Leadership at Home: perceptions of clinical leadership at Swan Care Group, Bentley Park: A pilot study report

Dr David Stanley
Summary:

**Aim:** To investigate perceptions of leadership and the approaches to leadership development of senior nurses and care home managers in an aged care residential facility in Western Australia (Swan Care Group, Bentley for the pilot phase).

**Background:** Although there is a plethora of literature related to nurses’ management and leadership roles in a range of care environments, there is a limited amount of research data that explores perceptions of leadership or leadership development strategies in the aged care environment, in Australia. Sometimes ideas, new practices, quality initiatives and positive change fail to materialise in the aged care area and understanding the care home manager or senior nurses’ approach to leadership or how they have learnt to practice leadership may shed light on ways to support improvements in and foster change, that build higher quality care and better resident outcomes.

**Methodology:** A phenomenological research approach was used, specifically descriptive phenomenology, as this approach supports the use of purposive sampling for recruitment and allows the researcher to “bracket” concepts, helping the researcher to reflect upon their own personal assumptions, biases, beliefs and attitudes about the phenomenon and set them aside. This approach also facilitates data about the topic under investigation to become evident and clearly related to plans for further leadership development.

**Method:** Questionnaire and interview format.

**Target group:** Senior clinical nurses and residential care home managers in one residential care home in Western Australia (Swan Care Group, Bentley, Perth) (pilot phase).

**Analysis:** Interview data will be analysed with the aid of an NVivo 0.6 computer package and with manual data configuration as required. Questionnaire data will be analysed with the aid of an SPSS computer program for quantitative data.
Conclusion: Results of the pilot study indicate that the attributes and characteristics of clinical leaders identified by the senior nurses and care home managers who participated in the study are consistent with results from other similar studies. With approachability, clinical skills, clinical knowledge, honesty, integrity, support for others and visibility in the clinical area being identified as dominant attributes of a clinical leader. It was also noted that participants saw a distinction between leadership and management and that their more clinically focused roles leading them toward a leadership centred approach to their role. However, few had any leadership instruction beyond clinical “experience” and almost all saw barriers that hindered their development or application of leadership in the care home environment. In order to play a more effective part in service improvement, care provision and impact positively on resident care and staff support, it is considered essential that senior nursing and care home managers are supported to recognise the significance of developing clinical leadership attributes and applying them in the care home environment.

Recommendations:

Recommendation 1:
Undertake a wider investigation of the perceptions of clinical leadership and approaches to leadership development for senior nurses and care home managers in aged care residential facilities across Western Australia.

Recommendation 2:
Initiate a training program for senior nurses and care home managers to support the development, understanding and application of clinical leadership.

Recommendation 3:
Develop strategies for dealing with staff who’s English language skills are poor or need to be developed further

Recommendation 4:
Consider approaches to securing more newly qualified and younger, qualified nursing staff to address the age discrepancy noted between carers and qualified staff and limit the impact of an aging qualified work force.

Recommendation 5:
Consider exploring how to clarify role boundary issues and limit role confusion so that senior nurses and care home managers are able to focus appropriately on their core responsibilities and develop skills that support their primary (clinical) function.
Recommendation 6:
Consider finding solutions to staffing issues, time constraint and workload pressures and support a path to more innovation and greater quality development in the aged care environment.

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Julie Atkinson: General Manager Aged Care Operations, Swan Care Bentley

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1. JUSTIFICATION FOR THE STUDY:

1.1 Background

In Australia (compared with many other nations of the world) people are living longer than expected and are in relatively good health well into old age. Older people are also well supported with an excellent health system and social welfare structures (AIHW, 2007). Nevertheless, 80% of people over the age of 65 in Australia (between 2004–2005) had three or more chronic conditions and older people with chronic illnesses (between 2006–2007) were the highest users of all health and aged care services (AIHW, 2006). The aged care sector while facing increasing care and quality demands is also feeling; the impact of a reducing qualified nursing staff pool; a transient and mobile management and nursing workforce; the perception that their service is of lower status compared with acute and community nursing services; and the view, in some quarters, that resources in the field are poor. These perspectives are compounded by the view that most of the care is offered by unskilled workers who, along with the qualified workforce, are poorly paid (Pearson et al., 2001; Pearson et al., 2002; Stack, 2003; Moyle et al., 2003; Hegney, et al., 2006; Eley et al., 2007 and Duffield et al., 2007).

Challenges and opportunities abound in the residential aged care sector and like other sectors of the employment sphere management skills and leadership approaches (in particular) are considered vital for addressing and dealing effectively with these challenges and opportunities. However, while much is known about the impact of management and leadership in the corporate or industry sectors, little is known about how leadership is perceived or how leadership can facilitate effective change and impact positively on residential care, quality and staff attitudes.

In May 2010, the Australian Government announced that it would promote and support the development of National and Local Lead Clinicians groups among nurses who were focused on exploring clinical areas for improvement, promoting change in practice and building clinical leadership capacity (DoH, 2011). Despite this high level initiative, limited research exists that explores and describes what clinical level leadership is, who the clinical level leaders are and the characteristics and attributes of clinical level leaders and almost no research has involved senior nurses.
and care home managers in aged care residential facilities in Western Australia (Stanley, 2006a, 2006b, 2011, 2012).

1.2 Context
The study has taken place in one residential aged care facility in Perth, Western Australia. Swan Care Group’s, residential facility in Bentley, Perth agreed to collaborate with the study. The link person at Swan Care Group was initially was Michelle De Ronchi, General Manager, Aged Care Operations although after she left, Julie Atkinson took over this role and also supported the project.

1.3 Implications for the Study
There are a number of reasons offered that support and justify this research.
1. The ability to generate leadership is clearly becoming recognised as a key factor in many areas of the health service (DoH WA, 2004; DoHA, 2008a, 2008b; Stanley, 2011). Investigating the practice of leadership and how leadership can be fostered in the aged care sector is vital for effectively establishing leadership’s influence on quality care and improvements in the life of residents and staff in the aged care area.
2. There are few empirically based, leadership focused studies identified in the literature and this study would set the scene for a fertile area of research that the Department of Health and Aging (2008a, 2008b) recognise as a key area in developing quality and establishing accountability in the aged care arena.
3. The primary researcher is well published in the area of clinical nursing leadership and has a good deal of experience with the data collection methods (interviews and questionnaires) proposed in this study.
4. The pilot study offered a minor collaboration opportunity that facilitated a link between UWA and Swan Care Group. This may be useful in terms of support for future student clinical placements, training support for Swan Care Group staff and further research ventures.
5. In 2010 a similar study was undertaken with the St. John’s Ambulance service in WA (Stanley, Cuthbertson & Latimer, 2012: Perceptions of clinical leadership in the St. John Ambulance Service in WA). Linking the results from this and previous research will offer interesting insights into the profile of clinical leaders in these diverse clinical fields.

1.4 Limitations:
This research is only offered as a pilot study and as such will focus on only one residential facility. The funding for the study was also limited, suggesting that while an adequate number of participants were recruited at the Swan Care Group facility in Bentley, a larger and wider spread study was not possible.

While four of the senior nursing or care home manager staff at Swan Care Group, Bentley at the time of the study were male. No male staff returned questionnaires and only one male volunteered to be included in the interview group. As such, the views expressed are dominantly those of the female senior nursing and care home staff at the facility.

2. LITERATURE REVIEW:

The literature search began with the consultation of a wide range of journals and books, previous research papers and Government documents. Searches were made of the terms; ‘nursing leadership,’ ‘aged care leadership’ ‘aged care home leadership’ and ‘nursing home clinical leadership.

The literature review has been informed by a consideration of literature about leadership and clinical leadership, as well as associated topics including literature related to change, the service improvement agenda in the WA, Department of Health literature, the Commonwealth Department of Health and Aging literature, organisational structure and culture, health professional boundaries and their relationship to leadership roles within health care.

The literature considered for this proposal was accessed via library databases that included, MEDLINE, ProQuest, CINAHL, EMBASE, Allied and Complementary Medicine (AMED), Your Journals @ Ovid and Journals @ Ovid Full Text, The date parameters in most cases represented the limits of the search facilities within the respective databases, although in some cases search limits were drawn in the early 1990’s to limit the volume of information gathered. As well as the libraries and their computer databases a number of websites were accessed for additional or supporting information. These included:

Some of the literature discovered was arrived at in a serendipitous fashion during random journal searches or from contact with nursing/professional colleagues. No specific country was excluded from the search, although much of the literature originates from Australia, the United Kingdom, the United States of America and New Zealand.

2.1 Leadership and Nursing.
There is a wealth of literature that deals with the role, nature and purpose of nursing leadership, the value of developing and nurturing nurse leaders and the characteristics of nurse leaders. Research papers, articles and books about nursing leadership are evident in large numbers and address the nature and purpose of leadership (Footit, 1999; McKinnon, 1999; Salvage, 1999; Shepherd, 2000; Horton-Deutsch & Mohr, 2001; Nohre, 2001; O'Neill, 2001; Ripporn & Monaghan, 2001; Wedderburn-Tate, 1999; Williams et al, 2001; Daly, Speed & Jackson, 2005, Frankel, 2008; Sørensen, Delmar & Pedersen, 2011; Swanwick & McKimm, 2011 and Stanley, 2011) and leadership styles (Girvin, 1996; Wedderburn-Tate, 1999; Alimo-Metcalf & Alimo-Metcalf, 2000; Bowles & Bowles, 2000, and Moiiden, 2002).

As well there are a multitude of articles and books about nursing leadership characteristics (McSherry & Brown, 1997; Bower, 2000; Cook, 2001a; Wedderburn-Tate, 1999; Chambers, 2002; Crouch, 2002; Lett, 2002; McCormack and Garbett, 2003; Gordin, 2011 and Stanley, 2011) and the developmental needs of those who aspire to leadership positions also remains a central pillar in nursing leadership publications (Rowden, 1998; Cunningham, 2000; Miller, 2000; Bulley, 2001; Cook, 2001b; Firth, 2001; Bostock, 2003; Watson, 2008; Stanton, Lemer & Mountford, 2010; Swanwick & McKimm, 2011 and Stanley, 2011).

It is important to note that much of the literature reviewed uses the terms ‘leadership’ and ‘management’ interchangeably with little attempt to define either term (Cook, 2001c; Firth, 2002; Stanley, 2006a, 2006b, 2008, 2011) and as a result, much of it
fails to clarify who the leaders are, other than deference to their hierarchical position (Malcolm, Wright, Barnett, & Hendry, 2003). The pool of information related to ‘management’ in the aged care arena is substantial, although literature related to ‘leadership’ in the aged care arena is quite shallow and in dire need of research to generate information and knowledge about the application and perception of leadership.

2. Nursing leadership in the aged care environment.
While many publications outline the role of effective management to address care and quality issues in the aged care sector, fewer publications were identified that outline the relevance of leadership in the aged care sector, although more and more appear to be evident as the significance of leadership issues are raised.

In 2008, the Office of Aged Care Quality and Compliance (a part of the Department of Health and Aging) released a report on residential care for people with psychogeriatric disorders and highlighted (in recommendation No.5) that aged care residential providers take a proactive role in promoting leadership in their facilities (DoHA, 2008a). This was reinforced at the ‘Better Practice in Aged Care’ conference supported by the Aged Care Standards and Accreditation Agency, when professor Nay suggested that visionary leadership can work towards improving the lives of care home residents (DoHA, 2008b).

Other publications have linked developments in aged care leadership with improving the care and management of elderly resident’s chronic pain (Higgins, Madjar & Walton, 2004) and with improvements in team work and communication (Vogelsmeier & Scott-Cawiezell, 2011). Two (Australian) papers link leadership development with innovative practice in the aged care sector (Jeong & Keatinge, 2004 and Venturato & Drew, 2010) although both fail to draw a clear distinction between management and leadership. Jeon, Merlyn and Chenoweth (2010) offer the most extensive literature review of leadership and management in the aged care sector with a ‘narrative synthesis’ that explored n=4484 initial publications that finally identified 153 publications relevant to the topic of leadership and management and aged care.
They concluded that the literature provided ‘ample’ evidence of the impact of management and leadership on matters of staff turnover, retention, leave and absenteeism. As well, the literature dealt in detail with management issues such as staff performance, staff organisational commitment, job satisfaction, productivity and care quality. However, they noted that little evidence of experimental studies existed and few studies dealt with ‘leadership.’ Indeed they concluded that while ‘most’ studies were conducted in the UK and North America, “no Australian study was found that describes a particular leadership program or model specifically designed for the residential aged care setting, thereby paving the way for a well-designed effectiveness study in the future” (Jeon, Merlyn & Chenoweth, 2010, p.58). From a nursing perspective, with few empirically based studies identified, this study sets the scene for a fertile area of research that the Department of Health and Aging recognise as a key area in developing quality and establishing accountability.

3. AIMS AND OBJECTIVES:

3.1 Aims

*The aim of the study was:*  
To investigate perceptions of leadership and approaches to leadership development of senior nurses and care home managers in one aged care, residential facility in Western Australia (Swan Care Group, Bentley in the initial proposal as this is for a limited pilot project).

3.2 Objectives

*The objectives of the study were:*

1. To identify how senior nurses and care home managers in an aged care residential facility understand and view leadership (as opposed to management).
2. To investigate how senior nurses and care home managers in an aged care residential facility developed their leadership skills.
3. To investigate how senior nurses and care home managers in an aged care residential facility can be supported to build and foster more effective leadership.
4. To evaluate the impact of leadership on care provision and quality patient outcomes.
4. STUDY DESIGN:

4.1 Research Process
The research process followed the steps outlined below:
1. Ethical approval for the study was sought and secured from the UWA, Human Research Ethics Committee.
2. Appropriate funding to support the study was sought and secured from the Western Australian Nurses Memorial Charitable Trust.
3. Appropriate dates/times for the study duration were negotiated with Swan Care, Bentley.
4. With the aid of Swan Care Group management, appropriate senior nurses and care home managers in an aged care residential facility were invited to be involved. This followed initial meetings with the care home manager and the senior staff.
5. Questionnaires were distributed and returned.
6. Interviews were set up and conducted.
7. Data was analysed with appropriate tools throughout the research and results collated.
8. A report was produced and publications sought with an aim to disseminate the results. Figure 1.1 offers a summary of the research process.

4.2 Population / Sample
The study population were drawn from senior nurses and care home managers at Swan Care Group, Bentley. Each senior nurse and care home manager was offered an opportunity to complete a questionnaire. Twenty questionnaires were distributed and 10 were returned. It was then planned that 8 – 10 senior nurses and care home managers would be identified from a variety of different clinical environments across Swan Care Group, Bentley to be interviewed. Eight interviews were conducted. A purposive sampling approach was used to gather a random cross section of study participants.

4.3 Data Collection Method
Data was collected via interviews, a questionnaire, the researcher’s personal reflections and research notes taken on site or in reflection following each interview.
4.4 Analysis

Interview data was analysed with the aid of an NVivo 0.6 computer package and with manual data configuration as required. Questionnaire data was analysed with the aid of an SPSS computer program for quantitative data.

4.5 Work plan / Time line

The research collaboration between Swan Care Group, Bentley and UWA was agreed. As such the project started after ethical approval was secured in early 2012. The data collection (questionnaires and interviews) was delayed because of a gastroenteritis outbreak at Swan Care, Bentley in early / mid 2012 but was complete by September, 2012. The analysis and data write-up was delayed because of a corrupt data file that took three months to recover / repair. As such the final report was not completed until early 2013.
5. ETHICAL CONSIDERATIONS:

Ethical consideration such as integrity, respect for persons, justice and beneficence was addressed in keeping with the National Health and Medical Research Council, Australian Code for the Responsible Conduct of Research (2007). Ethical approval was sought and secured through the UWA, Human Research Ethics Committee (Appendix A) (Number: RA/4/1/5084). Confidentially for all participants were respected and at no point did the researcher record the participant’s names or personal details. Each questionnaire (Appendix B) was provided with an accompanying explanation letter (Appendix C) outlining the research aims and addressing issues of confidentiality, ethical approval and the participant’s right to withdraw with impunity (by simply not returning the questionnaire). Each interview participant was offered the same set of questions to consider (Appendix D), was provided with a consent form (Appendix E) and an accompanying explanation letter (Appendix F) outlining the research aims and addressing issues of confidentiality, ethical approval and the participant’s right to withdraw, again with impunity.

No participant information in either the questionnaires or interviews was linked to individual respondents and participant anonymity has been assured. As well, it was made clear that the research was not related to the participant’s employment or work performance and any information of a confidential or sensitive nature was to be and has been kept secret and secure.

All data remains securely locked in a file at the University of Western Australia where the primary researcher now works. Returned questionnaires will be destroyed after 5 years.

6. METHODOLOGY / METHOD

The methodological principles of the research rest upon phenomenology, a methodological approach that can be used to describe the everyday world of human experience (Cormack, 2000; Richardson-Tench, Taylor, Kermode & Roberts, 2011 and Jirojwong, Johnson & Welch, 2011). The specific approach taken used descriptive phenomenology as this approach supported the use of purposive sampling for recruitment and allowed the researcher to “bracket” concepts, thus helping the researcher to reflect upon their own personal assumptions, biases,
beliefs and attitudes about the phenomenon and attempt to set them aside and reduce the possibility of allowing their own views and values to influence the findings of the study (Jirojwong, Johnson & Welch, 2011).

6.1 Methods
The principle methods employed to generate data in this study were a questionnaire (see Appendix B) and an interview (see Appendix D). Questions for both methods were develop from the literature review, consultation with colleagues and past experience in the application of nursing leadership approaches in practice, all based on a similar UK study and study with the St. John Ambulance Service in WA. The advantage of using interviews was that it allowed all the participants to offer their views and respond in a considered way to the questions asked. Although this approach is more expensive and more time consuming than other sampling methods, an interview, used in conjunction with the questionnaire allowed considerable depth of data to be secured and ensure a more personal approach to securing respondent participation. As well these methods facilitated an appropriate phenomenological approach to the study.

7. RESULTS:
As two data methods were used (a questionnaire and interviews) the results from both of these methods are offered separately.

7.1 The Questionnaire:
The results are presented as clearly and as simply as possible. The questionnaire used in this pilot study is offered in Appendix B.

7.1.1 Who took part?
There were 19 senior nurses or care home manager details provided to the researcher at the beginning of the research study. Of these one left during the research period and two new staff members were identified, bringing the final total of senior nurses or care home managers available during the research period (March 2012 to June 2012) to 20. Only 10 staff returned questionnaires, a respectable return rate of 50%.
Of those respondents, their average length of service with Swan Care, Bentley was just under 9 years (8.63 years) with the longest service of any respondent being 40 years (question 14). However, 4 of the respondents had worked at Swan Care for under 12 months.

In terms of formal leadership training no respondent indicated that they had any form of formal leadership training. A few indicated that they had "life experience" or experience from other careers, although none indicated any formal leadership instruction (question 13).

In terms of formal management training, only one respondent indicated that they had received some sort of management training, citing "some course work". All other respondents left the question blank, indicating that they had not had formal management instruction (90%) (question 12).

The gender make-up of the respondents to the questionnaire showed that no male staff responded. All ten respondents were female. This is not in keeping with the profile of men in nursing and indeed four of the senior nursing staff working at Swan Care, Bentley at the time of the study were men. They simply failed to respond to the questionnaire (question 17).

The distribution of the ages of respondents (question 18) is shown below:

Age ranges:

- Below 20 (0.0%)
- 21-30 (0.0%)
- 31-40 (0.0%)
- 41-50 (30.0%)
- 51-60 (50.0%)
- Above 60 (20.0%)

This indicates that staff who responded to the questionnaire were all over the age of 41 and most were over 51, with one staff member indicating that they were a remarkable 74 years of age!
7.1.2 How do you know a clinical leader?

The first question of the survey sought to explore the qualities and characteristics of clinical leaders. Respondents were offered a list of 54 attributes or descriptive words taken from a wide range of literature describing leaders. They were asked to indicate with a "tick" those characteristics/attributes they saw as "most" identifiable with clinical leaders. The most commonly selected attributes are shown on the list below. Nine of the top ten attributes were selected by all 10 respondents.

Qualities / characteristics "most" identified with clinical leaders:
1. 100% is clinically competent / is approachable
2. 100% is approachable
3. 100% is supportive
4. 100% has integrity and is honest
5. 100% is an effective communicator
6. 100% copes well with change
7. 100% considers relationships valuable
8. 100% inspires confidence
9. 100% is visible in practice
10. 90% is just and fair

Other terms that may have been expected to be associated with leadership roles such as vision (a term commonly affiliated with leadership) and creativity (associated with transformational leadership) were selected much less commonly. With vision rated as important by only 40% of respondents and creativity and innovation by a modest 50% of respondents.

The second part of question 1 sought to explore the qualities and characteristics least attributable to clinical leaders. Respondents were offered the same list of 54 attributes or descriptive words and asked to indicate with a "cross" those characteristics/attributes they saw as "least" identifiable with clinical leaders. The most commonly selected attributes are shown on the list below. In general, and in keeping with others studies of this type (Stanley, 2006a, 2006b: Stanley, Cuthbertson and Latimer, 2012) fewer respondents' selected negative terms, with the attribute least likely to be associated with clinical leadership being selected by only eight respondents.
Qualities and characteristics "least" identified with clinical leaders.

1. 80% is controlling
2. 50% is artistic / imaginative
3. 40% works alone (should be part of a team?)
4. 30% is an administrator
5. 30% must have a relevant post graduate degree
6. 30% deals with reward and punishment
7. 20% is conservative
8. 20% deal with routine
9. 20% takes calculated risks
10. 10% manages staff

7.1.3 Other Qualities
In question 2 respondents were asked to suggest other qualities or characteristics of a clinical leader not on the list of 52 attributes. Few additional words were suggested and most respondents offered none. The following list offers the words suggested (the number in brackets indicates that it was offered by this many respondents) the asterisk indicates that the word was already on the list of 52 offered in question 1.

Trustworthy (1)
Responsible (1)
None judgemental (1)
Reliable (1)
Visibility (1)*
Enthusiastic (1)
Experienced (2)*
Friendly / approachable (2)*
Knowledgeable (1) *

7.1.4 Are they seen as clinical leaders?
In question 3 respondents were asked if they saw themselves as clinical leaders. Half (50%) said "yes" and explained that this was because they thought they were "experienced in their role" or identified their role with the facilitation of change. None
of the respondents offered any reasons for not seeing themselves as a clinical leader.

7.1.5 Their role
In response to question 4, 30% of respondents thought their role called for them to engage in management. These 30% stated that they managed "the day-to-day operation," "worked in a complex environment," or "dealt with processes rather than people." The majority of respondents (70%) indicated that they did not see themselves as managers, stating that they, "preferred working directly with residents and their families" or simply that they "preferred to work with people." Implying that they saw managers as less, client / people focused.

7.1.6 Leadership capacity
Question 5 asked respondents to comment about their capacity to engage in leading and collaborating in clinical practice. All the respondents (100%) suggested that they were facilitated to lead and collaborate in clinical practice, with comments such as; "I am placed in a situation where I have to be a leader," "part of my role is to work collaboratively" and "I am required to provide clinical leadership across a number of facilities therefore I must lead and work collaboratively."

7.1. 7 Are they seen as leaders?
Question 6 sought to explore whether respondents thought their colleagues saw them as a leader or manager. Of all respondents, only 30% thought that their colleagues saw them as clinical leaders. One respondent was "unsure" and 60% indicated that they thought their colleagues saw them as both a leader and manager. When asked to offer a reason for their response, most indicated that they "were often the only member of staff that others could come to with issues," that "part of their role was to lead and manage services," that they, "provided strategic goals," or that they, "managed the operation on a daily basis."

Of the few that thought their colleagues did see them as a clinical leader, most suggest it was because they had, "relevant clinical experience", or "had their colleagues' respect". That "many staff had told them that they had enjoyed working with them and that they were seen as a leader", or that that their "work reflected best practice and related clinical experience." They also said it was because "people
asked for their opinion and advice", because "they were approachable and knowledgeable", "had valuable experiences", or because "they supported people".

7.1.8 The difference between leadership and management

Question 7 asked respondents to describe what they thought were the differences between leadership and management. Only five respondents commented, indicating that leadership was; "being able to work alongside your colleagues," "dealing with the 'big picture' and common goals." Leadership was described as relating to the "implementation of care," "leading by example," and was, "more directly involved with the 'floor level'." Management was described as being in an "overseer role," relating to "processes," "offering direction or orders," being removed from the day-to-day resident care" and "involved more corporate issues."

7.1.9 Barriers to hinder leadership

Question 8 asked respondents to indicate if they thought there were barriers that hindered effective leadership at Swan Care Group, Bentley. Most (60%) indicated "yes," some (30%) indicating "no," but added no reason why and 1 person (10%) suggested they were "not sure." When asked for the reasons for the barriers a number of responses were offered. These included:

- Workload - taking on all sorts of other responsibilities
- Filling in for others and putting your own work quality at risk
- Resistance from colleagues to change
- Many staff being unable to understand English
- Many staff being unable to speak effective English
- Old ways of doing things
- A lack of experience
- Confusion about leadership and management
- Few other experienced colleagues to act as role models
- An aging work force

7.1.10 More barriers

Question 9 sought to explore barriers that hindered or diminished the respondent's ability to manage effectively. Almost every respondent answered "not applicable" (90%) and indicated that this was because they did not see themselves as managers or did not aspire to be a manager. One respondent indicated "not applicable" but
suggested that if they were to be a manager they, "would have to undertake more training first."

7.1.11 Defining leadership
Question 10 asked respondents to define leadership. Only four respondents offered a definition. These suggested leadership was:

- A person able to lead by good example and lift the attitude of junior staff.
- A respected and effective communicator who is able to work through difficulties on a day-to-day basis, reliable, consistent and fair in decision making.
- Leadership requires someone to take control with confidence. Delegate staff, work with staff show the correct way.
- Ability to bring people of different skills together to co-operate to achieve a common goal.

7.1.12 Where was leadership and management learnt?
Question 11 sought to discover where respondents had learnt their leadership skills. Every respondent offered a view. Some had learnt about leadership, "during their nurse training," or "at university." Others had learnt, "from experience" or from working within or as part of, "good organisations." None of the respondents indicated that they had undertaken any formal leadership training or instruction. This was followed by question 12 that asked a similar question and sought to discover where respondents had developed their management skills. Only one respondent offered an answer suggesting that they had, "learnt on the job." All the other respondents failed to offer any answer, suggesting that none had any management instruction. This line of questioning was followed with a third question that sought to discover what else might have prepared them for their management / leadership roles at Swan Care, Bentley. Only five responses were offered, these included:

Learning from life
From family and life in general
Working in acute hospitals when younger
Working outside nursing
Mentored by a more experienced staff member
7.2 The Interviews:
The results are presented as clearly and as simply as possible. The interview questions used in this pilot study is offered in Appendix D.

7.2.1 Who took part?
Interviews were conducted with eight senior nurses or care home managers during the course of the research. This represents 40% of the potential interviewees. Interviews were conducted on site, usually in a ward office or dining area on the ward and at a time that was convenient to the staff member. Each potential interviewee was approached either opportunistically, when the interviewer was on site or at a pre-arranged time following a phone call to make an appointment. Not every person approached was able or prepared to talk to the interviewer and if a more convenient time was required the interviewer made an appointment to reschedule the interview. No one was coerced into an interview and every person was reminded that they did not need to take part and could withdraw at any point during or after the interview.

Each potential interviewee was offered the “Interview Participant Information Sheet” (Appendix F). It was explained that each interview would be recorded and each participant was given a consent form (Appendix E) to read and sign prior to the interview commencing. Each interviewee signed the consent form and none have been in contact to withdraw from the study. Interviews followed a standard format to achieve a degree of consistency (as two interviewers were used to gather interview data). Questions focused on a number of areas identified as significant following an analysis of the questionnaire data and as a result of a predetermined field of enquiry relating to the differences between leadership and management, clinical leadership attributes, the interviewee's role at Swan Care, Bentley and an exploration of the barriers that might impact on the staff member's leadership potential. Detailed demographic data was not recorded to aid in participant anonymity.

7.2.2 Themes identified:
The interviews were recorded and transcribed verbatim then subjected to a thematic analysis using Nvivo 6.0 computer program. This involved detailed analysis, reading and re-reading each interview and identifying categories, sub-themes and themes within the data that outlined and explained the interviewee's understanding of clinical
leadership and other related issues. Six themes were identified from the data analysed. They were:

<table>
<thead>
<tr>
<th>The clinical leader's role</th>
<th>The difference between a manager and leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leadership characteristics</td>
<td>Preparation for the role</td>
</tr>
<tr>
<td>Getting involved</td>
<td>Barriers to leadership potential</td>
</tr>
</tbody>
</table>

**Theme 1: The clinical leader’s role:**
This theme grew from the sub-themes “clinical skills”, “dealing with others” and “supervising and coordinating care at the bedside”. These themes developed as respondents discussed their role at Swan Care Group, Bentley. In describing their role respondents were suggesting that as well as focusing on caring for residents either directly (by providing medications and doing dressings) they also had a role in coordinating the activities of other carer staff and working as a link person with other disciplines or professionals. Management activities were not mentioned and in general each respondent saw themselves as central to the delivery of clinical care and the coordination of care in general (see table 1 below).

**Table 1: Categories / Sub-themes and Themes: Major Theme 1:**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-Themes</th>
<th>Major Theme 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN on the ward / Clinical skills / Medications / Care planning / Caring for clients / residents / &quot;Hands on stuff&quot; / Dressings / Making clinical decisions / Pain management</td>
<td>Clinical skills</td>
<td>Clinical Leader's role</td>
</tr>
<tr>
<td>Delegation / Pharmacy liaison / Dealing with relatives / Working with other disciplines / Resident orientation to the home</td>
<td>Dealing with others (relatives / staff / other professionals)</td>
<td></td>
</tr>
<tr>
<td>Handover role / Day-to-day running of the ward / Supervising other clinical / care staff / Coordinating care</td>
<td>Supervising / coordinating care at the bedside</td>
<td></td>
</tr>
</tbody>
</table>

**Theme 2: The difference between a manager and a leader:**
Categories identified to support this theme were sub-divided into “Leadership attributes” and “Manager attributes” with respondents identifying a range of attributes often in-keeping with the descriptive words identified in the questionnaire data that outlined their views of the key attributes for a leader or a manager within the aged
care environment. Leaders were described as dealing with the quality of care and how care can be improved, with the bigger picture, people, teams and with “hands on”, floor work. They were also described as having a vision and authority but also dealing with the “day-to-day stuff” and taking responsibility for the residents. As well they were seen to be recognised as functioning at “any level”. Managers though were described as being responsible for ordering people to “do” things, focusing on “saving the money” and telling, while not always being seen to listen to staff. Mangers were described as thinking differently from “floor staff” and were seen to focus more on administration and communication with people outside the organisation. Managers were described as the “bad guy” who resided in an office and it was felt that to be a manager a qualification was required. As well, managers were seen to deal with staff when they had “done something wrong” (see table 2 below).

Table 2: Categories / Sub-themes and Themes: Major Theme 2:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-Themes</th>
<th>Major Theme 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaders deal with quality of care / leaders looks at how care can be improved / leaders have followers / leaders look at the bigger picture / leaders deal with people / leaders deal with teams / leaders have a vision / leaders have authority / leaders involved with the day-to-day stuff / leaders are on the floor, “hands on” / leaders are responsible for the residents / leaders compromise more than managers / leaders are about teamwork / leaders can be at any level.</td>
<td>Leader attributes</td>
<td>The difference between a manager and a leader</td>
</tr>
<tr>
<td>Managers order you to do things // Managers are about saving the money / Mangers think differently / managers tell and may not always listen / Managers do admin and communication with outside / managers are the “bad guy” need a qualification to be a manager / deal with you when you have done something wrong / managers are in an office.</td>
<td>Manager attributes</td>
<td></td>
</tr>
</tbody>
</table>
### Table 3: Categories / Sub-themes and Themes: Major Theme 3:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-Themes</th>
<th>Major Theme 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teach carers / supervise others / friendly / good communicator / deals with conflict / communicates effectively / open to new ideas / assertive / approachable / effective communication at handover / understand that it is OK to ask if you don’t know something.</td>
<td>Communications skills</td>
<td>Leadership characteristics</td>
</tr>
<tr>
<td>Provides direct care / knowledgeable / Clinical experience / A caring person / be seen doing things in a positive way / don’t panic / be punctual / well organised / be flexible / must have sound clinical knowledge / responsible for updating their knowledge / good at delegation / good clinical skills / manages their time well / great clinical skills</td>
<td>Clinical skills and clinical knowledge</td>
<td></td>
</tr>
<tr>
<td>Be found on the “shop floor” with residents and carers / visible / build trust so people will come to you / be visible</td>
<td>Visible</td>
<td></td>
</tr>
<tr>
<td>Role model quality care / use EBP / not biased / does what they say they will do / acts on complaints / role model / building competence in those around you / leading by example</td>
<td>Role model</td>
<td></td>
</tr>
<tr>
<td>Leaders can be at any level</td>
<td>At any level</td>
<td></td>
</tr>
<tr>
<td>Teach others / works with a team / leads a team / helps build cooperation /</td>
<td>Team Worker</td>
<td></td>
</tr>
<tr>
<td>Honesty / Listens to others / approachable – most important / reliable / fair / consistent / friendly</td>
<td>Fair approach to others</td>
<td></td>
</tr>
</tbody>
</table>

### Theme 3: Leadership Characteristics

Many characteristics were used to describe clinical leaders. These fell into a number of sub-themes that supported many of the attributes identified in the questionnaire aspects of the study. These themes suggested that clinical leaders needed, communication skills, clinical skills and clinical knowledge, to be visible in the clinical area, to act as a role model to others in the clinical area, to work as part of a team and to be fair in their approach to others. It was also suggested that clinical leaders could be identified at any level of the clinical team. In keeping with the questionnaire data “approachability” was identified as the most important characteristics of a clinical leader, while sound clinical and communication skills were seen as central to
the ability of a clinical leader to function and be recognised as a clinical leader. The capacity of a clinical leader to act as a role model was also central to the clinical leader being recognised because they were prepared and able to follow their values and beliefs about care with actions, a key attribute of a Congruent Leader (Stanley, 2006b, 2008, 2011; Bishop, 2009) (see table 3 above).

Theme 4: Preparation for the role:
In response to questions about their preparedness for their role it is not surprising that respondents suggested they either felt “well prepared”, “not well prepared” or that they could do with “on-going education” to keep up-to-date. Most comments suggested that the respondents felt well prepared, by having previous experience, seminars and adequate university preparation, although a number of respondents sought further education or had had no formal preparation for their leadership role or any management functions they may have been required to undertake (see table 4 below).

Table 4: Categories / Sub-themes and Themes: Major Theme 4:

<table>
<thead>
<tr>
<th>Categories / Sub-themes</th>
<th>Major Theme 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feel I need more preparation / nothing formal offered / just thrown in / Wanted needed to learn more</td>
<td>Not well prepared</td>
</tr>
<tr>
<td>Previous aged care work experience / university course / previous nursing experience / seminars on aged care / learnt on the job / hospital training helped / diploma from the UK</td>
<td>Well prepared</td>
</tr>
<tr>
<td>Refresher courses / just keep updated</td>
<td>On-going education</td>
</tr>
</tbody>
</table>

Theme 5: Getting involved:
This theme resulted from questions about how they, as clinical leaders managed to encourage initiative and participation or involvement from their colleagues. In effect the respondents described how they could support their colleagues to get involved in care or care focused initiatives. The approaches suggested related to using clear communication, having their clinical experience recognised and continuing to treat others with respect while offering support. Clear communication included the issuing of orders as well as making clear what was expected of others, while some
respondents recognised the value in being positive toward others, getting to know people (as individuals) and not treating people like machines. Motivating and inspiring clinical staff, while recognised as important was sometimes viewed as less effective or less commonly employed than simply issuing directives (see table 5 below).

**Table 5: Categories / Sub-themes and Themes: Major Theme 5:**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-Themes</th>
<th>Major Theme 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clear communication of what is required / just tell them to do things and they do it</td>
<td>Clear communication</td>
<td>Getting involved</td>
</tr>
<tr>
<td>I am respected because of my experience / people recognise my experience</td>
<td>Experience</td>
<td></td>
</tr>
<tr>
<td>Treat people (carers) like humans and not machines / offer support and getting support from above / being positive towards people / getting to know people</td>
<td>Treat people well and with respect</td>
<td></td>
</tr>
</tbody>
</table>

**Theme 6: Barriers to leadership potential:**

This theme resulted from direct questions about the barriers that clinical leaders faced in the aged care environment. A number indicated that they faced no barriers, but these views were rare. Most felt there were a number of barriers or “potential” barriers. Offered were sub-themes such as communication issues with poor English language skills dominant among them. As well as being difficult for some staff it was identified that some residents struggled with their capacity to understand some staff’s English expression or accent. This was an interesting observation during the data collection as on a number of occasions the researchers were unable to make themselves understood or gather quality data because of the respondents poor English language comprehension. Low staff numbers or poorly qualified staff members were identified by a number of respondents as barriers to the development of their leadership potential, as was limited access to learning support and a lack of clarity around staff roles. Some respondents felt that staff numbers were not as much of an issues as much as access to (or support from) staff with higher qualifications who they could “bounce ideas off” or share ideas for further development. Also identified was a lack of time to carry out certain roles. Some staff also acknowledged that the barriers to their leadership development were personal.
and reflected their own limited motivation to engage with on-going professional development (see table 6 below).

### Table 6: Categories / Sub-themes and Themes: Major Theme 6:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-Themes</th>
<th>Major Theme 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language skills / poor English language skills / my accent / many staff with English as a second language = hard at times for the residents at times / often need to use slow talk or pictures to communicate with some staff</td>
<td>Communication issues</td>
<td>Barriers to leadership potential</td>
</tr>
<tr>
<td>Small number of registered nurses / not enough staff with registered nurse qualifications / Need more qualified staff / low staffing levels</td>
<td>Staffing issues</td>
<td></td>
</tr>
<tr>
<td>Need more knowledge / more training to do this job / recognised</td>
<td>Learning issues</td>
<td></td>
</tr>
<tr>
<td>Danger of being so dependant of careers / clearer boundaries about the role / not knowing the “tricks” of older staff / still have to follow up with some people to make sure they do things / carry a lot of responsibility / sometimes have to supervise two clinical areas at once / lack of other qualified staff to bounce ideas off</td>
<td>Role boundary or clarity issues</td>
<td></td>
</tr>
<tr>
<td>Feel I get a lot of support / management are wonderful</td>
<td>No problems or barriers</td>
<td></td>
</tr>
<tr>
<td>Limited time to do everything / Lots of demands on my time / busy job sometimes</td>
<td>Time</td>
<td></td>
</tr>
<tr>
<td>Self-imposed limitations</td>
<td>Personal limitation issues</td>
<td></td>
</tr>
</tbody>
</table>
8. DISCUSSION:

The discussion is a considered reflection of the results from the questionnaires, interviews, researcher’s observations and literature informing an understanding of leadership within the Swan Care Group, Bentley facility.

8.1 Participants

With a return rate from the questionnaire of 50% and the interview rate of 40% it can be assumed that a considerable number of the senior nursing and care home management staff at Swan Care Group, Bentley expressed opinions and views about the topic of clinical leadership. However, as no identification was recorded (in keeping with the ethical intentions of the study) it is impossible to say if the same 50% who offered questionnaire responses were also the same participants in the interviews or visa-versa. What can be stated is that the research has covered a substantial number of the senior nursing and care home management staff and as such offers valid and detailed research data.

Between March and June 2012 there was a potential of 20 senior nurses or care home managers that could have taken part in both aspects of the study. Demographic data was not collected during the interviews to aid in participant anonymity. The questionnaire data suggested that the average senior nurse or care home manager had worked at Swan Care Group, Bentley for just under 9 years with one respondent having worked at the facility for 40 years while 4 of the 10 questionnaire respondents had worked at Swan Care Group, Bentley for under 12 months. Significantly, the participants who responded to the questionnaire where all over the age of 41 with most being over the age of 51 with all eight of the staff interviewed sitting within the 41 – 51 age bracket. Unlike the questionnaire data the interviews included the views of one male, with the remaining interviewees being female.

8.2 How to recognise a clinical leader / the clinical leader’s role

Few of the respondents to the questionnaires or participants in the interviews saw themselves as managers, although a few indicated that they sometimes undertook management functions. This was consistent with the research results of Cook (2001b) who suggested that clinical leaders were likely to come from across the
spectrum of staff but be more likely from staff with a clinical, rather than management focus. The majority of those interviewed said that they preferred to work directly with the residents in a clinical capacity and that this was incompatible with a manager’s role, adding that they saw themselves as being clinically skilled and clinically focused or coordinating care through others. In spite of this few of the respondents to the questionnaire thought their colleagues saw them as clinical leaders. This view is consistent with the results of the WA Ambulance study (Stanley, Cuthbertson & Latimer, 2012) were most respondents to the questionnaire didn’t see themselves as clinical leaders and felt that their colleagues didn’t see them as clinical leaders either, while some felt they were seen, in fact as managers. In the original nursing research (Stanley, 2006a) the majority of those nominated as clinical leaders by their colleagues failed to recognise themselves as such. These elements of data all confirm that while clinical leaders are evident in clinical practice in significant numbers (Stanley, 2006b) many fail to recognise either themselves or their colleagues as leaders if they do not hold a management position or title.

Only a few (n=3) of those who responded to the questionnaire saw themselves as managers and these few talked of managing the day-to-day operation, complex work environment and the management of processes, rather than people as the reason for seeing their role in a management context. All of those interviewed failed to mention “management” as significant aspect of their role (although one mentioned the day to day “running” of the ward) and felt themselves drawn to the delivery of clinical care and the coordination of care by others as the key attributes of their role.

The net result was that while few saw themselves as managers (even if others may have), most failed to recognise themselves as clinical leaders either, leaving them to occupy a sort of limbo position between leadership and management and having as a result limited authority or power to effectively lead if needed or manage if desired. While those interviewed seemed to describe themselves in a clinical leader’s role, many failed to recognise themselves in this way and seemed to suffer from a degree of role ambiguity as a result (Stanley 2006c).

8.3 Management and leadership training / development
Limited detail was offered about the difference between leadership and management in the questionnaire data. The interview data proved far more informative with a
significant list of the attributes of both leaders and managers. The lists offered parallel reasonably closely with other information about the attributes of leaders and managers (Kotter, 1990; Forbes, 1993; Kakabadse & Kakabadse, 1999; Stanley, 2006c). It was significant that none of the respondents to the questionnaire or interviews discussed any formal leadership or management instruction or education and most if they had gathered information on the topic of leadership, had done so simply by picking it up along their learning journey with “life experience” featuring dominantly.

8.4 Who are the clinical leaders?
Half of the questionnaire responders indicated that they saw themselves as clinical leaders and all of those interviewed indicated that they saw their role as relating to that of a clinical leader and not a manager. Most of the questionnaire and interview data suggested that participants were not seen, or saw themselves as managers because they saw managers dealing with authority and finances and themselves dealing more with people, other staff, the coordination of care or the delivery of direct resident care. In many ways the people described as clinical leaders were the senior nurses and care home managers approached to be involved in this study. Less clinically focused staff (managers) where not regarded as fitting the description of a clinical leader and they were classified clearly as having more management responsibilities. These findings are consistent with research results identified by Cook, 2001b; Stanley 2006b and Stanley, Cuthbertson & Latimer, 2012). However it was suggested that clinical leaders could be found at any level of the organisation (Cook 2001b) as long as their role involved a substantial clinical focus and attention to direct resident care or the coordination of those who delivered direct resident care. Clearly the senior nurses and care home managers involved in this pilot study could be described as clinical leaders, but few saw themselves in this way and while they were less inclined to see themselves as managers, without a clear understanding of the role of a clinical leaders they seemed to be sometimes floundering with a limited insight into their limbo clinical role or pseudo-management responsibilities.

8.5 What is stopping more effective clinical leadership?
Both the questionnaire and interviews sought to discover if there were barriers hindering the participant’s development of clinical leadership. Most of the respondents to the questionnaire indicated that there were barriers while all but one
of those interviewed suggested there were barriers. In relation to the barriers a lack of effective communication, or more specifically limited English language skills seemed dominant with this theme standing out in both investigation formats. Staffing issues, time constraints or workload pressures were also mentioned in both investigation formats as a significant barrier. Role boundary issues or role confusion was also cited as a source of hindrance and in the questionnaires (in keeping with the conclusions drawn above), resistance to change and a lack of experienced role models and an aging workforce were also cited as burdens to the successful implementation of clinical leadership. Few of these problems seem insurmountable and some paralleled barriers identified in the WA Ambulance study (Stanley, Cuthbertson & Latimer, 2012) (e.g. resistance to change and poor or lack of training opportunities) and original nursing research (Stanley, 2006a, 2006b, 2011) (e.g. lack of staff support, poor motivation, staff shortages, lack of time and poor management structure) were evident. However, for them to be overcome, barriers need to be recognised and addressed openly and with considerable and wide consultation.

8.6 Understanding clinical leadership / clinical leadership characteristics
A key feature of the study was to identify the qualities and characteristics of clinical leaders in the aged care setting. As such, respondents and interviewees were offered an opportunity to rate and describe the characteristics they associated “most” or “least” with clinical leaders. The results were consistent with the results from the original nursing study 2001-2005 (Stanley, 2006a, 2006b) and the WA Ambulance study in 2010 (Stanley, Cuthbertson, & Latimer, 2012) (see table 7 below).

Clinical leaders were described as being clinically competent, approachable, supportive, having integrity and being honest, being effective communicators, coping with change, effective in their use of relationships, inspiring confidence, visible in the practice environment and being just and fair. Those interviewed re-enforced these attributes describing clinical leaders as having good communication skills, sound clinical skills and clinical knowledge, being visible in practice, acting as role models, being fair and approachable and working within and as part of a team. Therefore, a clinical leader may be seen at any (clinical) level within an organisation. Approachability was sighted as the most important characteristic and in the questionnaires and again in-keeping with the two previous studies, being seen as “controlling” was considered the least favourable clinical leader attribute.
<table>
<thead>
<tr>
<th>Table 7: Clinical Leadership Research Study comparison results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Nursing Research</strong></td>
</tr>
<tr>
<td>UK, Worcestershire Acute Hospitals Trust</td>
</tr>
<tr>
<td>Questionnaire (n=830 sent, n=188 returned = 22.6% ) Grounded Theory methodology Three hospitals / 36 wards Interviews (n=50) 42 clinicians and 8 clinical leaders 5% Male 95% Female</td>
</tr>
</tbody>
</table>

1. **Characteristic most commonly associated with Clinical leadership**

<table>
<thead>
<tr>
<th>Initial Research (42) %</th>
<th>Follow up Research (54) %</th>
<th>Swan care Group, Bentley (54) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is approachable 97.3%</td>
<td>Is approachable 96.2%</td>
<td>100%</td>
</tr>
<tr>
<td>Is clinically competent 95.2%</td>
<td>Is clinically competent 96.2%</td>
<td>100%</td>
</tr>
<tr>
<td>Motivated 94.1%</td>
<td>Has integrity / honest 93.3%</td>
<td>100%</td>
</tr>
<tr>
<td>Supportive 94.1%</td>
<td>Is a role model for others in practice 93.3%</td>
<td>100%</td>
</tr>
<tr>
<td>Inspires confidence 93.0%</td>
<td>Is supportive 91.3%</td>
<td>100%</td>
</tr>
<tr>
<td>Copes well with change 90.9%</td>
<td>Is a mentor 90.4%</td>
<td>80%</td>
</tr>
<tr>
<td>Flexible 90.4%</td>
<td>Is consistent 90.4%</td>
<td>80%</td>
</tr>
<tr>
<td>Sets Direction 89.3%</td>
<td>Is an effective communicator 89.4%</td>
<td>100%</td>
</tr>
<tr>
<td>Directs and helps people 88.9%</td>
<td>Is a critical thinker 88.6%</td>
<td>50%</td>
</tr>
<tr>
<td>Integrity 87.2%</td>
<td>Directs and helps people 88.6%</td>
<td>100%</td>
</tr>
<tr>
<td>Advocate 86.1%</td>
<td>Is a decision maker 86.5%</td>
<td>80%</td>
</tr>
<tr>
<td>Visible 85.6%</td>
<td>Is visible in practice 85.6%</td>
<td>100%</td>
</tr>
<tr>
<td>Mentor 84.5%</td>
<td>Inspires confidence 85.6%</td>
<td>100%</td>
</tr>
<tr>
<td>Creative 76.5%</td>
<td>Creative and innovative 61.5%</td>
<td>50%</td>
</tr>
<tr>
<td>Visionary 72.3%</td>
<td>Visionary 51.0%</td>
<td>40%</td>
</tr>
</tbody>
</table>

**Not used in first questionnaire**

2. **Characteristics least commonly associated with Clinical Leadership**

<table>
<thead>
<tr>
<th>Initial Research (42)</th>
<th>Follow up Research (54)</th>
<th>Swan care Group, Bentley (54) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is controlling 78.1%</td>
<td>Is controlling 84.1%</td>
<td>80%</td>
</tr>
<tr>
<td>Artistic 65.9%</td>
<td>Works alone (should be in a team) 68.8%</td>
<td>40%</td>
</tr>
<tr>
<td>Conservative 62.2%</td>
<td>Is conservative 56.8%</td>
<td>20%</td>
</tr>
<tr>
<td>Routine 57.4%</td>
<td>Is artistic / imaginative 52.3%</td>
<td>50%</td>
</tr>
<tr>
<td>Calculating 47.3%</td>
<td>Is an administrator 51.1%</td>
<td>30%</td>
</tr>
<tr>
<td>Reward / Punishment 30%</td>
<td>Deals with reward and punishment 47.7%</td>
<td>40%</td>
</tr>
<tr>
<td>Administrator 33.5%</td>
<td>Is responsible for others duty 45.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Regulator 32.4%</td>
<td>Has management experience 44.3%</td>
<td>0%</td>
</tr>
<tr>
<td>Visionary 8.5%</td>
<td>Visionary 25.0%</td>
<td>0%</td>
</tr>
<tr>
<td>Creative / innovative 9.5%</td>
<td>Creative / innovative 12.5%</td>
<td>0%</td>
</tr>
<tr>
<td>Clinically competent 1.5%</td>
<td>Is clinically competent 1.1%</td>
<td>0%</td>
</tr>
<tr>
<td>Is approachable 0.5%</td>
<td>Is approachable 0.0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
3. Other qualities and characteristics that were suggested to be associated with clinical leadership

<table>
<thead>
<tr>
<th>Initial Research</th>
<th>Follow up Research</th>
<th>Swan care Group, Bentley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sense of Humour (most common)</td>
<td>Trustworthy</td>
<td>Trustworthy</td>
</tr>
<tr>
<td>Positive</td>
<td>Visible</td>
<td>Responsible</td>
</tr>
<tr>
<td>Communicator</td>
<td>Responsible</td>
<td>Non-judgemental</td>
</tr>
<tr>
<td>Enthusiastic</td>
<td>Enthusiastic</td>
<td>Reliable</td>
</tr>
<tr>
<td>Non-judgemental</td>
<td>Non-judgemental</td>
<td>Visibility</td>
</tr>
<tr>
<td>Role model</td>
<td>Ambitions</td>
<td>Enthusiastic</td>
</tr>
<tr>
<td>Maintains confidentiality</td>
<td>Ethical behaviour</td>
<td>Experienced</td>
</tr>
<tr>
<td>Empathetic</td>
<td>Not a dreamer</td>
<td>Friendly / approachable</td>
</tr>
<tr>
<td>Caring</td>
<td>Humble</td>
<td>Knowledgeable</td>
</tr>
<tr>
<td>Reliable</td>
<td>Reliable</td>
<td></td>
</tr>
<tr>
<td>Knowledgeable</td>
<td>Knowledgeable (most common)</td>
<td></td>
</tr>
<tr>
<td>Loyal</td>
<td>Friendly / approachable</td>
<td></td>
</tr>
<tr>
<td>Clam</td>
<td>Experienced</td>
<td></td>
</tr>
<tr>
<td>Dynamic</td>
<td>Proactive</td>
<td></td>
</tr>
<tr>
<td>Vision for future (1 person)</td>
<td>No one added Vision</td>
<td>No one added Vision</td>
</tr>
</tbody>
</table>

Table 7 above offers evidence from three different clinical leadership studies, conducted in different countries and different time and with health professionals with different clinical roles and yet the data is consistently universal (Stanley, 2012a). In each study approachability and sound clinical skills/knowledge are rated as the most desirable skills for clinical leaders. However, being an effective communicator, supportive, visible in practice, a mentor and role model and being honest, inspiring confidence and having integrity are all consistent across the studies. As well, having vision or being creative is constantly under rated as a clinical leader attribute. While it is acknowledged that the questionnaire sample size from the Swan Care Group study is small, the results remain valid because the interview data supports the questionnaire data and the results seem to be consistent with data gathered from the two previous clinical leadership studies.

8.7 Preparation for the role of clinical leader

Most interview participants indicated that they had been well prepared for their role at Swan Care Group, although a number of interviewees felt the needed more formal leadership development or greater preparation for the leadership aspects of their role. An observation of the researcher’s was that while those interviewed indicated that they had been prepared for their clinical role, few indicated that they were prepared for their leadership responsibilities (or indeed management tasks if these were required). The questionnaire responses too, failed to indicate that leadership preparation had been well provided for and while the clinical aspects of the
participant’s roles were well covered, all the participants reflected a need to have a greater insight into leadership and specifically clinical leadership.

8.8 Getting involved / motivating others
Clinical leaders are (in part) recognised because they support and motivate others. The questions in the questionnaire and interviews that sought to explore how senior nurses and care home managers motivated or even inspired their colleagues and staff failed to offer a rich seam of information. This (in part) supports the evidence that few senior nurses or care home managers saw themselves as clinical leaders or genuinely understood their role as clinical leaders. Most felt clear communication, the possession of sound clinical experience and the ability to treat people with respect or be positive toward people were all that were needed to motivate and support others to get involved in making care better. While these approaches are essential, little more than these approaches was discussed and as such the potential for greater innovation or capacity to improve care seemed minimal. If clinical leaders are to genuinely impact on the quality of care and make care better they need to have a clear understanding of how to motivate others and build their team's capacity. The researcher’s noted that while often understated by the participants in the study, the barriers discussed seemed more in evidence than was acknowledged offering a possible reason for the limited motivational or innovative approaches discussed.

8.10 General summary comments
Results of the pilot study indicate that the attributes and characteristics of clinical leaders identified by the senior nurses and care home managers who participated in the study are consistent with results from other similar studies. With approachability, clinical skills, clinical knowledge, honesty, integrity, support for others and visibility in the clinical area being dominant. It was also noted that participants saw a distinction between leadership and management and that their more clinically focused roles lead them to want a leadership focus to their role. However, few had any leadership instruction beyond clinical “experience” and almost all saw barriers that hindered their development or application of leadership in the care home environment. Dominant among these was poor communication, specifically related to English language skills, staffing issues, role boundary issues, a lack of role models and an aging senior work force. In order to play a more effective part in service improvement, care provision and to impact positively on resident care and staff
support, it is considered essential that senior nursing and care home managers are supported to recognise the significance of developing clinical leadership attributes and applying them in the care home environment.

9. CONCLUSION:
This small pilot study has offered a set of data from questionnaires and interviews with senior nursing staff and care home managers at the Swan Care Group, Bentley residential care facility in Perth, Western Australia. The study sought to investigate the perceptions of clinical leadership and approaches to leadership development and in many regards this aim has been achieved. Participants were able to express their understanding of clinical leadership and describe the characteristics or attributes they saw as vital for a clinical leader. Also offered, was data about how leadership skills were obtained and insights into the difference between leadership and management. Participants were also able to identify the issues that may hinder or stifle clinical leadership development in the aged care environment and the recommendations that follow offer some suggestions for how these and other issues may be addressed.

10. RECOMMENDATIONS:
1. Undertake a wider investigation of the perceptions of clinical leadership and approaches to leadership development for senior nurses and care home managers in aged care residential facilities across Western Australia.
2. Initiate a training program for senior nurses and care home managers to support the development, understanding and application of clinical leadership with emphasis on the development of skills related to:
   Understanding the difference between leadership and management
   Understanding what clinical leadership means and how it can be understood
   Managing change
   Clinical decision making
   Working in teams
   Networking an delegation
   Dealing effectively with conflict
   Motivation
   The leader’s role in quality management and evidence based practice
Empowerment and oppression

3. Develop strategies for dealing with staff who’s English language skills are poor or need to be developed further.

4. It was noted that senior nurses and care home managers who participated in the study were generally of advancing age and while not a focus of the study it is suggested that the nursing home industry needs to look at securing more newly qualified and younger qualified nursing staff to address the age discrepancy noted between carers and qualified staff.

5. Consider exploring how to clarify role boundary issues and limit role confusion so that senior nurses and care home managers are able to focus appropriately on their core responsibilities and develop skills that support their primary (clinical) function.

6. Barriers mentioned included staffing issues, time constraints and workload pressures and solutions to these issues (while noted on-going problems within the nursing world) should be considered as a path to supporting more innovation and greater quality development in the aged care environment.
11. References:
http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-qualityreport-

http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nlcg-
geninfo Accessed on the 24/06/2011.

Duffield C., Roche M., O'Brian-Pallas L., et al. (2007). Getting it all together: Nurses their work environment and patient safety. Sydney, Centre for Health Services Management, University of Technology.


Dr. David Stanley  
Population Health (School of)  
MBDP: M431  

Dear Dr. Stanley,

HUMAN RESEARCH ETHICS APPROVAL - THE UNIVERSITY OF WESTERN AUSTRALIA

Leadership at Home: Nursing Leadership in Residential Care Homes

Student(s):

Ethics approval for the above project has been granted from 07 November 2011 to 01 November 2012 in accordance with the requirements of the National Statement on Ethical Conduct in Human Research (National Statement) and the policies and procedures of The University of Western Australia.

You are reminded of the following requirements:

1. The application and all supporting documentation form the basis of the ethics approval and you must not depart from the research protocol that has been approved.
2. The Human Research Ethics Office must be approached for approval in advance for any requested amendments to the approved research protocol.
3. The Chief Investigator is required to report immediately to the Human Research Ethics Office any adverse or unexpected event or any other event that may impact on the ethics approval for the project.
4. The Chief Investigator must inform the Human Research Ethics Office as soon as practicable if a research project is discontinued before the expected date of completion, providing reasons.

Any conditions of ethics approval that have been imposed are listed below:

Special Condition:

None specified

The University of Western Australia is bound by the National Statement to monitor the progress of all approved projects until completion to ensure continued compliance with ethical standards and requirements.

Please note that the maximum period of ethics approval for this project is five (5) years from the date of this notification. However, ethics approval is conditional upon satisfactory progress reports being received by the designated renewal date for continuation of ethics approval.

The Human Research Ethics Office will forward a request for a Progress Report approximately 60 days before the due date. A further reminder will be forwarded approximately 30 days before the due date.

If your progress report is not received by the due date for renewal of ethics approval, your ethics approval will expire, requiring that all research activities involving human participants cease immediately.

If you have any queries please do not hesitate to contact the Human Research Ethics Office (HREO) at breo-research@uwa.edu.au or on (08) 6488 3703.

Please ensure that you quote the file reference – RA/4/1/5084 – and the associated project title in all future correspondence.

07 November 2011
Leadership at Home: Nursing Leadership in Residential Care Homes: QUESTIONNAIRE
Date of design: August 2011 (Version 1)

Please read the information in the box below and on the covering letter carefully BEFORE answering any of the following questions.

Any information provided will be dealt with in the strictest confidence.
The information you provide will only ever be available to the researcher.
You do not need to put your name or any other name on this questionnaire.
You can be assured that this questionnaire is related only to this research and NOT to your employer or employment, again any information you provide will be kept safe and confidential.
Please complete every part of the questionnaire and do not leave any questions unanswered.
Please return the questionnaire to the researcher in person or post it back to the researcher in the envelope provided. Thank you for your assistance and participation.

1. Please put a tick ✓ next to the qualities / characteristics listed below that you would MOST identify with nursing leadership and a × next to the qualities / characteristics you would LEAST identify with nursing leadership. Consider each quality / characteristic carefully and if you can’t decide, leave the space blank.

<table>
<thead>
<tr>
<th>Copes well with change</th>
<th>Is a motivator</th>
<th>Deals with routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sets direction (planning)</td>
<td>Is controlling</td>
<td>Is consistent</td>
</tr>
<tr>
<td>Considers relationships valuable</td>
<td>Has management experience</td>
<td>Copes well with Complexity</td>
</tr>
<tr>
<td>Flexible</td>
<td>Is a teacher</td>
<td>Is visible in practice</td>
</tr>
<tr>
<td>A guide</td>
<td>Is a mentor</td>
<td>Is a visionary</td>
</tr>
<tr>
<td>Sets goals and targets</td>
<td>Is a negotiator</td>
<td>Directs and helps people</td>
</tr>
<tr>
<td>Has integrity and is honest</td>
<td>Is responsible for others duty/responsibilities</td>
<td>Deals with reward / punishment</td>
</tr>
<tr>
<td>Is inspirational</td>
<td>Takes calculated risks</td>
<td>Aligns people</td>
</tr>
<tr>
<td>Is a critical thinker</td>
<td>Is a regulator</td>
<td>Counts on trust</td>
</tr>
<tr>
<td>Is creative / innovative</td>
<td>Is analytical</td>
<td>Deals with resources allocation</td>
</tr>
<tr>
<td>Is clinically competent</td>
<td>Is an administrator</td>
<td>Maintenance of relationships</td>
</tr>
<tr>
<td>Is artistic / imaginative</td>
<td>Is conservative</td>
<td>Inspires confidence</td>
</tr>
<tr>
<td>Is supportive</td>
<td>Is an advocate</td>
<td>Is articulate</td>
</tr>
<tr>
<td>Is a change agent</td>
<td>Is approachable</td>
<td>Is just / fair</td>
</tr>
<tr>
<td>Can be a decision maker</td>
<td>Is a coach</td>
<td>Manages staff</td>
</tr>
<tr>
<td>Has a healthy sense of humour</td>
<td>Is caring / compassionate</td>
<td>Is an effective communicator</td>
</tr>
<tr>
<td>Evaluates the performance of staff</td>
<td>Is a role model for others in practice</td>
<td>Resolves conflict</td>
</tr>
<tr>
<td>Works alone</td>
<td>Must have relevant postgraduate training</td>
<td>Is courageous</td>
</tr>
</tbody>
</table>

2. Are there any other qualities or characteristics that are not on the list above that you would identify with nursing leadership?

___________________________________________________
___________________________________________________
3. Based on the qualities you have selected above. Do you see yourself as a leader?
   (Circle) YES NO Please state why?
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

4. Based on the qualities you have selected above. Do you see yourself as a manager?
   (Circle) YES NO Please state why?
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

5. Would you say your role at Swan Care, Bentley allows you to engage in leading and collaborating in clinical practice? (Circle) YES NO Please state why?
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

6. Do you think your colleagues see you as a leader or a manager?
   (Circle) Leader / Manager / Both (Why?)
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

7. What do you think are the differences between leadership and management?
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
8. Are there any barriers that hinder or diminish your ability to be an effective leader here at Swan Care, Bentley?
(Circle) YES NO If so, please describe them.
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________

9. Are there any barriers that hinder or diminish your ability to be an effective manager?
(Circle) YES NO If so, please describe them.
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________

10. How would you define leadership?
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________

11. Where and when did you learn your leadership skills?
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
___________________________________________________
12. Where and when did you learn your management skills?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

13. Apart from any training or education you have done, what else has prepared you for your management / leadership role at Swan Care? Why?

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

About you:
14. How long have you been in your current post (years/months) _______/_________

________________________________________________________________________________________
15. What is your current job title? ______________________________________________________

________________________________________________________________________________________
16. What qualifications do you hold? (Describe the qualification)
Certificate(s) ________________________________________________________________
Diploma Degree (s) ________________________________________________________
Master’s Degree (s) _________________________________________________________
PhD or Doctorate (s) _________________________________________________________
Others: _________________________________________________________________

________________________________________________________________________________________
17. Are you male / female (Please circle as appropriate)

Male / Female

________________________________________________________________________________________
18. Please indicate your age with a tick next to the corresponding figures on the scale below.

Below 20
21 – 30
31 – 40
41 – 50
51 – 60
Above 60

Thank You:
Again you can be reassured that any information provided will be kept confidential and dealt with in the strictest confidence.
Thank you for your assistance in completing this questionnaire. If you have any questions or concerns that this questionnaire has raised. You can contact the researcher at D.Stanley@curtin.edu.au
Please return the completed questionnaire in the envelope provided or to the appropriate collection point.
Appendix C

Date of Design: August 30th, 2011.

Participant Information Sheet:
Questionnaire
Leadership at Home: Nursing Leadership in Residential Care Homes

Dear Nursing Colleague,
You are invited to take part in this research study, however before you decide to do so or not, it is important for you to understand why the research is being undertaken and what it will involve. Please read the following information carefully.

This research project aims to investigate nursing leadership and approaches to the leadership development of senior nurses and care home managers in aged care residential facilities in Western Australia (Swan Care, Bentley). The initial proposal is for a limited pilot project.

The purpose of the study is:
1. To identify how senior nurses and care home managers in an aged care residential facility understand and view leadership (as opposed to management).
2. To investigate how senior nurses and care home managers in an aged care residential facility developed their leadership skills.
3. To investigate how senior nurses and care home managers in an aged care residential facility can be supported to build and foster more effective leadership.
4. To evaluate the impact of leadership on care provision and quality patient outcomes.

How were you selected?
The questionnaire is being offered to all senior nurses and care home managers at Swan Care Bentley.

Methods:
You are being asked to take part in completing a questionnaire.

Risks:
It is hoped that you feel confident to be able to help with this study. The research is purely related to a Swan Care Group / University of Western Australia research project and is in no way related to your employment or employer. As such, you can be assured that any information provided will be dealt with in the strictest confidence. The information you provide will only be available to the researcher and is unable to be linked with your name, work position or address. All the information collected will be kept safe and confidential. You are not identifiable as a result of participating in this study. As such there are no perceived risks to you for taking part in the study.
Inconveniences:
There are none, other than the time it will take to complete the questionnaire (about 8-12 minutes).

Benefits:
1. Support for, or insight into theories of leadership that better support an understanding of leadership in clinical practice and thus an ability to offer support to apply leadership in clinical practice in this aged care facility.
2. Information that leads to the development of more appropriate and focused education to better support leadership development for managers and senior nurses in this aged care facility.
3. A guide may be offered into how to better support service improvement initiatives across the aged care environment studied. This will support both the participants and clients in this aged care facility.
4. The most significant outcome is the potential to develop an understanding of how leadership practices impact on staff morale, staff retention, staff satisfaction and the implementation of care practices that lead to more effective patient care.
5. The results may support the need to expand the research study and include a wider target population across a wider range of aged care facilities.

What will be done with the data?
The information you provide will be analysed and used to help the research understand more about leadership and management in the aged care sector. It will be used to produce a report for Swan Care and possibly academic publications for the wider aged care sector. As well it may be used to develop specific educational provision for nursing staff at Swan Care Group.

Ethics process:
Participation **is not compulsory** and you are free to withdraw from the study at any time without prejudice in any way. If you chose to withdraw you need give no reason or justification for withdrawing and any record of your being in the study will be destroyed. Simply do not complete or return the questionnaire.

Who to contact:
Approval to conduct this research has been provided by The University of Western Australia, in accordance with its ethics review and approval procedures. Any person considering participation in this research project, or agreeing to participate, may raise any questions or issues with the researchers at any time.

In addition, any person not satisfied with the response of researchers may raise ethics issues or concerns, and may make any complaints about this research project by contacting the Human Research Ethics Office at The University of Western Australia on (08) 6488 3703 or by emailing to hreo-research@uwa.edu.au

All research participants are entitled to retain a copy of any Participant Information Form and/or Participant Consent Form relating to this research project.

Thank you for your time in considering this request to be involved in this study.
Respectfully yours,
Dr D. Stanley.

NursD, MSc HS, BA (Nursing), Dip HE (Nursing), RN, RM, TF, Gerontic Cert.
Leadership at Home – Modified Interview schedule:

Suggested questions:
1. Describe your role at Swan Care Group. How long have you been in this role?

2. Tell me what you think are the differences between leader and manager?

3. Do you see yourself more as a manager or as a leader? Why?

4. What are the attributes or qualities you look for in a clinical level leader (not a manager)? Why?

5. What sort of preparation have you had for your current role? Was it enough / what else would you seek to help you become prepared?

6. Are there any barriers (issues / concerns) that are stopping you from doing your job better?

7. Are you able to encourage initiative, involvement and innovation from your co-workers? If so, how? If not, why?

8. This study is about clinical leadership in the aged care sector. Do you have any other comments to make about your understanding of leadership or management in the care home environment?

Thank you.
Date of Design: August 30th, 2011.

Participant Consent Form: Leadership at Home: Nursing Leadership in Residential Care Homes

Dear Nursing Colleague,

You are invited to take part in this research study, however before you decide to do so or not, it is important for you to understand why the research is being undertaken and what it will involve. Please read the Participant Information Sheet carefully before considering this consent form.

This research project aims to investigate nursing leadership and approaches to the leadership development of senior nurses and care home managers in aged care residential facilities in Western Australia (Swan Care, Bentley). The initial proposal is for a limited pilot project.

I (the participant) have read the information provided and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realising that I may withdraw at any time without reason and without prejudice.

I understand that all identifiable (attributable) information that I provide is treated as strictly confidential and will not be released by the investigator in any form that may identify me. The only exception to this principle of confidentiality is if the documents are required by law.

I have been advised about what data is being collected, the purpose for collecting the information, and what will be done with the information upon completion of the research.

I agree that research gathered for the study may be published provided my name or any other identifying information is not used.

Do you have any final questions before you sign your consent?

(Signature) _____________________   _______________ ____________
Participant        Date

Approval to conduct this research has been provided by The University of Western Australia, in accordance with its ethics review and approval procedures. Any person considering participation in this research project, or agreeing to participate, may raise any questions or issues with the researchers at any time.

In addition, any person not satisfied with the response of researchers may raise ethics issues or concerns, and may make any complaints about this research project by contacting the Human Research Ethics Office at The University of Western Australia on (08) 6488 3703 or by emailing to hrero-research@uwa.edu.au

All research participants are entitled to retain a copy of any Participant Information Form and/or Participant Consent Form relating to this research project.
Date of Design: August 30th, 2011.

Participant Information Sheet:
Leadership at Home: Nursing Leadership in Residential Care Homes

Dear Nursing Colleague,

You are invited to take part in this research study, however before you decide to do so or not, it is important for you to understand why the research is being undertaken and what it will involve. Please read the following information carefully.

This research project aims to investigate nursing leadership and approaches to the leadership development of senior nurses and care home managers in aged care residential facilities in Western Australia (Swan Care, Bentley). The initial proposal is for a limited pilot project.

The purpose of the study is:
1. To identify how senior nurses and care home managers in an aged care residential facility understand and view leadership (as opposed to management).
2. To investigate how senior nurses and care home managers in an aged care residential facility developed their leadership skills.
3. To investigate how senior nurses and care home managers in an aged care residential facility can be supported to build and foster more effective leadership.
4. To evaluate the impact of leadership on care provision and quality patient outcomes.

How were you selected?
Your employer (Swan Care Group) provided a list of names of all the senior nurses and care home managers. Your name was chosen completely at random from this list. The data collected will relate to your views on leadership, management, how you learnt or were taught these matters and what might be stopping or helping you exercise your leadership and management potential.

Methods:
You are being asked to take part in an interview. The interview will also be recorded.

Risks:
It is hoped that you feel confident to be able to help with this study. The research is purely related to a Swan Care Group / University of Western Australia research project and is in no way related to your employment or employer. As such, you can be assured that any information provided will be dealt with in the strictest confidence. The information you provide will only be available to the researcher and is unable to be linked with your name, work position or address. All the information collected will be kept safe and confidential. You are not identifiable as a result of participating in this study. As such there are no perceived risks to you for taking part in the study.
Inconveniences:
There are none, other than the time it will take to be interviewed. Interviews are planned to take place at your place of work. Swan Care Group managers have agreed that you can take part in the interviews during your work time.

Time requirements:
Interviews should take between 30 minutes to 1 hour.

Benefits:
6. Support for, or insight into theories of leadership that better support an understanding of leadership in clinical practice and thus an ability to offer support to apply leadership in clinical practice in this aged care facility.

2. Information that leads to the development of more appropriate and focused education to better support leadership development for managers and senior nurses in this aged care facility.

3. A guide may be offered into how to better support service improvement initiatives across the aged care environment studied. This will support both the participants and clients in this aged care facility.

4. The most significant outcome is the potential to develop an understanding of how leadership practices impact on staff morale, staff retention, staff satisfaction and the implementation of care practices that lead to more effective patient care.

5. The results may support the need to expand the research study and include a wider target population across a wider range of aged care facilities.

What will be done with the data?
The information you provide will be analysed and used to help the research understand more about leadership and management in the aged care sector. It will be used to produce a report for Swan Care and possibly academic publications for the wider aged care sector. As well it may be used to develop specific educational provision for nursing staff at Swan Care Group.

Ethics process:
Participation is not compulsory and you are free to withdraw from the study at any time without prejudice in any way. If you chose to withdraw you need give no reason or justification for withdrawing and any record of your being in the study will be destroyed.

Who to contact:
Approval to conduct this research has been provided by The University of Western Australia, in accordance with its ethics review and approval procedures. Any person considering participation in this research project, or agreeing to participate, may raise any questions or issues with the researchers at any time.

In addition, any person not satisfied with the response of researchers may raise ethics issues or concerns, and may make any complaints about this research project by contacting the Human Research Ethics Office at The University of Western Australia on (08) 6488 3703 or by emailing to hreo-research@uwa.edu.au

All research participants are entitled to retain a copy of any Participant Information Form and/or Participant Consent Form relating to this research project.
Thank you for your time in considering this request to be involved in this study.
Respectfully yours,
Dr D. Stanley.

NursD, MSc HS, BA (Nursing), Dip HE (Nursing), RN, RM, TF, Gerontic Cert.