The way things are done around here: perceptions of clinical leadership in mental health nursing. A thesis submitted to the Victoria University of Wellington in partial fulfilment of the requirements for the degree of Master of Arts (Applied) in Nursing

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THE WAY THINGS ARE DONE AROUND HERE:

PERCEPTIONS OF CLINICAL LEADERSHIP IN MENTAL HEALTH NURSING

by

Wendy Catherine Trimmer

A thesis submitted to the Victoria University of Wellington in partial fulfilment of the requirements for the degree of Master of Arts (Applied) in Nursing

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ABSTRACT

Clinical leadership is the cornerstone to improved health outcomes and workforce development (Graham, 2003; Mental Health Workforce Development, 2005). This research project explored nurses’ perceptions of clinical leadership in mental health nursing practice. Within New Zealand no research exists that evaluates the role and impact the clinical leadership has in mental health nursing practice. From personal experience and discussion with colleagues I argue that clinical leadership in terms of support and guidance for nurses is often minimal and that there is a relationship between qualities of clinical leadership and poor retention rates of mental health nurses. The prime objective of this study was to increase knowledge about clinical leadership in mental health nursing practice. This research used a quantitative descriptive methodology, utilising survey design. A questionnaire was used to rank the attributes of the person the respondents identified as a clinical leader. The data was collected from 30 registered nurses working in mental health settings within the central region of New Zealand. Data analysis was performed using the Statistical Package for Social Sciences (SPSS) Version 10, including descriptive statistics and group correlations. Three open-ended questions sought the respondents’ opinion of how clinical leadership influenced their nursing practice, what clinical leadership skills were useful for assisting and retaining nurses and what barriers existed to prevent effective leadership. Responses to the three open-ended questions were analysed for their thematic content. Findings indicate that there is room for improvement with regard to clinical leadership in mental health nursing practice. Clinical leadership is perceived to be more effective by nurses in their second year of practice and in community settings. A statistically significant difference was indicated between nurses in their second year of practice and nurses in their third year of practice in terms of their ranking of clinical leadership abilities. Overall the respondents perceived poor communication and poor attitude as the biggest barriers to effective leadership. Support and good role models were said to influence nursing practice positively and the skills that were identified as being helpful in assisting and retaining nurses were mentorship and good communication. The results of the study are discussed in relation to the literature on transformational leadership skills. Finally, the general limitations of the study are outlined and implications for future research are discussed.
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Special thanks go to my family, I would have been unable to take on this task let alone complete it without your support and love. I hope the completion of this thesis is an inspiration to my children, if not now then in the future.

Finally, I wish to thank the respondents in this survey who without their time and honesty this research would not have been possible.

This thesis is for each nurse who is in a clinical leadership position and for the students, patients and colleagues who have taught me so much about staying committed to a vision of enhancing leadership for mental health nursing.
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Every leader can look back and recognise a critical action that propelled them into the journey of personal discovery, learning, courage and persistence that led to a significant leadership role. The journey usually starts when an individual decides to be personally accountable for an attempt to solve a complex and important problem. This first step may often be the accident of circumstances and few potential leaders are prepared for the enormous personal demands placed upon them. All developing leaders are ahead of their time: they spot the future trends or have a vision of different ways of working together.

(Youngson, 2004, p. 1)
CHAPTER 1: INTRODUCTION TO THE STUDY

This research has come about through my interest in clinical leadership in mental health nursing practice. In my nursing career I have experienced many variations of clinical leadership. In some cases clinical leaders have inspired and motivated me. I have looked up to these people as mentors and positive role models. I have respected them and enjoyed nursing. In other instances clinical leaders who have been ineffective and have not possessed the necessary leadership skills or qualities have made me want to leave mental health nursing altogether.

I am currently a nurse lecturer but prior to this position I was the coordinator of an acute mental health unit. This position requires the skills of clinical leadership. Originally I was a staff nurse in an acute mental health setting and due to an environment of unhappy nurses I became frustrated with the leadership within the organisation. I applied for the coordinator’s position with the hope of making a difference. I obtained the position and was orientated to the job by the previous coordinator. On reflection, although the unit appeared to run effectively, I see that I was not given the skills or education to effectively manage staff and resources, nor did I realise the importance of certain skills. In this position I was to rely on my identity as a staff nurse, and I used the communication and teamwork skills I had acquired over my years of nursing.

My interest in clinical leadership within mental health nursing also comes about because of the contact I have with new graduate mental health nurses. From discussions with nurses in their first year of practice, I was often left wondering if the support, mentoring and sharing of knowledge from clinical leaders that they received in their first year of practice would be readily available for them in their second and third year of nursing practice.

As I have experienced, an unhappy or stressed environment due to poor leadership can create problems for all concerned. It impacts greatly on the nursing staff and patient care. Again from personal experience and discussion with colleagues I would argue that clinical leadership in terms of guidance and support for others is often minimal and that there is a relationship between qualities of clinical leadership and poor retention rates in mental health nursing.
Purpose of the Study

The purpose of this study was to explore registered nurses’ perceptions of clinical leadership in mental health nursing practice. The objectives being:

- To increase knowledge about clinical leadership in mental health nursing practice.
- To gain understanding of ways in which clinical leadership influences new practitioners.
- To identify clinical leadership skills that are considered helpful in assisting and retaining nurses, and
- To identify barriers to effective leadership.

In New Zealand (NZ) there is currently no research that evaluates the role and impact that clinical leadership makes in mental health nursing practice. Harper (as cited in Lett, 2002) defines a clinical leader as “one that possesses expertise in a specialty practice area and who uses interpersonal skills to enable nurses and other health care providers to deliver quality patient care” (p. 17). Nationally there is considerable confusion and inconsistency surrounding the titles, descriptions and qualifications of clinical leadership positions (Clinical Leaders Association of NZ, 2002; Trim, 2001). This is consistent with nursing structures in other countries where there has been a rise in the number of clinical leadership positions (Rocchiccioli & Tilbury, 1998). Current systems of measuring the effectiveness of clinical leadership qualities are also not consistent. Despite the changes in mental health services in NZ and the implementation of differing clinical leadership positions there is also very little evidence that evaluates the role and impact that clinical leadership has on nurses. Research literature on leadership in nursing in NZ provides information on nurses that had become well-respected leaders in the profession but gives minimal information on nursing leadership or clinical leadership in practice.

Nursing performance appraisals, that I am familiar with, all contain the word leadership, but seldom define what leadership is or what skills or qualities are required. The clinical leader in addition to learning these new skills must also be competent to practice in his or her chosen profession. In response to the Health Practitioners Competence Assurance Act 2003, the Nursing Council of NZ (NCNZ) (2005) has recently approved competencies for the Registered Nurse (RN) scope of practice. These competencies replace the 2001 NCNZ generic competencies for specialty nursing practice and the advanced practitioner. The 2001 competencies were related to clinical judgement, clinical leadership, standards and practice
development. The NCNZ (2001) Specialty Nursing Practice Competency, Number 2: *Shows clinical nursing leadership*, clearly stated that to meet this competency the RN must show that he/she:

- Actively participates within the health care team,
- Acts as a positive role model of specialty nursing practice,
- Acts as a nursing resource for the health care team,
- Effectively communicates with members of the interdisciplinary team,
- Provides guidance, support and nurturing to novice nurses and those entering the specialty practice area,
- Acts as an advocate for nursing within the specialty practice area. (NCNZ, 2001, p. 17)

An advanced nursing practitioner would also show effective leadership and consultancy. To meet this competency the nurse:

- Takes a leadership role in complex situations across settings and disciplines,
- Demonstrates skilled mentoring/coaching and teaching,
- Leads case review and debriefing activities,
- Initiates change and responds proactively to changing systems,
- Is an effective nursing resource,
- Participates in professional supervision. (NCNZ, 2001, p. 22)

These competencies clearly showed that leadership is seen as an integral component of nursing. The newly approved competencies incorporate most of the above criteria, although unfortunately the word leadership is not mentioned at all. This is extremely surprising considering the developments in healthcare that are focusing on leadership at present. The NCNZ (2005) competencies are for all RNs, including those involved in management, education, policy and research. The domains that are covered in the 2005 competencies are professional responsibility, management of nursing care, interpersonal relationships, and interprofessional health care and quality improvement. These competencies provide a framework for measuring scopes of practice.

Clinical leadership in the context of this research refers to nurses in clinical leadership positions within mental health nursing practice. The Clinical Leaders’ Association of NZ (CLANZ, 2001) define clinical leadership as “leadership by clinicians of clinicians, where
clinical leaders are those that have a clinical role while, at the same time, may participate in management, including resource management” (p. 28). At times, the terms clinical leadership and clinical governance are used interchangeably in the literature. Clinical governance is similar to clinical leadership in that it is related to leadership in health, but from the literature it appears that clinical governance is the ‘top heavy’ approach and concerns those in higher positions in health care organisations. Nicholls, Cullen, O’Neill, and Halligan (2000) state that clinical governance can be viewed as “a whole system cultural change which provides the means of developing the organisational capability to deliver sustainable, accountable, patient focused, quality assured healthcare” (p.174). While this is needed in health care from time to time the top heavy approach does not always work and systems need to be changed from the worker up (International Council of Nurses, 2005). Clinical leadership is seen as a critical factor in promoting clinical outcomes (Graham, 2003). Clinical leadership exists in every level of health care, from chief medical and nursing advisors to the people working directly with the patient and their families. 

For the purpose of this research the definition of clinical leadership is based, not at a service management level but at the core of mental health services, that is, where patient contact is most evident, in the mental health units and community mental health services. Barker (2003) defines mental health nursing as “primarily ‘being’ and ‘becoming’ with people who are suffering (either directly or indirectly as carers) the effects of mental dis-ease and distress” (p. 26).

Registered Nurses working in mental health, including substance abuse in NZ, make up 8.8% of the population of RNs and Midwifes currently employed (NCNZ, as cited in NZ Health Information Service, 2004). Retention of nurses is a national concern (College of Nurses Aotearoa (NZ) Inc. (CNA(NZ)INC), nd). Mental health nurses are no exception to this, with the National Framework for Mental Health Nursing (Ministry of Health (MoH, 2005) discussing the importance of retaining and recruiting nurses. Effective clinical leadership is said to be vital for maintaining workforce numbers. Research concerning clinical leadership in mental health practice settings has not been undertaken in NZ. Therefore, this research is significant for NZ mental health nursing in that it explores a group of professionals that are at the beginning of their career in mental health nursing practice.
**Research Question**
From my interest and experience of clinical leadership I needed to clarify if clinical leadership had an influence on nursing practice and patient outcomes. I wanted to know what, if any, barriers existed to prevent effective clinical leadership and what clinical leadership skills were seen as helpful in assisting and retaining nurses. To do this the following research question was devised:

*What are the perceptions of registered nurses about clinical leadership in mental health nursing practice?*

**Organisation of the Study**
The registered nurses that were chosen as the sample population were nurses in their second and third year of mental health nursing practice. These groups of nurses were chosen as they were still relatively new to mental health nursing practice but were not seen as new graduate nurses. In mental health services throughout NZ most employing organisations, for example District Health Boards (DHBs) and Non Governmental Organisations (NGO), ensure that new graduate nurses are supported to complete a new graduate mental health programme. Once the nurse has successfully completed the programme they are deemed to be at a competent stage of practice, the nurse continues in their chosen career path without the support of programme, relying on guidance from their place of employment. Benner, Tanner and Chesla (1996) state that the competent stage of nursing practice typically occurs two years into nursing practice and is where the nurse has “increased clinical understanding, technical skill, organisational ability, and the ability to anticipate the likely course of events” (p. 78).

The literature review undertaken for this study examined literature relevant to leadership within health services. A vast amount of literature discussed transformational leadership styles and this was seen by many as a style for clinical leaders to adopt (Corrigan & Garman, 1999; Thyer, 2003). Based on the attributes identified in the literature on clinical leadership I formulated a questionnaire which asked the sample population to identify a clinical leader in their place of employment. The respondents were then asked to rank that person against the attributes of effective clinical leadership. Three open-ended questions sought the respondents’ opinion of how clinical leadership influenced their nursing practice, what clinical leadership skills were useful for assisting and retaining nurses and what barriers existed to prevent effective leadership.
This research used a quantitative descriptive methodology, utilising a survey questionnaire. Survey design was used as this is a methodology known for its value in obtaining baseline information and its ability to collect data about attitudes, opinions and intentions (Brown, 1999). Socio-demographic data was also requested to gauge the sample population and to ensure representation of the population of nurses in their second and third year of mental health nursing practice.

Research into mental health nurses perceptions of current clinical leadership in nursing practice and support in the workplace will make an important contribution to the recruitment and retention of nurses in NZ as it will increase our understanding of clinical leadership and how it influences new practitioners working in mental health services. It is anticipated that these research results will assist in the development of a postgraduate paper on clinical leadership in mental health nursing and that the outcomes from this research will be used in education across levels at the Nursing Centre of Learning, Whitireia Community Polytechnic. This study provides an insight into clinical leadership in mental health nursing and may have a broader impact on government decision making and better service provision as a result of improved understanding of clinical leadership in mental health nursing practice. This research will also increase knowledge in the discipline of mental health nursing within NZ.

**Overview of the Thesis Structure**

In this chapter I have set the parameters of this thesis. The background to the study has been introduced, the purpose of the study and the research question is outlined, and the organisation of the study is discussed.

Chapter Two reviews the national and international literature relevant to clinical leadership in nursing. Clinical leadership is discussed in relation to retention of nurses, patient outcomes, organisational support and leadership styles, in particular transformational leadership. A conceptual framework concludes this chapter.

Chapter Three outlines the methodological approach, method and design of the study. The characteristics of the sample population, ethical considerations, data collection process and data analysis are discussed.
Chapter Four presents the findings of the study from quantitative data analysed using SPSS (version 10) and qualitative data using thematic analysis. A multi analysis of variance (MANOVA) is undertaken to identify significant differences between year of practice and mental health setting employed groups. The respondent’s demographic data and results of the questionnaire are presented in terms of relevant relationships with respondents year of practice and mental health setting employed.

Chapter Five provides a discussion of the results related to the national and international literature reviewed. Perceived clinical leadership abilities are reviewed, including helpful leadership skills, barriers to effective leadership and how clinical leadership influences nurses in their second and third year of mental health nursing practice. Limitations of the study are revealed.

Chapter Six suggests areas for future research, the implications of this research for mental health nursing practice and proposed dissemination of the research. The conclusion of the research study is presented.
CHAPTER 2: REVIEW OF LITERATURE ON CLINICAL LEADERSHIP

This chapter reviews the current national and international literature in relation to clinical leadership in mental health nursing practice in NZ. A search strategy was undertaken using the nursing databases Proquest, Cinahl and EBSCO. Initially the key words used were NURS*, and LEADERSHIP, subsequently the words MANAGEMENT and RETENTION were also used to inform this study. The World Wide Web was also utilized in obtaining statistics and information about health leadership programmes in NZ and abroad. Leadership theory, in particular, transformational leadership style is discussed following the themes that emerged from the literature search, namely nursing recruitment and retention, organisational support and patient outcomes.

As stated in the definition of clinical leadership (CLANZ, 2001), as outlined in Chapter One, clinical leaders are those that may have some management responsibilities. Often the literature discussed management and leadership together and for clinical leaders in this role it is difficult to separate the two. The dual role of the clinical leader is discussed further in this chapter. A broad view of clinical leadership is given to set the scene.

Clinical Leadership in New Zealand

New Zealand’s mental health services are required to lead and manage, effectively and efficiently, to facilitate the delivery of coordinated services, thus ensuring effective communication systems and working relationships (MoH, 2001). Slowly NZ nurses are being encouraged to seek the management skills or skills-development education that allows them to be effective at this level. The Ministerial Taskforce on Nursing (1998) proposed:

That nurses be involved at a managerial level in all provider organisations and that nursing leadership be supported and more fully developed. The need for strong nursing leadership flows into workforce resourcing issues. It is difficult to maintain the morale of nurses in institutions if leadership is lacking, and declines in nursing morale can have an effect on patient outcomes. (p. 73)

The health care reforms over the last 20 years in NZ have had a significant impact on the nursing profession. Destruction of senior nursing positions that provided direction and vision for developing nursing practice led to a lack of clinical leadership in nursing (Dyson, 1994:
Harris, Smith, & Betts, 2003). For mental health nursing this time of change coincided with deinstitutionalisation of mental health patients. Not only were nurses restructured, patients also encountered change by being moved out of large institutions into society. The mental health consumer movement began to grow within NZ, with expectations of maintaining rights, being involved in health care and demanding better health outcomes for people with mental illness (Youngson, 2004).

Over the last two decades there has been a rise in the number of clinical leadership positions within mental health nursing practice. A typical inpatient mental health unit may have a coordinator, clinical nurse specialist, nurse consultant, team leader and/or a clinical nurse manager (Rocchiccioli & Tilbury, 1998). These titles are essentially all clinical leadership positions. They meet Harpers (as cited in Lett, 2002) definition of a clinical leader (refer to page 2). This definition covers positions in health that have great influence in both patient and staff outcomes. Clinical leadership at this level of health care could also be defined as ‘first level managers’ as their focus is primarily on the activities of their own work units, these positions have a major impact on the delivery of care (Rocchiccioli & Tilbury, 1998).

More recently there has been an increasing awareness of the contribution that nursing makes in health care. Evidence for this position is the National Framework for Mental Health Nursing, Mental Health Workforce Development (MHWD) initiatives and the introduction of Nurse Practitioners (MoH, 2005). Currently nurses who are clinical leaders in NZ have access to resources such as CLANZ, the Health Leaders Network and Blueprint, an executive leadership and management programme. These resources identify common key skill areas required for leadership within the mental health sector. These skills cover areas concerning managing people, interests and interfaces, for example, the ability to implement change, assess performance, manage conflict, negotiate, and mentor. These skills are essential to an effective and efficient working environment (Blueprint, n.d.; CLANZ, 2004; Health Leaders Network, n.d.).

**Recruitment and Retention**

New Zealand’s Health Workforce Advisory Committee (HWAC) focuses on future directions for the NZ health workforce. Professor Hornblow (as cited in HWAC, 2003) argues DHBs need to “facilitate positive working relationships between groups of health practitioners, and invest in healthy workplace initiatives that will contribute to the retention of health
practitioners” (p. 2). Professor Hornblow states that to do this will require strong leadership. Many government initiatives focus on retention of the health workforce, the NZ MHWD is particularly relevant to this research as it has a strong focus on leadership and retention.

Clinical leadership is becoming more topical especially in relation to recruitment and retention rates of nurses and particularly in mental health. The MHWD Programme has five strategic areas, the most relevant to this research is organisational development, and retention and recruitment. The delivery of a 12 month nationally coordinated mental health executive/leadership development programme through Blueprint Centre for Learning and links to the International Institute for Mental Health Leadership are a clear commitment to organisational development. The rationale behind the Leadership Development Programme is that “Good leadership is the key to workforce development” (MHWD, 2005, p.7 of 13). Another initiative from the MHWD is a recruitment research project, which aims to increase understanding of current mental health recruitment issues.

The Ministry of Health (MoH, 2005) is currently establishing a National Framework for Mental Health Nursing, with the aim of strengthening both nursing leadership and practice. Globally nursing turnover rates are very high (Kerfoot, 2000; Lu, While, & Barriball, 2005) and nursing turnover is seen as a significant problem for NZ, this high turnover rate impacts not only on nursing practice, but also patient outcomes, workforce outcomes and broad health system quality outcomes (CNA(NZ)INC, n.d.). Studies to determine the cost of nursing turnover in NZ have been undertaken only in medical and surgical units within DHBs (Hughes, 2003). I believe the cost of turnover would be greater in mental health service environments, where continuity for patients is of utmost importance, as the nurse’s key role is the use of self as the therapeutic tool. Retention of nursing staff is vital to maintaining continuity in mental health care.

It is well known that recruitment and retention are closely associated to job satisfaction (Cline, Reilly, & Moore, 2004; Happell, Martin, & Pinikahana, 2003; Lu, While, & Barriball, 2005). Leadership is seen as a management practice that directly impacts on turnover and retention. More often than not the key reasons for high nursing turnover are either concerns with management or inadequate staffing. Cline et al. state “although nurse managers don’t have direct control over certain variables, they do have choices regarding management style” (p. 45).
The International Council of Nurses (2005) identify that internal and international migration of nurses and achieving effective health sector reform and re-organisation are critical challenges related to nursing shortages. In highlighting a policy framework to address these shortages they recognise that change requires leadership, stating that ‘top down’ change/leadership is often unsustainable and that the support of nurses and other stakeholders is required.

Joshua-Amadi (2003) studied views on recruitment and retention in the National Health Service, United Kingdom. The reasons why nurses leave the profession were identified and recommendations were made in regard to leadership, equitable pay, caring organisation, performance appraisals and conflict management. Joshua-Amadi also recommended practical ways of improving retention of nurses; clear, two-way communication, managerial supervision and skills that allow managers to become more self-aware. She stresses that “nurses with leadership potential should be nurtured, developed and supervised instead of being left to get on with it” (p. 17). In my experience this is often the case; usually someone seen with potential is given a position of greater responsibility without being given the skills or education to effectively lead.

One of the most important responsibilities of a clinical leader is the ability to recruit and retain staff (Kerfoot, 2000). Valentine (2002) agrees that the nursing shortage is a serious problem, she states “Now, more than ever nursing needs vibrant and dedicated leaders” (Para. 2). Nurses have a distinct advantage to influence policy, but to do this leadership characteristics need to be developed as well as clinical practice.

**Organisational Support**

Leadership is often concerned with management roles, yet often it is the ordinary nurse who shows the persistent leadership to organise what is needed to get the job done. There are many differences between leadership and management roles, generally though management is focused on systems and structure, and activities are related to efficiency and cost-effectiveness. Leadership on the other hand tends to focus on people and activities are related to vision and judgement (Grossman & Valiga, 2000), this seems the perfect role for the nurse who is patient focused and wants to make a difference. It could be said that managers ‘do things right’ while leaders ‘do the right thing’ (Bennis & Nanus, as cited in Grossman & Valiga, 2000; Rocchiccioli & Tilbury, 1998).
McConnell (2002) discusses balancing of the two sides of the clinical leadership role. The health care professional who assumes a clinical leadership role must recognise that he or she is adopting a second and concurrent career of equal importance to his or her primary occupation. McConnell states that it is necessary to remain current in both roles, but without training and support the leader becomes ineffective, “often one cannot help but let both sides of the role suffer to some extent” (p. 7). He goes on to say that the clinical or technical side of the role receives the most attention because it is the role that is most familiar.

Clinical leaders have a dual role. This dual role of nurse and manager are almost diametrically opposed, it is assumed that nursing is associated with ‘caring’ and management is seen as ‘ruthless’. CLANZ (2002) states “Clinical leaders are required to walk an uneasy path between claims for autonomy by their clinical ‘rank and file’ colleagues at the same time as developing a relationship with management and its demands for clinical accountability” (p. 38). Clinical leadership is not about taking sides, it is about understanding that quality health outcomes or improvements can only be achieved in an organisation if all clinicians and leaders are committed to pursuing common goals (CLANZ).

Organisational support or development are recurring themes throughout the literature, often organisational culture is described as ‘the way things are done around here’. Current literature concludes that great importance should be placed on ensuring that nurse leaders have both support and education from their employing organisations (Graham, 2002; Hendal & Steinman, 2002; Judkins & Ingram, 2002; Stein, 2001; Sullivan Havens, 2001; Van Engen, Van der Leeden, & Willemsen, 2001). Stein examined the informal processes through which professionals gain skills, for example mentoring, coaching, trial-and-error, observation and networking. While Judkins and Ingram suggest stress and hardiness training as a way of educating and supporting nurse managers. Education and organisational support are components that impact or influence many factors, most importantly retention of nurses and patient outcomes, for example increases in patient time waiting for services and suboptimal staffing affecting patient care (Kleinman, 2004a).

A study conducted by Acker (2004) examined the relationship between organisational conditions of social workers practicing in mental health and their job satisfaction and intention to leave. Acker conclude that a supportive work environment is essential “it provides workers with an appropriate atmosphere to conduct high quality services, to derive gratification from
their job and to be committed to their profession, even when the total mental health care environment is problematic (p. 6 of 7).

The Registered Nurses Association of British Columbia (2004) identified that knowledgeable, strong nursing leadership was believed to be one of the most important workplace attributes in supporting new nurses. One way of developing leadership is by continued nurse education. Gerrish, McManus and Ashworth (2003) states “the master’s level nurse is seen to exercise influence and leadership and this strengthens the power and status of nursing” (p. 103). While continued nursing education is important it must be acknowledged that it is only one component of nurse leadership and that specific qualities and skills are required of clinical leadership positions.

Currently ‘magnet hospitals’ are being trialed in NZ in an attempt to recruit and retain nurses. One of the principles of magnet hospitals under professional development is the development of management and leadership skills. It is hoped that this initiative will meet the needs of nurses in its aim of “improving patient outcomes through quality, safety and retention and recruitment of skilled nurses” (Hughes, 2003, p. 4).

**Patient Outcomes**

Patient outcomes are commonly identified in the literature with clinical leadership (Cunningham, 2000; Graham, 2002; King, 1999; McNeese-Smith, 1999; Sullivan Havens, 2001). McNeese-Smith examined relationships between managerial motivation, leadership, nurse outcomes and patient satisfaction, concluding that achievement motivation of the manager influences staff and patient outcomes in health care. While Sullivan Havens compared nurse infrastructure and quality of patient care, finding congruence on appraisals of the quality of care and organisational support for nursing practice. Alternatively Cunningham clearly stated that “although employers can influence the quality of patient care, it is the qualities of the individual nurses that have a more direct effect on the way patients are looked after” (p. 18). She also argues that clinical leaders can influence patient outcomes by transferring their skills, techniques and talents to nurses in their teams. All nurses are leaders in a sense; they lead patients toward improved health outcomes while working in collaboration with the health team (Rocchiccioli & Tilbury, 1998). Sullivan Havens and Cunningham agree that quality of patient care improves when organisational support for nursing practice is present.
The needs of mental health patients are constantly changing, gone are the days of institutionalised care and hierarchical nursing structure. In this current environment care is focused on recovery and individualised treatment (MHWD, 2005). Mental health care is provided throughout primary, secondary and tertiary services, in Primary Health Organisations (PHOs), NGOs, DHBs and Iwi Providers. Mental health services need to continually evolve to meet the needs of mental health patients.

Increasingly quality improvements in healthcare are being sought from patients, communities and the government. Grant-Mackie (2002) states that “Nurses have a responsibility to take a leadership position in the health sector because of their unique knowledge of patient’s experiences of the health sector” (p. 20). Fontaine (2003) in his discussion on clinical leadership states that “no other role makes a more direct impact on care and services that patients and their families require. No other role is as pivotal in shaping healthy work environments that successfully recruit and retain nurses” (p. 6).

**Leadership Theory**

Leadership has many aspects and there is no single definition that encompasses all the attributes or aspects of it (Grossman & Valiga, 2000). Through the centuries we have moved from theory to theory of leadership. Originally the ‘Great Man Theory’ applied, this asserted that one was a leader if born into a family of nobility and had unique characteristics, most of which were inherited. ‘Trait Theories’ emerged where personal traits attempted to distinguish leaders from the general public. These theories failed to acknowledge the importance of the environment in which leadership occurred. ‘Situational Leadership Theories’ then evolved, these clearly acknowledged the significance of the environment as factors in the effectiveness of a leader. The leader then was someone in a position to institute change when a situation was ready for change. This was usually the person who “happened to be in the right place at the right time” (Grossman & Valiga, 2000, p. 5). More modern theories recognise that effective leadership depends partly on the person leading, partly on the situation and partly on the followers. Followers, being those people that actively invest themselves in fulfilling a vision that they support (Grossman & Valiga, 2000).

It is my perception that we often still work in the ‘Situational Leadership Theory’ where leadership positions are filled by the person who ‘is in the right place at the right time’. This concept is not all bad if that leader is given the skills and know-how to effectively lead, then
the person can develop the potential to become an effective leader. Mental health nurses work with ever increasing pressures, often apart from nursing patients with dual diagnoses and increasing co-morbidity. For the nurse it is possible that there are no experienced nurses to ask questions of or bounce ideas off. Nursing staff are increasingly overwhelmed by the number and intensity of their own case loads, patient expectations of health care are greater, with today’s society being more aware of rights and outcomes. Often managers are too overworked to support others and resources are in short supply. Individuals become overwhelmed when human and material resources are in short supply and when effective leadership seems absent (Cangelosi, Markham, & Bounds, 1998; Grossman & Valiga, 2000). Is it any wonder then that retention rates in nursing are low?

It is in this uncertainty that change can be made. In mental health it is sometimes said that ‘a person may have to reach crisis point for their situation to improve’. This could be said for an organisation under pressure, the health care system, where people generally come together for the common good in crisis situations. At this point leadership can be instrumental by using the chaos and the ultimate change it produces as a positive opportunity (Grossman & Valiga, 2000).

A leadership theory that finds growth in chaos is ‘Quantum Theory’. This theory suggests that a connectedness or interface between all members of a team is critical. Each person needs to be acknowledged for his or her talents and potential, and followers need to be nurtured. Recognising that each nurse has a contribution to make is necessary if nursing is to succeed in delivering high quality health care, “valuing hard work and respecting one another are values that need resurrection” (Grossman & Valiga, 2000, p. 33). Graham (2003) agreed that nurses required an environment, culture and organisation that valued their work.

Leaders and followers have an equal influence on each other, they exist side by side and work together for a common goal or the greater good (Grossman & Valiga, 2000). Although the word follower may conjure up a negative image, it must be acknowledged that leaders would not exist if they did not have followers. A leader must realise that in every decision they make, with every interaction and the way they support and acknowledge others, their behaviour reflects on the organisation they are employed in. Everyone watches the clinical leader for signs of what is important and what is valued (Rocchiccioli & Tilbury, 1998). It is important that those in leadership positions develop leadership skills in their followers. The
components of transformational leadership allow this. Bass (1998) states “Evidence has accumulated that transformational leadership can move followers to exceed expected performance” (p. 2).

Clinical leaders are in positions where they are still involved with patient care as well as having the responsibility of managing resources. Specialist skills are required for nurses to be able to function in clinical leadership roles; the nurse should not be expected to be a nurse leader on clinical nursing experience alone (Chen, 2004). Clarity of job description and adequate and supportive education in leadership roles needs to exist for nurses who take up leadership positions (Chen, 2004; Fletcher-Campbell, 2003; Herrman, et al., 2002). Urden and Rogers (2000) describe the essential qualities of a clinical leader as the ability to think globally, be accessible, be able to resolve conflicts, be an effective communicator and be an appropriate and timely decision maker. Other qualities seen as being of equal importance are being clinically competent, being able to advocate and be responsive to both staff and patients, having the ability to create strong partnerships, being self directed and self-motivated, and having the ability to mentor and empower staff. Urden and Rogers have captured the qualities of clinical leadership well and highlight the importance of partnerships and responsiveness to others.

Grossman and Valiga (2000) state that although there are hundreds of ways that leadership can be defined, there are several elements of leadership that recur in the literature. These elements are vision, communication skills, change, stewardship (partnership and commitment), and developing and renewing followers. The latter element of developing and renewing followers concerns recognising the potential in followers so that change can be sustained, this can occur through the leader role modeling, or mentoring others. Leadership is needed for growth and progress of individuals, groups and organisations. Nurses are in a position to provide leadership in health settings with their ability to communicate and work collaboratively, these skills and the vision for better patient outcomes make them excellent candidates for clinical leadership positions (Grossman & Valiga, 2000).

It must be acknowledge that there is a lot of literature on leadership and different leadership styles. For the purposes of this research transformational leadership style was focused on as this was seen as a leadership style that would be best suited to the clinical environment (Corrigan & Garman, 1999; Thyer, 2003). Clinical leadership literature focused on utilising
Bass’s (1998) transformational leadership style within health services. There are two main types of leadership used in health organisations, transactional leadership and transformational leadership. The following skills are relevant to making leadership effective: Transactional leadership skills where leaders attend to day to day tasks so the system operates smoothly and transformational skills where effective leaders help the staff to meet the ever evolving needs of the patient (Corrigan & Garman, 1999).

Bass (1998) describes transactional leadership as the transaction or exchange that occurs among leaders and followers, where “the leader rewards or disciplines the follower depending on the adequacy of the follower’s performance” (p. 6). There are three components of transactional leadership:

- Contingent Reward, a constructive transaction where the leader assigns tasks and promises rewards,
- Management-by-Exception, this is deemed to be more ineffective than contingent reward and is where the leader monitors deviation from standards or mistakes in the followers work and takes action if necessary,
- Laissez-Faire Leadership, this is the avoidance or absence of leadership from someone in a leadership position. This type of leadership style is casual and provides little direction, group members are expected to lead themselves.

Although there may be some type of connection between the leader and followers in transactional leadership it is often not the shared goal or vision that connects them, it may be that they only perceive their work as a job and not a career (Grossman & Valiga, 2000).

Transformational leadership as described by Bass (1998) is an expansion on transactional leadership, “transformational leaders motivate others to do more than they originally intended and often more than they thought possible. They set more challenging expectations and typically achieve higher performance” (p. 4). Transformational leaders behave in ways to achieve positive results by using one or more of the following components of transformational leadership:

- Charismatic Leadership: where leaders result in being role models, they are admired, respected and trusted, and they are willing to take risks and are consistent in the way that they lead.
• Inspirational Motivation: the way the leader inspires and motivates the followers, they provide meaning, commitment to goals and a shared vision by encouragement and optimism.

• Intellectual Stimulation: where leaders stimulate others to be innovative and creative by questioning assumption and reframing problems. Followers are encouraged to try new approaches and be creative in the process of problem solving.

• Individualised Consideration: here the leader is considerate of each persons need, they act as a coach or mentor, the leader listens effectively and individual staff differences are accepted (Bass, 1998).

The attributes of an effective clinical leader that have emerged from reviewing the literature can be grouped into four constructs of effective leadership as identified by Perkins (2004). These constructs include listening and communicating, encouraging and facilitating, having vision, and being goal oriented. These constructs are linked very closely with transformational leadership.

The first construct, listening and communicating covers the skills of managing change. In each setting a variety of agendas is ever present. The skills of making decisions, negotiating, being responsive and flexible, and communicating interpersonally, across systems and cross culturally are at the core of balancing change with maintaining service delivery. Youngson (2004) states that clinical leaders cannot manage change, but by personal example they “can create the conditions where others are willing to take risks, to listen, to learn and to find better ways of working together” (p.5). Effective clinical leadership then is about creating conditions in which innovation and improvement can emerge from those working on the ground level (Perkins, 2004). Manion (2004) in a study undertaken to determine what creates a culture of retention found that 23 of the 26 managers identified “listening carefully to what staff members say as essential in how they relate to and care for employees’” (p. 33).

The second construct of encouragement and facilitation is said to be central to the leadership role in health settings (Perkins, 2004). The skills involved in achieving this are being able to manage conflict, mentoring, facilitating change, and the ability to inspire and motivate staff. To do this leaders must be able to gain an understanding of emotions and attitudes of all staff and be able to communicate this understanding to others, thus integrating emotional competence into leadership (Porter-O’Grady & Malloch, 2002).
Having vision is the third construct, where leaders have visions, purposes and goals, but to be effective the leader must recognise what is possible for the group being led (Perkins, 2004). An effective leader must build vision and purpose, be innovative and creative, realise talent and be a positive role model. Vision is central to the nature of leadership (Graham, 2003).

The final construct identified by Perkins (2004) is goal orientation. This is considered an important construct for effective leaders, as goals must be responsive to consumer need. The clinical leader must have the ability to retain staff, effectively assess performance, and demonstrate high standards of ethical and moral conduct. Being able to achieve goals and make progress inspires staff to be proactive. Focusing on results was seen as a factor to creating a culture of retention, where successful leaders or managers consistently achieved improvements within their departments, often based on feedback from others (Manion, 2004).

Perkins (2004) constructs link very closely with transformational leadership, where in promoting communication, team building, motivation and role modeling by clinical leaders may hold the key to reducing nursing shortages. A move to transformational leadership would promote nurturing and valuing within the nursing profession, thus the leaders and employees would work in partnership to achieve mutual goals (Cann, 2004).

**Conceptual framework**

The review of literature presented gives evidence to the complexity of clinical leadership in mental health nursing. Clinical leadership as a critical factor in promoting quality health outcomes (CLANZ, 2002) and it is clearly linked to retention of nurses and patient outcomes. Because of the importance of the clinical leadership role and the impact this role has on the nurses who work with them and indirectly the patients in their care, it is necessary to obtain an understanding of how new nurses perceive clinical leadership in mental health. It is well known that people work better when led by effective leaders (Corrigan & Garman, 1999).

This study is similar to research undertaken in a community hospital in the northeastern United States. The purpose of that study was to describe perceptions of leadership associated with nurse turnover and to compare leadership behaviours as perceived by managers and their staff nurses (Kleinman, 2004b). The study used the Multifactor Leadership Questionnaire (MLQ) as a tool to rate leadership styles. The results of this study indicated that nurse
managers consistently perceived that they demonstrated a higher level of transformational leadership behaviours compared with perceptions from the staff nurses.

Due to the size and scope of a two paper thesis this study was not replicated. The research project undertaken for this thesis focuses only on nurses perceptions of clinical leadership in an attempt to obtain baseline data and increase understanding of clinical leadership in mental health nursing. Kleinman’s (2004b) research did not directly ask the respondents how clinical leadership influenced their practice, nor did they ask respondents’ opinion of barriers to effective clinical leadership. Because of this I chose to develop a questionnaire that incorporated transformational leadership skills, whilst seeking the respondent’s opinion of clinical leadership in mental health nursing practice.

The literature reviewed often discussed the ‘MLQ’, ‘Organisational Job Satisfaction Scale’ or ‘Index of Work Satisfaction’. These rating scales were not replicated in this research study as the researcher wanted to obtain specific information about clinical leadership and by identifying leadership qualities and designing a purpose built questionnaire the data received would hopefully give a clear description of clinical leadership in mental health nursing practice. The MLQ is designed to give comprehensive feedback on managers’ leadership styles and is a comprehensive survey completed by the leader or manager and the people who are being led (the followers). The MQL dimensions include transformational leadership, transactional leadership, non-transactional leadership and outcomes of leadership (Transformasian, n.d.).

The main themes and attributes of clinical leadership that were made evident in the literature review were incorporated into the research questionnaire. Themes of retention, and the ability to be responsive to patient need and responsive and flexible to staff were important to include. Attributes that linked strongly with transformational leadership style, for example the ability to build vision and purpose and be innovative and creative, were deemed to be essential to effective leadership. Perkins (2004) constructs that linked closely to transformational leadership, for example communicating and encouragement and facilitation were also to be included in the questionnaire. These key components of clinical leadership were extracted from the literature review; and were used to inform section two of the questionnaire which asked respondents to rate their clinical leader against leadership attributes. These attributes of
effective leadership also contained the skills such as managing change and performance assessment.

**Summary**

The literature review demonstrated that clinical leadership is closely linked to retention of staff, organisational support and patient outcomes. Transactional and transformational leadership may hold the key to reducing nursing shortages and improving health outcomes. Many leadership studies have been undertaken in regard to job satisfaction and patient outcomes. Most utilise survey design. Factors that remain constant throughout the literature are that a clinical leader must be an expert practitioner who is able to provide guidance and vision and also has the ability to empower others (Lett, 2002). This definition can be closely likened to transformational leadership. The following chapter presents the methodological approach, method and design employed for the survey of a sample of registered nurses currently employed by mental health services in NZ.
CHAPTER 3: METHODOLOGY, METHOD AND DESIGN

The information in this chapter describes the methodology, method and design of the survey research. Characteristics and recruitment of the sample population, ethical and cultural considerations, consent and anonymity are discussed. The instrumentation, data collection and analysis will be outlined and intended dissemination of the results from this research project is described.

Methodology

This research used a quantitative descriptive design methodology. Quantitative description entails the use of surveys to obtain common data on variables that are pre-selected. Descriptive statistics are analysed to summarise and describe this data (Sandelowski, 2000). Survey designs are seen as particularly important and relevant to social, health and nursing researchers because well conducted surveys can provide a great deal of valuable information while being relatively economic to administer (Brown, 1999; Gillis & Jackson, 2002).

Surveys are associated with the positivist approach to knowledge (Crotty, 1998; Gillis & Jackson, 2002). Positivists are interested in understanding the patterns of human response, identifying, measuring and expressing the relations among variables using statistics. Positivist researchers are “interested in understanding which factors best predict the phenomenon under investigation” (Gillis & Jackson, 2002, p. 19). The researcher’s personal values, interests or theory must be put aside to avoid influencing the outcome of the research.

Survey design was chosen for this research project as a tool to gather baseline data about what nurses in their second and third year of practice perceive clinical leadership to be in mental health settings. Brown (1999) states that “surveys are particularly useful for collecting data about behaviours enacted in everyday life; about elements of cognitive thinking such as attitudes, opinions, intentions, reasons, about values, needs, and desires; and about demographic facts” (p. 105).

A descriptive survey design was adopted for this research as this was seen as the most appropriate approach to meet the aim of the study, which was to recruit a reasonable number of respondents to obtain an overview of the role and impact of clinical leadership as perceived by nurses in their second and third year of practice. This quantitative descriptive method has
been chosen as it is useful for preliminary research that may lead to further research questions. Although Roberts and Taylor (1999) state that quantitative description design is “considered weak research in comparison with experimental research” (p. 78). It should be acknowledged that well constructed surveys can provide a wealth of knowledge about a particular phenomenon, even though causal relationships are not examined.

**Method**

Surveys are widely used in most of the developed countries of the world (Gillis & Jackson, 2002; Rea & Parker, 1997). As a research technique in the social science and professional disciplines, survey research has derived credibility from its widespread use in academic institutions. The ultimate goal of survey research is to allow researchers to generalise about a large population by studying only a smaller portion of the population. If the researcher needs information that is not available elsewhere and if generalisation of findings to a larger population is desired, sample survey research is the most appropriate method (Rea & Parker, 1997). Surveys typically collect three types of information: descriptive, behavioural, and preferential. Descriptive information includes data such as the respondents age, gender and ethnicity and behavioural information is interested in the respondents behaviour. Preferential information seeks the respondents opinion or preferences regarding issues of social and political relevance. Rarely does a study fit into only one of the informational categories. Scientific investigation requires that relationships be identified in terms of the three types of data so we may fully understand the different complexities of the population from which a sample has been drawn.

There are three methods of survey data collection; telephone, interviewing and mail (including email and internet). Mail-out survey involves the dissemination of questionnaires to a pre selected sample, respondents are asked to complete the questionnaire and return it to the researcher. This method was chosen for this research as it has the advantage of anonymity and reduced interviewer-induced bias. Survey by mail tends to have the disadvantage of a lower response rate than telephoning or interviewing and lack of interviewer involvement means that unclear questions cannot be explained (Rea & Parker, 1997). The disadvantages of mail-out survey were taken into consideration and the possibility of lower response rate due to mail out was anticipated, so two follow-up letters were sent to the sample population following the questionnaire being sent. Due to the lack of interviewer involvement in relation to unclear questions, the questionnaire was reviewed for content and consistency by 10 nurses and the
research supervisor prior to distribution to the sample population. The choice of survey via mail out was also influenced by budget and time constraints.

**Design of Questionnaire**

To ensure the survey was conducted in a vigorous and unbiased fashion, initially the focus of the study and the methodology was identified. Prior to the development of the survey instrument (questionnaire) it was necessary to gather information about clinical leadership and nursing, both nationally and internationally. A literature search in leadership and clinical leadership was undertaken to provide an information base which was used to devise the questionnaire for the formal survey process.

The attributes from the literature review were used in the questionnaire construction process. The questionnaire utilised a variety of question formats. Every effort was made to construct the questions in an unbiased and unambiguous way to insure against systematic response bias. The questionnaire was developed in stages. Section one requested socio-demographic data and asked the respondents to identify a clinical leader in their workplace. Section two asked the respondents to rank the identified clinical leader against the attributes of effective clinical leadership. Section three asked respondents their opinion of clinical leadership in terms of influence, helpful skills and barriers.

The first section consisted of closed questions that obtained socio-demographic data. A range of alternative answers were given and this intended to make completion of the questionnaire less onerous and thus increase the response rate (Rea & Parker, 1997). Respondents were asked to provide demographic data such as age, gender, and ethnicity, included in the ethnicity was “other, please specify”. Demographic data was sought to see if the respondents were representative of the target population.

Respondents were also asked to provide information in regard to their year of practice, the area of mental health they are employed in and if this mental health service was a DHB, NGO, PHO or Iwi Provider. This information was requested to provide information about clinical leadership in different areas of mental health nursing practice. The respondents were not asked to identify individual DHBs, NGOs, PHOs or Iwi Providers to enhance anonymity. This was a consideration especially in a country as small as NZ. Section one identified my sample
population by age, gender, ethnicity, year of practice, area of mental health employed in and employing organisation.

The literature search revealed that clinical leadership nursing titles were not consistent nationally (CLANZ, 2002; Rocchiccioli & Tilbury, 1998; Trim, 2001). Included in the first section following respondent’s area of employment was an open question which asked the respondent to identify what role or designation they saw as a clinical leader position in their workplace. The question informed the researcher of what designations were seen to be clinical leadership positions in mental health nursing practice. This, the most challenging question to develop, originally gave the respondent a group of options to choose from, for example, Clinical Nurse Specialist and Team Leader. Discussions with peers and my supervisor highlighted the need for further clarification, this changed to an open question which asked the respondent to identify the clinical leader in their current mental health setting. The rationale for changing this was that I did not want to influence the respondent’s way of thinking in regard to clinical leaders. When the questionnaire was reviewed by the 10 nurse lecturers at WCP, it became apparent that the respondents would possibly name the clinical leader. As this was not the purpose of the questionnaire and would create problems in regard to confidentiality, it was decided to include with the question a prompt that stated not to name the person. The question now asked the respondent to identify the designated role of the clinical leader in their workplace.

The literature search into leadership styles and attributes identified key skills and abilities that were required of effective clinical leadership. In section two of the questionnaire these attributes were listed and the respondents were asked to rank the clinical leader that they had identified in section one against them. Respondents were given a four point rating scale to rank the effectiveness of their clinical leader. The rating scale consisted of ‘excellent’, ‘good’, ‘fair’ and ‘poor’. This section contained 18 attributes, the first nine were related to organisational leadership where the attributes focused on systems and structures, for example the ability to manage conflict, assess performance and communicate. The following nine attributes focused on people and activities related to vision and judgement, for example mentoring, building vision and purpose, and being responsive to staff and consumers needs. The inclusion of all of the main themes and attributes, identified in the clinical leadership literature, into the questionnaire ensure content validity of the study (Peat, Mellis, Williams, & Xuan, 2001).
Section three of the questionnaire contained three open-ended questions. This was added to provide respondents the opportunity to give their opinion in regard to certain aspects of clinical leadership. The questionnaire asked the respondent:

- How does clinical leadership influence your nursing practice?
- What clinical leadership skills are considered helpful in assisting and retaining nurses in their second and third year of practice?
- What, if any, are the barriers to effective leadership?

Nursing literature about leadership was very closely related to job satisfaction and retention. An objective of the research was to find out how clinical leadership influenced nurses in their second and third year of practice. The first question was chosen as the researcher wanted to gauge how much of an effect clinical leadership had on relatively new practitioners, and what if any influence clinical leadership had in the workplace. The second question related to retention and aimed to give the researcher information about what nurses require from clinical leaders and what skills were necessary to assist and retain nurses in their second and third year of mental health nursing practice. The third question aimed to find out what were the barriers to effective leadership in the eyes of those relatively new to mental health nursing. Barriers to effective leadership in mental health nursing practice were not overt in the literature search. The purpose for this question was to increase knowledge of barriers to effective leadership, as perceived by nurses in their second and third year of mental health nursing practice.

The questionnaire (refer to Appendix III) was brief and concise, a total of three pages and an had an estimated time of 10-15 minutes to complete. Rea and Parker (1997) state “longer questionnaires tend to lead to lower response rates” (p. 12). The researcher devised a series of unbiased, well structured questions that systematically obtain information related to the research question and goals. Questions were carefully worded and formatted to prevent ambiguity and to ensure the questionnaire was easily understood, open and closed questions were balanced, and the element of time with respect to questionnaire length was considered.

After ensuring that the questionnaire was consistent with the research aim and objectives formatting of the questionnaire was required. The researcher placed related questions together, wording was kept clear and concise and adequate spacing was allowed between questions. Some parts of the questions were underlined to emphasize what was required or to clarify questions. Instructions were given as to how to complete the questions. The researcher
expressed appreciation to the respondents for their participation and provided a return mailing address and stamped and addressed envelope with instructions for returning the questionnaire.

An information sheet was developed to accompany the questionnaire. The Health Research Council of New Zealand (2002) suggests that informed consent should include comprehensive information about the proposed research given in a proper and appropriate medium, including any likely outcomes of participating in the research. The purpose and procedures of this study were provided in the Information Sheet (see Appendix III). Consent to participate was voluntary and not influenced by financial reward or by duress. Registered Nurses could exercise the right to decline in this research by not completing the questionnaire. Completion of the questionnaire implied that the respondent had given consent to use the data for this research project and the publication of the results. Contact details of the researcher and the research supervisor were included in the information sheet if the sample population had additional queries.

The Clinical Leaders Association of NZ’s (2001) definition of clinical leadership was given in the information sheet. This definition was chosen as it broadly gave the sample population an idea of who would be a clinical leader. The definition of a clinical leader as cited by Lett (2002) was omitted so as not to influence the response by providing biasing or manipulative information (Rea & Parker, 1997). Harper (as cited in Lett, 2002) defines a clinical leader as someone who is an expert practitioner who enables others to deliver quality patient outcomes. This definition was not used as the respondents would then look for leaders that existed in their environment who would fit this definition. The information sheet also conveyed the approximate length of the questionnaire, confidentiality, and data collection and analysis processes. Details of the researcher and purpose of the research study was given. Return mail instructions were also provided to ensure anonymity. Wording of the information sheet was kept clear and concise. For ease the sample populations were given a stamped and addressed return envelope to return the questionnaire and an initial reminder letter was sent out 10 days after the questionnaire was distributed.

Many processes were undertaken in this research project to ensure that the results obtained would be valid. It is acknowledged that bias can influence most phases of a research project, even unintentionally (Gillis & Jackson, 2002). To maintain objectivity the findings aimed to be free of research bias, thus the questionnaire was pre-tested, reviewed and revised prior to
distribution to the sample population and the research project has been supervised at every stage. The questions were formulated to address the objectives of the study. The researcher was careful to resist the temptation of developing questions that, although interesting, were not the primary focus of the research. The survey was presented as a short (three-page) questionnaire, containing both open and closed questions, to maximise the response rate.

Face validity is the “extent to which a method measures what it is intended to measure” (Peat et al., 2001). Relevant questions increase face validity, as does ensuring that the questionnaire is consistent with the purpose of the research. After a draft questionnaire and information sheet was prepared, and prior to the pre-test, the questionnaire was reviewed by the researcher to ensure consistency and comprehensiveness.

A pre-test of the questionnaire was undertaken by 10 nurse lecturers. All of these people are experienced nurses who have undertaken research. Questionnaire acceptability was also reviewed; this was to ensure that the questions were appropriate and that the length of the questionnaire was acceptable. Feedback concerning overall quality of the questionnaires construction was very positive; only one question was seen as slightly ambiguous, this question was altered to elicit the desired information and improve clarity. These nurses also assisted in ensuring that demographic questions were appropriate in regard to culture within a NZ setting.

Although this is a newly developed questionnaire and there was no ‘gold standard’ to measure it by, the questionnaire had internal validity (Peat et al., 2001). The questionnaire had content and face validity and by ensuring the theme of retention was in two sections of the questionnaire this allowed for construct validity when reviewing the results. Construct validity is the extent to which “a test agrees with another test in a way that is expected” (Peat et al., 2001). Ensuring that the questionnaire was pre-tested gave the questionnaire credibility, ensuring that it was suitable and appropriate for the sample population.

**Sample**

The sample population was determined by the researcher. The inclusion criteria for the sample population were:
Registered Nurses who have successfully completed a new graduate mental health programme in the central region of NZ (New Plymouth, Wanganui, Palmerston North, Masterton, Wellington, Lower Hutt, Nelson, Marlborough),

Those employed in mental health nursing practice by a DHB, NGO, PHO or Iwi Provider one or two years following the new graduate mental health programme.

Nurses who had successfully completed a new graduate mental health programme were chosen because they are deemed to be in a competent stage of practice (Benner et al., 1996). Successful completion of a first year of practice programme indicates that the nurse is considered to be at a competent stage of nursing practice.

Nurses in their second and third year of practice were selected as it was recognised that these nurses are in a critical stage of their career concerning retention. The first year of mental health nursing practice involves a minimum of two supported placements in mental health services, where by in the second year of nursing practice it is common that the nurse has chosen his/her place of employment and is functioning as RN without the support of an academic programme. The researcher was certain that this selected population possessed the knowledge and information required to fulfil the requirements of the research project. These groups of nurses are more likely to have a better understanding of how clinical leadership impacts on nursing practice and patient outcomes than new graduate nurses. Nurses who had four or more years experience in mental health nursing were not chosen for this study due to size and time constraints. Another reason for not selecting this group was that there was a possibility that some of these nurses would be clinical leaders within their workplace and that this would skew the results.

A central regional survey was decided on as these nurses have had contact with the researcher. A national study would possibly be skewed by the majority of the responses coming from the central region. A central regional study was also undertaken as a national study was deemed to be too large for a two paper thesis; it is acknowledged that a national study would have yielded a higher degree of accuracy in relation to results. This study was to include all nurses employed by DHBs, NGOs, PHOs and Iwi providers. The latter two were included as these are seen as areas that now encourage mental health skills and thus employ nurses with postgraduate mental health knowledge.
The sample population were recruited from the Whitireia Community Polytechnic (WPC) database and are past students that have successfully completed the Graduate Diploma in Psychiatric Mental Health Nursing programme at WCP in 2003 and 2004. To promote confidentiality, the Programme Co-ordinator of the new graduate mental health programme sourced the names and addresses of the sample population. An information sheet, questionnaire (refer to Appendix III) and a stamped and addressed return envelope were distributed to the sample population on the 24 August 2005. Sixty nine RNs in their second or third year of mental health nursing practice were invited to participate in the research.

A reminder letter (refer to Appendix IV) was sent out 10 days following to enhance the response rate. The reminder letter contained the research assistants name and contact details, should the recipient require another questionnaire. A research assistant was employed to receive, via a post office box, the returned questionnaires and remove any identifying data. The research assistant signed a confidentiality agreement prior to the study commencing (refer to Appendix V). The research assistant ensured confidentiality and collated the responses. There were no markings on the questionnaire or envelopes to identify respondents or employing organisations.

No payments were made nor expenses reimbursed to the sample population. No incentives were given, the rationale for this being to maintain total anonymity. It was acknowledged that the sample population would know the researcher as a nurse lecturer in the Graduate Diploma in Psychiatric Mental Health Nursing programme and that this may influence the response rate.

Consideration of the sample population and survey process was in accordance with the Te Tiriti O Waitangi principles; of partnership, protection and participation. It is a given that the respondents would be from various ethnic and cultural groups and that the questionnaire was checked to ensure it was culturally safe. The information sheet and questionnaire were reviewed in consultation with 10 nurse lecturers from WCP which consisted of Maori, European and Pacific Island ethnicity and the research supervisor.

This research has the potential to benefit nurses, both Maori and non-Maori, by increasing knowledge of clinical leadership in mental health nursing practice in NZ. If differences between cultural perspectives of clinical leadership emerged when analysing the data this
would be identified in the research findings and discussed against current literature. Maori people are not a specific focus for this research, although cultural advice was sought as issues arose.

Also in regard to culture, the sample population was viewed as representing the ‘culture’ of mental health nursing – ‘the way things are done around here’. Closed questions regarding clinical leaders abilities asked the respondents perception of communication; interpersonal, across systems and cross culturally, and clinical leaders ability to be responsive to patients needs. Other questions in the survey can also be directly related to the principles of partnership, protection and participation.

**Ethical Implications**

Ethical approval from WCP and Victoria University Wellington (VUW) was required for this study. This was initially requested from WCP Research and Ethics Committee as I am currently employed as a nurse lecturer for the Nursing Centre of Learning, WCP and the sample population were past students of this institution. Approval was also required from WCP because as part of the study the mental health new graduate Programme Coordinator was to source the students and distribute the information sheet, questionnaire and stamped and addressed return envelopes, this person is also an employee of Whitireia Community Polytechnic. Ethical approval had to be obtained from WCP prior to seeking approval from the VUW Human Ethics Committee.

The first step to obtaining ethical approval was to submit the research proposal to the Health, Education and Social Sciences Faculty Board of Studies Research Subcommittee, WCP. This occurred on 24th May 2005, an application for research funding from this committee was also submitted on this date. From this meeting the ethics committee requested that I:

- Purchase a PO Box for the duration of the research rather than have the mail delivered to WCP where it is opened prior to delivery.
- Employ a research assistant to collect the returned questionnaires and remove any identifying data.
- Add to Question 7 - (N.B. Do not include the name of this person)

The above was amended on the ethics proposal and resubmitted, this was then approved by the subcommittee and required submission to the WCP Research and Ethics Committee for full
approval. Ethical approval and funding for this project was finalised on the 25 July 2005 (Letter of approval refer to Appendix I). No ethical issues or conflicts of interest were anticipated. A requirement of funding is that the completed study is to be lodged as a thesis in the WCP Library.

Ethical approval was then required through VUW Human Ethics Committee, the study was ethically approved on 15 August 2005 (refer to Appendix II) after one alteration. Question 1 of the survey asked the respondent to specify their age; the VUW Human Ethics Committee required that this question be replaced by a five year age cohort. The research project conformed to the Health Research Council of NZ (2002) Guidelines on Ethics in Health Care Research. The findings of the research are to be lodged as a thesis in both WCP and VUW libraries.

Anonymity and Confidentiality

The research was not strictly anonymous in that the respondents knew me as a nurse lecturer in the Graduate Diploma in Psychiatric Mental Health Nursing programme. To promote anonymity the Programme Coordinator sourced the sample population and distributed the information sheet, questionnaire, stamped and addressed envelope and reminder letter. An information sheet was supplied and informed consent was implied by voluntary participation of filling out the questionnaire. All data was considered confidential to the research and was only discussed between the researcher and the supervisor from the Graduate School of Nursing and Midwifery, VUW until it was ready for presentation to the public via publication.

To safe guard anonymity the researcher agreed to destroy the returned questionnaires one year after the conclusion of the research. Until this time the returned questionnaires will be kept safely, with information only accessible to the researcher and the research supervisor. Particular care was taken to ensure that respondents were not pressured to participate, the information sheet was an invitation only to participate and explained that confidentiality and anonymity would be maintained. In addition, questionnaires were not pre-coded to ensure the anonymous nature of the process.
**Data Collection**

After the research project received ethical approval, the information sheet, questionnaire and stamped and addressed envelope was distributed by the new graduate mental health programme coordinator to the 2003 and 2004 students on the 24 August 2005. The time commitment for completing the questionnaire was expected to be limited to 10-15 minutes. Reminder letters were posted on 2 September 2005 to enhance response rate. The final date for sending the completed questionnaire was 16 September 2005, a time frame of three weeks to ensure that all recipients had enough time to consider participation. Due to a low response rate a further reminder letter (refer to Appendix V), information sheet and questionnaire were sent to the sample population. This reminder letter thanked those that had participated and informed those who may not have responded that the date for returning the questionnaire had been extended until the 31st October 2005 if they wanted to take up the opportunity of being involved in this study. The extension of time was to ensure that all recipients of the questionnaire had enough time to consider participation, taking into account a busy working environment that incorporates rostered and rotating shift work.

Completed questionnaires were sent back to a post office box and the research assistant collected and opened the responses, and removed any identifying data, for example named DHBs or mental health settings, to protect anonymity of all respondents and employing organisations. The research assistant signed a confidentiality agreement (refer to Appendix VI) prior to the study commencing. Returned questionnaires were kept secure by the researcher after identifying data had been removed by the research assistant. The returned questionnaires were kept in a locked and secure filing cabinet, and computer records were password protected from unauthorised entry.

**Data Analysis**

The completed questionnaires were returned to the researcher via the research assistant who had removed any identifying data. All questionnaires were checked for the appropriate number of entries, making sure that each questionnaire had the minimum number of questions completed that was required to answer the question. Three questionnaires were returned with not all questions answered. The data from these questionnaires were still included in the analysis as on a whole they provided valuable information that was relevant to this research. A master questionnaire was coded; numerical codes were provided for each category of response, for example male was coded as ‘1’, female as ‘2’. Each completed questionnaire was
coded according to the master and entered into the computer for data processing. The questionnaire was not pre-coded prior to administration as the researcher saw this to be obtrusive in appearance and due to the small sample number each questionnaire returned was able to be checked and coded against the master. Once the questionnaires were received by the researcher, checked and coded, the questionnaires were then deemed ready for the data entry process.

The Statistical Package for Social Sciences (SPSS) Version 10 was used for data analysis. SPSS is a primary statistical programme that is seen as both sophisticated and comprehensive, and capable of processing large amounts of data and generating both the very basic and the most highly advanced descriptive and analytical statistics and graphics (Rea & Parker, 1997). Once I had entered the data into SPSS, the data base was checked to ensure the data had been accurately entered. The data were summerised with descriptive statistics which included frequency distributions, means and standard deviations. Demographic data were analysed to see if it was representative of the target population, namely age, gender and ethnicity. The area of employment and the year of practice were also analysed along with the clinical leadership skills and qualities questions producing descriptive statistics using SPSS in order to look for patterns of response, for example rates of response from nurses in their second year of practice compared with nurses in their third year of practice.

Responses to section two of the questionnaire were also analysed using SPSS. Although the data were clearly of an ordinal and interval nature, means were calculated to allow the researcher to identify important information that would not be apparent in the use of median alone (Rea & Parker, 1997). The questionnaire asked respondents to rank their clinical leader against attributes of effective leadership. The rank consisted of excellent, good, fair and poor. Numerical values were given to the ordinal data, in this case 1 to 4, for ‘excellent’ to ‘poor’.

A multivariate analysis of variance (MANOVA) was undertaken to compare groups and determine whether the mean differences between the groups is likely to have occurred by chance. Clinical leadership attributes were compared with year of practice and employment setting. Parametric tests, for example MANOVA, make assumptions about the shape of the population distribution. Multivariate normality was checked by obtaining Mahalanobis distances to identify multivariate outliers. Outliers are scores that are different from the rest of the data (Pallant, 2001). As part of the MANOVA, Wilks’ Lamda tests were undertaken
compare year of practice groups and mental health settings. Tabachnick and Fidell (as cited in Pallant, 2001) indicate that the Pillai Trace test is more robust for data of small sample size and unequal N values. But for situations where you have only two groups the F-tests for Wilks’ Lambda and Pillai Trace are identical.

A non-parametric test, Mann-Whitney U Test was also undertaken. Non-parametric statistics do not have such stringent requirements and do not make assumptions about the population distribution (Pallant, 2001). Non-parametric tests do have the disadvantage of being less sensitive than parametric tests. The Mann-Whitney U test is ideal for ranked scales and useful for very small samples (Pallant, 2001). This test was undertaken to support the findings of the MANOVA.

Qualitative analysis was used for the three open-ended questions. As answers to open questions could not be predetermined the following strategy was used to analyse the responses. First, the returned questionnaires were reviewed and responses to the three open-ended questions were collated verbatim in a master document. These responses were reviewed for themes that appeared to be emerging. Each returned questionnaire received a identification (ID) number and individual comments, for example quotes, were labeled with the ID number to facilitate tracking if necessary. Themes were identified and words with shared meaning were collapsed into the major themes, and coding by question was completed. The statistical software package SPSS was not used to analyse this data as some of the respondents identified more than one theme per question. Alternatively the data received from the open questions were coded into themes and these themes were correlated by year of nursing practice and placement.

To ensure external validity demographic data was analysed to see if it is representative of the target population. Information from the Clinical Training Agency (CTA) regarding gender and ethnicity was sought so that a comparison of data could be made. The CTA is part of the MoH and funds the new graduate mental health programmes. A central region study of both nurses in their second and third year of practice was chosen to ensure that the number of respondents would be large enough to establish significance, if it existed and therefore some representation of the population.
Summary
This chapter outlined the methodological approach, method and design utilised for this research into clinical leadership in mental health nursing practice. The respondents, data collection and analysis have been described and ethical implications have been discussed. The results of the research will be presented in the next chapter. Socio-demographic characteristics of the respondents will be summarised and clinical leaders abilities will be ranked by nurses in their second and third year of nursing practice. Data is presented correlating results of clinical leadership abilities by respondent’s year of nursing practice and mental health employment setting.
CHAPTER 4: RESULTS

Results from the analysis of the clinical leadership in mental health nursing questionnaire are presented in this chapter. An overview of socio-demographic characteristics is given and identifies respondents’ employment setting and their year of practice. Nurses’ perceptions of clinical leadership abilities in relation to their own practice are presented, along with who they identify as a clinical leader in their work environment. Tables are used to present findings. Qualitative data from the three open questions will be presented with verbatim excerpts. Discussion of these results related to the literature, conceptual framework on leadership and importance to research will follow in chapter five.

Response Rate
In total 69 Registered Nurses were sent an information sheet and questionnaire, 21 completed questionnaires were returned to the research assistant within the time frame established in the information sheet (30% response rate). A further reminder letter, information sheet and questionnaire were sent to the sample population, the date for returning the questionnaire was extended until the 31st October 2005, nine more completed questionnaires were returned. A final total of 30 questionnaires were returned (43.5% response rate). The data set analysed for this study was generated from all the questionnaires received. Of the questionnaires returned, three respondents did not answer all of the questions, for example one respondent stated they did not have a clinical leader at present and so did not complete section two of the questionnaire. The other two respondents did not complete one of the questions in section three. These questionnaires were still included in the data analysis as they provided information valuable to the research. All respondents’ answers to the open ended question were legible.

Socio-demographic Data
The respondents were primarily female (80%, n=24). The number of male respondents (20%, n=6) is representative of the average male distribution within the mental health post entry clinical training (PECT) programmes (CTA, 2005) which is twenty three percent. Of the respondents 53.4% (n=16) were aged between 30 and 44 years. The sample was consistent with the average age of students in the mental health (PECT) programmes (CTA, 2005) which had a mean age of 40 years.
Respondents were asked to identify their year of mental health nursing practice. The response rate for nurses in their second year of practice was 63.3% (n=19) compared with 36.7% (n=11) of nurses in their third year of practice. Table 1 gives an overview of the socio-demographic features of respondents related to year of mental health nursing practice.

**Table 1: Socio-demographic Features of Respondents**

<table>
<thead>
<tr>
<th></th>
<th>Second year of practice (n=19)</th>
<th>Third year of practice (n=11)</th>
<th>Total (n=30)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency (Percent)</td>
<td>Frequency (Percent)</td>
<td>Frequency (Percent)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24 years or under</td>
<td>1 (5.3)</td>
<td>2 (18.2)</td>
<td>3 (10.0)</td>
</tr>
<tr>
<td>25-29</td>
<td>5 (26.3)</td>
<td>1 (9.1)</td>
<td>6 (20.0)</td>
</tr>
<tr>
<td>30-34</td>
<td>3 (15.8)</td>
<td>2 (18.2)</td>
<td>5 (16.7)</td>
</tr>
<tr>
<td>35-39</td>
<td>5 (26.3)</td>
<td>1 (9.1)</td>
<td>6 (20.0)</td>
</tr>
<tr>
<td>40-44</td>
<td>2 (10.5)</td>
<td>3 (27.2)</td>
<td>5 (16.7)</td>
</tr>
<tr>
<td>45-49</td>
<td>2 (10.5)</td>
<td>1 (9.1)</td>
<td>3 (10.0)</td>
</tr>
<tr>
<td>50-54</td>
<td>1 (5.3)</td>
<td>1 (9.1)</td>
<td>2 (6.6)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NZ Maori</td>
<td>8 (42.1)</td>
<td>2 (18.2)</td>
<td>10 (33.3)</td>
</tr>
<tr>
<td>European/Pakeha</td>
<td>10 (52.6)</td>
<td>9 (81.8)</td>
<td>19 (63.4)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (5.3)</td>
<td></td>
<td>1 (3.3)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>1 (5.3)</td>
<td>5 (45.5)</td>
<td>6 (20.0)</td>
</tr>
<tr>
<td>Female</td>
<td>18 (94.7)</td>
<td>6 (54.5)</td>
<td>24 (80.0)</td>
</tr>
</tbody>
</table>

A possible reason for the higher response rate for nurses in their second year of practice is that these respondents had only completed the new graduate mental health programme six months prior to the questionnaire being distributed. These respondents have had a more recent connection with the researcher.

The respondents were identified predominantly as NZ European/Pakeha descent (63.4%, n=19), NZ Maori consisted of 33.3% (n=10) and one respondent identified as ‘Other’. In regard to NZ European/Pakeha the sample population is representative of the mental health PECT programme statistics where trainees of New Zealand European/Pakeha ethnicity ranged between 51% and 66%, in the years 2001 to 2004 (CTA, 2005). The sample of respondents that identified as New Zealand Maori in this study was higher than the PECT statistics, who report that the proportion of Maori involved in postgraduate mental health study average around nineteen percent.
Although the questionnaire was sent to NGOs, PHOs and Iwi Providers, all respondents were employed by DHBs (100%). The area of mental health that respondents were employed in consisted of four specialties, the type of settings are indicated in Table 2.

Table 2: Area of Employment

<table>
<thead>
<tr>
<th>Area of mental health nursing practice</th>
<th>Second year of practice (n=19)</th>
<th>Third year of practice (n=11)</th>
<th>Total (n=30)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency (Percent)</td>
<td>Frequency (Percent)</td>
<td>Frequency (Percent)</td>
</tr>
<tr>
<td>Community</td>
<td>5 (26.3)</td>
<td>4 (36.4)</td>
<td>9 (30.0)</td>
</tr>
<tr>
<td>Acute</td>
<td>10 (52.6)</td>
<td>5 (45.4)</td>
<td>15 (50.0)</td>
</tr>
<tr>
<td>Forensic</td>
<td>3 (15.8)</td>
<td>1 (9.1)</td>
<td>4 (13.4)</td>
</tr>
<tr>
<td>Youth</td>
<td>1 (5.3)</td>
<td>1 (9.1)</td>
<td>2 (6.6)</td>
</tr>
</tbody>
</table>

Respondents were asked to identify what type of mental health setting they were employed in. The questionnaire gave an example of the type of information required. Nurses working in acute mental health settings accounted for almost 50% of respondents (n=15). For both nurses in their second and third year of nursing practice the greatest area of employment was acute mental health settings, followed by community mental health settings (30%, n=9).

Clinical Leadership

Table 3 indicates the identified titles of clinical leaders in mental health nursing practice. Clinical leaders’ titles varied and it is impossible to equate a title in one organisation with that in another. Respondents were asked to identify what role they perceived to be a clinical leader position in their workplace.

Table 3: Identified Titles of Clinical Leaders in Mental Health Nursing Practice

<table>
<thead>
<tr>
<th>Role of clinical nurse leader</th>
<th>Second year of practice (n=19)</th>
<th>Third year of practice (n=11)</th>
<th>Total (n=30)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency (Percent)</td>
<td>Frequency (Percent)</td>
<td>Frequency (Percent)</td>
</tr>
<tr>
<td>Team leader</td>
<td>1 (5.3)</td>
<td>1 (9.1)</td>
<td>2 (6.6)</td>
</tr>
<tr>
<td>Clinical nurse specialist</td>
<td>5 (26.3)</td>
<td>2 (18.2)</td>
<td>7 (23.5)</td>
</tr>
<tr>
<td>Nurse educator</td>
<td>3 (15.8)</td>
<td></td>
<td>3 (10.0)</td>
</tr>
<tr>
<td>Clinical coordinator</td>
<td>1 (5.3)</td>
<td>2 (18.2)</td>
<td>3 (10.0)</td>
</tr>
<tr>
<td>Clinical nurse manager</td>
<td>1 (5.3)</td>
<td></td>
<td>1 (3.3)</td>
</tr>
<tr>
<td>No clinical leader</td>
<td>1 (5.3)</td>
<td></td>
<td>1 (3.3)</td>
</tr>
<tr>
<td>Clinical nurse leader</td>
<td>2 (10.5)</td>
<td>2 (6.6)</td>
<td>2 (6.6)</td>
</tr>
<tr>
<td>Charge nurse</td>
<td></td>
<td>1 (9.1)</td>
<td>1 (3.3)</td>
</tr>
<tr>
<td>Designation not specified</td>
<td>5 (26.3)</td>
<td>5 (45.4)</td>
<td>10 (33.4)</td>
</tr>
</tbody>
</table>
Respondents named several positions in mental health nursing which were deemed to be clinical leadership positions. One respondent stated they had no clinical leader, but ‘not for want of trying’. Seven respondents (23.5%) identified ‘Clinical Nurse Specialists’ as a clinical leadership position. Of the respondents 33.4% (n=10) either: (1) did not state the designated role of the clinical leader, writing registered nurse in response to the question or (2) wrote in multiple clinical leadership positions. On reflection this question required further clarification; this aspect of the questionnaire will be discussed in the following chapter.

The results in Table 4 indicate clinical leadership attributes as perceived by the respondents and compares year of practice. Total results show that clinical leadership overall was ranked ‘good’ in every aspect apart from the ability to ‘retain staff’ and be ‘innovative and creative’. These two attributes were ranked ‘fair’ overall by respondents.

Table 4: Clinical Leadership Attributes as Perceived by Respondents in their Second and Third Year of Practice

<table>
<thead>
<tr>
<th></th>
<th>Second year of practice (n=18)</th>
<th>Third year of Practice (n=11)</th>
<th>Total (n=29)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Median</td>
<td>Mean (SD)</td>
<td>Median</td>
</tr>
<tr>
<td>Facilitate change</td>
<td>Good</td>
<td>2.11 (.83)</td>
<td>Fair</td>
</tr>
<tr>
<td>Manage conflict</td>
<td>Good</td>
<td>2.06 (.99)</td>
<td>Fair</td>
</tr>
<tr>
<td>Negotiate</td>
<td>Good</td>
<td>2.0 (.91)</td>
<td>Fair</td>
</tr>
<tr>
<td>Assess performance</td>
<td>Excellent</td>
<td>1.83 (.99)</td>
<td>Good</td>
</tr>
<tr>
<td>Make decisions</td>
<td>Good</td>
<td>1.78 (.88)</td>
<td>Good</td>
</tr>
<tr>
<td>Communicate interpersonally</td>
<td>Good</td>
<td>2.0 (1.14)</td>
<td>Good</td>
</tr>
<tr>
<td>Communicate across systems</td>
<td>Good</td>
<td>1.83 (.92)</td>
<td>Fair</td>
</tr>
<tr>
<td>Communicate cross culturally</td>
<td>Good</td>
<td>1.83 (.86)</td>
<td>Fair</td>
</tr>
<tr>
<td>Retain staff</td>
<td>Good</td>
<td>2.28 (1.07)</td>
<td>Fair</td>
</tr>
<tr>
<td>Mentor</td>
<td>Excellent</td>
<td>1.78 (1.06)</td>
<td>Fair</td>
</tr>
<tr>
<td>Inspire and motivate</td>
<td>Excellent</td>
<td>1.89 (1.08)</td>
<td>Fair</td>
</tr>
<tr>
<td>Build vision and purpose</td>
<td>Good</td>
<td>2.06 (1.00)</td>
<td>Fair</td>
</tr>
<tr>
<td>Realise talent</td>
<td>Good</td>
<td>2.0 (1.03)</td>
<td>Fair</td>
</tr>
<tr>
<td>Be responsive and flexible</td>
<td>Good</td>
<td>1.94 (1.06)</td>
<td>Fair</td>
</tr>
<tr>
<td>Be innovative and creative</td>
<td>Good</td>
<td>2.11 (1.02)</td>
<td>Fair</td>
</tr>
<tr>
<td>Be a positive role model</td>
<td>Excellent</td>
<td>1.89 (1.08)</td>
<td>Fair</td>
</tr>
<tr>
<td>Be responsive to consumers needs</td>
<td>Good</td>
<td>1.78 (.88)</td>
<td>Good</td>
</tr>
<tr>
<td>Demonstrate high standards of ethical and moral conduct</td>
<td>Excellent</td>
<td>1.89 (1.08)</td>
<td>Good</td>
</tr>
</tbody>
</table>
Twenty nine respondents (96.5%) ranked their ‘clinical leader’ against each leadership attribute identified from the literature review. Respondents ranked their clinical leader as ‘excellent’, ‘good’, ‘fair’ or ‘poor’ indicating whether the clinical leader that they had identified in the previous question effectively met each leadership attribute. Nurses in their second year of practice had median scores of either ‘excellent’ or ‘good’ in every attribute, total median of ‘good’ for ranked effective leadership attributes. Nurses in their second year of mental health nursing practice ranked their clinical leaders as excellent in five of the 18 attributes. These attributes were the ability to effectively assess performance, mentor, inspire and motivate, be a positive role model and demonstrate high standards of ethical and moral conduct.

Nurses in their third year of practice, however had median scores of either ‘good’ or ‘fair’ with a total median of ‘fair’ for perceived leadership abilities. These nurses ranked their clinical leaders as ‘fair’ in 13 of the 18 attributes.

Means were assigned to all attributes with ‘excellent’ being 1 and ‘poor’ 4 (refer to Table 4). For this research project mean results indicate that the higher the score the worse the result. All attributes received a mean score of 1.93 – 2.62 which indicates an average score of ‘good’. The ability of the clinical leader to ‘retain staff’ (mean of 2.62) was ranked highest by the respondents, along with the clinical leaders’ ability to ‘be innovative and creative’ (mean of 2.45). Leadership skills that scored the lowest were the ability to ‘make decisions’ (mean of 1.93) and the leaders’ ability to ‘demonstrate high standards of ethical and moral conduct’ (mean of 2.0). The attributes with the largest standard deviations were the ability of the clinical leader to effectively: be a positive role model (SD 1.21), communicate interpersonally (SD 1.17), mentor (SD 1.16) and be responsive and flexible (SD 1.14). The attributes with the smallest standard deviations are the abilities of clinical leaders to: communicate cross culturally (SD 0.88), be responsive to consumers' needs (SD 0.88) and make decisions (SD 0.88).

Perceptions of clinical leadership attributes were compared with mental health setting employed (refer to Table 5, p. 42). Respondents identified four areas of employment; community, acute, forensic and child and youth. Only a few respondents indicated that they were working in forensic and child and youth settings, and they appear to be from one
particular DHB. These areas of practice results are not specifically displayed in Table 5, but the total median and mean are inclusive of all four practice settings.

Table 5: Clinical Leadership Attributes as Perceived by Respondents in Different Mental Health Settings

<table>
<thead>
<tr>
<th></th>
<th>Acute (n=15)</th>
<th>Community (n=9)</th>
<th>Total (n=29)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>median Mean (SD)</td>
<td>median Mean (SD)</td>
<td>median Mean (SD)</td>
</tr>
<tr>
<td>Facilitate change</td>
<td>Good 2.67 (.90)</td>
<td>Good 2.0 (1.07)</td>
<td>Good 2.38 (.94)</td>
</tr>
<tr>
<td>Manage conflict</td>
<td>Good 2.47 (.92)</td>
<td>Good 2.0 (1.07)</td>
<td>Good 2.28 (.96)</td>
</tr>
<tr>
<td>Negotiate</td>
<td>Good 2.33 (1.05)</td>
<td>Excellent 1.88 (1.13)</td>
<td>Good 2.17 (1.00)</td>
</tr>
<tr>
<td>Assess performance</td>
<td>Good 2.4 (.83)</td>
<td>Excellent 1.63 (1.06)</td>
<td>Good 2.10 (1.01)</td>
</tr>
<tr>
<td>Make decisions</td>
<td>Good 2.13 (.83)</td>
<td>Excellent 1.63 (1.06)</td>
<td>Good 1.93 (.88)</td>
</tr>
<tr>
<td>Communicate interpersonally</td>
<td>Good 2.73 (1.16)</td>
<td>Excellent 1.25 (.71)</td>
<td>Good 2.17 (1.17)</td>
</tr>
<tr>
<td>Communicate across systems</td>
<td>Good 2.53 (1.06)</td>
<td>Excellent 1.37 (.74)</td>
<td>Good 2.14 (1.06)</td>
</tr>
<tr>
<td>Communicate cross culturally</td>
<td>Good 2.13 (.74)</td>
<td>Good 1.75 (.89)</td>
<td>Good 2.07 (.88)</td>
</tr>
<tr>
<td>Retain staff</td>
<td>Fair 2.93 (.96)</td>
<td>Good 2.13 (1.13)</td>
<td>Fair 2.62 (1.05)</td>
</tr>
<tr>
<td>Mentor</td>
<td>Good 2.4 (1.12)</td>
<td>Excellent 1.63 (1.06)</td>
<td>Good 2.14 (1.16)</td>
</tr>
<tr>
<td>Inspire and motivate</td>
<td>Fair 2.53 (1.06)</td>
<td>Excellent 1.75 (1.16)</td>
<td>Good 2.24 (1.09)</td>
</tr>
<tr>
<td>Build vision and purpose</td>
<td>Fair 2.73 (1.10)</td>
<td>Good 2.0 (1.07)</td>
<td>Good 2.41 (1.09)</td>
</tr>
<tr>
<td>Realise talent</td>
<td>Good 2.6 (1.06)</td>
<td>Good 2.25 (1.04)</td>
<td>Good 2.41 (1.09)</td>
</tr>
<tr>
<td>Be responsive and flexible</td>
<td>Good 2.67 (1.11)</td>
<td>Good 1.88 (1.13)</td>
<td>Good 2.31 (1.14)</td>
</tr>
<tr>
<td>Be innovative and creative</td>
<td>Fair 2.73 (.88)</td>
<td>Good 2.0 (1.20)</td>
<td>Fair 2.45 (.99)</td>
</tr>
<tr>
<td>Be a positive role model</td>
<td>Good 2.47 (1.19)</td>
<td>Excellent 1.63 (1.06)</td>
<td>Good 2.24 (1.21)</td>
</tr>
<tr>
<td>Be responsive to consumers needs</td>
<td>Good 2.2 (.86)</td>
<td>Good 1.88 (.99)</td>
<td>Good 2.07 (.88)</td>
</tr>
<tr>
<td>Demonstrate high standards of ethical and moral conduct</td>
<td>Good 2.27 (.96)</td>
<td>Excellent 1.38 (.74)</td>
<td>Good 2.0 (1.00)</td>
</tr>
</tbody>
</table>

Results indicate that overall the perceptions of clinical leadership in acute mental health settings are ‘good’. Respondents in acute settings ranked four of the 18 attributes as ‘fair’, these were the ability to retain staff, inspire and motivate, build vision and purpose and be innovative and creative. Respondents in community settings ranked clinical leaders well with medians of ‘excellent’ or ‘good’. The median and mean scores indicate that clinical leadership is ‘good’ in all identified mental health settings, apart from the ability to retain staff and be innovative and creative.
MANOVA

The results of the MANOVA test indicated a statistically significant difference between nurses in their second year of practice and nurses in their third year of practice in their ranking of clinical leadership abilities. The Wilks’ Lambda, one of the MANOVA tests, indicated that there was a statistically significant difference between nurses in their second year of practice and nurses in their third year of practice in their ranking of clinical leadership abilities.

A more conservative alpha level to determine significance for the variable ‘be innovative and creative’ was required after completing a Levene’s Test of Equality of Error Variances test. An alpha of 0.025 was suggested by Pallant (2001) who states that the higher alpha level should be set to reduce Type 1 error (that is finding a significant result when there isn’t one). Following the Wilks’ Lambda test a Between Subjects Effects test indicated that the attributes ‘realise talent’ and ‘be innovative and creative’ recorded a significant value less than alpha 0.017. This indicates that in this study the only significant difference between year of practice was on the clinical leaders perceived ability to ‘realise talent’ and ‘be innovative and creative’ scores. The Mahalanobis distance test indicated no substantial multivariate outliers.

The importance of the impact of year of practice on these abilities was evaluated by the effect size statistic (Eta Squared). The attribute ‘realise talent’ scored 0.246 and ‘be innovative and creative’ scored 0.199. This represents 24.6% of the variance in perceived ‘realise talent’ by year of practice and 19.9% for ‘be innovative and creative’. Group means were compared for these variables. In the ‘realise talent’ attribute the mean=2 (SD.226) for nurses in their second year of practice and mean=3.09 (SD .290) for nurses in their third year of practice. For ‘be innovative and creative’ the mean=2.11 (SD.212) for nurses in their second year of practice and mean=3 (SD.271) for nurses in their third year of practice. On both occasions nurses in their third year of practice scored these clinical leadership attributes higher than nurses in their second year. A mean of 3 indicates a ranking of ‘fair’.

The same tests were undertaken to compare acute and community mental health settings. The Wilks’ Lambda scored 0.147 this was not less than 0.05 therefore there are no significant differences between areas of practice in terms of ranking clinical leaders abilities.
Non-Parametric Test

The results of the Mann-Whitney U Test indicated that there was a significant difference in the scores between nurses in their second and third year of practice and a significant difference in the scores between acute and community settings. Table 6 shows the P values for each clinical leadership attribute for year of practice and community/acute employment setting.

Table 6: Mann-Whitney U Test: P Values for Clinical Leadership Attributes

<table>
<thead>
<tr>
<th>Leadership Ability</th>
<th>Year of Practice P value</th>
<th>Community &amp; Acute P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitate change</td>
<td>.05</td>
<td>.11</td>
</tr>
<tr>
<td>Manage conflict</td>
<td>.08</td>
<td>.24</td>
</tr>
<tr>
<td>Negotiate</td>
<td>.26</td>
<td>.30</td>
</tr>
<tr>
<td>Assess performance</td>
<td>.05</td>
<td>.04</td>
</tr>
<tr>
<td>Make decisions</td>
<td>.18</td>
<td>.10</td>
</tr>
<tr>
<td>Communicate interpersonally</td>
<td>.30</td>
<td>.01*</td>
</tr>
<tr>
<td>Communicate across systems</td>
<td>.06</td>
<td>.01*</td>
</tr>
<tr>
<td>Communicate cross culturally</td>
<td>.05</td>
<td>.27</td>
</tr>
<tr>
<td>Retain staff</td>
<td>.03</td>
<td>.10</td>
</tr>
<tr>
<td>Mentor</td>
<td>.03</td>
<td>.10</td>
</tr>
<tr>
<td>Inspire and motivate</td>
<td>.02*</td>
<td>.10</td>
</tr>
<tr>
<td>Build vision and purpose</td>
<td>.02*</td>
<td>.13</td>
</tr>
<tr>
<td>Realise talent</td>
<td>.01*</td>
<td>.46</td>
</tr>
<tr>
<td>Be responsive and flexible</td>
<td>.03</td>
<td>.10</td>
</tr>
<tr>
<td>Be innovative and creative</td>
<td>.02*</td>
<td>.12</td>
</tr>
<tr>
<td>Be a positive role model</td>
<td>.05</td>
<td>.09</td>
</tr>
<tr>
<td>Be responsive to consumers needs</td>
<td>.01*</td>
<td>.30</td>
</tr>
<tr>
<td>Demonstrate high standards of ethical and moral conduct</td>
<td>.34</td>
<td>.03</td>
</tr>
</tbody>
</table>

* Statistically significant at p<0.025 level

With the reduction of the alpha as indicated in the MANOVA, results are comparable. Both the MANOVA and Mann-Whitney U Test identified significant difference in the attributes ‘realise talent’ and ‘be innovative and creative’ between second and third year of practice groups. The Mann-Whitney U Test also identified three other attributes that showed significant differences between year of practice and two significant differences for community and acute employment settings. As stated the Mann-Whitney U Test is less sensitive than the MANOVA. For this research the Mann-Whitney U Test was used to confirm findings in the more stringent MANOVA.
The following results are from section three of the questionnaire and contain qualitative descriptive data. Each question is explored separately and individual quotes and ID numbers are presented.

**How Clinical Leadership Influences Nursing Practice**

The sample population was asked - How does clinical leadership in your workplace influence your nursing practice? Twenty nine respondents (96.6%) answered this question. Table 7 gives an overview of the statements made by respondents related to clinical leadership and how it influences practice.

The main way clinical leadership influences nurses in their second and third year of practice is by role modelling, providing support and assessing practice. One respondent noted:

> *Can be inspiring – if you can see qualities in others that you would want for yourself, being set a good example. Being positive and energetic about the practice of nursing. Being supportive and friendly and approachable* (118).

In contrast another respondent stated:

> *It should have a major influence. At the moment it doesn’t* (110).

Role modelling by clinical leaders had the largest influence on nurses in their second and third year of practice. Role modelling or leading by example was reported by 10 respondents. One respondent stated:

> *She helps me – she's my role model. She ensures that I am competent and accountable* (104).

Support was another theme that emerged strongly from eight respondents; one respondent commented that clinical leadership:

> *Dictates how supported I feel in the work environment and decisions I make* (125).

Often role modeling and support were identified together:

> *To provide role modeling, support (moral and ethical)* (107).

Assessing performance was identified by six respondents. One respondent stated the clinical leader influenced practice:

> *By presenting positive/negative feedback with sensitivity and being open to discussion around decisions that I have made* (119).
### Table 7: How Clinical Leadership Influences Practice

<table>
<thead>
<tr>
<th>Cluster Themes</th>
<th>Quotes (code number)</th>
</tr>
</thead>
</table>
| Feeling Supported    | - By providing support for myself and my colleagues (113).  
- Recognises strengths, supports growth in developing characteristics. Valid, current, ward specific support not global (101).  
- Source of support, able to clarify issues that may arise. Offer impartial listening however able to facilitate change if necessary (103).  
- Dictates how supported I feel in the work environment and decisions I make. Dictates how comfortable I feel when conflict and difficult situations arise (125).  
- One of them you can talk to, bounce ideas off, be guarded by, go to when you are feeling frightened, lost and out of your depth. That’s what you need in a CNL. Everything else is secondary to that (120). |
| Having a Good Role Model | - She helps me – she’s my role model. She ensures that I am competent and accountable (104).  
- Provides role modeling for my practice (105).  
- An excellent example to follow – aspire to (115).  
- A good role model always influences good and safe practice. A poor role model makes me question what I am doing much more (117).  
- Leading by example, guiding on best practices, motivating to learn new skills. Ensuring we can justify our actions (127). |
| Assessing Performance | - Having an accessible team leader who is willing to listen. Gauge my performance against guidelines set. Implementing attainable performance reviews (112).  
- By being approachable to guide my nursing practice in regards to sound decisions in treatment care. By encouraging me to voice my opinion and try other strategies in treatment care of our patients. By presenting positive/negative feedback with sensitivity and being open to discussion around decisions that I have made (119).  
- Guides practice in rarely encountered, ambiguous or particularly risky situations. Provides a default or consistent example of how to practice in ordinary circumstances. Validates good practice and encourages development (114). |
| A Negative Effect     | - Some days I don’t want to go to work because of the lack of leadership. Staff do their utmost best to keep the ward environment safe for clients and staff, stress is inevitable. Power struggles between staff and management, horizontal violence ultimately affects the moral of ward and quality of care given to clients (116).  
- It should have a major influence. At the moment it doesn’t (110).  
- Has mostly been a struggle due to personal differences as our CNL is a very forceful nature, so can be intimidating and feel threatening and suffocated (111).  
- I feel in some instances it oppresses and belittles my clinical and nursing practice due to leadership overriding decisions made in working environments. Often decisions relating to nursing care are delivered as orders without liaison and collaboration with front line staff therefore leaving both the client and myself disempowered (122).  
- Because the clinical leader tends to accept inappropriate referrals and the unit is often over numbers without additional staffing. I feel that the majority of time my nursing practice is reactive and moving from crisis to crisis, often neglecting my best practice (124).  |
As suggested by eight respondents poor clinical leadership influenced practice negatively. One respondent commented on the lack of leadership:

*Some days I don’t want to go to work because of the lack of leadership. Staff do their best to keep the ward environment safe for clients and staff, stress is inevitable. Power struggles between staff and management, horizontal violence ultimately affects the morale of the ward and quality of care given to clients* (116).

The need for leadership was expressed by one respondent:

*We continue to ask for a clinical leader – to discuss our practice, one person to ask questions and gain support and advice from. Have knowledge and vision for our work and help implement the vision* (121).

Clinical leadership clearly influences practice, one respondent stated that it:

*Makes me more confident in my own practice* (128).

Another respondent agreed stating that clinical leadership influenced their practice:

*Greatly – through leadership I have a sense of safety. I am comfortable in my workplace. I can approach my C/L with any concerns big/small* (129).

**Helpful Skills for Assisting and Retaining Nurses**

Twenty-nine respondents identified five main skills that they thought would be helpful for assisting and retaining nurses in their second and third year of nursing practice. The skills identified were communication, mentorship, role modelling, ongoing education and performance assessment. The majority of the statements were close to the wording of some of the original questionnaire items that were retrieved from the relevant literature on clinical leadership. Table 8 gives an overview of the statements made by respondents in regard to helpful skills for clinical leaders.

The most common theme that emerged was ‘communication’ (n=22). Respondents wrote about listening, empathy, open and honest communication, the ability to manage conflict and recognise if staff are requiring support or guidance. One respondent noted:

*Good communication skills – management, culturally* (106).

The ability to mentor and role model good practice was also identified as skills that would assist and retain nurses. One nurse commented that clinical leaders should be:

*Sharing knowledge and helping second years integrate into the nursing profession so they don’t feel dropped after the RN1 (new graduate) programme* (104).
Table 8: Helpful Skills for Assisting and Retaining Nurses

<table>
<thead>
<tr>
<th>Cluster Themes</th>
<th>Quotes (code number)</th>
</tr>
</thead>
</table>
| Communication        | • Being able to talk to the CNLs about practice, direction service is going in (120).  
                        • Communication (104) (124).  
                        • Approachable, experience, good listener, able to manage conflict in the workplace, efficiency (113).  
                        • Communication, support (115).  
                        • Clinical skills to be able to manage conflict, negotiate and be constant in their decision making. Have good ethical moral values and defined professional values (116).  
                        • Communication, flexibility, listening to staffs concerns/needs, ability to support staff as needed/recognize if staff are requiring support/guidance (107).  
                        • Good communication skills – management, culturally (106).  
                        • Listening skills, empathy (112).  
                        • Being available on the floor and being approachable and constructive rather than dictatorial and judgemental (114).  
                        • Being supportive and available to offer advice, being approachable, being on the floor and realistic about expectations of nurses (127).  
                        • Open, honest communication (126).  |
| Mentorship           | • Vision, interpersonal skills, positive regard, mentorship, respect, clinical supervision, innovation, trust, honesty (101).  
                        • To give and advocate appropriate support ie mentors/clinical supervision (106).  
                        • Sharing knowledge and helping second years integrate into the nursing profession so they don’t feel dropped after the RN1 (new graduate) programme (104).  
                        • Mentorship or clinical supervision skills. Support nurses to continue having confidence within their roles/practice e.g. education, taking advantage of all opportunities offered (103).  |
| Role Modeling        | • By being available to new staff. Encouraging/guiding nurses in professional development areas. By being inclusive /supportive of new staff. Leading by example. Providing supervision (119).  
                        • Positive role models. Good personal and professional boundaries (125).  |
| Ongoing Education    | • Ongoing education sessions (104).  
                        • To offer further education options (106).  
                        • Encourages professional development e.g. postgrad study (125).  
                        • Encourage further study and advocate for financial support re: same (124).  
                        • Allowing nurses adequate time off the ward to attend and pursue further education options (122).  |
| Assessing Performance| • If CNL could take each RN aside, discuss and listen to their experiences, fears and accomplishments. Give feedback on their performance. Acknowledge achievements. Make new nurses feel part of the team (108).  
                        • Assessing and evaluating practice – providing effective feedback. Providing relevant/helpful education/new experiences (105).  
                        • Giving informal feedback on a case by case basis around difficult decision making/planning (128).  |
Thirteen respondents identified ongoing education as a helpful skill to assist and retain nurses. The respondents wrote about clinical leaders encouraging, providing and supporting ongoing education, for example:

*Encourage further study and advocate for financial support re: same* (124).

At the same time respondents (n=7) also identified that assessing performance would be helpful, the word feedback was mentioned six times:

*Giving feedback (both positive and negative)* (125).

Two respondents also made reference to the need for clinical leaders to have increased skills. One respondent stated that it would be helpful if the clinical leader

*Had fairly recent experience of nursing in the area they are providing leadership for* (114).

Another skill that was identified as helpful for assisting and retaining nurses was:

*Education in management (or working towards same)* (110).

**Barriers to Effective Clinical Leadership**

Twenty-eight respondents (93%) identified one or more barriers to effective clinical leadership. The statements from the questionnaire in regards to barriers were reviewed for themes. The themes that emerged were attitude, poor communication, lack of support, systems issues, staffing shortages, lack of experience and knowledge, and heavy workload. Table 9 gives an overview of the statements made by respondents regarding barriers to effective clinical leadership.

The barrier most often mentioned was ‘attitude’ and this was suggested by 10 respondents. Attitude was sometimes worded implicitly: ‘fixed/unmoving attitude’ (112); and often as a consequence of poor communication and lack of experience

*Exuding a superior or disapproving attitude. Not sufficiently experienced in the area. Not being able to advocate or achieve resolution of problems identified by staff* (114).

The issue of communication was raised by seven of the respondents, especially in regard to poor communication. Clinical leaders were seen to be not spending the time to communicate with all staff, with a focus on only providing negative feedback to nurses. Another barrier mentioned by respondents was the lack of support for clinical leaders; this was closely related to system issues and the clinical leaders’ heavy workload.
<table>
<thead>
<tr>
<th>Cluster Themes</th>
<th>Quotes (code number)</th>
</tr>
</thead>
</table>
| **Staffing Shortages** | • 80% of their time is spent staffing shifts. I would rather have a CNL guiding and helping on the floor ... than have the CNL telephoning like a maniac from their office to get enough staff (120). Staffing levels (112).  
• Clinical nurse leaders ignoring staff nurse concerns re: safe staffing numbers and refusing to help out on ward to ensure client: staff ratios are at a manageable level (122).  
• Allowing the unit to go over numbers and not approving extra staffing in relation to acuity (124).                                                                                                                                                                                |
| **Poor Communication** | • Favouritism. Not spending time to communicate with all staff members and poor communication (108).  
• Team issues – communication issues (103).  
• Senior staff who are now management openly belittling and speaking condescendingly to staff (122).  
• Non communication with staff on the floor (124).                                                                                                                                                                                                                           |
| **Lack of Support**  | • Respect from other clinical leaders. Cohesion in leadership – not always strong (101).  
• Non consistency and stressful environments that lack support from management (105).  
• Lack of strong and appropriate supports at times (106).                                                                                                                                                                                                                       |
| **Systems Issues**   | • Politics, paperwork, personality clashes (113).  
• System issues e.g. management, budget constraints, staffing shortages (103).  
• Not having defined roles for nursing staff and management (116).  
• District Health Board/management will or ‘have not paid’ for the position despite asking at monthly meetings for a clinical leader (121).  
• Budget, management constraints. Systems issues. Historical practices. Reluctance to change (126).                                                                                                                                                                                     |
| **Attitude**         | • One of them is trustworthy and cares about the staff, the other three just want to get their job done and go home (120).  
• By receiving negative feedback in front of peers. No feeling that you can approach CNS or team leader when you are struggling in your clinical vision (119).  
• Fixed/unmoving attitude (112).  
• Dominating personalities (111).  
• Unavailable on the floor or unapproachable personality. Exuding a superior or disapproving attitude (114).  
• Too often I am seeing management negating and oppressing staff nurses autonomy. Too much focus on looking for negatives about the nurses practice instead of acknowledging the hard work and dedication that is occurring (122).  
• People who do not feel passionate about what they do (118).                                                                                                                                                                                                 |
| **Lack of Experience/ Knowledge** | • Lack of experience – both clinical and as a leader – which has led to disgruntlement in the workplace (125).  
• Clinical leader is not particularly assertive. Management and organizational skills somewhat lacking (107).  
• Ability to problem solve effectively, not understanding expertise within the MDT, no knowledge of team dynamics and effectively managing same (110).  
• A lack of skills and knowledge (117).  
• Not sufficiently experienced in the area. Not being able to advocate for or achieve resolution of problems identified by staff (114).                                                                                                                                                     |
| **Heavy Workload**   | • Our CNS only working part time she is unable to give effective clinical leadership 5 days a week. Her time is often stretched (104).  
• High workload on and off floor (101).  
• Lack of time caused by too many managerial responsibilities, or too little time caused by having their own case load (118).  
• Too many duties for CNL not enough time to provide guidance, mainly doing other roles which they should not have to do ie. Having a big case load (127).                                                                                                                         |
Staffing issues were considered to be a barrier by seven respondents. Staffing issues concerned clinical leaders spending large amounts of time trying to staff shifts, high patient numbers and adequate staffing levels, for example:

*Clinical nurse leaders ignoring staff nurse concerns re: safe staffing numbers and refusing to help out on ward to ensure client: staff ratios are at a manageable level* (122).

Lack of experience or knowledge was highlighted by the respondents as a barrier to effective leadership. One respondent noted:

*Lack of experience – both clinical and as a leader – which has led to disgruntlement in the workplace* (125).

Several respondents thought that management and organisational skills were somewhat lacking and they saw this as a barrier to effective clinical leadership.

Only one respondent stated there were no barriers to effective clinical leadership in the workplace. This respondent noted:

*We have a good CNS who is approachable and will listen to our opinions. There are no barriers* (102).

**Summary**

This chapter reported data generated by 30 returned questionnaires. The data included demographic characteristics of the respondents and data related to clinical leadership from a ranking scale and open-ended questions. Overall clinical leadership attributes as perceived by respondents were ranked ‘good’ in every aspect apart from the ability to ‘retain staff’ and be ‘innovative and creative’. These two attributes were ranked ‘fair’ by respondents. Nurses in their second year of practice perceptions of clinical leadership differed from nurses in their third year of practice. Nurses in their second year had a median rank of ‘good’. Nurses in their third year had a median rank of ‘fair’. In regard to area of employment, nurses in acute mental health settings ranked leadership as ‘good’ to ‘fair’, while nurse in community settings ranked leadership as either ‘excellent or ‘good’.

The MANOVA indicated a statistically significant difference between nurses in their second year of practice and nurses in their third year of practice in terms of their mean scores of the clinical leadership abilities to ‘realise talent’ and ‘be innovative and creative’. On both
occasions’ nurses in their third year of practice scored these clinical leadership attributes higher than nurses in their second year (a higher score indicates a worse result). No significant differences between areas of practice in terms of the mean scores of clinical leaders abilities was found. The Mann-Whitney U Test was used to confirm findings in the more stringent MANOVA.

Respondents identified three specific elements of clinical leadership that influenced their practice positively. These elements were having a good role model, feeling supported, and assessment of performance. The results also indicated that lack of clinical leadership can have a negative influence on practice. The skills identified by respondents as being helpful in assisting and retaining nurses were communication, mentorship, role modelling, ongoing education and performance assessment. The biggest barriers to effective clinical leadership were identified as attitude, poor communication, lack of support, systems issues, staffing shortages, lack of experience and knowledge, and heavy workload.

The results, from the sample of NZ registered nurses who are currently employed in mental health services, are of some interest and concern in regard to clinical leadership in mental health nursing practice. In the next chapter these findings will be discussed related to the reviewed literature and the conceptual framework. Limitations of the study will also be discussed.
CHAPTER 5: DISCUSSION

The main purpose of this study was to explore the perceptions of clinical leadership in mental health nursing practice. The respondents were registered nurses in their second and third year of practice. Their perceptions were measured by a questionnaire, which consisted of both open and closed questions. The results compare with other international studies investigating clinical leadership in nursing practice and will be discussed in relation to the reviewed literature on clinical leadership. The research instrument used to gather data for the study will be discussed and the limitations of the study will be related to the research methodology used.

The research question that will be answered in the following discussion is:

What are the perceptions of registered nurses about clinical leadership in mental health nursing practice?

The discussion will also address the aims of the study, which were:

- To increase knowledge about clinical leadership in mental health nursing practice.
- To gain understanding of ways in which clinical leadership influences new practitioners.
- To identify clinical leadership skills that are considered helpful in assisting and retaining nurses, and
- To identify barriers to effective leadership.

Clinical leadership in Mental Health Nursing Practice

The first aim of this study was to increase knowledge about clinical leadership in mental health nursing practice as perceived by nurses in their second and third year of practice (n=30) via a questionnaire. This questionnaire focused on clinical leadership attributes and opinions of clinical leadership in mental health nursing practice.

The results of this study indicate that there are no consistent titles for clinical leaders in mental health nursing practice. Respondents indicated that titles of clinical leaders varied. The most common title reported was that of ‘clinical nurse specialist’ (23.5%, n=7). Titles and job descriptions are inconsistent both nationally and internationally (CLANZ, 2002; Rocchiccioli & Tilbury, 1998; Trim, 2001). Ten respondents (33.4%) either responded by writing registered nurse or wrote in multiple clinical leadership positions. This research indicates that
all senior nurse positions in mental health nursing practice could be classed as clinical leadership positions.

Overall clinical leadership attributes as perceived by respondents were ranked ‘good’ in every aspect apart from the ability to ‘retain staff’ and ‘be innovative and creative’. These two attributes were ranked ‘fair’ by respondents. The ability to be innovative and creative is linked to Perkins (2004) construct of having vision. Perkins discusses the importance of clinical leaders’ having visions, purposes and goals. He argues that to be effective the leader must recognise what is possible for the group being led (Perkins, 2004). Vision is central to the nature of leadership (Graham, 2003).

There was a statistically significant difference between nurses in their second year of practice and nurses in their third year of practice in terms of their ranking of clinical leadership abilities. This significant difference between year of practice was on the clinical leaders’ perceived ability to ‘realise talent’ and ‘be innovative and creative’ scores. The ability to ‘realise talent’ is linked to the respondents answers to the open questions. Respondents indicated that they wanted clinical leaders to assess their performance, providing feedback and validating good practice. Respondents in the open questions reported that assessment of performance and the ability to realise talent were skills that would assist and retain nurses.

Apart from the statistically significant difference of the ability to ‘realise talent’ and ‘be innovative and creative’, the mean scores and median ranks differed greatly between year of practice. Nurses in their second year of practice had median rankings of either ‘excellent’ or ‘good’ in every attribute. Nurses in their third year of practice, however had median rankings of ‘fair’ for 13 of the 18 clinical leadership attributes. The results indicate that nurses in their third year of practice perceive clinical leadership to be not as effective and are less satisfied with clinical leadership than nurses in their second year. This could be due to nurses in their third year of practice being more acculturated into mental health nursing. Another reason for this could be that as nurses become more experienced and competent in mental health nursing they see the bigger picture of the system they work in.

Although no significant difference was found between acute and community mental health settings in regard to clinical leadership abilities, means and medians indicated that respondents in community settings perceived clinical leadership to be better than in acute settings.
Respondents in acute settings rated four of the 18 attributes as ‘fair’. These were the ability to retain staff, inspire and motivate, build vision and purpose and be innovative and creative. Respondents in community settings rated clinical leaders well with median scores of either ‘excellent’ or ‘good’. Effective clinical leadership in community mental health settings was evident. Retention of staff was ranked ‘good’. This indicates that community mental health settings are less likely to have the stresses of staff shortages and systems issues.

In relation to Bass’s (1998) transformational leadership, the components of inspirational motivation and intellectual stimulation were ranked ‘fair’ by nursing working in acute mental health settings and by nurses in their third year of practice. These components are important in that by doing them the clinical leader provides meaning, commitment and a shared vision through encouragement and optimism. If clinical leaders are not effective in these areas this could have a negative influence on practice.

**Influence on New Practitioners**

The second aim of this study was to gain understanding of ways in which clinical leadership influences new practitioners. The first open question asked the respondents ‘How does clinical leadership in your workplace influence your nursing practice?’ Respondents identified three specific elements, that having a good role model, feeling supported, and assessment of performance by clinical leaders influences how they practice. The results also indicated that lack of clinical leadership can have a negative influence on practice.

Respondents said that role modelling had the largest influence on practice. Having a good role model appeared to influence good and safe practice. This was closely related to how supported and mentored the nurse felt. The importance of good role modelling is supported by the NCNZ (2005) in the competencies for the RN scope of practice. Positive role modelling should not be underestimated and is essential for creating an environment that supports and mentors nurses. Bass’s (1998) discussion on transformational leadership highlighted that good role models are respected and trusted, consistent in the way that they lead and are willing to take risks. Role models also facilitate change by recognising the potential in followers so that change can be sustained (Grossman & Valiga, 2000). Role modeling was also highlighted by respondents as a skill that would help assist and retain nurses in mental health nursing practice. This is discussed further in the next section.
Cunningham, (2000), Kleinman (2004a) and Sullivan Havens (2001) assert organisational support is a component that impacts directly on retention of staff and patient outcomes. Acker (2004) strongly advocates for a supportive work environment, clarifying that it provides workers with the appropriate atmosphere to produce quality health outcomes and derive job satisfaction. The concept of support from clinical leaders was brought up many times by respondents and revealed that a source of support guides and encourages good practice. Unfortunately the term ‘support’ is difficult to define, what one person may think as being supportive another might find constricting. This brings forward the importance of working with the individual nurse in partnership.

The results from this study indicated that nurses practice was influenced positively by clinical leaders who provided support. Clinical leaders did this by being approachable, friendly, by advocating appropriate supports, for example mentors and clinical supervision, and by supporting the nurse to have confidence within roles and practice. Supporting growth and ongoing education also appeared to influence practice.

Support or lack of it reflects on the organisation (Rocchiccioli & Tilbury, 1998). The results of this research, identified lack of support from clinical leaders as a barrier to effective clinical leadership. It is important that mental health settings offer clinical leadership that supports and mentors nurses, especially those in their second and third year of practice. Making clinical leadership more effective in mental health settings can be cost-effective for nurses, the organisation and patients. Acker (2004) states “when workers do not derive satisfaction from their job they are more likely to provide inadequate services, are more likely to be absent or late, and eventually may leave the job and even the profession” (p. 7 of 7).

Assessment of performance was another key influence on practice that was slightly unexpected by the researcher. Performance assessment was minimally discussed in the literature (CLANZ, 2004; Health Leaders Network, n.d.; Blueprint, n.d.; Joshua-Amadi, 2003). Respondents clearly indicated that this was an important aspect of clinical leadership that influenced their practice. Respondents indicated that assessment and evaluation of practice by clinical leaders had a positive influence on their practice. Respondents also report that the assessment of performance by clinical leaders was an indicator of the clinical leaders support for their practice.
Respondents stated that clinical leaders influenced their practice when they gave encouragement, were approachable and were open to discussions, especially in relation to difficult decision making and planning. Validation of good practice was also important to respondents.

The results indicate that lack of clinical leadership can have a negative influence on practice. Several respondents (refer to Table 7) stated that the attitude of the clinical leader, personal differences and high workload interfere with practice. Respondents reported that power struggles, horizontal violence and the overriding of decisions can affect the moral of the working environment and quality of patient care, leaving both the patient and nurses disempowered. This in turn has an effect on retention rates and quality health outcomes.

Skills to Assist and Retain Nurses

The third aim of this research was to identify the helpful clinical leadership skills to assist and retain nurses. The skills identified to achieve this were communication, mentorship, role modelling, ongoing education and performance assessment. Twenty-two respondents identified good communication as the most helpful skill clinical leaders could have to assist and retain registered nurses in their second and third year of practice. This was seen as the most important skill and covers open and honest communication, listening and empathy. Communication was a recurring theme throughout the literature reviewed (Grossman & Valiga, 2000; MoH, 2001; Perkins, 2004). Leaders are expected to be effective in both written and oral communication; it is a vital tool within an organisation (Scott-Cawiezell, et al., 2004).

Communication and mentorship are seen as essential to an effective and efficient working environment (Blueprint, n.d.; CLANZ, 2004; Health Leaders Network, n.d.; Urden & Rogers, 2000). The results from this research confirm the literature, and reveal that mentorship; the sharing of knowledge, encouragement and facilitation would be a helpful skills in assisting and retaining nurses. Respondents in this research have closely linked mentorship to role modeling. The demonstration of skilled mentoring is also a requirement of NCNZ (2001) competencies for advanced practitioners. Mentoring is part of transformational leadership where the leader listens, acts as a mentor and is considerate of each persons needs (Bass, 1998).
The results from this study indicate that role modeling has the biggest influence on nursing practice. Respondents also stated that role modeling is a helpful skill in assisting and retaining nurses in their second and third year of practice. Fletcher-Campbell (2003) argues that role models set the standard of performance and foundations of practice. It is therefore important that clinical leaders are good role models.

The literature reviewed identified great importance should be placed on ensuring that nurse leaders have both support and education from their employing organisations (Chen, 2004; Fletcher-Campbell, 2003; Graham, 2002; Hendal & Steinman, 2002; Herrman, et al., 2002; Judkins & Ingram, 2002; Stein, 2001; Sullivan Havens, 2001; Van Engen, et al., 2001). This research identified the need for leadership education for clinical leaders. Respondents identified the need for encouragement and support to continue with their own ongoing education.

Performance assessment is identified as a positive influence on practice and necessary for assisting and retaining nurses. It becomes evident in this research that respondents need to get feedback from clinical leaders about their performance and the decisions they make. Communication with leaders, mentoring and role modelling stand out as being components that nurses in their second and third year of practice need.

Leadership in clinical practice is of primary importance in patient care and outcomes. Leadership style is therefore important in building a culture that values clinical excellence. Rocchiccioli and Tilbury (1998) believe that some leadership styles are “motivating and empowering, whereas others create uncertainty, fear and confusion” (p. 103).

**Barriers to Effective Leadership**

The final aim of this research was to identify barriers to effective leadership. Some respondents identified systems issues, staffing shortages and heavy workload as barriers. A lack of support for clinical leaders and the clinical leader’s lack of experience and knowledge were also identified as barriers to effective leadership.

Poor attitudes and poor communication from clinical leaders was seen as a major barrier to effective leadership by one third (n=10) of the respondents. Poor attitude was often seen by respondents as a consequence of poor communication or lack of experience. Respondents
indicated that some clinical leaders had disapproving or dominating attitudes, were unapproachable or focused on negatives of the job. It appears that these clinical leaders are working from a transactional leadership style, with no shared goal or vision that connects them to the follower (Bass, 1998; Grossman & Valiga, 2000). This is reflected in comments from respondents that state that ‘not feeling passionate about the job’ and ‘just want to get the job done and go home’ are barriers to effective leadership.

This study raises concerns about the effectiveness of current clinical leaders in mental health nursing practice in regard to attitude and poor communication. Respondents wrote personal accounts of the barriers to effective leadership in their workplace. Respondents noted clinical leaders not spending the time to communicate, providing only negative feedback, favouritism, openly belittling and speaking condescendingly to staff or not communicating with staff at all was a major barrier.

Barriers, such as poor attitudes and poor communication that impede effective clinical leadership must be removed. Given the complexity of caring for people with mental disorders, there is a great need for effective communication among providers, patients and families. Scott-Cawiezell, et al. (2004) state “The role of communication is fundamental. Communication must be open. Nurses need to feel comfortable in making suggestions, bringing forth information, and sharing their insights” (p. 250). Clinical leaders need to understand the importance of good communication and the effects of poor communication in regard to both multidisciplinary team work and individual nurses.

The barriers created by systems such as staffing shortages and heavy workload were identified by respondents. These contribute to ineffective clinical leadership. Clinical leaders were seen as having heavy workloads and too many managerial responsibilities. Too much time was spent trying to staff shifts. This in turn prevents clinical leaders from providing guidance and support to nurses. Respondents described lack of safe staffing levels in relation to patient numbers and acuity. This along with issues of politics, paperwork, management, budget constraints and a reluctance to change were identified as challenges.

A survey undertaken by NurseWeek and the American Organisation of Nurse Executives (2002) highlighted that 70% of nurses employed in hospital settings had witnessed a negative impact on the quality of patient care as a result of higher caseloads and higher turnover of
experienced nurses. The same study also reports that 14% of the current nurse workforce plan to leave the profession within the following three years, 50% of those surveyed stated they would reconsider leaving if there was better staffing and 48% said they would reconsider leaving if management respected them more. Barriers to effective clinical leadership, such as system issues, staffing shortages and heavy workload, impact greatly on not only clinical leaders but the nurses who work under them. A more concentrated effort on ways to retain nurses instead of recruitment drives will improve job satisfaction and ultimately patient care.

Nurses constitute a large proportion of mental health care professionals. If it were not for nurses, the needs of patients would not be met. Often nurses are ignored except during cyclical crises (Cangelosi, et al., 1998). An increase in ineffective clinical leadership will lead to declining levels of quality health care. Creating new strategies and the implementation of already existing performance reviews would help to alleviate current problems and prevent future ones. Grossman and Valiga (2000) argue nursing’s future as having “To continue to participate successfully in healthcare, nursing will continue to need to find ways to use resources wisely, validate the effect of nursing interventions on patient outcomes, and develop new ways to provide quality and cost effective care” (p. 26).

Lack of support for clinical leaders was identified as a barrier to effective clinical leadership. Respondents reported the cohesion in leadership not always being strong, stressful environments and a lack of consistency and support from management for both themselves and clinical leaders. Several respondents connected the clinical leader’s lack of experience and knowledge as a barrier to effective leadership. When management and organisational skills were somewhat lacking, the ability to resolve problems, manage team dynamics, advocate or be assertive were considered weak. As nurses require support, so do clinical leaders.

Results indicate a need for increased education and support for clinical leadership positions. Care must be taken though, that strategies from the MoH and policies of DHBs do not narrow the focus on management services. New Zealand has achieved improved health care through the clinical leadership displayed in PHOs, an example of clinically led change (Klap, 2003). The role of clinical leadership should not be undervalued. The more focus on management that health care takes, the less vision clinicians have for a better health service.
Clinical leadership in NZ is now focusing on “a trusting and collaborative partnership based on common goals” (Malcolm, 2004, p. 9). This partnership is seen as a critical factor in building a quality and safety culture, moving away from a culture of blame to a culture of safety.

The barriers identified in this research are consistent with my experience of clinical leadership in mental health nursing practice. In relation to retention it is well documented that individuals become overwhelmed when resources are in short supply and when effective leadership seems absent (Cangelosi et al., 1998; Grossman & Valiga, 2000). Despite staffing shortages being identified as a barrier, respondents indicated that communication, mentorship and role modeling were more critical for effective clinical leadership. Resourcing barriers should not affect the clinical leaders’ ability to communicate appropriately with staff, providing feedback on an individual basis. Attitude of the clinical leader is paramount. Positive role modeling for nursing is the key to effective clinical leadership. Junior nurses are our leaders of the future and require clinical leaders to be positive role models if nursing is to have a future. Clinical leaders need to be resilient, looking to their own practices to find opportunities for caring better within the given resources, rather than being defensive and blaming the government for inadequate funding (Youngson, 2004).

**Limitations of study**

This study has a number of limitations that have to be acknowledged, and the results of this study are exploratory for the following reasons. First, the selection of nurses was limited to nurses who had successfully completed a new graduate mental health programme and were in their second and third year of mental health nursing practice. Whether perceptions of clinical leadership would be different from nurses with more experience cannot be determined. The external validity of these results may be limited to nurses in their second and third year of mental health nursing practice in NZ. Second, the selection of the sample population from the central region of NZ was done solely on the basis that all respondents would have known the researcher and that in a larger scale study results would have been skewed. While the selection of the sample was done on the basis of quota (size) and cooperation (convenience), it is hoped that the 30 respondents provide a representative cross-section of mental health nurses in their second and third year of practice. The lack of responses did limit the types of analysis that could be completed.
A convenience sample of nurses in their second and third year of mental health nursing practice limits the generalisability of the study’s findings. The response set to the questions of clinical leadership could be a result of a temporary mood of the respondents or the result of what may be considered socially appropriate at the time of responding to this survey. Another limitation is that the researcher had no information about the non-respondents. It is possible that the nurses who did not choose to respond to the questionnaire were those that were less satisfied with clinical leadership in mental health nursing practice and therefore, did not want to expose those kinds of feelings. Or alternatively non-respondents might be satisfied with the current clinical leadership within their employment setting.

Limitations of this research are that data is only collected through a questionnaire and no comparison is made with registered nurses who did not complete a new graduate mental health programme or nurses that worked in other areas of health care. Given the fact that the sample was restricted to mental health nurses and that the respondents were employed by DHBs, the results can not be easily transferred to other health care settings or mental health services outside of DHBs. Further research on clinical leadership for these groups of nurses is warranted in order to establish differences or similarities to the study and to further the understanding of clinical leadership in health care in New Zealand.

Finally, some of the limitations arise from the questionnaire. The question that asked respondents to identify the role of the clinical leader was found to be not clear enough. A choice of options and an ‘other’ category would have clearly identified the role that nurses in their second and third year of practice perceive to be a clinical leader position. Clearer questions in regard to whether clinical leadership supported nurses to stay in mental health nursing or alternatively had an effect on nurses want to leave the profession would have clearly identified the impact that clinical leaders have on nurses in their second and third year of practice.

**Summary**

This initial exploration of clinical leadership in mental health nursing practice suggests that there is an opportunity for improvement in clinical leadership. With respect for communication, respondents provided clear data that identified poor communication as a barrier to effective leadership. Respondents also indicated that open and honest communication influenced their practice positively. Clinical leaders lack of education was
seen as a barrier to effective leadership. Respondents also identified education as a skill that would be helpful in assisting and retaining nurses. The clinical leaders ability to role model and assess practice was seen to influence practice. These two abilities were also highlighted by respondents as helpful skills in assisting and retaining nurses. Support from clinical leaders also influenced practice positively. Respondents also highlighted the lack of support for clinical leaders as a barrier.

Respondents had the most concerns and challenges in regard to communication. Results from this study suggest that nurses in clinical leadership positions may need to be assessed on a regular basis to ensure that they are providing effective leadership. Another important finding is that nurses in their third year of practice perceive clinical leadership to be less effective than nurses in their second year. This could indicate a increasing dissatisfaction with clinical leadership as years of practice increase. Taking into account the limitations of the study, further research is required in regard to generalisability, age, experience or years of practice, and other health care settings, for example, medical wards. Further qualitative studies using in depth individual or focus group interviews would be of value to extend understanding particularly to further conceptualise clinical leadership and retention.

Clearly evident is the importance of performance reviews. The individualised feedback provided gives nurses the ability to reflect on their own practice and allows for discussion of complex situations. This assessment is an opportunity for the clinical leader to encourage and mentor nurses in their second or third year. As stated these nurses have, in their first year of practice, been supported by an academic programme where clinical and academic practice is continually assessed.

This study has provided baseline data about the perceptions of clinical leadership in mental health nursing practice from nurses in their second and third year of practice. Nurses require clinical leaders that are good role models, have good communication skills, a positive attitude, and a willingness to assess performance on an individual basis. These aspects are a positive influence on practice. Good communication was identified as a skill to assist and retain nurses, while poor communication was seen as a barrier to effective leadership.

A clinical leader’s inability to accurately assess personal strengths and weaknesses and provide vision for followers may affect professional development, performance and promotion
(Roemer, 1996). Performance assessment was seen as a skill that would assist and retain nurses in their second and third year of mental health nursing practice. The new nurses that are currently employed in mental health are our leaders of the future. Often beginning nurses are earmarked for promotion by virtue of their performance, and their willingness to take on additional tasks.

Barriers to effective clinical leadership require acknowledgement. The results indicate that clinical leaders require further education and knowledge in relation to effective communication and performance assessment. This study clearly shows that clinical leadership has an effect on nurses in their second and third year of practice, and indirectly the patients in their care. Retention is clearly linked to clinical leadership. This study presents convincing evidence that clinical leadership in mental health settings and its effect on relatively new practitioners requires further researching. Recommendations from this study are discussed in the following chapter.
CHAPTER 6: RECOMMENDATIONS AND CONCLUSION

The topic of clinical leadership is important for the future of mental health nursing. It is evident from this research that clinical leadership is clearly related to retention of nurses, organisational support and patient outcomes. This study increases our understanding of how current clinical leadership is perceived by those relatively new to mental health nursing and identifies the positive or negative support, knowledge and management qualities of leaders and their effect on nursing. This chapter provides recommendations, discusses the dissemination of this research and concludes the study.

Recommendations

Although the results of a single survey cannot be considered a solid foundation for making decision in health planning, the results of this study suggest that interventions should be carried out for increasing the effectiveness of clinical leaders in mental health settings. Further research is required in this area to see if there is a causal relationship between retention and leadership, to find out what qualities, support and education clinical leaders need, the role of clinical leaders and who should monitor these roles in mental health in order to promote good clinical leadership.

As for many exploratory studies, the next logical step would be to expand the geographical base and sizes of the population studied, and to replicate this study with a national, random sampling of nurses in a variety of health settings. Another area for additional research is comparing perceptions of clinical leadership, from both clinical leaders and nurses who work with them.

Studies such as this provide the basis for further exploration into the area and also for the argument that development of educational programmes for nurses will promote increased clinical leadership. Education on clinical leadership, communication and mentorship, for both leaders and followers, should be considered as an important intervention that can reduce the stress that is associated with the demands of mental health work. Overall nurses want a sense of participation in their organisation, they share the vision of better patient outcomes and this vision of improved health outcomes will ultimately lead to improved job satisfaction for nurses. According to Graham (2003) the cornerstone to clinical leadership is healthcare improvement and “all nurses will need to be part of this movement in order to improve health
care” (p. 214). Each nurse will need to demonstrate leadership ability as part of the overall functioning of the profession as a whole “developing strong leadership skills is probably the single most important task in health care today” (Graham, 2003, p. 215).

Organisations have a responsibility to improve health outcomes. Nurses have an individual responsibility to provide leadership in clinical situations (Cunningham, 2000). Clinical leaders have a responsibility to ensure they are providing effective leadership. Retention of nurses and positive patient outcomes depend on the skills and attitude of the clinical leader. Organisations need to ensure that the clinical leadership that exists in areas with most patient contact is effective and positive. Nurses must ensure that they are provided the education for clinical leadership positions. Buresh and Gordon (2000) state “being silent and unknown is a persistent problem in nursing” (p. 16). They continue to discuss the importance of ‘ending the silence’ and offer ways to heighten the visibility and improve the way the nursing profession is regarded. Nurses must take the opportunity of learning clinical leadership skills so that nursing has a strong voice in the health care system. As Fontaine (2003) states no other health care professional makes a more direct impact on patient outcomes and the work environment than nurses do.

Clinical leaders must nourish leadership in others. As Grossman and Valiga (2000) state “Nurses must understand how to lead in order to understand how to nurse” (p. xiii). The results of this study indicate that priority should be given to improving communication and mentorship skills in clinical leaders. Clinical leadership has a large influence on nurses in their second and third year of practice.

**Research Dissemination**

In order to maintain confidentiality and anonymity, feedback from this study has not been directly given to the respondents. The sample population was informed that this thesis would be lodged at VUW and WCP Libraries as stated on the participant information sheet. Articles arising out of the research will be offered for publication in appropriate nursing or education journals and for presentation at conferences. The tertiary institution in which I am employed aims to use the results of the study by incorporating clinical leadership skills into postgraduate nursing programmes. I see this research contributing to nursing knowledge and believe that it will have implications for health policy advisors and be of interest to the NCNZ. It is hoped
that future research further explores the impact that current nurse leaders in mental health have on retention.

**Conclusion**

Mental health nursing, like most health care systems is a complex working environment. Communication and leadership are critical for patients and families to be assured of safe care. Understanding the perceptions of nurses in their second and third year of practice about clinical leadership is pivotal to creating the environment where continuous improvement can thrive. Two key points have emerged from the results. First there is an opportunity for improvement in the leadership strategies and structures currently used in mental health. Second, further exploration is required to determine how to best measure leadership in mental health nursing practice. The findings are based on perceptions of clinical leadership from mental health nurses in their second and third year of practice. A message for clinical leaders that emerges from the findings clearly suggests the need to continually reflect on how they are communicating with others in their organisations.

Through being involved in this research, respondents have had the opportunity to reflect on the impact of clinical leadership on their professional and personal development. This creates a potential for a positive outcome on nursing, as respondents become aware of effective leadership abilities, the influence clinical leadership has on practice and the barriers to effective leadership. The respondents who participated in the study have contributed their experiences of clinical leadership in mental health nursing. This study should benefit subsequent nurses via clinical leadership skills and qualities being developed and further integrated into nursing positions. This research may also positively influence respondents’ attitudes towards further ongoing development processes.

While the findings of this study need to be tested with a larger sample and in a broader range of contexts, they do suggest tentatively that the retention of nurses in their second or third year of mental health nursing practice may depend to quite a large extent on whether there is effective clinical leadership in their employment setting. The data identifies that nurses in their second and third year of mental health nursing practice value being listened to with respect to their particular needs and would welcome flexible approaches. Strategies to improve communication and mentorship between clinical leaders and their nurses must be made a priority.
The questionnaire developed for this research has gathered together the main components required for effective clinical leadership. The attributes of effective leadership that were identified could be used to assess performance of current clinical leaders within mental health settings. This questionnaire has clearly assisted in gaining the perceptions of clinical leadership from nurses in their second and third year of practice and has identified the need for clinical leadership to be assessed within all levels of health care. Clinical leadership within mental health nursing practice greatly influences practice and is clearly linked to retention of staff and patient outcomes. There is a critical need to better understand what nurses are thinking and feeling in regard to clinical leadership. As Grossman and Valiga (2000) suggest “Each of us can be a leader and, perhaps, needs to be a leader if nursing is to advance as a profession and have a significant impact in the twenty-first century” (p. xiii).

To conclude, this study has provided valuable information regarding clinical leadership in mental health nursing practice. Clinical leadership is seen to influence nurses in their second and third year of practice greatly. The positive or negative influence depends largely on the individual clinical leader and their ability to communicate effectively and role model good practice. Nurses found that they required the clinical leader to have good communication skills and the ability to assess performance. The attitude of the clinical leader indicated how supported the nurse felt in the working environment. Barriers to effective leadership were identified as lack of education, lack of support from management, staffing issues and heavy workload.

Overall clinical leadership abilities were ranked ‘good’ by respondents. Although areas such as communication, role modeling and performance assessment required improvement. Clinical leaders require support and education to develop their role and become effective. Clinical leadership is pivotal to retaining staff and improving patient outcomes. This study provides evidence that clinical leadership positions and the effect that they have on nursing practice requires further researching.

*Leadership is practiced not so much in words but attitude and actions*

*(Harold S Geneen, n.d., p. 1)*
APPENDIX I: Ethics Approval WCP
APPENDIX II: Ethics Approval VUW
Dear Colleague,

I am a Registered Nurse undertaking study towards a Master of Arts (Applied) in Nursing at Victoria University of Wellington (VUW). This study has been ethically approved by the VUW Human Ethics Committee and Whitireia Community Polytechnic. Please read the following information carefully to decide if you would like to take part in this research project.

The aim of this study is to explore nurses’ perceptions of clinical leadership in mental health nursing practice. You will be asked both open and closed questions as an opportunity to share your views and experiences of clinical leadership in nursing practice. The Clinical leaders’ Association of New Zealand (2001) define clinical leadership as “leadership by clinicians of clinicians”, where clinical leaders are those that have a clinical role while, at the same time, they may participate in management, including resource management (p. 28). The objectives of this project are to increase knowledge about clinical leadership in mental health nursing practice, to gain understanding of ways in which clinical leadership influences new practitioners and to identify barriers to effective leadership.

This study involves you completing the attached questionnaire. Your participation in this study is entirely voluntary. The questionnaire takes 10-15 minutes to complete. Once you have finished answering the questions please place the questionnaire in the reply paid envelope and post it back to the Research Assistant, PO Box 50709, Porirua by the 31st October 2005.

Completion of the questionnaire implies that you have given consent to participate in this study. As you will see there is no means to identify you and so all replies will be anonymous. All information obtained will be used only for this research and publications arising from this research project. The data will be analysed using a computer programme called SPSS. Responses to the three open-ended questions will be analysed for key ideas and themes. All information will be treated with strict confidence, stored securely and only those involved directly in the research project, namely myself, the research assistant and my supervisor will have access to the data. The research assistant has signed a confidentiality form; she will receive the completed questionnaires and remove any identifying data that may occur. At the completion of the study, the questionnaires will be destroyed.

This study will be lodged as a thesis at VUW Library and Whitireia Community Polytechnic Library. If you would like any further information please feel free to contact me or the supervisor of this research. Please retain this top sheet for your reference.

Research Student
Wendy Trimmer
Whitireia Community Polytechnic
Private Bag 50 910
Porirua
Phone: 04 2373103 ext 3732
E-mail: w.trimmer@whitireia.ac.nz

Research Supervisor
Dr Rose McEldowney
Graduate School of Nursing & Midwifery
Victoria University of Wellington
PO Box 600
Wellington
Phone: 04 4636651
E-mail: rose.mceldowney@vuw.ac.nz
MENTAL HEALTH NURSES PERCEPTION OF CLINICAL LEADERSHIP

Section 1: General information about you
Answering the questions in section one about yourself and the mental health setting you are employed in, will help to see if this survey has reached a cross-section of mental health nurses. The information you provide will be strictly confidential and anonymous.

1. Please indicate your age:

24 years or under
25-29
30-34
35-39
40-44
45-49
50-54
55 years or over

2. Please indicate your gender: ______________________

3. Please specify ethnicity:

☐ New Zealand Maori
☐ European/Pakeha or New Zealand European
☐ Samoan
☐ Cook Islands Maori
☐ Tongan
☐ Niue
☐ Tokelauan
☐ Fijian
☐ Chinese
☐ Indian
☐ Other: Please specify________________________

4. Please indicate your current year of mental health nursing practice:

☐ Second year of practice
☐ Third year of practice

5. Please specify the area of mental health you are employed in (e.g. community, acute, forensic):

________________________________________________________

6. Is this service a:

☐ District Health Board
☐ Non Government Organisation
☐ Primary Health Organisation
☐ Iwi Health Provider

7. Please state the designated role of the person you perceive to be a clinical nurse leader in your workplace? (NB: Do not include the name of this person).

________________________________________________________
**Section 2: Leadership attributes**

The following questions ask for information about the abilities of the clinical leader you have identified above. The skills and abilities have emerged from a literature search into effective leadership.

8. Please rate the ability of the clinical leader that you have identified above to **effectively**:

<table>
<thead>
<tr>
<th>Ability</th>
<th>EXCELLENT</th>
<th>GOOD</th>
<th>FAIR</th>
<th>POOR</th>
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<tbody>
<tr>
<td>Facilitate change</td>
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<td>Manage conflict</td>
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<td>Negotiate</td>
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<td>Assess performance</td>
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<tr>
<td>Make decisions</td>
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<tr>
<td>Communicate interpersonally</td>
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<td>Communicate across systems</td>
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<tr>
<td>Communicate cross culturally</td>
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<td>Retain staff</td>
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<tr>
<td>Mentor</td>
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<tr>
<td>Inspire and motivate</td>
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<td>Build vision and purpose</td>
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<tr>
<td>Realise talent</td>
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<tr>
<td>Be responsive and flexible</td>
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<tr>
<td>Be innovative and creative</td>
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<td>Be a positive role model</td>
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<td>Be responsive to consumers’ needs</td>
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<tr>
<td>Demonstrate high standards of ethical and moral conduct</td>
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</table>
Section 3: In your opinion

In this section you are asked to consider:

1. How clinical leadership influences your nursing practice,
2. What clinical leadership skills are useful for assisting and retaining nurses, and
3. What barriers exist to prevent effective leadership in your workplace?

9. How does clinical leadership in your workplace influence your nursing practice?

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

10. What clinical leadership skills do you consider are helpful for assisting and retaining nurses in their second or third year of practice?

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

11. What, if any, are the barriers to effective clinical leadership in your workplace?

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

Thank you for taking the time to fill in this questionnaire. Your response is greatly appreciated. Please place this questionnaire in the envelope provided and post no later than 31 October 2005 to:

Karen Blyde
Research Assistant
PO Box 50709
PORIRUA.
Dear Colleague,

On the 23rd of August you received an information sheet and questionnaire for a nursing research study. The study aims to explore nurses’ perceptions of clinical leadership in mental health nursing practice. I am undertaking this study towards a Master of Arts (Applied) in Nursing at Victoria University of Wellington (VUW).

I would like to invite you again to participate in the research by completing and returning your questionnaire and remind you that the questionnaires returned after 16 September cannot be included in data analysis. If you have mislaid your questionnaire and would like to participate in this study please contact Karen Blyde, Research Assistant on (04) 2373103 extension 3788 or email k.blyde@whitireia.ac.nz. Karen will send you a copy of the information sheet and questionnaire as requested.

Thank you very much for your interest. Please feel free to contact me or my research supervisor with any questions you might have regarding the information sheet and questionnaire or the research in general.

Kind regards,

Wendy Trimmer
Whitireia Community Polytechnic
Private Bag 50 910
Porirua
Phone: 04 2373103 ext 3732
E-mail: w.trimmer@whitireia.ac.nz

Research Supervisor: Dr Rose McEldowney
Graduate School of Nursing & Midwifery
Victoria University of Wellington
PO Box 600
Wellington
Phone: 04 4636651
E-mail: rose.mceldowney@vuw.ac.nz
APPENDIX V: Reminder Letter 2

MENTAL HEALTH NURSES PERCEPTION OF CLINICAL LEADERSHIP

THANK YOU

Thank you to those who completed and returned the questionnaire about clinical leadership in mental health nursing practice.

The data so far looks great but unfortunately is not enough to complete my research properly.

For those of you who have not completed and returned the questionnaire please assist me by doing so.

I have enclosed another copy of the questionnaire and information sheet.

The final date to return the questionnaire is now 31 October 2005.

Thank you for your support.

Wendy Trimmer
APPENDIX VI: Confidentiality Form

CONFIDENTIALITY AGREEMENT

I, Karen Blyde, Secretary, Faculty of Service Industries and Trades, Whitireia Community Polytechnic agree to hold confidentiality in relation to those Registered Nurses participating in the research project being undertaken by Wendy Trimmer.

My role in the research project currently undertaken by Wendy Trimmer is to:

- Collect the returned questionnaires from Post Office Box 50 709,
- Remove any identifying data from the questionnaires, and
- Return all of the questionnaires, with identifying data removed, to Wendy Trimmer for safe keeping.

This confidentiality agreement is in relation to all correspondence reviewed by me, in particular:

- Any identifying data (names of participants, clinical leaders and/or location) of the respondents will remain confidential.
- No copies will be made or retained of any written information supplied.

I agree to maintain confidentiality by not discussing any aspects of the returned questionnaires. No other person will have access to the information while they are in my care.

AGREED AND ACCEPTED BY:

Date: __________________

Name: ___________________________

Signature: ________________________
REFERENCES


Dyson, L. (1994). Where have all the leaders gone. *Nursing New Zealand, 2* (9), 28-29.


Herrman, H., Trauer, T., Warnock, J., & Professional Liaison Committee (Australia) Project Team. (2002). The roles and relationships of psychiatrists and other service providers in mental health services. *Australian and New Zealand Journal of Psychiatry, 36,* 75-80.


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


Valentine, S. O. (2002). *Nursing leadership and the new nurse*. Retrieved February 17, 2005, from [http://juns.nursing.arizona.edu/articles/Fall%202002/Valentine.htm](http://juns.nursing.arizona.edu/articles/Fall%202002/Valentine.htm)
