional nursing and/or midwifery forums
5.11 Considering the effect of current issues, trends and policies on the profession
5.12 Networking across organisational and professional boundaries
5.13 Understanding the impact of internal organisational politics on the work of the profession
5.14 Representing the interest of the profession at the national policy-making level
**Skills for Clinical Leadership**

6.1 Developing effective working relationships with the interdisciplinary team

6.2 Motivating others to provide optimal patient care

6.3 Fostering the development of a shared vision within the nursing or midwifery team

6.4 Building integrated interdisciplinary teams to ensure optimal care

6.5 Managing and resolving conflicts effectively

6.6 Accepting accountability for own actions

6.7 Enabling team members to be responsible and accountable for their actions

6.8 Acting appropriately when professional standards are compromised

6.9 Understanding the roles of others in the work setting

6.10 Understanding the financial aspects of healthcare delivery

6.11 Being accountable for the resource implications (e.g. costs) of one’s practice

6.12 Initiating change to ensure optimal care

6.13 Implementing change to achieve desired goals

6.15 Responding effectively to changes in the internal environment

6.16 Identifying and addressing the underlying causes of problems

6.17 Contributing to the resolution of individual and organisational problems

6.18 Anticipating unexpected obstacles to problem resolution

6.19 Knowing when to seek advice and support to deal with problems

6.20 Creating alternative solutions to address problems

6.21 Anticipating potential problems

6.22 Basing decision making on the best available information

6.23 Evaluating the impact of one’s decisions
**Construct 2: Barriers and enablers to clinical leadership development**

**Quality care factors**

7.1 There is organisational support for nurses’ or midwives’ participation in clinical decision making

7.3 Existing skill mix ensures that optimum care is possible

7.5 There is effective collaboration between clinical and academic settings

7.6 There is high regard for the status of clinical nursing or clinical midwifery

7.8 Clinical decision-making is systematic, routine, transparent and evidence-based

7.9 Nurses or midwives are viewed as equal members of the interdisciplinary team

7.12 Nursing or midwifery patient assessments are clearly expressed and documented

7.13 There are effective collaborative working relationships between members of the interdisciplinary team

7.17 Care and treatment plans for patients are negotiated by all members of the interdisciplinary team

7.20 There is a shared ethos of clinical care within the organisation

7.21 The expertise of nurses or midwives is recognised and valued by other health professionals

**Recognition**

7.2 Nurses or midwives often have little say in decisions about patient care and treatment

7.4 There is little support for nurses’ or midwives’ continuing professional development

7.7 There are few opportunities for nurses or midwives to progress along clinical career pathways

**Interdisciplinary relationships**

7.10 There are professional tensions among members of the interdisciplinary team

7.11 Interdisciplinary clinical care is fragmented

**Influence**

7.14 There is ineffective communication between administrators and nurses or midwives providing direct patient care

7.15 There is poor communication in the workplace

7.16 Nursing or midwifery interests are not well represented at the organisational level

7.18 Nurse or Midwife managers lack authority at the organisational level.