

**Context of Leadership: Nursing and midwifery
in the Western Australian public health system**

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ABSTRACT *The paper reports on Stage One of a three stage research project undertaken for the Nursing and Midwifery Office, Western Australian Department of Health. It was designed to contribute an understanding of perceptions of the practice of leadership in nursing and midwifery through interviews and focus groups with key stakeholders. We found that nurses recognised that in their changing environment there was a need for adaptive leadership supported by leadership which was open, encouraged and nurtured nurses. The importance of administrative leadership to manage the ongoing operation of the system was also remarked on. We found that organisational context and the values framework of a professional workforce can have a significant impact, in practice, on the influencing capacities of leaders.*

Keywords: **Critical perspectives on leadership; Public sector and community leadership; Stakeholders; Strategic leadership**

The aims of the three stage research project undertaken on behalf of the Nursing and Midwifery Office, Western Australian Department of Health, were to determine an appropriate structure of nursing leadership to enhance clarity for nurses and midwives about roles, accountability and communication channels within the alternative settings of professional nursing practice. The objective of the first stage of the project, which is the subject of this paper, was to contribute a detailed understanding of perceptions of the practice of leadership in nursing and midwifery in the environment of the WA public health system.

The Literature

Leadership overview

The literature review targeted key academic literature focussing on Australia, New Zealand, the UK, and North America since 2005. The review considered models of leadership that focus on professional occupations, nursing leadership and formal and informal networks within organisational settings.

Leadership is highly researched, with a wide range of theoretical approaches used to describe leaders and the leadership process. The resulting picture is one of considerable sophistication and complexity

(Northouse 2004). Leadership has been defined as a process in which an individual influences others in order to achieve a common goal (Northouse 2004). Leaders are seen as those who have some form of authority, power or control that they can draw upon to influence others (Sinclair 2007). Northouse (2004: 3) states that 'without influence leadership does not exist'. Despite a level of agreement amongst scholars about a definition of leadership and a process of influence it has been noted that it is a 'grudging agreement' (Sinclair 2007: xvi) and that there are 'as many different definitions of leadership as people who have tried to define it' (Northouse 2004: 2).

Zaccaro and Horn (2003) suggest that most studies of leadership focus on direct leadership within organisations where processes of influence are easily observed. Grint (1997: 9) has suggested that leadership is 'essentially interwoven with acts of persuasion' and that leadership 'is what certain powerful 'voices' make it'. Kotter (1999), on the other hand, sees leadership as involving the development of vision and strategies and aligning of people to achieve that vision despite obstacles.

While the range of theories keeps increasing (Ladkin 2010), much of the theory development involves categorisation and description focused on the objectives or styles of leadership and leader/follower relationship. Ladkin (2010) argues that many of our studies of leadership have focussed on trying to identify component parts of leadership characteristics, traits or competencies. The danger of this type of approach is that it loses sight of the context within which leadership occurs and the relationship between leaders and followers. To understand the continuing issues interacting with and shaping how nursing leadership is practiced and perceived by nurses, the researchers considered it would be important to consider nursing leadership in context (Jepson, 2009). Jepson's research considered how characteristics of the workplace can be tied to leadership behaviour and impact on the interpretation of effective leadership (Jepson 2009; Edwards 2011: 304). Jepson (2009: 38) argues that to understand how individuals construct their own understanding of leadership we need to consider the dynamic interaction of contexts.

Leadership and nursing

Nursing is one of many professions that have struggled to define the concept of leadership and the complexity of nursing leadership literature is evidenced by the plethora of often contradictory definitions of leadership (Stanley 2006b; Watson 2008). Leadership may be the art of influencing a group of others towards the achievement of common goals (Calpin-Davies 2003; Cummings et al. 2008; McArthur 2006); unifying people around values and then constructing the social world for others around those values and helping them get through change (Stanley 2006b); identifying goals and providing support and motivation to achieve them (Davidson, Elliott & Daly 2006); empowering individuals and teams (Pinch & Della 2001). Leadership may mean articulating a vision, and working with others to transform that vision into reality (Woods 2003).

There have been attempts to craft a nursing-specific definition and these generally focus on leadership related to the professional practice values of nursing. Chadwick (2010: 159) defines leadership as 'the ability to represent masses of people by facilitating dialogue between various levels of professional and non-professional staff'. Carney (2009: 436) believes that 'leadership means providing health care through a collaborative and ethical process that uses advocacy to effect change for the benefit of patients'. The Canadian Nurses Association suggests that 'nursing leadership is about the competent and engaged practice of nurses, who provide exemplary care, think critically and independently, inform their practice with evidence, delegate and take charge appropriately, advocate for patients and communities, insist on practising to their full and legal scope and push the boundaries of practice to innovative new levels' (Canadian Nurses Association 2009). While lacking the pithiness of some definitions, this one may be more meaningful.

From the review of the nursing literature, it was apparent that there is considerable misunderstanding of the relationship between leadership and management (Calpin-Davies 2003). There are those who use the terms synonymously, those who see a symbiotic or co-dependent relationship between the two concepts (Canadian Nurses Association 2009; McArthur 2006; Stanley 2006a), and those who see leadership as just one of the many skills used by managers. Some writers attempt to distinguish

between leadership and management; for example, Davidson et al. (2006: 182) define management as ‘referring to the planning and organization of services’ and leadership as ‘the activities of an individual that are visionary and critical in directing and sculpting clinical practice’; ‘Leadership equals direction, management involves the logistics, speed and tools to go in that direction’ (Laurent 2000: 86).

Researchers and participants in various studies have attempted to describe the role of nurse leaders. Nurse leaders make sure of information supply, promote a positive atmosphere and keep the unit together (Rosengren, Athlin and Segesten 2007); they ‘create a structure and processes within the organization that supports nursing practice in order to achieve the best outcomes’ (Harrington 2010: 47).

A significant amount of the literature on nursing leadership explores leadership styles and theories. Pearson, Laschinger, Porritt, Jordan, Tucker and Long (2007: 208) found that the majority of the 48 papers reviewed examined the relationships between leadership styles and characteristics and particular outcomes, such as satisfaction. Other nursing literature focuses on what are variously described as leadership skills, competencies, qualities and characteristics (Pearson et al. 2007). NSW Health (2008) has identified five common leadership skills – people-skills, mediation, problem-solving, delegation and mentoring, while Stanley (2006b) identified a number of attributes seen to be associated with clinical leadership – clinical competence, clinical knowledge, effective communication, decision-making, empowerer, approachability, role model, and visibility.

A 1990 review of the career structure of nurses in the Australian Capital Territory (Perrett & Monck 1990) identified a fragmented approach to leadership and management and a lack of role clarity and twenty years later there continues to be a lack of clarity, particularly between managing and clinical leadership. The tension between nurse leaders and clinical nurses has been described by Bolton (2004) as the “we/they” dichotomy. Clinical nurses may believe leaders are out of touch with clinical practice and make decisions based on financial or political expediency. Leadership knowledge and

skills are devalued and while leaders may be tolerated, they are also seen as barriers to nurses fulfilling their own needs. Stanley's findings (Stanley 2006a: 36) that 'conflict appeared if clinical leaders' managerial responsibilities appeared to diminish their effectiveness as clinical leaders' is a key recurring issue in the nursing literature: i.e. 'real' nursing equates to clinical nursing.

While the literature provides evidence of considerable discussion of the ideals of nursing leadership there is a deficit in our understanding of the practice of nursing leadership, both from the perspective of nurses who experience the exercise of leadership and that of those who seek to provide leadership. Carryer, Gardner, Dunn and Gardner (2007) report a lack of clarity and understanding about particular leadership roles such as nurse practitioner while similar findings relate to nurse unit manager (NSW Health 2008), and different leadership roles, such as the team leader and the in-charge nurse (Williams, Parker, Milson-Hawke, Cairney & Peek 2009). The literature identifies role conflict and role ambiguity among nurse executives (Tarrant & Sabo 2010); lack of preparation for the role and the need for authority to match their responsibilities (Ashworth 2010); role overload – multiple demands from wide ranging sources and never enough time (McCallin & Frankson 2010).

Thus the literature builds a picture in the practice of nursing leadership of ambiguity and role confusion along with concerns about leadership legitimacy in the clinical setting. The research team undertook primary data collection and analysis to build an understanding of current experiences of the exercise of leadership in nursing, drawing on the perceptions of stakeholders within the WA public health system.

Data Collection and Analysis

Interview and focus group data

The main purpose of the data collection and analysis undertaken in this section of the project was to identify perceptions and understandings of leadership among nurses in the WA public health sector. The questions were developed following the extensive literature review and discussion with the Office of the Chief Nurse. They were piloted using a selected group of nurses. The questions were designed

to be open-ended and to allow participants to raise the issues which they believed to be relevant to their context (Appendix 2). The resulting data were then analysed to identify the key themes and issues which emerged. The analysis was designed to identify potential key variables and possible causal relationships which could then be further investigated through larger scale, purposively designed survey data collection. The approach was designed to enable the researchers to gain a deep understanding of “on the ground” issues and the interrelationships that exist within nursing in the health system studied. With N*Vivo to facilitate data organisation, the transcripts and notes from the qualitative data collection process were analysed for key themes.

Data collection was undertaken following Curtin University ethics approval for the research. Interviews were undertaken with nurses in leadership positions in both metropolitan and selected country hospitals (16), six medical professionals and one other health professional who had associations with hospitals. Eleven focus group discussions were undertaken with a cross section, both in respect of level of practice and geography, of nurses and midwives (70) and a consumer group (7). Nurses in metropolitan and selected rural and remote locations were invited by the Office of the Chief Nurse to provide the researchers with expressions of interest to participate. The researchers then arranged their participation in focus groups, each designed to have a cross-section of participating nurses (Appendix 1).

Key Findings

A strong realisation was surfaced among stakeholders that a need for change had arisen partly from pressure from external forces, including political pressures, the changing profile of nurses and nursing, community demographics and the forces bearing down for the industry to be more efficient and effective. However internal contextual issues emerged as themes which appeared very important to the experience of leadership of nurses and midwives. Key internal contextual themes are highlighted below.

Current Leadership Issues

Role clarity: A number of aspects of the present organisation of the delivery of nursing care, particularly within the larger, predominantly metropolitan, hospitals were seen by our participants as being inimical to the provision of appropriate leadership. Issues were raised around lack of role clarity including confusion about what is encompassed within ‘clinical management’, confused lines of authority and compartmentalisation of nursing, leading to role restriction or silos. A widely discussed issue was the lack of clarity in the nursing leadership roles, lack of consistent role titles and ability for incumbents to modify particular roles to meet their specific interest. Illustrative quotes from the data are provided below.

//...some of it is about lack of clarity about what your role is.//We need to look at what is the definition of clinical management and I often hear from senior nurses “that’s not my responsibility because it is not clinical”//...clinical work takes priority over leadership role.//...its around “Okay if I make that decision I am accountable for it. Alright I’ll get someone else to make that decision//...each site has done it individually, called it differently, ...now we’ve got this hotch potch of different positions, or positions with different titles... //...over time its evolved because of the skill the person brought to the position...rather than us saying we want you to do this role.

Identifiable leadership is not always clear to nurses: respondents identified confused or tangled lines of accountability and in some instances failure of accountability, inadequate or confused communication and fragmented procedures for the delivery of care, especially in respect of the linkage between appropriate types of resourcing and the specific resource needs of care givers. Inadequacies in decision making and difficulties in leading responses to the changing requirements for care are a result. Respondents reported that informal leadership had arisen to fill some of the gaps.

//... accountability for the right level of care and what prevents that accountability...//...from the nurse point of view the staff think “Okay I’ve got two leaders (CNS and Nurse Manager)...so we have set up a two tier system of leadership... //...at the end of the day the problem may not be addressed because everybody thinks somebody else is addressing it. //The informal leadership keeps that (ward) going on a regular basis...Philosophy and passion to keep going...//...on the coalface I think probably the informal leadership is...the stronger leadership...these people who get things done, have the knowledge, seek out the knowledge...//

Succession planning and leadership development: there was considerable discussion about the need to identify potential leaders and ensure their skills development through mentoring and learning opportunities. The issue was seen as taking on extra urgency because of the age structure of nursing

and the expectation that many existing nursing leaders are moving towards retirement. Many stressed there was an important role for current leaders in both identifying and mentoring/coaching future leaders. Some also saw the need for more support for accredited courses. There was a perception that succession planning was not occurring, especially in the country, that on some occasions it was “the last person standing” who took on the leadership role. A related leadership issue raised by a number of country nurses, but also an issue for metropolitan nurses, was the very high prevalence of acting positions at “leadership” levels and the excessive time taken to select and appoint to these positions. It was noted that this situation created paralysis in the ability to lead and make changes, was demotivating for those with applications for positions or appointed for long periods in acting positions and reduced staff confidence in those in leadership roles who were in an acting position only. For some it seemed that it was expected that leadership skills could be assumed to “just happen on-the-job”. Some respondents noted that, while support for the development of clinical skills and knowledge was available, development of leadership potential in nurses was unsuitable/lacking.

//succession, I think we have a huge problem with people in their 60's retiring and people in their 30's not wanting to take it on...//succession planning historically something we have not done well...making sure the next people coming along actually do have the skills... people don't have the skills...need to give them time to mentor, to be mentored and be coached...//There is an expectation the people will just learn things as they come up...//Clinical leaders...we've expected them to have leadership attributes, leadership skills to be able to cope with the reform and they actually haven't ...//We don't put any importance on filling roles...in a timely way....there is a number of people 'acting' ...one on site here has been vacant for 4.5 years...three people acting but A has been in it 2.5 years now...can't expect people to lead knowing it's only for three months and then another three months...//

Intergenerational leadership challenges: respondents noted that there were challenges for nursing leadership in the expectations of what they termed tertiary educated Generation Y nurses. These challenges were around three aspects. The first was the perceived differences in Gen Y lifestyle choices and the challenges and issues for nursing leaders in responding to/accommodating these. The second related to differences in leadership style expectations of current leaders and Gen Y nurses; these were in part related to the confidence and knowledge of the latter. The third relates to the

willingness of younger nurses to take on leadership roles and related to this, resentment of such leaders by some older nurses.

//Gen X, Y, don't give them their Saturday afternoon off...they vote with their feet. //Its about being mindful that these people coming through are different...older nurses in clinical positions...a little bit apprehensive because they are having to change the way they manage and lead...some of our senior nurses struggle with that.//Younger people are more assertive at an earlier age...no problems at all with saying "I'm sorry this is not right"//Newly educated ones might be a bit challenging...very well informed about things.// Gen Y, they're looking for a different style of leadership//...Gen Y ...they're actually looking to be leaders//

Management and leadership: a lot of confusion surrounded leadership and management. The perception often expressed was that the management role lacked status relative to clinical roles; it was downplayed and not perceived to provide opportunities for the exercise of leadership in nursing.

For some nurses management is perceived as a distinct role which is quite separate from leadership and involves no leadership responsibilities, accountability, attributes or skills. When this distinction is made there is a tendency to consider direct clinical practice as an implicit requirement (necessary but not sufficient) for leadership. This is a challenge for some nursing leaders interviewed, who noted that they are at times perceived not to be clinically involved and thus feel they have need to reinforce their clinical credentials with staff at the coalface. For other respondents, however, while leadership functions differ from management tasks, they perceive the two to be interrelated and see providing management leadership as an important component in developing the conditions of trust and the resourcing required to support staff and implement change.

//Clinical leadership and nurse managers are different...//Nurse Manager...classified at the same level as the CNS, but they are only managing the staff component, leave, rosters, resources, so they are more the doer rather than leading...//...see them (management and leadership) as two separate things ...I think anybody can be given the tools to actually get the job (of management) done because it is quite routine//I have an SRN 7and he said ...I'd like to go and work on a ward" and I said , " yes, why?" and he said "for credibility" ...//You can manage an organisation for a short while without leading, but it doesn't last very long...//I've always thought it was a false dichotomy between leader and manager...overlap more than they don't overlap...//

Issues specific to particular groups: Midwives, mental health nurses and nurses from rural and remote areas did raise issues specific to leadership within their particular context. However, many of the issues these nurses raised were in common with all nurses in focus groups and interviews.

The outcomes from Stage 1 of the project were verified in the second stage of the project in which the initial findings were explored in a large scale survey of nursing and midwifery staff. While the second stage is not the focus of this paper, it is perhaps worth noting that the two sets of data and analysis were complementary.

Discussion

In describing their experience of leadership our respondents brought to the discussion a range of insights from the contexts of their own practice of nursing. Our analysis of the themes emerging identified that contextual factors had, in many instances, created situations where the essential conditions for achieving 'influence' (Northouse 2004:3) and successful 'acts of persuasion'(Grint 1997: 9), hence successful leadership, did not apply. We have identified two sets of contextual issues impeding successful leadership within the public health system we studied. The first is identified as organisation specific issues while the second is related to the professional values sets of the groups of nursing professionals studied.

Organisation-specific contextual barriers included the identified problems of role clarity, where lines of authority and communication were not clear, or where procedures were fragmented. Perceived lack of preparation of nurses for leadership roles, coupled with a high prevalence of acting positions, often in place for long periods, was also seen to detract from the capacity of some in designated leadership roles to wield appropriate influence and persuasion in those roles.

The strongly identified ambiguity around whether leadership can be compatible with 'management' roles appears to be closely linked with the context of professional values, which implicitly identify clinical practice as synonymous with nursing leadership. This also underlies the indications from

some of the nursing leaders interviewed that they were seeking opportunities for hands-on nursing to provide them with the 'street cred' they felt would not be accorded if they did not have current clinical experience. Such issues go to the heart of who is seen to legitimately wield influence and is able to persuade effectively. Issues related to leadership within specific fields of nursing such as midwifery and geographical locations such as country, as well as the generational divide, involve related values issues.

An analysis of the context of leadership has enabled this research to identify factors specific to the context of the WA public health system which can be addressed to support effective leadership in nursing. A set of organisational issues around the clarity of role design and communication along with leadership development and management of leadership successions and new appointments have been identified for action. At the same time, recognition of the issues posed by the values frameworks of nurses will facilitate actions by nursing, as well as organisational leadership, to respond to the need to ensure leaders are seen by nurses to have legitimate influence and clinical credibility.

Conclusion

Our investigation of the practice of nursing leadership within the WA public health system highlighted for us the importance of studying leadership in context (Jepson 2009). While there was also considerable comment (not the focus of this paper) that external contextual factors such as the regulatory and funding environment are having an impact on how nurses perceive their leadership, many of these are not within the influence of the health system and the profession. However, our results suggest that the organisational context and the values framework of a professional workforce can have a significant impact on the influencing and persuasion capacities of leaders and hence on the extent to which leadership is seen to be provided. Here there is an opportunity to make changes to the contextual framework within which nursing leaders work and thus support the influencing and persuasion capabilities of nursing leaders.

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Appendix 1: Focus groups

1. Nurses by level, gender, and location

Level	Gender		Location	
	Male	Female	Perth metro*	WA country**
Graduate nurse		1		1
EN		2	1	1
RN		8	3	5
CN		14	8	6
SDN		3	3	
SRN 2		6		6
SRN 3	4	17	18	3
SRN 4		3	2	1
SRN 6		2		2
SRN 7	1	2	1	2
SRN 8		1		1
SRN 9		1	1	
SRN 10		4	3	1
Aboriginal Health Worker***		1		1
TOTAL	5	65	40	30

*Seven focus groups with a total of 40 participants, conducted in the GSS lab

** Two face-to-face groups with a total of 19 participants; one videoconference group of 4 participants from 3 remote sites; one teleconference group of 8 participants from 4 remote sites. One CN participated in both a face-to-face group and the videoconference but is only counted once in the above table.

***Non-nursing participant

2. Consumers

One metro group with 7 female participants, conducted in the GSS lab

Appendix 2: Focus group protocol

Data collection protocol for Nurses Leadership study

The data collection process for this study will be via focus groups. The MeetingWorks technology in the Stratcom facility at the Graduate School of business will be the principle means of recording the perceptions of the respondents.

'MeetingWorks' described

MeetingWorks is a Group Decision Support System used to support face-to-face meetings. Participants brainstorm, structure lists, plan, discuss and evaluate on a network of microcomputers with a large public screen at the front of the room. MeetingWorks, a LAN based system, is an advanced groupware product that includes tools for electronic brainstorming, idea organisation, ranking, voting, cross impact analysis and multiple criteria (weighted factors) analysis. These tools help to ascertain group preferences.

Several advantages are inherent in MeetingWorks. These include the **preservation of anonymity**, helping participants' focus on relevant issues, the provision of automatic documentation and formal evaluation, and increased participation. Information from individual terminals or aggregated information can be displayed through projection facilities. A "chauffeur" manages the hardware and software of the system and interacts with the group where appropriate.

Benefits of the MeetingWorks Process

Key benefits of the proposed facilitation process and structure include:

- Ability to capture a large number of ideas in a short time frame
- Identification of key issues
- The procedurally structured process ensures "best bet" outcomes
- Facilitates learning about the issues and their interrelationships
- Participants can see how 'their' issues interact with others
- Provides a forum for people with different skills and backgrounds to come together – this can also have the benefit of developing creative new insights

The proposed questions for the MeetingWorks sessions include the following:

- How is leadership provided to nurses in your workplace?
- What leadership dimensions are necessary to allow nurses at all levels to perform their roles effectively?
- How can the effectiveness of leadership in nursing be improved to facilitate the continuing development of quality nursing care in your organisation?
- What do you consider to be effective leadership; can you provide an example of this in practice?
- What is missing when there is no leadership – and how does this impact on the work you do?
- How would you distinguish between management and leadership; can you provide an example from your workplace?

It is envisaged that in some cases, because of the lack of access to the technology (e.g. country town respondents), interviews will be conducted that will pose the same questions as listed above. Confidentiality will be assured via an informed consent form and the interviewer will ensure that an ethical stance is adopted so that participants are not compromised in any way.