

# Empowering Registered Nurses in Aged Care Teams to be Clinical Leaders

Drew Dwyer, BASS, BSN, MClInSc, MACN, QMACA, CFJBI

Doctor of Philosophy

The Joanna Briggs Institute, School of Translational Health Science, Faculty of

Health Sciences

The University of Adelaide

May 2015

## **Thesis declaration**

This work contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition I certify that no part of this work will be used in a submission in my name for any other degree or diploma in any university or any other tertiary Institution without prior approval of the University of Adelaide and, where applicable, any other partner institution responsible for the joint award of this degree.

I give my consent to this copy of my thesis, where deposited in the University Library, being made available for loan or photocopying, subject to the provisions of the Copyright Act 1968.

Signature:

Date: May 2015

# Table of contents

---

Table of contents.....	3
Acknowledgements.....	6
Abstract.....	7
Chapter 1: Introduction to the Study .....	9
1.1 Situating the Study .....	9
1.2 Background to the study: Nursing in the Australian aged care context.....	10
1.3 The concern for a focus on clinical leadership .....	12
1.4 Situating the Researcher.....	14
1.5 Structure of the dissertation.....	16
Chapter 2: The Literature Review.....	18
2.1 Introduction.....	18
2.2 Acronyms.....	19
2.3 Operational definitions.....	19
2.4 What is known by the researcher and what is leading this doctoral study.....	21
2.5 The Move Forward .....	23
2.6 The history of the role of Registered Nurses .....	27
2.7 Nursing Education as a process within the profession that establishes the roles of nurses in aged care .....	29
2.8 The role of the registered nurse today “A Global Shortage” and its effects on policy development.....	33
2.9 Registered nurses in aged care: A “Resistance and Resilience” towards policy implementation and change.....	36
2.10 Nurses and the aged care organisations, “singing from different hymn books” .....	39
2.11 The conflicting paradigms for nurses roles in aged care .....	42
2.12 The role of the RN and distress in aged care .....	43
2.13 Recruitment and retention of the registered nurse in the aged care setting: “getting the balance right” .....	47
2.14 The aged care nurse as ‘clinical leader’ or ‘manager’ or ‘both’?.....	51
2.15 Building the future “Nurse Empowerment” through clinical leadership development: The way forward.....	57
Chapter 3: Methodology.....	59
3.1 Introduction.....	59
3.2 The Research Question .....	60
3.3 Understanding the use of Quantitative Methodology.....	64
3.4 Selecting the Quantitative Methods.....	65
3.5 Understanding the use of Qualitative Methodology .....	65
3.6 Selecting the Qualitative Methods .....	67
3.7 Understanding the use of Mixed Methodology .....	68

3.8	Choosing the right 'Fit' for methodology .....	70
3.9	Study design and Methods .....	71
3.10	Study Objective and Aims:.....	72
3.11	The Hypothesis:.....	72
Study Design.....		74
3.12	Methods .....	74
3.13	Setting and sample .....	76
3.14	Administrating the groups and project plan.....	77
3.15	Phase 1: Baseline Data Collection and Survey Construction .....	80
3.16	The Survey Questions Pre Test.....	81
3.17	Phase 2: Development of the intervention (the learning and development program)	82
3.17.1	<i>Module 1: The structure and profile of the current aged care sector in Australia</i>	83
3.17.2	<i>Module 2: Understanding the Multi-Disciplinary Health Team approach to care</i>	84
3.17.3	Module 3: Maintaining effective workplace communication and environments.....	85
3.17.4	Module 4: Performance Management and Reflective Practice.....	86
3.17.5	Module 5: The key aspects of a quality framework for management and clinical practice.....	87
3.18	Phase 3: Delivery of the intervention (the learning and development program) .....	89
3.19	Phase 4: Post-intervention and qualitative data collection .....	90
3.20	Phase 5: Analysis of data and report writing.....	91
3.21	Study Timeframe: .....	92
3.22	Ethical Issues.....	93
Chapter 4: Results On Quantitative Assessment.....		95
4.1	Introduction.....	95
4.2	Demographic Data Analysis .....	95
4.3	General Survey Results .....	97
4.4	Summary .....	107
Chapter 5: Results Qualitative .....		110
5.1	Introduction.....	110
5.2	Thematic Data Analysis.....	110
5.3	Theme One: Leadership training is challenging in a positive way.....	112
5.4	Theme two: Leadership training builds confidence in the RN to lead the team. ....	114
5.5	Theme Three: Leadership training has improved the knowledge and application of clinical leadership for the nurse. ....	116
5.6	Theme Four: Team Based leadership can improve person centred care. ....	118
5.7	Theme Five: Successful clinical leadership training needs to be more supported by individuals within the organisation .....	120
5.8	Theme Six: Leadership training has a positive impact on professional development, personal growth and career retention. ....	123
5.9	Summary .....	124
Chapter 6: Results Mixed Methods .....		126
6.1	Mapping and Integrative Analysis.....	126
6.2	Finding One: Leadership Training is significant for the role identity of the RN in aged care.....	127

6.3	Finding Two: Leadership training is a positive change agent for transmutation and getting the evidence into practice. ....	129
6.4	Finding Three: Clinical leadership training should be a core principle for the organisation and valued as a key performance area.....	131
6.5	Finding Four: leadership training is essential for successful recruitment and retention and building healthy workplace environs.....	133
6.6	Discussion summary.....	134
Chapter 7: Discussion, Recommendations and Conclusion .....		137
7.1	Introduction.....	137
Industry and sector support strategy (for the future delivery of aged care) .....		138
7.2	Discussion: The aged care industry and its sector support need to collaborate towards a strategy for the future needs of the ageing population and clinical leadership through nursing. ....	138
7.3	Recommendation: .....	141
7.4	Recommendations .....	143
Organisational Implementation strategy (transforming the current workforce .....		144
7.5	Discussion: Leadership training should be a core principle for the organisation and valued as a key performance area .....	144
7.6	Recommendation: .....	146
7.7	Recommendation: .....	149
7.8	Discussion: Clinical leadership training is a positive change agent for transforming nurses and getting the evidence into practice. ....	150
7.9	Recommendation: .....	152
7.11	Conclusion.....	155
References:.....		158
APPENDIX A: Flyer for Control Group 2.....		163
APPENDIX B: Proposal Flyer for Intervention Group 1.....		164
APPENDIX C: Survey Questions.....		165
APPENDIX D: Integrated Analysis Table for Convergence.....		165

## Acknowledgements

---

I want to take this opportunity to thank the people who have motivated and guided me through the process of learning this research topic at a higher degree level and assisting me to focus on the subject and reaching the outcome of the study.

Thank you to Professor Alan Pearson and the entire JBI team. I appreciate them for providing me with their time and assisting me in finding the focus of higher degree learning over the past 8 years. Professor Alan Pearson was my principal supervisor and mentor during the preparation of this thesis. I greatly appreciate his guidance, encouragement and support. His motivation for excellence in Evidence-Based Healthcare was a driving force.

Dr Anthony Tuckett, as my associate supervisor for distance students, provided his knowledge and nursing research expertise in a timely and supportive way. He guided me in the subject knowledge and the specialised nursing focus of the topic. Without his input I would never have finished the project in time. Thank you Dr Kirsten Gibbons and Dr Jinlin Fu for your assistance and input on the statistical data analysis, as your acumen was needed in interpreting the data as it presented to me.

My special thanks to my wife Raeleen for her support in all she does to encourage the vision and passion within me that keeps the 'oil in my lamp' burning bright. Thanks to my two children, Masyn and Dane, for being patient and supportive during my long periods of time away, being separated from home life due to focusing on study.

Finally, my colleague Chris Curnow for keeping me sane and my supportive office staff who have managed things around my schedules, I thank you as well.

## Abstract

---

This Doctoral study explored the impact of structured clinical leadership training on registered nurses who hold positions as clinical leaders and managers in Residential Aged Care Facilities (formally Nursing Homes) in Australia. The aim of the study was to empower nursing workforce in Australian aged care settings through a formal clinical leadership and leadership training program that represented an intervention designed to empower participants to become care team leaders. The study followed a sequential mixed-methods design and included a pre and post-intervention survey completed by the 150 members of the intervention/study and the 150 members of the control group.

The intervention group engaged in a structured 5-module training course in clinical leadership undertaken over a period of 5 months. This group was then involved in a qualitative interview and a process of thematic analysis was used to analyse transcripts of these sessions to enhance the findings of the quantitative survey results. The results from both the quantitative and qualitative inquiry were then synthesised through integrative analysis.

The findings from this study suggest that nurses are well suited to being transformational leaders in aged care and that clinical leadership training has the capacity to empower registered nurses to become care team leaders in managing the multidisciplinary team. Clinical Leadership training gave clarity to the position of RN Team Leader and provided skills in leading the team to improved outcomes for all stakeholders.

The role of the RN in aged care is a specialised one and as such requires contextualised clinical leadership training that empowers the nurse to transact with the team and transform the care. The study findings also suggest that, if organisations respect the value of a nurse's autonomy and skills to practice, along with the valued role of the RN as the Clinical leader, then improved recruitment and retention of nurses in aged care will be achieved.

Society is changing and so too are the demands on healthcare. As the population of the world ages, there will be a fundamental shift in how we provide care and support to an increasing number of frailing individuals and their circles of influence. Nurses are instrumental for leading change and, once trained in clinical leadership, become empowered and positively disposed towards what is usually a complex and diverse care setting. Nurses and nursing care continues to hold the high ground on the values and principles of society that reflect the expectation of the profession in supporting their needs. The true value will be realised when we empower the nurses to be the change champions in clinical leadership in aged care.



# Chapter 1: Introduction to the Study

---

## 1.1 Situating the Study

*'I have an almost complete disregard of precedent, and a faith in the possibility of something better. It irritates me to be told how things have always been done. I defy the tyranny of precedent. I go for anything new that might improve the past.'*

*(Clara Barton)*

This study examines the impact of structured clinical leadership training on registered nurses who hold positions as clinical leaders and managers in Residential Aged Care Facilities (formally Nursing Homes) in Australia.

Prior to embarking on this doctoral program of study, I completed a Master of Clinical Science degree that culminated in a published comprehensive systematic review on 'The experiences of registered nurses as clinical leaders in residential aged care facilities'<sup>(1)</sup>. This systematic review identified that RNs are generally considered to be the clinical leaders in aged care work environments and that leadership is the hallmark of effective management and retention within the service. However, recruitment to this healthcare sector is low, and retention of nurses has become problematic <sup>(2)</sup>. Given that this leadership expectation was already a phenomenon being experienced globally, new research was needed to investigate what impact leadership training has on the registered nurse in the aged care setting.

I was thus interested in taking a pragmatic approach to investigating the impact of a 'transformational leadership' training program as an intervention on nurses in aged care. This interest became the driving force for this study.

## 1.2 Background to the study: Nursing in the Australian aged care context.

The role of the registered nurse (RN) in Residential Aged Care Facilities (RACF) is as complex as it is diverse, as nurses attempt to manage the individual impact of ageing and the expectations of clients and their representatives in regard to care and support needs<sup>(3)</sup>. Nurses are required to provide leadership and guidance in care planning and to delegate direct care activities to the team. As clinical leaders of multidisciplinary health teams, they provide learning and development to subordinate staff and other professional team members as well as assisting clients to make informed decisions, particularly on issues regarding treatment choices, palliative pathways and end-of-life issues<sup>(4, 5)</sup>.

The complexity of the clinical leadership role of the nurse in aged care is, however, not well known or understood. Pearson et al (2006)<sup>(6)</sup> explain that the perception of 'Best Practice' in aged care is usually achieved through the internal management systems utilised within the structure of the aged care facility, that enhance compliance to regulation and benchmark the organisation's performance against industry standards using Continuous Quality Improvement (QCI). Consequently 'Evidence Based Healthcare' as a platform for achieving 'Best Practice' in patient care is being missed. The organisation generally assumes that the health professional is already skilled and educated in the field of clinical best practice, and the opportunity to action the nurse as a vital tool in clinical leadership and transforming the care is underutilised. Nurses often report in the literature that they feel unprepared for the role as leader of the multidisciplinary care team and lack the skills necessary to meet the Key Performance Areas (KPA) of their job descriptions<sup>(1)</sup>.

Evidence suggests that the RN working in the aged care sector within Australia is often faced with personal and professional conflict. Although trained and confident in maintaining their own organisational skills when delivering direct patient care as a nurse, they are not usually the instrument doing the task in the aged care setting. This role is undertaken by an Assistant in Nursing (AIN) or a Personal Care Assistant (PCA) following the delegation and supervision from the RN. This tiered approach to the nursing workforce is largely due to the increasing numbers of elderly within the population and the decreasing numbers of nurses within the workforce. Ethically the RN still feels responsible for total patient care and believes that management do not value the complexity of their role when transforming the needed skills into a less educated and lower skilled member of the team<sup>(7)</sup>. Skills in clinical decision making and team leadership become paramount for the nurse, at the same time remaining focussed on quality management and organisational needs in productive healthy work environments. Added to this, is the discourse over compounding issues such as pay parity and continuing education for specialised skills in gerontic care and team leadership which in turn create barriers for nurses wishing to enter aged care work, and also retaining those nurses currently holding the frontline in aged care<sup>(7, 8)</sup>.

There is increasing concern within nursing peak bodies and consumer groups in relation to recruitment and retention of registered nurses in the aged care sector, as the numbers of nurses graduating decreases and the number of nurses retiring from practice increases. This demographic issue in the nursing workforce is experienced globally, however, in the Australian context replacing nurses with aged care assistants broadens the gap in clinical governance and the resulting increases in clinical risk to the care recipients and a decrease in the quality of care has been identified by the governments accreditation agency<sup>(2, 3)</sup>. Numerous studies have identified that the image of nurses working with elderly people is poor and this is reflected in the limited

focus on ageing and aged care in undergraduate nursing curricular<sup>(9)</sup>. This enigma also causes a level of frustration and concern in the management, recruitment and retention strategies for organisations hiring nurses into “age care services”, and becomes a direct deterrent for nurses who will need higher skills and advanced nursing practice to perform at a clinical leadership level<sup>(10)</sup>.

### 1.3 The concern for a focus on clinical leadership

The literature suggests that aged care, long-term care (LTC) and geriatric care environments are characterised by turbulence, complexity and increasing frustration as a global increase in the older population places pressure on the healthcare system to provide choices in services that maintain a philosophy of healthy and positive ageing<sup>(4, 13)</sup>. An increased emphasis on the clinical leadership role of the aged care registered nurse may have a positive impact on the status of registered nurses working in the sector, and in turn it may improve standards of care for the recipients<sup>(14)</sup>. The importance of leadership and in particular clinical leadership has increasingly caught the attention of service delivery agencies and researchers over the past few decades<sup>(12, 15)</sup>. Currently there are numerous aged care service organisations privately funding studies in order to develop strategies so that they can survive in the increasing diverse and changing workplace environments that are delivering care services to an ageing population requiring chronic disease management<sup>(13)</sup>.

Recruitment and retention are important elements in maintaining a healthy workplace<sup>(11)</sup>, albeit this emerging expert area of nursing practice is poorly recognised and attracts a lower pay parity with other nursing and professional roles<sup>(3, 12)</sup>, it still remains attractive to nurses who have a strong fundamental for caring for other human beings and see nursing the frail and vulnerable as their call of duty.

The literature in the Australian context demonstrates that the consumer-driven healthcare is the new domain for an ageing population in Australia as aged care reform evolves out of government directives driven by the consumer groups and Medicare becomes the largest consumer of public health services. With the new reform comes an increasing call for innovation and leadership to steer the aged care ship through the storm of change.

A number of systematic reviews and literature reviews have investigated the impact of leadership and management on staff experience in the healthcare services sector,<sup>(4, 16)</sup> as well as in the aged care context<sup>(15, 17)</sup>. These experiences have included staff turn-over patterns, staff members' decisions to leave or continue working in this care environment, and the impact of workforce movements on the quality of outcomes of residential care. Moiden (2002)<sup>(13)</sup> claims that clinical leadership is generally acknowledged as being context-specific, which in itself provides challenges to care homes as they are heavily bureaucratic and over-regulated. Clinical leadership within the residential aged care home will depend on the leadership style of the individuals in charge at specific times. Although well understood as a key performance indicator for the care organisation and its management, clinical leadership skills are not structured into the training of the registered nurse, and particularly not as a specialised skill for nurses transitioning into aged care services. It is more the case that the nurse is expected to be the leader of a team of care workers, and manage the assessment of care, care planning and ongoing review as only part of their Key Performance Area (KPA) within their given roles. Although registered health professionals are experienced in dealing with people, it is debatable that nurses in aged care settings are well prepared for the role and responsibility of care leadership and management. As a clinical leader and educator, it was important for this doctoral study to provide

new research in clinical leadership of the registered nurse in aged care and recommend a tentative model for reaching best practice.

## 1.4 Situating the Researcher

My background originates in nursing where I undertook entry to hospital-based general nursing at a young age. Nearing the completion of the standard three-year training in the Rydalmere Psychogeriatric Hospital in Sydney, I was recruited by what was then known as the 'Caravan of Courage' into the Australian Defence Force Royal Australian Army Nursing Corps (RAANC) to continue my career as a military nurse on the promise of better pay, better conditions, world travel, and the motto 'Be all you can be.....Be Army'. This journey was one filled with excitement, empowerment, discipline and leadership training. Given that military nursing is quite different from most civilian-streamed nursing, I eventually transitioned into the Royal Australian Army Medical Corps (RAAMC) and undertook training in Emergency Management of Surgical Trauma (EMST), Advanced Paramedical level 5 training, and Aviation Medical Evacuation (AME) physiology. My 15 years of service enabled me to work in numerous multidisciplinary, international and multi-level nursing environments, including active service within the United Nations and deployment on overseas humanitarian and military active service missions. My personal passion for providing quality care also enabled me to hold a civilian part time role, usually as an agency nurse and nearly always in a nursing home, when absent from military duties.

Personal growth and professional development eventually compelled me to return to Australia as a husband and father undertaking transition into a civilian nursing role. This transition was perhaps one of the hardest, both personally and professionally, in my life, as re-entry to nursing in Australia had changed considerably and the nursing boards were in the midst of reform.

Much to my surprise, my years of military nursing and medical skills training were not understood nor highly regarded by the registration board's criteria, and I was eventually provided registration as an Enrolled Nurse and placed into the pathway of a university degree transition program.

Working within nursing homes to maintain a family and complete full time studies was challenging enough without the personal and professional confrontation and struggle to work within institutionalised care environments alongside nurses who appeared to be poorly motivated and under heavy demands from disgruntled care staff and patient families. Utilising my experience and motivation to lead change and challenge the status quo, I began to put forward my ideas within the workplace. I was usually met with strong resistance and noticed negativity from colleague nurses, management and the university facilitators of my program at the time. What was well known to me to be a case of enhancing the leadership skills amongst the nurses was, in their view, culturally adverse and inimical to nursing. I remember thinking 'Florence Nightingale would turn this opportunity into a platform for leadership and change', and so I would attempt to do the same.

The conflict I was experiencing was a clear indicator for me to drive and motivate a change in professional nursing that would promote good leadership in all nurses that work in aged care. Achieving this required a parallel move out of nursing and a direct focus of my studies on understanding culture and organisational development. I realised that to change nursing you have to leave nursing and take the objective stance from the outside looking in.

With the support of my wife, who was also ex-military and now a successful business woman, I removed myself from the nursing transition program, and took up a Bachelor

of Applied Social Sciences, focusing on the role of nursing in aged care, and specifically on the skills sets required of registered nurses to perform their duties. Looking back on this decision, it was my wife who provided me with the cornerstone to becoming a Gerontologist, undertaking new research in aged care and establishing the current consultancy and training college business we both lead today. This pathway was new and exciting, and it complimented my passion for leading change, and the journey after completion enabled me to open doorways into the new world of Evidence Based Healthcare. This journey of discovery was to continue into a Clinical Fellowship Program with the Joanna Briggs Institute and a Higher Degree by Research (HDR) through the completion of a Master of Clinical Science. The Master degree study identified new opportunities in primary research, and ignited this doctoral journey. Some might say that my journey is coming to an end with the completion of this study and writing the dissertation, however I see it as the beginning in specialised aged care and clinical leadership. Sixteen years later, I am now more optimistic about the role of the nurse in aged care than ever before, as this research has helped me to understand what I did not know, and showed me that there is still much more to learn.

## 1.5 Structure of the dissertation

This dissertation comprises seven chapters:

- Chapter 1 presents the introduction to the study and its aims and objectives, including situating the researcher and an overview of this dissertation.
- Chapter 2, the Literature Review, presents the overview of literature that supports the concepts that are key to this study and includes the history of nursing, the education of nurses, the role of registered nurses in aged care and the issues of leadership and management among nurses generally and in aged care.



- Chapter 3, Hypothesis and Methodology, sets out the philosophical, theoretical and methodologies that underpin the study.
- Chapter 4, Results Quantitative presents the quantitative research results and main findings.
- Chapter 5, Results Qualitative, presents the qualitative research results using a thematic analysis of data and presenting six themes as findings.
- Chapter 6, Results Mixed Methods, presents the mixed methods results.
- The final chapter, Chapter 7, is an overall discussion of findings including the recommendations for nursing practice in aged care presented as a tentative model for clinical leadership, and the conclusion.

## Chapter 2: The Literature Review

---

### 2.1 Introduction

*'Nursing is an art: and if it is to be made an art, it requires an exclusive devotion as hard a preparation, as any painter's or sculptor's work; for what is the having to do with dead canvas or dead marble, compared with having to do with the living body, the temple of God's spirit? It is one of the Fine Arts: I had almost said, the finest of Fine Arts'*

*(Florence Nightingale)*

Chapter One has explained the background to this research study and highlighted the need for new primary research on this particular topic of clinical leadership for the registered nurse in aged care environments. The chapter has situated the researcher and the structure of the following chapters in the thesis.

This chapter provides an outline of the literature review undertaken in the course of this research study. It explains the general terms used that describe nursing as a profession and further more situating nursing and the nursing care of the elderly both globally and in Australia. The review has been undertaken to provide an understanding of the journey that nursing has taken to establish the nurse's role in aged care today. It provides explanation to the discourse being experienced in the aged care industry in relation to the role of nursing and the expectation of aged care industry, and what is known in regards to the current lived experiences of nurses as they struggle to find autonomy and recognition as health professionals in a specialised field of work. The intention of this chapter is to provide the scientific rationale for undertaking this primary research project.

## 2.2 Acronyms

Throughout this thesis there are a number of acronyms used that will be explained in full wording first with bracketed acronym placed after. The term 'Nurse' is used in numerous ways throughout the literature, many terms are understood to be universal, however within the context of this body of work, the term 'Nurse' will be used to describe a licenced or registered nurse who holds a qualification that allows registration or licensure to a nursing regulatory board at the senior level of Registered Nurse (Div1) or (RN) reflecting a three year degree qualification in Australia and Registered Nurse (Div2) or (EN) reflecting a Diploma of Nursing qualification. The term 'aged care' is used to describe the setting that nurses provide care to older people, and can reflect residential (formally a nursing home) or community settings such as a private dwelling or respite centres.

## 2.3 Operational definitions

For the purpose of this study, the participants, their roles and care environments are defined and characterised using terms that best describe these things according to the common understandings internationally and in the Australian context. The following terms were applied to the diversity of nursing and care settings:

### 1. *Registered Nurse (RN) and Enrolled Nurse (EN)*

A nurse who holds a professional registration by a governing body, who, after completing extensive training and passing a state examination, is qualified to perform complete nursing services<sup>(18)</sup>.

## 2. *Nurse Leader*

A registered nurse (as defined) and a nurse who is considered a leader of nurses — a person or thing that leads; directing, commanding, or guiding head, as of a group or activity<sup>(18)</sup>.

## 3. *Leadership roles*

Roles in the working environment that have specific Key Performance Indicators (KPI) for leadership, delegation and accountability of and for junior staff and peer groups<sup>(18)</sup>.

## 4. *Management roles*

Roles in the care working environment that have specific Key Performance Indicators (KPI) or Key Performance Areas (KPA) for the management of resources, staff, organisational capability, policy and procedure and including performance management. The act, art or manner of managing, or handling, controlling, directing, etc.<sup>(18)</sup>.

## 5. *Residential aged care facility (RACF)*

A facility that provides care service and assisted living to older people residing in it (i.e. aged care home; nursing home; nursing home for the aged; hostel for the aged; residential aged care home)<sup>(18)</sup>. It includes the following:

- Long term residential care home
- Community homes
- Shared care house

## 6. *Multi-Disciplinary Health Team*

A multidisciplinary health team consists of three or more qualified health team professionals (i.e. Doctor, Nurse, Physiotherapist), that collaborate between

each other for the delivery of multiple services to an individual consumer that is care team managed<sup>(19)</sup>.

#### *7. Community and Home Care:*

Services provided by a private or charitable professional care organisation, such as home healthcare, personal care, adult day care, respite care, and assisted living services, Consumer Directed Care programs provided into private dwellings to all people of all needs<sup>(20)</sup>.

### **2.4 What is known by the researcher and what is leading this doctoral study**

In 2011/12, I conducted a Comprehensive Systematic Review (CSR) as part of the requirements for the degree of Master in Clinical Science (Evidence Based Healthcare). The objective of this review was to critically appraise, synthesise and present the best available evidence on the experiences of registered nurses as clinical leaders and managers in residential aged care facilities. Given that a CSR is considered 'Gold Standard' secondary research, it naturally establishes the foundations for new primary research and was a solid start to this research journey.

The body of work published in the comprehensive systematic review made the following recommendations based on the meta-syntheses conducted at the time:

Employers and policy-makers should be aware that nurses in aged care and geriatrics have a strong motivation to work in the aged care sector and want to be valued by the community. (Level I Evidence)

Educational pathways and programs are needed to improve the professional practice and continuous development of nurses with clinical and leadership skills. (Level I Evidence)

Aged care providers and healthcare policy-makers should understand that aged care and geriatrics is a specialised area of healthcare warranting its own recognition in professional practice. (Level I Evidence)

Organisational barriers need to be reviewed and policy implementation improved in order to promote a healthy workplace environment, support continuous improvement, promote clinical governance and improve care outcomes. (Level I Evidence)

Providing positive and healthy workplace environments that concentrate on skills development in clinical leadership and governance improves the workforce's productivity and holistic environment. (Level I Evidence)

From this systematic review, it was suggested that further research needed to be undertaken to validate the recommendations and take action to have a positive impact on the industry and to produce a tentative model of clinical leadership for registered nurses in aged care.

This research study will identify and measure the impact and outcome of specialised RN clinical leadership education on individuals and their working environments in residential aged care homes. This platform of scientific investigation is the validation for undertaking this research as part of my Doctoral studies.

## 2.5 The Move Forward

*‘Unless we are making progress in our nursing every year, every month, every week, take my word for it we are going back’*

*(Florence Nightingale)*

The literature included in this thesis was chosen through a set of search boundaries to separate the clinical leadership and management issues impacting on the Multi-Disciplinary Health Team (MDHT) approach being undertaken in the aged care sector. A defined focus on nurses in aged care for the literature review was established from those of other health disciplines that are publishing in the aged care literature. In today’s Australian healthcare environment, aged care is the fastest growing health service of concern to government and community leaders. Professional nurses are considered the clinical leaders in contemporary aged care work, and are driven by the principals of Evidence Based Practice (EBP) and the fundamentals of nursing care<sup>(1, 17)</sup> that provide the foundations for successful and healthy ageing and the premise of a ‘good death’ for care recipients as they enter the end stages of life.

The boundaries for researching this literature review were set by the following factors:

1. Previous work undertaken conducting the Comprehensive Systematic Review (CSR) contained in my masters study to be included<sup>(1)</sup>;
2. Investigation around the hypothesis and rationale of this research study; and
3. Utilising the keywords search words as:
  - “leadership”, “management”, “Nursing Homes”, “Residential Facilities”, “Long-term care facilities”, “Nurse”, “registered nurse”, “experience”, “perception” “education” “Recruitment” and “Retention”;

- clinical leadership, leadership, management, nurse management, care management, multidisciplinary, nurse leader, contemporary nursing, geriatrics; and
- methodology, nursing, philosophical inquiry, philosophy, and theory.

It was decided to streamline the database searches to reduce the time spent. Investigating three main subjects such as nursing education, nursing, and clinical leadership or management, produced preliminary search results that were large in number and diverse in content.

Numerous papers, books and articles were searched for, utilising the standard academic search engines available such as PubMed, Scopus, MEDLINE, and CINAHL. Extensive searching identified interesting material and evidence, consisting of peer reviewed journals, grey literature, popular print media, and digital theses. The Joanna Briggs library contained numerous and relevant comprehensive systematic reviews.

Four search outcome subject lines were chosen for smart grouping of the literature for their alignment to the PICO and development of the research questions and outlined as subject headings within this chapter 2: The literature review.

1. The history and role of the Registered Nurse and in aged care settings.
2. Nursing Education as a process within the profession that establishes the role of nurses.
3. Nursing Leadership and Management in aged care: a recruitment and retention strategy: what is currently known?
4. Building the future “Nurse Empowerment” through leadership development: The way forward.



Literature was included from the Australian Department of Health and the Australian national peak bodies of aged care that have been established during an industry reform in Australia over the past 5 years<sup>(21)</sup>. The trawl identified popular authors that have a known continuum in publications within the aged care sector of health and outline particular issues in current debate around Multi-Disciplinary Healthcare Management (MDHCM), Evidence Based Practice (EBP) and nursing leadership. Nursing leadership institutes in the USA had high publication rates in leadership for nursing managers and described set competencies in this field, as they have been experiencing the impacts of an ageing population and its protracted effects on geriatric nursing services for some time. The literature selected for this study was also undertaken to explore the subject of skill sets for Multi-Disciplinary Healthcare Managers (MDHTM) in Residential Aged Care Facilities (RACF) as the subject for hypothesis was on the impact of education.

This literature review examined the role of the Registered Nurse (RN) in residential and community aged care settings, which are multidisciplinary and heavily bureaucratic in general, including a focus on Australian residential aged care facilities (formally nursing homes) and the experiences of those nurses in carrying out their duties. The literature in this topic is extensive and also distinctly fragmented by the individual nursing roles that include a scope of practice in aged or long term care. Academics from multiple health disciplines are experiencing the same issues within the ageing population and healthcare service delivery and appear to be publishing much discourse and opinion papers. This drive for academics to write extensively in regards to multidisciplinary healthcare approaches is being drawn from:

1. The current philosophy in the Australian government to fund research from a platform of evidence based practice to collaborate services, to encourage the integration of the Medicare Enhanced Primary Care Program or MEPCP as it

moves to the reformed Chronic Disease Management (CDM) model under Medicare<sup>(22)</sup>.

2. A definite increase in employee frustration and dissatisfaction in the workplace<sup>(23)</sup>.
3. Changing roles in nursing practice, policy and ethics and its impact on the ageing population <sup>(9, 24)</sup>.

The published literature presents a cultural understanding within aged care work that frontline management of care services is a Key Performance Area (KPA) for the registered nurse holding the role of aged care team leader, as service-level staff under their guidance play a significant role in progressing change as a result of new opportunities which emerge at the service level<sup>(25)</sup>. Registered nurses are presented throughout the literature as being better connected to the service delivery level staff and are therefore better positioned to identify the activities necessary to ensure successful implementation and application of healthcare policy directives at this level of care on a daily basis. Having nurses that specialise in aged care settings, and the recruitment and retention of nurses in aged care are key recommendations from the body of knowledge examined.

Reading through the extent of literature it was evident that a gap in the knowledge of aged care nursing was appearing. The gap in the literature was identified as “knowledge needed” for developing the confidence and ability among nurses to make clinical leadership decisions using evidence based healthcare through the continuing education of nurses and subordinate care staff, in order to reach and maintain “best practice”. It was important for this study to also examine the history of nursing and to understand the journey of the nursing profession in order to narrow down the objectives of providing a new tentative model of clinical leadership in aged care nursing, which filled the skills gap and provided confidence in practice for the nurse and the

organisation. The profession of nursing has come a long way, and its history is rich with examples of how nurses have moved with, changed with and, have been great leaders of our times.

## 2.6 The history of the role of Registered Nurses

The history of nursing is well established within the extent of literature, incorporating the beginning of nursing which occurred during the breaking up of the Roman Empire. This breakup saw the emergence of Christianity, and new social reform opened up the legitimacy for service to the frail and vulnerable in regards to the Christian devotion to health and welfare<sup>(26)</sup>. Charitable care service has been in existence since 650 AD, through Christian-based nursing orders established in Europe. These orders of nurses eventually saw the implementation of formal nursing services in 1836 with the establishment of a nursing school for Deaconesses, in Germany, after the protestant reformation of Europe. The creation of early nursing education schools began with a formal three year standard of study, lectured by physicians with a core focus in medical science. This approach had begun the profession of nursing, as nursing history demonstrates, it was taking its lead through the eyes of Florence Nightingale's work<sup>(27)</sup>.

The era of the Nightingale nurse produced education standards and nursing schools across Europe and America. Nursing theorists emerged in numbers, making significant contributions to science and society, establishing a medium for feminist theory to nurture and grow<sup>(28)</sup>. Nursing theory was at the time based on the early works of Nightingale (Notes on Nursing 1859) that produced the Nightingale concepts:

1. Person
  - Patient who is acted on by nurse,
  - Affected by environment,

- Has reparative powers.
2. Environment
    - Foundation of theory. Included everything, physical, psychological, and social.
  3. Health
    - Maintaining well-being by using a person's powers,
    - Maintained by control of environment.
  4. Nursing
    - Provided fresh air, warmth, cleanliness, and good diet, quiet to facilitate person's reparative process.

These Nightingale concepts paved the way for future nursing theorists such as Dorothy Dix, Linda Richards, and Vivian Bullwinkel, who individually drove a mission for an evolution in nursing, which is still seen today. As nursing was evolving into a profession, so too were the expectations of society. Legislative guidelines and the regulation of professionals were key aspects of quality assurance and performance for the community in holding health professionals accountable for their actions. Nursing eventually took the inevitable pathway following the leadership within medicine, and created its own legal frameworks and registration standards for licensure to practice.

Nursing roles over time have become internationally acceptable in common society, as the expectations of a professional registered nurse have been established<sup>(26)</sup>. Nursing and society have held each other's hands through historical change and diversity. As society has changed, education standards have improved and technology increased, so too has the profession and education of nursing changed. Registered nursing today is rich with diversity and expertise, as we find nurses and nursing having an impact in all walks of society and specialising in many domains of healthcare.

## 2.7 Nursing Education as a process within the profession that establishes the roles of nurses in aged care

A subject of discussion that never fails to receive lively debate and some discourse within the profession, is the education of nurses. Since the beginning of nursing there has been the debate on what it is that a nurse should know in order for them to carry out their duties. Nightingale was a pioneer in three-year hospital-based learning environments for developing the nursing frameworks and the development of the profession. This educational framework created an acceptance from the medical profession that identifies and respects nursing and its contribution to medicine <sup>(26-28)</sup>. Once established as professionals, the nursing fraternity began driving education reform and eventually changed the learning platform from hospital trained nurses to formal three year degree qualification conducted in a university education system. Over time, this has created a tiered ranking system in the profession, one that is flexible and different internationally. In Australia, the common tiers seen are Degree-qualified and Hospital-trained registered nurse (RN), Diploma- or college-qualified RN/ Enrolled Nurse (EN) who are both able to hold a licence with the Australian Health Professionals Regulation Authority (AHPRA)<sup>(29)</sup>, and the certificate qualified Assistant in Nursing (AIN) who works under the daily delegation and supervision of licenced nurses<sup>(30)</sup>.

Contemporary academic nursing qualifications begin at Graduate Certificate or Graduate Diploma, and move up into higher degree by research or coursework, a Master's Degree in a nursing subject, or Doctor of Philosophy (PhD) in nursing. Nurses and nursing education in Australia are now regulated and formalised by a specific professional board known as the Australian Health Practitioner Regulation Agency (AHPRA). The standards of nursing and nursing education are advised to the board by the Australian Nursing and Midwifery Accreditation Council (ANMAC). This council also sits as a collaborating member with the International Council of Nursing (ICN) to set

international standards in nursing globally<sup>(31)</sup>. Although there are many hospital-based qualified nurses' still holding registration and licensure, the current standard of education for a registered nurse is the completion of a recognised university or college course that will allow registration in either one of two tiers with the AHPRA as mentioned above and outlined in the operational definitions.

A critical review of issues surrounding nursing education and training in aged care, and the current nursing shortages faced in the Australian aged care sector is presented clearly by Pearson and colleagues in their 2001 critical review of education, recruitment and retention of aged care settings in Australia<sup>(12)</sup>. On the basis of observational and descriptive studies addressing the issues in residential and community-based aged care, both in Australia and overseas, this review examined and recognised the best available information on concerns surrounding training and education for nurses who were either studying to work in, or were currently working in aged care. However, this review was not designed to focus on the RN as a leader in the aged care sector or the experiences of those nurses in their roles. The authors indicated that recruitment and retention were issues of concern, and that nurse clinical leadership was lacking within nursing workplaces.

The review recommended that further research is needed into leadership styles, and into learning and development for nurses in general, particularly in the aged care sector of healthcare, in order to improve the workforce overall.

Throughout the literature there is a common language used to justify the education and identify the position of nurses within the clinical setting. Nurses are used in diverse healthcare environments and must collaborate interdisciplinary or work autonomously for better outcomes for their clients <sup>(32)</sup>. Essentially, this use of language becomes grounded in the subculture of nursing, and has become essential knowledge for

undergraduate nurses to prepare themselves with the skills to 'collaborate' within the Multidisciplinary Health Team philosophy during clinical placement or practical learning and for their future career uptakes within the profession.

Collaboration is a concept and philosophy that has been used in health circles to improve health outcomes for people with chronic and complex health issues and is the most commonly cited concept in healthcare policy today <sup>(33)</sup>. A number of different terms are used to describe collaboration with the main ones being *Interdisciplinary Case Management*, *Multidisciplinary Case Conferencing*, and *Integrated Care* <sup>(25, 33)</sup>. The terms are used interchangeably between programs and, at times, within the same programs. The Case Conference framework is identified as a good vehicle for 'real time' education and provides a good opportunity for health professionals to become better acquainted with each other, assisting the development of a team-based approach to service provision and utilising scenario based learning environments to which nursing and medicine are familiar with. The role of the nurse is situational to the position they hold within the collaborating team and aligned with the expectation their skills bring to that team at the time <sup>(34)</sup>.

Nurses are regularly referred to as being transformational leaders within the care teams they collaborate with and share nursing care values across the different domains.

In general, it was useful to see that common issues do exist within the literature, providing a strong baseline and framework for implementing Multidisciplinary Case Management which is currently contemporary practice in the aged care sector by executive level managers<sup>(33)</sup>. This framework, suggested by Coombs<sup>(33, 35)</sup> is built on the following key recommendations, which form the guiding principles for collaboration

in the Residential Aged Care Facility (RACF) as outlined in the body of knowledge that was reviewed.

1. A concise definition for Multidisciplinary Case Management and clear roles for all participants be determined.
2. A concise tool to better coordinate collaboration, that is, the case conference template is developed to support the conference process.
3. An education program for participants outlining the purpose of collaboration and how it is implemented is developed and this be supported by ongoing development of service level managers in how to better respond to the challenges within their external environment.
4. A performance framework for the measurement of program outcomes that measure improvements in health of the recipient of care be established.
5. A committee or working group committed to program implementation and program evaluation with representation from GPs, RACF staff, the Health Insurance Commission and consumers is developed.

There was a lack of strong empirical data within the literature identifying the level of skill required to manage such a team in measurable terms.

This may very well be the result of there being no consensual definition for collaboration, or of confusion in this area for what a nurse does in collaboration. Evidence suggests it can be due to the differing perceptions of what collaboration may mean to professionals from differing disciplines that may use different terms to describe collaboration (Taylor cited in Coombs, 2004)<sup>(33)</sup>. The absence of clear performance indicators to measure benefits of collaboration may point to agendas not concerned with improving health outcomes for the recipients of care but more in response to politics and the need to rationalise service provision by individual



disciplines and healthcare organisations. Nurses are reported as having difficulty with the difference between the values they hold for care of the human being, against those of the organisation and service to meet the bottom line in the cost of delivering the care.

The diversity of contemporary nursing has now opened up different professional areas of practice in which nurses can specialise as clinicians or senior managers in specific healthcare fields such as obstetrics nursing, paediatric nursing, mental health nursing and in some countries geriatrics or gerontic nursing as subspecialties <sup>(36)</sup>. Apart from the standard bedside nursing application in practice, nurses are able to take up executive power roles in management teams, adapt to an academic life in research and education, or transition to Nurse Practitioner (NP) where nurses operate independently as a practitioner, with skills in clinical and medical diagnosis, and hold prescribing rights to medications. Broadening the diversity has not only given choice to professional nurses, it has also elevated the nurse from the traditional bedside role.

## 2.8 The role of the registered nurse today “A Global Shortage” and its effects on policy development

Registered nursing today is a global profession. Although the regulation of nurses differs from continent to continent, it is a profession that is subject to the push and pull factors that result from the changes in society. These factors include an ageing population which will influence the immigration of nurses to look for work in more affluent countries that offer better wages and conditions<sup>(37)</sup> and the ageing nurse population itself that is at risk of losing a majority of its own workforce as it ages within its professional domain. The literature is filled with discussion on the contributing factors affecting the global shortage of nurses. The International Council of Nursing (ICN) <sup>(31)</sup>, in collaboration with the World Health Organisation (WHO), has recently

conducted research that identifies five themes influencing the global shortage of nurses:

1. Policy and practice improvement;
2. Economic funding to address the crisis;
3. Retention and recruitment, including the migration of nurses;
4. Leadership in nursing; and
5. Workforce planning<sup>(38)</sup>.

Policy and practice issues are in need of improvement as society changes and the global economy has its peaks and troughs. Countries that offer nursing education in English such as Ghana, Pakistan, India, and the Philippines suffer problematic economy of scale issues associated with the push and pull factors of immigrating nurses<sup>(38)</sup>. The experienced shortage is due to the migration of nurses towards developing countries where the pay and conditions are an improvement on their current lifestyles.

As the number of nurses who are retiring rises and the number of nurses who graduate from degree qualifications falls<sup>(39)</sup>, the need for nurses globally is increasing and creating a pull factor away from lower socio economical countries.

One example is the European Union (EU) with nurses now having the ability to transfer registration to another country through meeting the correct combination of immigration standards and holding a nursing licence or registration to practice. These nurses are currently filling the void of the nursing shortages in countries such as America and Australia and are part of what is referred to as the 'scramble'<sup>(39)</sup> for nurses as they are seen more and more as a commodity and an expendable workforce, particularly in aged and long term care populations. This factor supports the view that nurses as a profession are also underpaid as a collective professional, and are not paid at a rate

that is considered to be on a par with other healthcare professionals or qualified occupations such as teachers and lawyers. Notwithstanding this, the shortage of nurses has been at a global crisis point since 2002<sup>(38)</sup>.

An American study<sup>(40)</sup> reinforced the findings of the ICN and WHO in that it discussed the contributing factors to the nursing shortage in the country as being:

1. The migration of nurses globally;
2. The poor image of nursing;
3. The changing work environment of nursing;
4. The ageing RN population; and
5. The reduced numbers of new intakes to the profession <sup>(31, 38, 40)</sup>.

In Australia, the Australian Health Practitioners Regulation Authority (AHPRA) has implemented the Australian Nursing & Midwife Councils (ANMC) standards for the immigration of the Overseas Trained Nurse (OTN) so that they are able to meet the competency standards to practice <sup>(30, 37, 40)</sup>. On arrival to Australia, the candidate is subjected to proof of currency to practice against the standards which include a competency in the International English Language Testing System (IELTS) set to the standards of university exit levels for the Bachelor of Nursing for the Registered Nurse or College diploma standards for the Enrolled Nurse. Should the candidate fail to meet the standards, the candidate has options to enrol and complete contemporary bridging courses in order to meet the requirements to register to practice within Australia.

Currently, this process is used to streamline the profession and to categorise nurses as Registered General Nurse, Registered Midwife or Nurse Practitioner, however no formal recognition to the subspecialty of geriatric or gerontic nursing is available. This utilisation of both post graduate and overseas trained nurses appears to be filling the shortfall of registered nurses needed to operate long term care and residential aged

care facilities in Australia as they grow in demand simultaneously with the ageing population crisis. Evidence based healthcare and policy is changing rapidly in order to keep up with society's needs, and the specialisation of geriatric or gerontic care is on the reform agenda.

## 2.9 Registered nurses in aged care: A “Resistance and Resilience” towards policy implementation and change

Prior to 1950 Geriatric nursing had not been pre-dominantly identified within the medical or nursing literature, although the care of elderly has been part of practice since the 1800s through the development of alms-houses that were society's answer to institutionalising all marginalised peoples together in one house. Although many of the nursing specialities have been birthed from the ideas and concepts of medicine, geriatric nursing emerged from the USA and the UK with the acknowledgment that caring for the frail and vulnerable elderly was the role of the nurse.<sup>(36)</sup> Subsequently the nursing home was established to care for the specific needs of the older adult, and professional nurses focusing on providing a “good death” and end of life care emerged as forerunners in the new reforms of nursing and society.

Unlike the USA and the UK, geriatric and gerontic nursing is not yet formally recognised as a specialisation within Australia, as the general nurse is regarded as being suitable to work in a number of healthcare settings.

It is obvious when reading through the pages of qualitative research outcomes and published works, that senior nurses have found ground in their own career retirement strategy and take up leadership roles within the aged care setting, as they are presumed to have lifelong professional skills to offer the care organisation. Academic nurses are direct in their statements claiming that gerontic nursing is a specialised field,

and the role of the specialised gerontic nurse requires establishment to enable pathways for nurses to become Gerontic nurse leaders or Geriatric Nurse Practitioner (GPN) is regularly recommended, yet this knowledge has not been transformed into practice, as fewer graduates are focused on aged care as a career beginning, and education pathways are not established.

In an Australian context of successful population ageing, there are different care settings available to the elderly population to live with assistance, advice and support as society demands a blending of the 'medical model' with the 'social model' of healthcare to allow a holistic approach and choice driven by the consumer. Independence to remain living at home with supportive services directed by the consumer is the current government philosophy known as Consumer Directed Care (CDC)<sup>(41, 42)</sup>.

The CDC model is well established in America and the UK and is slowly replacing the generic model of community care in Australia, where the registered nurses' roles can be specialised to provide direct clinical care and reporting, case management and care services deployment<sup>(42)</sup>. Other Australians may opt for residential retirement living (over 55s and retirement villages) and receive flexible support to remain independent within their own dwelling, at the same time utilising the CDC model. Although the philosophy for home care support is strong, the sick, frail, and vulnerable may find themselves living in a nursing home or Residential Aged Care Facility (RACF), where there is 24 hour per day assisted nursing care, with registered nurses in charge and supervising the services.

This tiered, flexible, blending of social and medical models for care settings or long term care environments is similar to that found in 1<sup>st</sup> world countries around the globe that are facing complex issues with supporting ageing populations. The role of the

registered nurse in a long term care setting or Residential Aged Care Facility (formally a nursing home) is filled with complex scenarios and diversity within the delivery of service<sup>(3)</sup>. The contemporary registered nurse today is usually found in a clinical leadership role within a healthcare team, or autonomously working in the community with interdisciplinary collaboration utilised through a social worker, case manager or a community care coordinator. In general, the RN is identified as the clinical leader of the care team on shift or the link nurse for specific case management and coordination and clinical directorship in care needs <sup>(43-45)</sup>.

The literature has painted a global representation of nursing, much like a collage. Stories expound a broad range of experiences for nurses working in aged care settings and one that reflects practice in Australia clearly, almost in 3D, if books could allow it.

Colourful descriptions of diverse role delineations and job descriptions for nursing in geriatric or long term care tell the story of what it takes to provide quality care to the most frail and vulnerable in our society, keeping them independent and empowered and at the same time safe and secure with clinical governance in place. In residential care homes (formally nursing homes), the registered nurse is placed in the leader's role to manage the care team on different shifts over twenty four hours a day, seven days a week, and clinically leading a multidisciplinary team. This role has been established to transition the care recipients, who traditionally enter the care home at a 'low care' state of wellness and then care managed into a 'high care' or the palliative stage for end of life.

As society has changed and age care reform has taken hold of the industry, demand for services is being directed into the consumer's private home <sup>(9, 13, 20)</sup>. This reform change still requires the leadership of the registered nurse to conduct clinical and care assessment for collaborating the care service to the individual and at the same time

providing quality auditing and case management. Care service providers offer services to recipients across all domains of living and utilise the registered nurse across the services in different ways.

Practicing here also are those nurses who are acting independently in the community and in remote rural areas, and are providing or coordinating multidisciplinary care services within recipients' homes, day respite centres, or assisted living for the disabled <sup>(32, 46, 47)</sup>. The lived experience of the nurses who have the role of team leader in these care settings is often described in negative terms with moments of paradoxical feeling appreciated by some and not others for the work they do, yet they remain stoic and loyal to nursing care for the elderly and vulnerable. This core value of nurses is understood by nurses to be the foundation to professional practice and nursing ethics, however not jointly recognised by the organisations they work for.

Being nursing's newest or youngest specialised area of practice, Schwab (1973, cited in Eborlsole & Touhy 2006) stated that care for the elderly demands the mix of the best skills that nursing can offer, yet it is considered the lowest rung of the professional nurse<sup>(36)</sup>.

## 2.10 Nurses and the aged care organisations, “singing from different hymn books”

Much of the discourse published within the aged care domain is also representative of the organisational impacts and key performances such as timelines, budgets, culture, and the identified lack of leadership skills in general <sup>(3, 9, 12, 48, 49)</sup>.

Although not difficult to find literature that adopts a negative view of the current philosophy of care to the elderly, it does exist more evidently in the context of role definition for the nurse and accountability for patient care outcomes as the

multidisciplinary healthcare reform takes shape. In general the nurse is seeing the role in care leadership differently from that of the employing provider and policy maker. Feelings of 'a lack of appreciation' experienced by nurses are based on the lack of recognition for clinical nursing knowledge and feelings that utilising results and tabulated data from multiple sources to create care management plans is not being valued as much as organisational compliance and management goals (1, 10, 47).

Aged care nurses express that they are overworked and underpaid, yet remain true to the call that is the foundation of nursing and resistant to the calls for change. Aroskar, Moldow, Good, (2004) (24) used a series of qualitative focus groups with registered nurses across mixed areas with the same age medium and length of service. This piece of work outlines the determination of some nurses who maintain stoic attitudes toward the traditions in the practice of nursing, and resistant to the changing roles being established in today's healthcare settings.

This underpinning culture is a cause of conflict for the registered nurses within aged care, who are increasingly under pressure to deliver services based on the heavy regulatory compliance overarching the industry including the individual client's particular healthcare needs and meeting the ethical and legal obligations as a nurse. Providing complex care correctly and to a standard that is evidence based and reflects best practice is adding pressure to follow the budgetary requirement or "meeting the bottom line" for the business of care delivery, and the two are in conflict and not singing from the same hymn book (24).

Overall, the general literature outlines a universal thread, where nurses' experiences seem to generate an abundance of negative themes while working in the aged care setting, however, the positive experiences were also well established in more balanced arguments of literature and systematic reviews. One key finding that was familiar



throughout the literature is that nurses working with frail and elderly clients have a strong motivation to work in aged care and strive to improve things for each individual client (1, 48, 50, 51). This positive finding resonates strongly in nurses who have the stoic traditional core values and fundamental principles of nursing, depicted as a service to the sick and needy. It is also the driver for organisational recruitment of nurses to work in aged care.

Nurses in aged care regularly experience feelings of being valued at different times by different people under their care, and also by other team members during practice in aged care settings (49), however, experience quite the opposite appreciation from senior management. This paradox is usually linked to a value conflict for the nurse, as the specialised role they hold is not considered known or appreciated by the senior managers in the organisation or by the direct care workers on the frontline under their supervision and delegation.

Much of the conflict described in the literature is focussed on the distinctness of values between nurses and the service organisations. There is a definite dissimilarity between how the nurse views their role as to that of how the management views their role. Venturato<sup>(21)</sup> identifies this as the nurse is looking for traditional value and recognition that would normally have been given by the recipient of direct care from the nurse. Today the nurse's role varies and nursing care is usually delegated by the nurse to team members within a complex and multidiscipline care environment, where the values of nursing and the values of care management are not shared or in sync.

The value of nursing for the organisation is seen as a commodity of need to the service compliance and care management and therefore devalues the skill and practice for the nurse (21).

## 2.11 The conflicting paradigms for nurses roles in aged care

Organisational expectations in many aged care settings have a major impact on the experiences of nurses in leadership roles. Capezuti et al.<sup>(50)</sup> and Hasson et al. (2008)<sup>(48)</sup> found that the registered nurses in aged care who initiate clinical leadership programs for their teams are often disheartened when these programs are disrupted by staffing and time restrictions, working conditions and economic factors. The high demands of regulatory compliance and meeting government accreditation standards are experienced as a 'problem' and classed as a 'hindrance', creating numerous obstacles to care delivery for nurses leading the multidisciplinary care environment<sup>(21, 47, 51, 52)</sup>. Review of the literature indicates the disconnect between the values of nursing care and the values of organisations, and the individuals that manage them<sup>(51)</sup>. There is a strength of argument for adopting the clinical leadership models of Multi-Disciplinary Healthcare Management (MDCM), however, in contrast, the argument lacks the availability of evidence that provides answers or solutions to the open ended variables and a rationale for why the registered nurse is usually positioned as the team's clinical leader within these workplaces.

There is a strong recommendation raised from previous research for establishing the formal role of the registered nurse in the aged care setting in regards to benchmarking new standards of competency and Key Performance Indicators (KPI) for nurse leaders within the aged care framework. Weston, Falter, Werbylo, et al<sup>(23)</sup> outline their evidence that competencies in clinical leadership for nursing usually focus on the standards of evidence based clinical procedures and required outcomes for the specific client and health professional. Their research identifies a need for competencies to be set out for key nursing managers and leaders to be able to manage healthcare teams and meet the organisational KPI holistically while still producing good care for the clients as nurses<sup>(23)</sup>.

This research evidence in particular gives definite argument for the articulation of nurses as professional healthcare managers in long term care settings, confident to give clinical leadership and support to both the frontline staff, other colleagues and the organisation as a whole, and still meet the nursing duty of care requirements for the care recipient, resident, or client, however termed. This articulation with the literature was achieved by an educational model that developed competency in communication amongst allied health peer groups, critical thinking and calculated risk taking for both client outcomes and organisation performance measurement<sup>(23)</sup>.

The literature of other authors <sup>(9, 10, 23, 46)</sup> has outlined specific skill sets needed in the role of nurse to achieve the delivery of care in a Multi-Disciplinary Healthcare Management (MDCM) approach.

This has opened up areas in need of future investigation and new research required in order to define parameters that integrate clinical and managerial skills needed by the RNs/Team Leaders in aged care settings and specifically Residential Aged Care Facilities (RACFs), and a major recommendation from experts such as Pearson et al <sup>(16)</sup>.

## 2.12 The role of the RN and distress in aged care

The literature collage of nursing and nursing roles continues with a diverse mix of job and role descriptions for nurses within aged care organisations. Although named, each was presented without clarity or structured boundaries to its role.

This was a common finding and one that reflected the diverse working environments experienced in community home care and residential elder care settings, and one that aligned with consumer expectation. Registered nurses experience a clouding of the

professional boundaries <sup>(49)</sup> and nurse clinical leadership is often shared among tiered levels of nurses working in aged and long term care in Australia and globally <sup>(49, 53, 54)</sup>. This phenomenon, in conjunction with the care recipients' co-morbidities, increases the stressors that already exist in the aged care workplaces <sup>(47-49, 53)</sup>. Nurses experience a sense of doubt in their competency and have little, if any, professional nursing support in the clinical leadership context of their role <sup>(48, 49, 53)</sup>. This role confusion is viewed as a negative impact on care outcomes as nurses struggle to find autonomy in their role as clinical leaders in long term care settings and specifically geriatric and end of life care scenarios, when they are no longer the instrument of direct care and must delegate to others in the team and manage the resources. Although numerous institutes that support evidence based best practice with guidelines, education and resources available, it appears out of reach to the average aged care nurse.

There are examples in the literature that identify and highlight the troubled conscience experienced between nurses of different skill levels, ranks or roles, such as that presented by Juthberg and Sundin<sup>(53)</sup> as they face the ethical and professional dilemmas in aged care nursing. Nurses are regularly described as having a lived experience of paradoxical feelings because they feel challenged by the lack of support to develop specialised skills, overwhelmed with the level of autonomy and accountability, and feeling both valued and devalued at times in their work <sup>(49, 53)</sup>. Many nurses working in aged care settings feel overwhelming low self-esteem issues associated with other colleagues looking at those nurses working in the aged care or long term care sector as having poor competency and low skills in nursing <sup>(49)</sup>. In fact, this was reinforced on those occasions when critical clinical decision-making was needed in multidisciplinary practice settings <sup>(50, 53)</sup>, and it identifies that clinical leadership skill is needed to transform the team, however no pathway for education

and learning is in existence for the registered nurse in aged care to achieve or master this skill.

Often there is a clear link within research findings to the nurses' education that explains the low self-esteem being experienced <sup>(48, 50, 52)</sup>. Common threads are presented in the literature which identify that operational and organisational barriers often hinder the availability for nurses to attend planned education sessions. Resources, and specifically time, were often limited in aged care settings and education sessions usually took second place to time and resources being used for matters of compliance and organisational capability needs <sup>(48, 50)</sup>. When given the opportunity to attend education or planning sessions, however, nurses often felt positive empowerment towards lifting the competency of the whole care team, as they were identified as the RN Team Leader and were expected to pass on their knowledge.

Venturato <sup>(51)</sup> provides a balance of negative and positive experiences of nurse leaders in aged care. The exploratory study was an extension of other qualitative work carried out by the author <sup>(21)</sup> on the impact of a changed care model inside a residential aged care nursing home. The model of care designated the role of clinical leadership to the registered nurse, incorporating focussed training to support the registered nurses to lead team-based care. The study demonstrated the positive impact of supporting the registered nurses' as the clinical leaders and empowering members of the team providing care to take delegation and strengthen communication and collaborative work with the clinical lead.

The study showed how clinical leadership changed the focus of care team members from 'reactive' to 'proactive' care, and the registered nurse moved to a focus of 'leading' rather than 'doing' the work as an individual in the team <sup>(51)</sup>. The stress factors markedly

decreased and the multidisciplinary leadership model was well supported by the organisation.

Examining both qualitative and quantitative research literature and taking the recommendations for practice on face value, it is recognisably important for the organisation and the nurse to work in collaboration and improve the health of the workplace in aged care environments. Recruitment of the best skilled nurse who is a clinical leader and manager of care services would be viewed as the best outcome for the business of care and a common theme in the literature.

## 2.13 Recruitment and retention of the registered nurse in the aged care setting: “getting the balance right”

*‘Knowing is not enough; we must apply.  
Willing is not enough; we must do’  
(Johann Wolfgang von Goethe)*

The literature review demonstrates that the aged care, long-term care (LTC) and geriatric care environments are characterised by turbulence, complexity and increasing frustration as a global increase in the older population places pressure on the healthcare system to provide choice in services of healthcare and end of life (4, 13). However, there is a lack of recommendations that address the impacts of research on practice and more of a lean towards new research on healthy ageing, re-ablement and wellness for the ageing population. The gerontological associations that have been established globally as peak bodies and evidence based leaders, appear to have a collective voice on researching the aspects of active ageing, positive ageing and providing the evidence on improving the quality of life for older populations (55, 56). In contrast, this direction befuddles the care organisations and industry workforce as they struggle to address the lived experience of caring for the negative aspects and impacts of ageing and frailty on the emerging client base.

Nurse retention and leadership fallout as a result of social change is another contentious topic in the healthcare sector, with rich examples of the correlation and relationship between nursing turnover, retention, nurse leadership, and the autonomous role of nurses striving for the satisfaction of the patient (57). Chenoweth et al.(58) conducted a systematic review on the recruitment and retention of nurses in aged care in order to identify and recommend the best strategy to deal with the current crisis being experienced in Australia.

The review described the culture and experiences of the nurses in the care working environment and identified leadership and policy as areas in need of improvement in organisational recruitment and retention. It recommended new policy frameworks be developed that reflect the same caring and nurturing values that nurses hold strongly to in order for nurses to evolve into nurse leaders in aged care. This review by Chenoweth et al. <sup>(58)</sup> demonstrates a need for a focus on the positive aspects of the geriatric specialty care area for nurses and a more positive change that is required to provide support and structure to improve recruitment and retention rates of nurses in these roles. The review, however, does not elaborate on the experiences of nurses being asked to clinically lead teams in daily care work or provide a guideline for contextualised programs that develop clinical leadership in nurses managing care teams.

Nurses in aged care settings are required to provide leadership and guidance in care directives and delegation. They provide learning and development to subordinate staff and team members, and they assist clients to make informed decisions, particularly on issues of treatment choices, palliative pathways and end of life issues<sup>(4, 43, 46)</sup>. Concerns are growing over the increasing numbers of nurses leaving the aged care sector as the ageing population rises and the need for clinical nursing expertise is on the increase<sup>(2, 3)</sup>. Another general theme the literature identifies is that registered nurses are considered to be the clinical leaders in aged care and that leadership is the hallmark of effective management and retention within the service. However, recruitment to this healthcare sector is low <sup>(2)</sup>. Numerous worldwide studies have identified the devalued image of working with elderly people, and this is represented in the limited focus on teaching and implementation of geriatric nursing skills and clinical leadership in the undergraduate nursing curricula<sup>(9)</sup>.



This paradox causes frustration and concern in the management of recruitment and retention strategies for aged care organisations and is also a barrier for nurses wanting to change career or acquire advanced skills in geriatric nursing practice yet have not identified with the leadership and management performance area of the role as designated by the healthcare organisation.

Over the past few decades, leadership issues and inquiries into recruitment and retention of clinical leaders in care organisations have been identified by researchers and attracted funding for research programs from the government. With changing workplace impacts and fluid movement within government reform, organisations that deliver funded care models are engaging in research to provide guidance with the aims of better practice and quality care through improved recruitment strategy <sup>(13)</sup>. Part of this movement is focused on how to best utilise the roles and skills of the registered nurse as effective clinical team leaders in care to address the social change that is being driven by the evidence of research lead by the peak gerontological associations.

The predominant methodology in much of the research undertaken in aged care and nursing is qualitative, where survey questions and focus groups were consistently used as methods to research and collect the data that was reviewed throughout the body of evidence. Anthony, Standing, Hertz <sup>(46)</sup> have used a self-evaluation model through the use of a skills assessment proforma. This method allowed the subjects in their research to utilise time in their workplace under set scenarios to be evaluated. The set scenario placed the subject in a position where there was a requirement to delegate and lead others in a particular situation for direct patient care. The analysis of findings discovered the registered nurse team leaders demonstrated a lack of skills to lead and mentor others, delegate tasks and complete this performance area with confidence in one's own ability <sup>(46)</sup>.

Dumas et al.<sup>(59)</sup> describes the current need for organisations to provide professional nursing entry points for registered nurses who are considering careers in geriatric care or long term care, and for unregulated care workers (that being the Assistant in Nursing (AIN) and the Personal Care Assistant (PCA)) to be formally trained in specific geriatric nursing skills, as these staff already have the underpinning culture and a positive attitude towards the industry and its objectives<sup>(59)</sup>. It is obvious in the literature that career pathways need to be developed to improve retention of registered and qualified workers already in the system before they leave due to frustration or attraction to higher paid curative settings.

Declining numbers of registered nurses and an increasing ageing population will require strategic and definite leadership to effectively deliver care services to the growing elder population. The literature identifies a need for more social sciences contribution to identify certain skills gaps and learning strategies to resolve emerging issues in implementing evidenced based healthcare and positive ageing in long term care environments <sup>(60)</sup>. An increasing approach to improving long term palliative care is currently underway in Australia, as care needs are increasing and consumer preference is voicing a need for care in the private home with assistive support for rehabilitation and wellness. The feared result is that the residential care setting will become the hospices of the community and particularly for those that have not lived a healthy life consisting of active and healthy ageing.

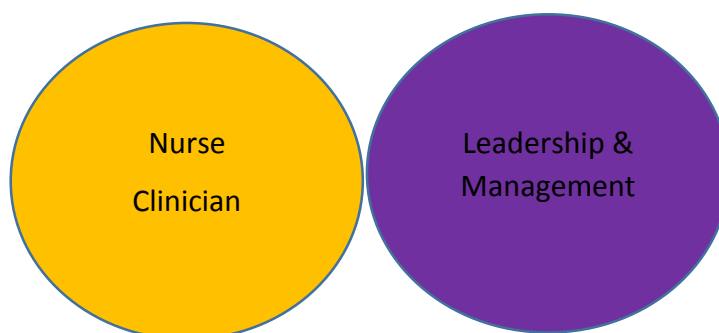
A common theme for further research has appeared from the body of knowledge reviewed that has provided support for the direction of this particular research project. Exploration is needed to identify the skill sets that the RN/Team Leader feels will satisfy the known KPI for this diverse and challenging new role within aged care settings.

## 2.14 The aged care nurse as 'clinical leader' or 'manager' or 'both'?

There is strong and clear recommendation and support for frontline nurse leadership in the readings and recommendations from numerous academics <sup>(17)</sup>. Noticeably, much of the literature integrates the language and interpretations for nurse leader, nurse manager, clinical leadership and management. Simultaneously there is a definite clouding of meaning and interpretations of the terms leadership, clinical leadership and management within the literature. The discourse appears to be that nurses identify themselves as trained expert clinicians, but not specifically as managers or leaders of people and resources, and the two are seen as distinctly different roles, adding more personal and professional frustration for individual nurses. On the other hand, the organisation as a whole views the nurse as a leader and manager of the care team, delivering the service and also holding the senior clinical skill as a registered nurse.

So whether they are nurses or managers is often the cloudy issue for nurses themselves or their supervising managers, as the values of the organisation and the values of the registered nurse are distinctly different at some point and power becomes positional within the organisation <sup>(1)</sup>.

**Figure 2.1 Are they nurses or managers?**

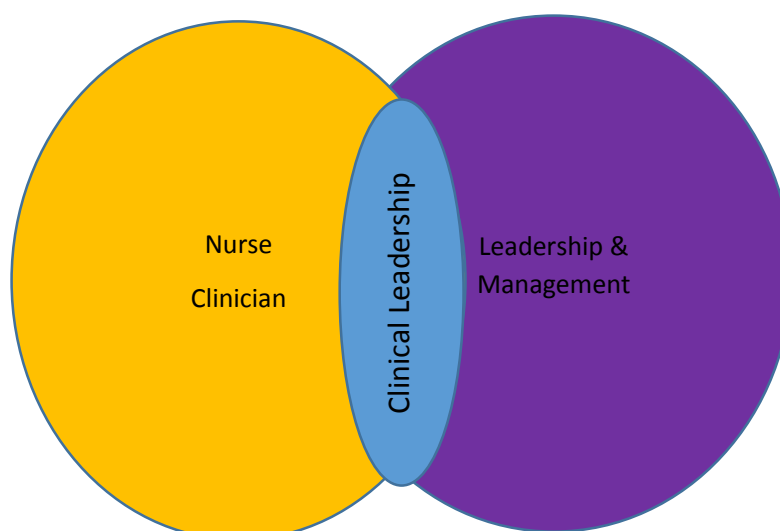


There are two distinct areas or skills sets being discussed within the literature that are used interchangeably throughout the discussions on findings and lack commonality or understanding between staff.

- Clinical scope and accountability, with
- Leadership and Management

A Nurse's clinical decisions in care assessment and planning is one skill set owned by the nurse. The other skill set, which is owned by the organisation, is aligned with leadership and management for delegation and compliance, which are expectations of the role in leading healthcare teams in aged care environs. There appears to be an overlapping of the skill sets within the role for the registered nurse in aged care settings and should be identified as a Key Performance Area (KPA) in Clinical Leadership, as seen in Figure 2.2.

**Figure 2.2 Clinical leadership**



Leadership development is now considered critical for the sustainability of modern healthcare organisations that deliver aged and community care services, and nurses now play a significant role in future recruitment and development of professional

partnerships in care rather than being utilised as a mere workforce expense, which is regularly debated through much of the literature <sup>(1, 10, 19, 45)</sup>. Internally, organisations on the surface are doing much to educate and support leaders and managers of residential care through ongoing training. However, the number of published studies documenting the implementation and evaluation of leadership development programs for nursing professionals in aged care is limited to corporate or senior management and misses the clinical component and synergy with leading a care team in the frontline service.

According to Kimball and O'Neil <sup>(39)</sup> building clinical leadership competency in the nursing profession begins with innovative educational programming that rethinks the way professional nurses are integrated into the healthcare system. As an example, the foundation and structure of the Arizona Nurse Leadership Model is based on the work of Longest (1998, cited in Weston, Falter, Werbylo, et al.<sup>(23)</sup> Longest describes six critical leadership competencies in healthcare today:

1. **Conceptual:** *knowledge and skill to envision one's place in the organization within larger society.*
2. **Technical:** *direct work performed in one's domain.*
3. **Interpersonal or collaborative:** *human interactions and relations through which one leads others in pursuit of common objectives.*
4. **Political:** *dual capacity to accurately assess the impact of public policies on the performance of one's domain of responsibility and the ability to influence public policy making at both state and federal levels.*
5. **Commercial:** *economic exchanges between buyers and sellers in which value is created.*

6. **Governance:** *establishment and enactment of a clear vision for the organization* <sup>(23)</sup>.

This research in particular gives definite argument for the articulation of nurses as professional healthcare managers in long term care settings, confident to give clinical leadership and support to both the frontline staff, other colleagues and the organisation as a whole, and still meet the nursing duty of care requirements for the care recipient, resident, or client, however termed. This articulation described was achieved by an educational model that developed competency in communication amongst allied health peer groups, critical thinking and calculated risk taking for both client outcomes and organisation performances utilising integrated care and case conferencing<sup>(23)</sup>. Throughout the literature there are a number of systematic reviews and literature reviews that investigate the impact of leadership and management experiences of staff within the aged care sector <sup>(4, 16)</sup> and more specifically within the Residential Aged Care Facility (RACF) <sup>(15, 17)</sup>.

These reviews explain the experiences of staff working within the sector, and their rationale for patterns of staff turnover, recruitment and retention issues and their direct impact on care outcomes. Some authors <sup>(13)</sup> claim that clinical leadership is generally context-specific and, given that nursing homes are heavily bureaucratic and over regulated, the workplace will change depending on the values of the leader in charge at the time who may not have a clinical skill set.

Aberdeen and Angus<sup>(4)</sup> validate that the clinical leadership within aged care settings is a well acknowledged principle, however poorly understood and implemented. In the past, managers in private aged care services were often experienced clinical nurses who have adopted dual roles in management positions such as Director of Nursing (DON) that eventually separate them from the direct care and move to the senior management focus of business operations.

This collective group of DONs is today underrepresented in management roles as the industry corporatises and organisations expand. Clinicians now hold few if any managerial skills which, in turn, renders them subservient to the regulations and compliance expectations of the organisation when recruited into the role of manager or leader. Clinicians who do have managerial roles quickly lose what has been learned and applied in their original professional skills base in nursing and also become subservient to organisational compliance as a benchmark in quality care <sup>(4)</sup>. This is the basis for a move towards change within aged care as the focus on clinical leadership becomes the 'bigger' issue. Aged care peak bodies are looking forward to the positive impacts that clinical leadership change brings to the industry and the effect it has on productivity in the business of providing care.

As an example, the work of Pearson et al. <sup>(61)</sup> points out the positive impact of effective clinical leadership and management on staff productivity and care quality in healthcare workplaces in general.

Nurses react well and perform at higher standards when the workplace environment is healthy and under strong clinical leadership. Leadership styles were identified as measurable in terms of staff positiveness and a sense of fulfilment derived from being in the workplace. Leadership is connected to positive experiences in collaboration and teamwork, and in turn improves the outcome for patients, which is well documented in his comprehensive systematic review.

Building on previous work, Pearson et al's. <sup>(61)</sup> further research in quality clinical leadership is well represented through extensive government funded systematic reviews. For clinical leadership and management to be effective, the collective authors' investigations are based around staff recruitment, retention and turnover, finding that they have a direct relationship to leadership and management <sup>(17, 58)</sup>.

Five themes associated with the impact of leadership and management are clearly stated, namely:

- I. staff job satisfaction and retention;
- II. successful change and positive work place culture;
- III. staff productivity and unit performance;
- IV. care quality and resident outcomes; and
- V. associated costs <sup>(17)</sup>.

Throughout this body of knowledge is the discussion of nursing clinical leadership's impact on policy. Although discussed, much less is known about the systems and policies required to facilitate effective clinical leadership and management in the aged care area as a workplace, as resistance to change is a common barrier identified for research innovation. In addition, these reviews could not articulate in-depth intensive information or document the synthesised evidence on the 'personal meaning' of a particular clinical leadership and management role of the registered nurse in this well documented complex area of aged care.

It was noted that these reviews contained a broad focus and were more related to general healthcare environments or non-clinical leaders of multidisciplinary teams. Given that the registered nurse holds a team leader's role and is usually a supervisor of numerous multidisciplinary staff, there is argument for new research into supporting the role through policy improvement, education and skills development <sup>(1, 17)</sup>. The current reform in Australia is looking at the science and building a strategy for implementation. Consequently the work of Pearson et al has established the successful clinical fellows program within the Joanna Briggs Institute (JBI) in order to develop clinical leadership skills in health professionals through grounding the knowledge and utilisation of Evidence Based healthcare.



## 2.15 Building the future “Nurse Empowerment” through clinical leadership development: The way forward

It is evident that the leadership role of the registered nurse, nurse manager however it is interpreted, has become an emerging key driver in a healthy workforce culture <sup>(15, 17, 59)</sup>. Notwithstanding any interpretation, as previously discussed, in the past 10 years there has been a significant decrease in the retention of nurses as clinical leaders or managers of residential aged care, while the context for the role of the nurse in management and clinical leadership has grown extensively in relation to its responsibilities. Many registered nurses are poorly equipped with both managerial and clinical leadership skills and find themselves unprepared for the complex supervisory role they hold in aged care settings where delegation and huge accountability issues are at stake. This reflects their training preparedness and inadequate role description in the organisation <sup>(17)</sup>.

In choosing the research questions and selecting the integrity of the methodology for this piece of primary research, consideration had to be given to the fact that the results of comprehensive systematic reviews are considered by many, including myself, to be a gold standard research outcome and open the doorway for new primary research as discussed at the beginning of this chapter. There have been a number of important systematic reviews completed over the past 10 years that have made substantial recommendations to improve practice in aged care and for the role of the registered nurse. Of those reviews, and the review conducted by Dwyer <sup>(1)</sup>, the following recommendations were developed based on the meta-syntheses carried out:

- Employers and policy-makers should be aware that nurses in aged care and geriatrics have a strong motivation to work in the aged care sector and want to be valued by the community. (Level I Evidence)

- Educational pathways and programs are needed to improve the professional practice and continuous development of nurses with clinical and leadership skills. (Level I Evidence)
- Aged care providers and healthcare policy-makers should understand that aged care and geriatrics is a specialised area of healthcare warranting its own recognition in professional practice. (Level I Evidence)
- Organisational barriers need to be reviewed and policy implementation improved in order to promote a healthy workplace environment, support continuous improvement, promote clinical governance and improve care outcomes. (Level I Evidence)
- Providing positive and healthy workplace environments that concentrate on skills development in clinical leadership and governance improves the workforce's productivity and holistic environment. (Level I Evidence)

From this review, it was suggested that further research be undertaken to validate the recommendations and take action to have a positive impact on the industry. From completing the master's degree and comprehensive systematic review it was inevitable to begin the primary research needed to improve the clinical leadership practice for nurses within the aged care setting. It is these recommendations that have been the primary reason for undertaking this doctoral study and working towards providing a tentative model of clinical leadership for the registered nurse in aged care. The following chapter will outline the methodology design and methods used within this research project, including the breakdown of the whole project administration and scientific structure in detail.

## Chapter 3: Methodology

---

### 3.1 Introduction

*'The best way out is always through'.*

*(Robert Frost)*

The previous chapter provided the literature review of the position that nursing and particular registered nursing has evolved to in today's contemporary aged care environments. The understanding of the evidence is that there is much discourse and turmoil within the scope of practice for nurses who work in aged care as their role is primarily that of a clinical leader of a multidisciplinary team. Although well understood to be in a position of power and holding the clinical expertise for the role, the leadership component is one that presents a gap in the knowledge of the registered nurse to be effective for the best outcomes in care. With already numerous literature and systematic reviews completed, that provide recommendation for practice, new primary research in clinical leadership is needed to support the clinical leadership role of the registered nurse in aged care in order to validate any recommendations to move forward.

This chapter will outline the research project methodology, the research design and methods used, including the rationale for adopting a Sequential Mixed Methods approach for this primary research <sup>(62)</sup>. The chapter will include a breakdown of the rationale for each method undertaken and the research design of the project including a detailed explanation of the participant groups, and the intervention utilised for the participant group. Details on project administration, timelines and ethical guidelines are also provided.

## 3.2 The Research Question

Choosing the right methodology for this piece of research work was a challenging experience from the beginning. Reading and interpreting the literature surrounding research methodology provided a solid foundation in finding the starting point for making decisions from which pathway and direction follow in this study. Choosing the research question was a matter of knowing what it is that one is researching by reviewing the research question.

- 'What is the impact of formal clinical leadership training on registered nurses in aged care?'

This question is best categorised as a variance research question, and probably best serviced by the quantitative methods. Knowing "what it is you want to research" is one question a researcher will ask themselves at the beginning of the journey and then meander down the pathway to decide on the "How am I going research this subject" as another dimension and process of thought. Applying a standard quantitative methods approach will allow the significance of variance to be identifiable. However a more deep and meaningful explanation of any variance would be needed to explain 'how' it is experienced by the participant and what it adds to our understanding. In this case, it was applicable to apply the qualitative interviews to look deeper at the meaning of any variance<sup>(63)</sup>. Therefore this research was developed as a sequential mixed methods approach.

The reality is that these are only a few of the several layers of questions a researcher needs to ask themselves when choosing the research pathway <sup>(64)</sup>. A researcher will always take the journey to face the deeper philosophical aspects of research investigation that provide more than covering the mere incidentals of research and begin to consider the 'Why am I studying this research?' aspect <sup>(64)</sup>.

There is a range of dimensions of science that have influence on research and these dimensions each involve either a subjective or an objective approach to research that provides a paradigm within which to locate the study. One of the two controversial issues that plagues mixed methodology application is 'Paradigm Method Fit'. This issue relates to the debate over whether philosophical paradigms (Post Positivism, Constructivism) and methods have to 'fit together'. The philosophical approach is outlined in the following paragraphs.

Table 3.1: Philosophical Approach (taken from Holden et al (2004))

Mixed Methodology	
Objectivist	Subjectivist
Quantitative	Qualitative
Positivist	Interpretivist
Scientific	Humanistic
Experimentalist	
Traditionalist	Phenomenological
Functionalist	

These two major philosophical approaches, dimensions or paradigms, as they are often referred to, are then delineated by several levels of core assumptions recognising identified paradigm differences between post-positivist philosophical assumptions and naturalistic assumptions in terms of epistemology (how we know what we know), ontology (the nature of reality), axiology (the place of values in research), and methodology (the processes of research). This has led to a dichotomy between traditional inquiries <sup>(64-66)</sup>. Table 3.2 is a table representation of validating the paradigm selection for this study.

Table 3.2 Table of paradigm selection (taken from Holden et al (2004))

The Subjective-Objective Dimension		
The subjectivist approach to social science		The objectivist approach to social science
<b>Assumption</b>		
Nominalism Anti-positivism Voluntarism Ideographic	← ← ← ← ← ← ← ← ← ← Ontology Epistemology Human Nature Methodology	→ → → → → → → → → → Realism Positivism Determinism Nomothetic

As the researcher, my intent in the beginning was to stay focused on the qualitative paradigm, as my personal and professional experiences in research were grounded in nursing and social sciences. Another reason for this was acknowledging the bias that I would bring to the research in playing my roles both as the researcher and the facilitator of the leadership course <sup>(67)</sup>. Most qualitative researchers bring themselves into their studies and therefore would be seen by reviewers of the research as having a bias and influencing the outcome of any proposed intervention. Applying quantitative methods to the research was ideal for statistical information. Utilising survey questions to collect data, however, the planned intervention would have had an impact on the participants. There was a perceived subjective view of this phenomenon and a need to balance this information with data best collected through qualitative interviews and questions. This direction was rationalising the approaching mixed methodology decision made for this study.

Part of this chapter will explain the rationale for making the decision to choose a Sequential Mixed Methods design for this research, an important question that was contemplated by myself at the beginning of my 'journey', as it is so often referred to in

other dissertations. Part of the decision-making is investigation into finding the right fit for this research. Babbie <sup>(68 p 405)</sup> states that *'Knowledge is power'* and building that power can provide clarity for research design and outcome. Utilising mixed methods also assisted in interpreting the rhetoric being used in the academic literature review undertaken in this research. There seemed to be some imbalance in the language between the use of the terms 'methodology' and 'methods'. Undertaking the learning journey to master my own thinking in Evidence Based Healthcare (EBHC), I soon realised that the purist paradigms did not necessarily link to a matching method being used in every research case. There were a number of similarities in quantitative and qualitative studies that showed different methods being applied to the same paradigm and vice versa.

The pragmatic interpretation of research undertaken during this research project indicates that there is a break in the connections between the methods used and the methodological paradigm. Reading the works of Reinharz <sup>(69)</sup> and Cook <sup>(70)</sup> confirmed my own interpretations that many studies in both the purists' paradigms use different methods of data collection and validation. However utilised, the authors expressed connection to the methodology in their rhetoric used to validate the particular research undertaken at the time. Firestone <sup>(71)</sup> explains that the rhetoric is the art of language used in academic writing, and as a general rule it should be largely ignored, and the facts that have arisen from the research should speak for themselves. It is clear that the two terms, method and methodology, have different meanings to different researchers and this draws criticism from peer review that may be focused on the purist's paradigms. This research study and this thesis will be clear in regards to the methods used and the methodological approach or theory taken.

This study examined the impact that structured clinical leadership training had on the individual nurses in the participants group for intervention, in comparison to the impact

on the control group of nurses that received no structured clinical leadership training. Both quantitative and qualitative research methods were employed to address the research aims and objectives. The results of the inquiries were then processed through an integrative analysis for convergence and final findings, and is explained in due course.

### 3.3 Understanding the use of Quantitative Methodology

Quantitative research is heavily based on the positivist philosophy <sup>(67)</sup> which seeks to explain change or known social facts. This approach is conducted through using methods such as observation, data collection and statistical analysis <sup>(71)</sup>. Babbie (p.405) <sup>(68)</sup> describes quantitative analysis as *'The numerical representation and manipulation of observations for the purpose of describing and explaining the phenomena that those observations reflect.'* This assumes that in order to control the world around us, we first need to make sense of that world, and what it is that we do or do not know, or need to understand in order to control it. The positivist paradigm researcher in general will ground themselves in this purist theory and engage a known and legitimate framework of scientific investigation and analysis. This framework will provide rigor around the research in order to present the findings with clear objectivity and also distance the researcher themselves from the point of subjective bias in the critique. The positivist paradigm is well accepted by the social and political worlds and in particular the Western healthcare systems, as it is currently a driving force in modern healthcare research. Lockwood et al <sup>(72)</sup> explain that the credibility of the positivist paradigm is consistent throughout the literature as critics review the assumption of the purists, that the world as we know it can be reduced to interpretation of the philosophy that known reality is achieved through objectivity, and this remains part of the intellectual debate while not placing positivism itself at risk.



### 3.4 Selecting the Quantitative Methods

The true purpose of quantitative research is to examine the relationships between variables or characteristics. For this research, the variables are simple to interpret as:

1. independent (those characteristics that are manipulated by the researcher) is for the purpose of designing the intervention for the participants group;
2. dependent (variables that are impacted by the manipulation) is for the development of hypothesis; and
3. extraneous (variables that specify demographic information needed such as age, sex, education level, etc.) <sup>(68)</sup>

A survey questionnaire was designed and placed into the online research data collection tool 'Survey Monkey'. The hypothesis was created and utilised to form the questions within the survey. A detailed outline of this process is explained in section 3.6.2 Study Design.

### 3.5 Understanding the use of Qualitative Methodology

Merriam <sup>(73)</sup> explains that the paradigm of qualitative research grounds itself in a long history of anthropology, sociology, and clinical psychology. There are numerous qualitative methodological texts available worldwide that guide the research and practice of expert fields such as nursing, psychology and gerontology, and it is widely noted that methodological texts are being utilised for organisational and cultural development worldwide <sup>(74, 75)</sup>.

Qualitative methodology is generally based on interpretivism and constructivism <sup>(67)</sup>, a scientific enquiry into a phenomenon of particular interest to the researcher. The researcher and the subject are undoubtedly connected, as the investigation of hypotheses can be undertaken through close personal interviews, group sessions and

reporting. Babbie (2007) <sup>(68)</sup> informs us that *'qualitative analysis is the nonnumeric examination and interpretation of observation, for the purpose of discovering underlying meanings and patterns of relationship'*. This is most typical of field research and historical research, and also resonates strongly with nursing and feminist theorists. When reading the literature on nursing research, one can quickly identify that many researchers are drawing on critical social theory on which to base the hypothesis<sup>(73)</sup>. Reflecting on my own experiences in aged care and understanding what is known reality (ontology) and moving towards the knowledge gained through researching at a higher degree level of that reality (epistemology) and the different aspects of that reality (methodology) provided validity to apply a qualitative element to this research. A qualitative study is usually undertaken in the setting of the subjects that are experiencing the phenomenon, and the critics of this paradigm quickly identify the bias of influence as the researcher is usually embedded into the project and its environment. As the researcher and course facilitator it will be qualitative enquiry that balanced the research as mixed methods.

Qualitative researchers use interpretive and naturalistic approaches in order to bring an understanding of knowing what is the experience of the person experiencing the phenomenon, as there are many different ways that individuals see, feel and understand the world around them <sup>(76)</sup>. Pearson et al.<sup>(77)</sup> describe the paradigm as one that broadens the meaning of knowledge that one can already interpret from quantitative measurement. This is achieved through the practical application of data collection utilising questionnaires, survey instruments and or interviews.

Introduction to formal qualitative methodology enquiry (or moving toward epistemology) was established while undertaking the Bachelor of Applied Social Sciences, as a personal and professional journey to understand the nature of organisational thinking and the culture amongst nurses. At that time my inquiry was

into aged care nursing itself and my chosen research subject was based in the qualitative hypothesis question:

*“What are the skills gaps being experienced by registered nurses in clinical leadership and management of multidisciplinary health teams in long term or aged care”?*

The results of that research saw the development of the Multidisciplinary Health Team Leader Course, a course designed to meet the skills gaps for registered nurses who are team leaders in contemporary aged care. This course was chosen as the intervention for the participant group, and was utilised within this doctoral study during Phase Two, and subsequently part of the methods used to conduct the research.

### 3.6 Selecting the Qualitative Methods

As there is no recipe book or set of rules to design interview questions<sup>(63)</sup>, it was decided to set a formal structured set of questions for the qualitative investigation. The questions were open ended and designed to make the participant think broadly and reflect on themselves as nurse leaders, before and after the intervention of leadership training.

Table 3.3 Table of Qualitative interview questions

Q1	Can you explain your perception to this training?
Q2	Can you describe your understanding of clinical leadership and has it changed from doing this training?
Q2	How Has this training improved your understanding of your role at work?
Q3	How has this course improved your leadership for the team?

Q4	Do you believe you now have a better understanding of your team's needs and how to support it at work?
Q5	How has there been an improvement in resident care outcomes since applying your leadership training?
Q6	Do you believe you have been supported in your role by your organisation?
Q7	Tell me your views on the impact of this training on your personal career and professional development?

The thematic analysis of the responses to the interviews is explained in detail under Chapter 5: Results Qualitative.

### 3.7 Understanding the use of Mixed Methodology

Mixed methods research, although considered 'new' in the theoretical and philosophical debate, has been used in research for a number of years <sup>(75)</sup>. The origins of mixed methodology remains in dispute as far as who claims the right to be seen as the founder, however, the works of Campbell and Fiske (1959) placed multi-trait, multi-methods research into the spotlight <sup>(66)</sup>.

Johnson <sup>(75)</sup> defines mixed methods research as:

*'The class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study'.*

Creswell<sup>(74)</sup> adds to the clarity to defining mixed methods by stating that it is an approach to research methodology which:

- ✓ focuses on research questions that call for real-life contextual understandings, multi-level perspectives, and cultural influences;
- ✓ employs rigorous quantitative research assessing magnitude and frequency of constructs and rigorous qualitative research exploring the meaning and understanding of constructs;
- ✓ utilises multiple methods (e.g. intervention trials and in-depth interviews);
- ✓ intentionally integrates or combines these methods to draw on the strengths of each; and
- ✓ frames the investigation within philosophical and theoretical positions.

Underpinned by its partnership with the pragmatist theory <sup>(78)</sup>, that ‘truth’ cannot be defined by scientific investigation using only one of the purists’ methodologies and mixed methodology offers its place as the third phase in approaches to research methods. The argument is simple, in that a researcher should not be restricted to using one framework in answering a hypothesis or research question. Quantitative research may be good for a particular area of a study, however it may not be good for another area in the same study, or there may be validity in sequential qualitative research methods to provide deeper meaning or reason-for-being as an explanation for quantitative data. In these cases, the researcher can combine methodology and use a choice of methods and leverage the clarity of findings in the outcome <sup>(79)</sup>.

Mixed methodology is often seen as the bridge between the positivist’s and the constructivist’s theories, and referred to as ‘dialectical’ <sup>(66, 74)</sup>. The essence of the approach to using the mixed methodology is that the researcher has the opportunity to utilise and interpret diverse forms of data in one study or combine methods in other studies for analysis of inference. This piece of primary research allows the researcher to connect data or to find links and correlation between the thematic analysis of the qualitative inquiry and the quantitative results, merge data to support findings, and

build answers to clarify the interpretation through integrated analysis or what is commonly known as triangulation.

The triangulation metaphor is referred to as the analysis of variance or convergence between the quantitative results and the qualitative results to assist with the integration analysis and its adaption in mixed methods. It is drawn from the military sciences, where as an example, the Navy will utilise different grid points to identify a position in the ocean or on a map through triangulation and narrow down the point of focus. Triangulation was considered to be too ridged in its framework for this study, and the decision to diversify the metaphor to be interpreted as utilising an integrated analysis was used. A table of the integration is displayed in the schedules of appendix in this thesis.

### 3.8 Choosing the right 'Fit' for methodology

*'Research under a paradigm must be a particularly effective way of inducing paradigm change.'*

*(Thomas S. Kuhn)*

My professional experience of research was developed during my extensive training within the Joanna Briggs Institute in the University of Adelaide. The research journey began during my studies in the Clinical Fellowship program, and extending out into the undertaking and completion of a Masters in Clinical Sciences. The learning journey within the master's program was valuable towards understanding the obvious research 'paradigm wars' being disputed between the purists of either quantitative or qualitative paradigms<sup>(79)</sup>. Undertaking the studies in comprehensive systematic reviews grounded my underpinning knowledge in the differences between the two purist methodologies, and also grounded the acceptability and applicability in regards to a rationale for utilising both paradigms in a mixed method design.

The study design required the use of quantitative survey results that also needed the support of qualitative interviews to weed out deeper understanding through an integrated analysis or triangulation (as a metaphor) of the results of both methods of data collection to strengthen the outcome against the hypothesis. Investigation and further inquiry confirmed the methodological approach that is outlined in Figure 3.1.

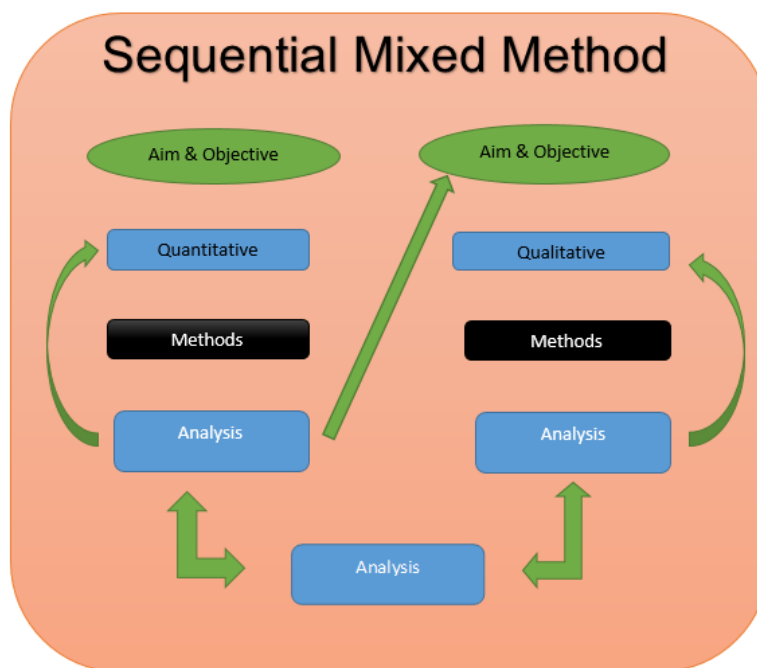


Figure 3.1 Sequential Mixed Methodology

The next section of this thesis will explain the answers to those questions in a logical sequence.

### 3.9 Study design and Methods

This primary research study is a sequential mixed methods approach to research and consists of five Phases that follow a pre-test post-test design using a control group, the use of focused questions post intervention, and the integrated analysis of the findings.

**Phase 1** focuses on the collection of baseline data from both the intervention group and the control group; **Phase 2** involves the development of the intervention (the

learning and development program); **Phase 3** consists of the delivery of the intervention (the learning and development program); in **Phase 4**, post-intervention data will be collected from the intervention group and the control group will be surveyed; and analysis of the data and the writing of the report comprises **Phase 5**.

### 3.10 Study Objective and Aims:

This study seeks to evaluate the effects of a structured learning and development program in clinical leadership and management for registered nurses practicing in residential aged settings. The objectives of the study are to:

- deliver an intervention as a structured learning and development program on clinical leadership for registered nurses practicing in residential aged care;
- examine and describe the experiences of study participants in this learning program;
- examine the impact that specialised training and education has on:
  - a) the skills of study participants related to the role of clinical leadership and management;
  - b) the confidence and morale of study participants;
  - c) the work environments of study participants; and
  - d) the retention of study participants in the workforce.

### 3.11 The Hypothesis:

The hypothesis of this study is that registered nurses who hold the position of Clinical Team Leader in a residential facility who undergo formal training in clinical leadership and management are more likely to derive a positive impact from the training than those registered nurses in the same role who do not undergo the training, in that:



1. The learning and development training will have a positive impact on attitudes to the role of clinical leader for the RN participant.
2. The improved skills training will have a positive impact on leadership skills in the RN participant.
3. The learning and development training will have a positive impact on retention of the RN team leader in the workforce.

Figure 3.5 is a representation of the hypothesis mapped against examples from the pre and post-test survey questions undertaken by both participant and control groups as part of the quantitative methods used in this study. The research should identify any significant positive changes in knowledge and attitude for participants of the intervention, and whether any positive impact was experienced in gaining retention of registered nurses in aged care settings in Australia.

If there is significant positive impact from the intervention and survey, this study should make a large contribution to the sector in regards to the learning pathways and skills sets to support the recruitment and retention of registered nurses in aged care.

Table 3.5 Table of Research Questions and Hypothesis

	<b>Research Question</b>	<b>Data set based on</b>
RQ1	The impact and outcomes that the program of learning and development has on developing positive attitude towards leadership as an RN team leader in aged care.	Survey questions used in the pre and post-test survey design e.g. <b>Q9.</b> I have been formally trained in the clinical leadership and management of care teams <b>Q17.</b> This role meets my expectations as an RN in aged Care
Hyp 1	<b><i>Hypothesis:</i></b> <i>The learning and development training will have a positive impact in developing positive attitudes to the role of clinical leader for the RN participant</i>	

RQ2	Measure the impact and outcome that improved skills has on the RN to clinically lead a healthcare team and its environs,	<b>Q10.</b> I am confident with delegating tasks to my care staff. <b>Q27.</b> I have had formal leadership skills training
Hyp 2	<b>Hypothesis:</b> <i>The improved skills training will have a positive impact in developing leadership skills in the RN participant</i>	
RQ3	Measure the impact on improving morale and staff retention in the registered nurse who holds the position of clinical leader in the team.	<b>Q33.</b> I am planning a career in aged care <b>Q37.</b> I am looking forward to a long career in aged care
Hyp 3	<b>Hypothesis:</b> <i>The learning and development training will have a positive impact in improving retention of the RN team leader in the workforce</i>	

## Study Design

---

### 3.12 Methods

This section will firstly explain the rationale for choosing web-based virtual classroom settings for the delivery of the intervention and feedback sessions. Secondly, an online survey instrument to engage the participants and collect the data for extraction will be described, and finally the process of administering the intervention and methods used will be set out.

Over the last two decades, since the introduction of computers, science research has seen a dramatic increase in the implementation of computer technology and software in areas such as data collection, methods of interpretation and validity testing.<sup>(80)</sup> The scale of the demographics and locations of the participants in this research study were spread over 5 states in Australia. Consideration of cost was a preliminary and planning barrier to conducting the study. Taking time to plan the rollout of extensive training

used in this study as the intervention, the researcher validated the use of online delivery of the intervention, and survey method <sup>(81)</sup>. Taking the positives for streamlining the control and administration of the project into consideration was also balanced with the understanding that not all people use computers, and not all nurses are comfortable with engaging technology<sup>(80)</sup>, however the process of selecting the sample and progressing with preliminary investigations into the suitability of using web-based intervention and survey collection identified that within Australian demography;

- most people have access to the internet,
- most people have an email address,
- registered nurses in Australia must demonstrate contemporary practice,
- nursing registration requires an English competency known as an IELTS level of 7 to be registered by the Australian Nurses and Midwifery Council (ANMC),
- It is expected practice that nurses be able to utilise computerised technology within the scope of their practice and ongoing professional development framework, issued by the Australian Nurses and Midwifery Council (ANMC).

Since the early works of Kiesler <sup>(80)</sup>, the internet has now become more widely used and an entrenched part of the normal daily life of a health professional. It was established within the chosen organisations taking part in this project, that access to network connections and email addresses would be available to all participants. Practical experiences within aged care had also reinforced the notion that many, if not all, institutional care organisations have information technology as a Key Performance Area (KRA) within their operations, and formally communicate through computers daily. Contemporary nurses are well attuned to computer-based care planning, reporting and interpersonal communication and is reflective of the national standards of the contemporary nurse.

### 3.13 Setting and sample

As discussed in Chapter 1, a total of 300 registered nurses from 44 accredited residential aged care facility sites in two service providers' organisational groups were chosen as the study sample. Of these 300 participants, 150 were randomly assigned (using a computerised random numbers table) into two separate groups. **Group one** (the Intervention Group **IG1**) consisted of the 150 registered nurse participants that would receive the intervention, and **group two** (the Control Group **CG2**) consisted of the 150 registered nurses in the control group who would not be engaging in the education course <sup>(82)</sup>. The **CG2** control group was demographically similar to the participant group **IG1**.

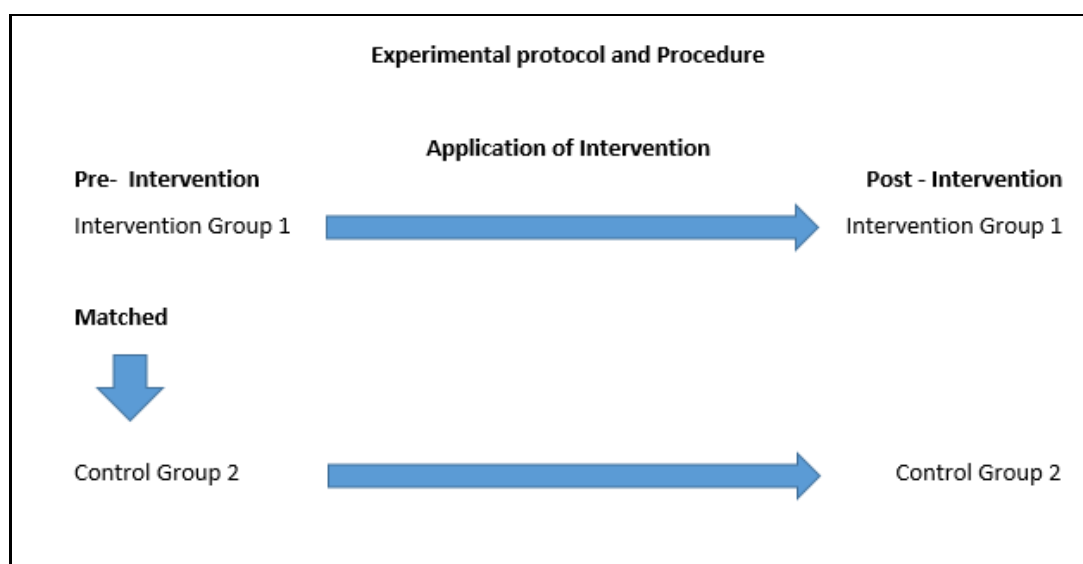


Figure 3.6 Sample Groups

The most recent available data (AIHW, 20012) <sup>(30)</sup> shows that 41,300 nurses were employed in geriatrics and gerontological nursing in residential care settings, 8.4% less than in 1996. Of these, 14% were employed in public nursing homes, 69.8% in private nursing homes, the prominent role for 78% of them was identified as clinician and for the remaining 22%, clinical manager.

The demographics of the registered nurse in aged care in Australia consists predominantly of females who are both hospital-based and university trained.

A sample size <sup>(83)</sup> for this project was calculated using an online sample size calculator for surveys created by Creative Research Systems. The confidence level was chosen at 95% and the confidence interval was set at 0.05. This gave a calculated sample size of 300 against the population of 30,000 nurses in aged care. A review of the literature on sampling <sup>(83, 84)</sup> was carried out to gain an appreciation of the methodology and the rationale for deviation and appropriateness.

The number of aged care nurses had been identified according to the latest available statistical information <sup>(30)</sup> at the time of commencing this study project, dated 2010 - 2012.

### 3.14 Administrating the groups and project plan

It is well established in the literature that although web-based surveys allow for larger platforms and sample groups to be engaged in research, and demographics can be dealt with cost effectively and efficiently <sup>(80, 81)</sup>. Coordination of a large number of participants, spread over the entire country, required some careful consideration to manage the preliminary data collection and deliver the intervention effectively. The barriers that exist in registered nurses in aged care settings were well known to be that nurses are pressed for time and require clear instruction to manage their daily schedules. A breakdown of the process conducted was carried out as follows:

- **Confirm source:** A residential aged care service provider in NSW Australia (Catholic Healthcare and the Scalabrini Villages). These particular service providers have over 40 individual residential care facilities within their corporate services arms (aged care).

- **Number:** 300 participants.
- **Age range:** At this stage the expected age range is adults from 21 to 75 as this is the age range of nurses in aged care.
- **Selection and Exclusion criteria:** Participants were selected according to the normal education and professional development for the organisations' care team leaders, who are registered nurses.
- **Intervention group IG1:** (150) were identified from registered nurses in identical positions who were receiving the intervention through undertaking the clinical leadership course as a part of organisational training and who were employed in the large organisation and its sub-facilities.
- **Control group CG2:** (150) were identified from registered nurses in identical positions who were not undertaking the clinical leadership course as a part of training and who were employed in the large organisation and its sub-facilities.
- **Selection Criteria:** Participants of the training course who agreed to participate in the research project.
- **Exclusion Criteria:** The exclusion criteria were based on two simple categories.
  1. Any participant of the training course choosing not to participate in the research project, and
  2. Any participant that has undergone similar leadership and management training.
- **Procedures:** The organisations were aware of the research project outline and the roll-out of the clinical leadership training courses, and assisted in distribution of information flyers and registrations.
- **Material 1:** A flyer that explained the project was distributed to all nurses within the organisation, and attached to the internal notification of the clinical leadership training course. Full details of the project were supplied in the internal staff newsletters.

- **Material 2:** A second flyer that explains the need for a control group of nurses within the project was distributed internally and attached to the internal notification of the training course and on facility notice boards.
- **Group sizes:** Each group of 150 nurses was divided randomly into smaller groups of 15 nurses, ending in a total of 10 groups in **IG1** and 10 groups in **CG2** and a total lot of 20 groups in each silo. A schedule of clinical leader's course (the intervention for PCG1) dates was distributed to each member of the perspective groups. Each applicant had previously submitted their work email addresses as part of the application process, which resulted in a formal email and introduction letter outlining the specific instruction for their role in a specified group, this then began the administration of **Phase 1** and collection of the baseline data and pre-test survey answers.
- **Specific instruction: IG1**—each participant received an email as part of their specific groups 1 – 10, and were instructed to read the participant agreement and print to sign off. Once complied, the participant was invited and *attended* a calendared course induction day within the head office at a central location in Sydney, NSW. The purpose of the structured day was to receive full induction and orientation to the research project and the clinical leadership program. Signed participant agreements were collected and witnessed during this procedure as a key point of meeting ethics approval and verifying voluntary participation. This step in the administration completed Phase 1 of the project for PG1 as base line data was collected in the pre-test survey conducted prior to or on the day. The participants receiving intervention continued into the Clinical Leadership training course through the web-based learning portal under the supervision of the facilitator/researcher.

- **Specific instruction: CG2**— each member of Control Group 2 was also issued a letter of instruction as a member of the control group, with instructions to print out and sign the agreement and to scan and return copies to the researcher's nominated email or postal address. As these participants were not receiving any intervention, they were instructed to click the prescribed hyperlink within the email that guided them to the pre-test survey. This step in the administration completed Phase 1 of the project for **CG2** as base line data was collected in the pre-test survey conducted prior to or on the day.
- **Payment:** the participants did not receive payment for participation, however they did receive a certificate on completion of the intervention course.

### 3.15 Phase 1: Baseline Data Collection and Survey Construction

As discussed previously, all participants enrolled in the study (from both the intervention **IG1** and control group **CG2**) were asked to complete an electronic survey via 'Survey Monkey', a highly recognised and well-utilised web-based survey system. The specific instruction for the Intervention Group **IG1**, was to read the instruction for participation, to print and sign the participant agreement, and complete the survey prior to engaging in the Clinical Leader's course induction day. The survey was collected from each participant in their group's scheduled day and used to elicit responses and extraneous data related to the following:

- demographic information;
- knowledge of and attitudes to current roles;
- knowledge of and attitudes to self and future career;
- knowledge of and attitudes to skills and confidence.



Demographic information was collected in the first 7 questions of the survey and included:

- Age;
- Gender;
- Educational background;
- Time in service/ level of experience; and
- Qualifications and specialised skill.

Responses were coded for data entry to enable analysis of numerical data and of qualitative data and will be detailed in **chapter 4: Results Quantitative** of this dissertation.

### 3.16 The Survey Questions Pre Test

There are a total of 37 questions in the survey; seven questions that capture specifics on demographics of interest and the remainder of the 30 questions were designed to allow clear analysis of the data using a standard Anova test to the hypotheses.

Investigating the options in standard and accepted surveys available for use, there were common threads relating to McCloskey & Mueller's Satisfaction Scale (MMSS) as perhaps the most common survey used in researching nurses and healthcare workers' attitudes to workplace or job satisfaction <sup>(85)</sup>. Consideration was given to using the MMSS within this study, however the investigation was on the impact of the intervention including attitudes to the nurse workplace, and standard MMSS questions were not rationalised. After further research to gain an understanding of the best evidence surrounding the development and evaluation of Interprofessional Education (IPE) <sup>(86, 87)</sup>, there was a collaborative decision between myself and my supervisors at the time to create my own survey questions that essentially mapped the known skills

gap being experienced by the registered nurse to the learning being delivered in the intervention. This would collect data that would demonstrate any change in the positiveness of the intervention group before and after the training intervention and answer the hypothesis positively or negatively. A pre-test of sample survey questions was undertaken with a group of nurses currently studying an RN Team Leaders course (the proposed intervention course) as a matter of their own continuous professional development.

### 3.17 Phase 2: Development of the intervention (the learning and development program)

As discussed earlier, the development of the intervention was carried out as a result of previous research and development work undertaken by myself during the course of studying the Bachelor of Applied Social Sciences within the Australian College of Applied Psychology.

The study was conducted in three phases:

- Phase One: Investigate the knowledge and skills gap.
- Phase Two: Conduct the research.
- Phase Three: Report findings and design an implementation to improve practice and contribute to the field of study.

Although unpublished work, this was the starting point for formal and scientific investigation into designing an Interprofessional Education (IPE) <sup>(86)</sup> course framework that filled the gaps in applying clinical leadership knowledge that was being experienced by the registered nurses and leaders or managers in aged care<sup>(87)</sup>. I was later to confirm much of the findings in this unpublished work, while undertaking the Masters of Clinical Science, where I conducted and published the results of a

comprehensive systematic review titled: *'The Experience of Registered Nurses as Managers and Leaders in Residential Aged Care Facilities'* <sup>(1)</sup>.

An IPE learning and development program has already been designed based on skills gaps identified in the literature at the time. The course program has been subjected to a rigorous process of peer review and accreditation by the Australian College of Nursing (ACN). The course has been approved and credited with 25 Continuous Nursing Education (CNE) points for professional practice to demonstrate competency within the framework of the Australian Nursing & Midwifery Council (ANMWC) and registration as a nurse under the Australian Health Practitioners Regulation Authority (AHPRA). This is a requirement for maintaining professional registration as a registered nurse in Australia, as discussed in Chapter 2: The Literature Review.

The IPE course consists of 5 modules of training delivered using a blended approach that incorporates face-to-face facilitation and the use of workbooks and e-learning modules completed through distance learning in a virtual classroom via the internet.

### *3.17.1 Module 1: The structure and profile of the current aged care sector in Australia*

#### *The Learning outcome*

At the end of this module the participant will demonstrate underpinning knowledge of the contemporary Aged Care Sector in Australia today. This stage specifically deals with the current reform changes and legislation guidelines that are important to the RN in clinical leadership. This stage also delivers the underpinning knowledge of the accreditation standards and the philosophy surrounding clinical risk management and staff safety.

### *Management Knowledge Objectives*

- Framework around Accreditation
- Mastering the admission process
- Understand the incident reporting system
- Aged care documentation systems
- Investigate quality documents that guide clinical assessment

### *Clinical Knowledge Objectives*

- Investigate quality documents that guide clinical assessment
- Observation in clinical assessment
- Understanding clinical risk
- Liaising with your clinical team members
- Understand and utilise research and best practice

## *3.17.2 Module 2: Understanding the Multi-Disciplinary Health Team approach to care*

### *The Learning Outcome*

At the end of the module the participant will have acquired underpinning knowledge of the contemporary aged care philosophy of Multi-Disciplinary Team Management. An RN identifies with the role of team leader of a shift and has the responsibility to delegate tasks and supervise the coordination of services to the client. These services are carried out by numerous members of a healthcare team. In this stage the participant

learns the roles and scopes of the team to develop positive understanding of quality control of the service to the consumer.

The module introduces the participant to the concept of a systemised care model in the facility, including admission, assessment, case conference, implementation and clinical review. This stage is further consolidated in Stage 5, which focuses on clinical review in the framework of geriatric care.

#### *Management Knowledge Objectives*

- Framework around Multidisciplinary teams
- Understand the roles in the team
- Understand the case conference framework
- Investigate research and best practice
- Investigate quality documents that guide clinical assessment

#### *Clinical Knowledge Objectives*

- Understand a case conference framework
- Liaise with your clinical team members
- Referral process
- Understand and utilise research and best practice
- Care documentation systems

### **3.17.3 Module 3: Maintaining effective workplace communication and environments**

#### *The Learning Outcome*

At the end of this module the participant will be able to utilise different communication strategies that maintain a team's effective workplace. The participant will understand

and be confident in delegation of direct care work to staff, understand and manage conflict, and demonstrate emotional intelligence skills that are important to the RN in clinical leadership. The participant will be also able to demonstrate proactive knowledge of positive leadership styles and philosophy around clinical risk management and staff safety.

#### *Leadership & Management Knowledge Objectives*

- Effective communication skills to lead teams
- Developing emotional competency
- Delegation
- Introduction to conflict

#### *Clinical Knowledge Objectives*

- Understanding the admission and case conference delivery frameworks
- Validation of assessment and goal setting
- Delegation and supervision
- Utilising data

### **3.17.4 Module 4: Performance Management and Reflective Practice**

#### *The Learning Outcome*

At the end of this module the participant will be able to demonstrate knowledge of the contemporary skills for performance of individuals and the teams that work in the Aged Care Sector in Australia today. Identify with the current staff management protocols and legislation guidelines that are important to the registered nurse in leadership. Provide input to an annual appraisal and its importance for developing a healthy

workplace. The participant is also introduced to continuous nurse education and reflective practice journaling for professional development.

#### *Leadership & Management Knowledge Objectives*

- Allocating tasks and follow up
- Setting goals for improvement in the care team
- Delegation and feedback strategies
- Reflective practice journaling

#### *Clinical Knowledge Objectives*

- Daily routines in care services
- Training and managing competency
- Delegation and care standards for directives
- Reflective practice journaling

### **3.17.5 Module 5: The key aspects of a quality framework for management and clinical practice**

#### *The Learning Outcome*

At the end of this module the participant will be able to demonstrate application of the contemporary models of care planning and quality review of services to the client in the Aged Care Sector in Australia today. Specifically, the participant will demonstrate a formal process and format for clinical admission, assessment, case conference and Aged Care Funding Instrument (ACFI) submissions that are important to the registered nurse in clinical leadership. The final outcome is the demonstration of the clinical care

review process using an evidence-based framework of case conferencing and care team management.

In this stage, the participant is consolidating the last six months of learning and preparing to case conference a client in a formal setting, using a designed system. The participant also utilises the outcomes of quality management using clinical audits and continuous improvement strategies.

#### *Leadership & Management Knowledge Objectives*

- Continuous Improvement to services in the home
- Setting goals for improvement
- Complaints mechanisms

#### *Clinical Knowledge Objectives*

- Daily routines in care services
- Validation of clinical assessment
- Care directives and care planning
- Managing the case conferencing
- Conducting Clinical Audits and care review processes
- Applying a Palliative approach in care



### 3.18 Phase 3: Delivery of the intervention (the learning and development program)

As outlined in the literature review, nurses in general have identified numerous barriers to undertaking professional development or education. Obtaining full organisational support for this study was crucial for removing potential organisational barriers.

The utilisation of the web-based classroom enabled the participants to undertake the education with the calendar that is detailed in the following heading 'Study Timeframe'. Nurses were usually able to gain access to the web-based sessions from anywhere that was private with internet access. Nurses who were on duty for the delivery of education sessions were permitted time off the floor with support staff to attend to the learning. Each module required attendance at a live and interactive webinar on the subject, followed by the completion of e-learning workshops and engagement in recommended readings. Assessments were attached to each module for completion with a time limit of one month for each module. The ten participants' course groups overlapped by 2 weeks for congruence with the research program and timeline as explained in Table: 3.7.

Table 3.7: Intervention Rollout

<b>Phase Three: Intervention</b>		
Course one	2 April 2013	8 August 2013
Course Two	16 April 2013	13 August 2013
Course Three	1 May 2013	4 Sep 2013
Course Four	16 May 2013	18 Sep 2013
Course Five	5 June 2013	2 Oct 2013

Course Six	15 June 2013	16 Oct 2013
Course Seven	3 July 2013	1 Nov 2013
Course Eight	17 July 2013	16 Nov 2013
Course Nine	2 August 2013	4 Dec 2013
Course Ten	17 Aug 2013	18 Dec 2013

### 3.19 Phase 4: Post-intervention and qualitative data collection

On completion of the final module in the course, the participants were directed to undertake a final session to review the learning and participate in the post course assessment and completion. Once the process of assessment marking was complete, each participant was then invited by email and directed to complete the post course survey (post-test) by clicking the links provided. The quantitative survey design was identical to the design of the pre-test survey that was undertaken in the induction stage in Phase 1.

At this phase of the project, all participants were invited to volunteer for participation in the focus group and qualitative interview to be held at the completion of training, that was outlined in the debrief on the project. Hoping to select one from each of the 10 groups, a final 8 participants volunteered to continue with the qualitative component of the research project. These interviews were undertaken through the web-based virtual classroom as a structured interview conducted and recorded separately for each nurse. The qualitative investigation was used in this stage to ask a series of questions that allowed a deeper understanding of the nurse's experience of the training and its impact on their role, retention in the job, and perceived outcomes for care.

### 3.20 Phase 5: Analysis of data and report writing

The analysis of data was carried out in three steps, in accordance with the methodological paradigm that directed the method of data collection for that area of investigation, and will be reported on as separate 'results' chapters within this thesis.

In endeavouring to learn and understand quantitative research methods on the higher degree by research journey, however enlightening, the interpretation of the data required an experienced eye for quality.

Due to a lack of experience and confidence in analysing quantitative data, the quantitative survey results were downloaded from the online Survey Monkey and the engagement of private consultancy expertise and advice was granted and acknowledged in the forward of this paper. This engagement with the expert purist consultant was extremely educational and beneficial in interpreting the numbers, grading the scales and identifying the significance of variance, if any, when represented in the quantitative results.

Qualitative analysis was completed through Thematic Analysis taken from the web-based interviews. A series of seven questions was asked in relation to the nurse's experience of the training program, and its impact on their role. Analysis was conducted utilising the Joanna Briggs Institute - Thematic Analysis Program (JBI-TAP) software to support and validate the inquiry and outcomes explained in the coming chapters. Both qualitative and quantitative results were then integrated for a convergence of themes similar to the concept of triangulation (used as a metaphor), however interpreted.

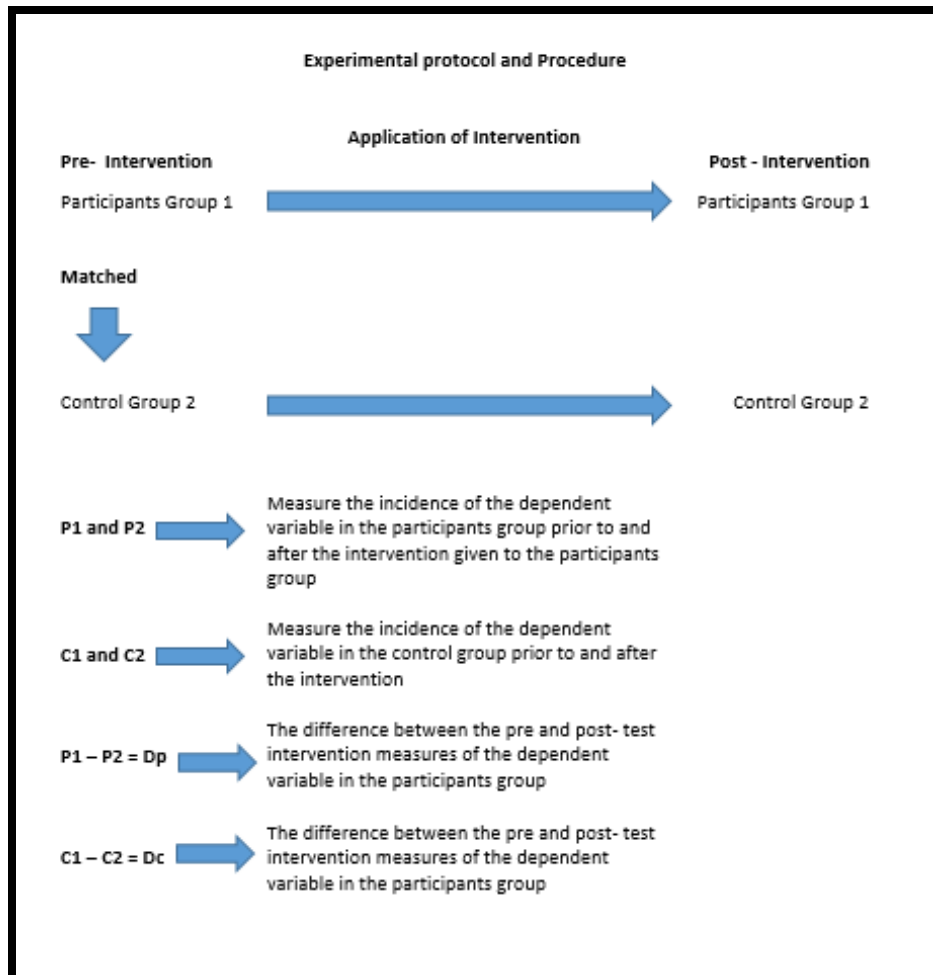


Figure 3.4: Rational for pre and post-test design and mixed methodology. Adapted from Holden<sup>(64)</sup>

### 3.21 Study Timeframe:

The timeframe for the projects was structured to fit the needs of the intervention roll-out for each sub group within **PG1**. Each module of the Clinical Leadership course was to be completed by the participant within one calendar month. This set a structured five month course to be completed within a 6 month timeframe, allowing for 2 weeks within the time to allow flexibility in application from the participant. With a total of 10 groups to place through the program, it was decided to begin the first group in April and commence consecutive groups in two week separations, commencing two groups per month for 5 months. This allowed for the completion of all groups by December 2013.

Table 3.8: Table of the Study Timeframe.

<b>Activity</b>	<b>Start</b>	<b>Finish</b>
<b>Phase One:</b> Pre-test survey		
<b>Phase Two and Three:</b> Intervention		
Course one	2 April 2013	8 August 2013
Course Two	16 April 2013	13 August 2013
Course Three	1 May 2013	4 Sep 2013
Course Four	16 May 2013	18 Sep 2013
Course Five	5 June 2013	2 Oct 2013
Course Six	15 June 2013	16 Oct 2013
Course Seven	3 July 2013	1 Nov 2013
Course Eight	17 July 2013	16 Nov 2013
Course Nine	2 August 2013	4 Dec 2013
Course Ten	17 August 2013	18 Dec 2013
<b>Phase Four:</b> Post-test survey and qualitative interview		
<b>Phase Five:</b> data Analysis during 2014		

### 3.22 Ethical Issues

Ethical approval for this study has already been sought and approved by the University of Adelaide ethics board (Appendix 4) and from the organisations taking part in the research.

Participation was voluntary and followed strict guidelines to ensure anonymity. A participant information sheet was made available to facilitate informed consent. All participants who may have felt they had been placed in a situation that caused harm or was likely to cause harm had access to qualified counsellors for debriefing and support. No participants raised concerns throughout the study.

The following chapters 4, 5 and 6 are the presentation of the results. Each chapter will present the results that reflect the methodology undertaken. Chapter 4 is the presentation of the quantitative analysis. Chapter 5 is the presentation of the qualitative analysis, and chapter 6 will be the presentation of the integrated analysis of both of the different data.

## Chapter 4: Results on Quantitative Assessment

---

### 4.1 Introduction

*'Statistics are the triumph of the quantitative method, and the quantitative method is the victory of sterility and death'.*

*(Hilaire Belloc)*

This chapter is a detailed explanation of the quantitative data and the results of the analysis undertaken to interpret the significance of variance in the survey tools used by the participants and control groups. Descriptive statistics were calculated using SPSS ver15 and StataSE ver12. Continuous variables were presented as means and their standard deviations (SDs), frequencies and proportions were used for description of count or categorical variables. T-test was employed for comparison of means between two groups and chi-square for those of proportions. A  $p$  value of less than 0.05 was considered as statistically significant and a  $p$  value of greater than 0.05 not significant.

Some questions in the survey contained variable answers that were graded as always, sometimes, never, and agree, strongly agree, disagree. A further variable was created for each respondent so that the response could be analysed as a 'yes' or 'no' answer for clarity.

### 4.2 Demographic Data Analysis

The demographic information has been tabulated from the quantitative survey results have been generated from analysing questions 1 to 7 and included information relating

to age, gender, educational background, time and length of service. The data has been presented in Figure 4.1 below for ease of viewing and interpretation.

Statistically, there was no difference in the demographics between the participants group and the control group. All nurses in both intervention and control groups averaged a mean of 10 years' experience in aged care work, and 50% of nurses within each group were born and educated in Australia, or born and educated overseas. An average of 5% of each group were male nurses, and all nurses averaged a workload of 50 to 100 residents under their care. Statistics on education and qualification showed no disproportions between the two groups, and an average of 40% of all nurses held a bachelor degree in nursing and 21% held a post graduate qualification under masters' level.

<b>Demographical Statistics</b>	<b>Participant Group</b>		<b>Control Group</b>	
<b>Mean Age</b>	49 years		49 years	
<b>Sex</b>	M 5%	F 94%	M 5%	F 94%
<b>Educational Background</b>	24% hospital		34 % hospital	
	56% Bachelor		66% Bachelor	
<b>Time in service</b>	27 % between 1 to 10 years		30% between 1 to 10 years	
	43% between 10 to 20 years		43% between 10 to 20 years	

Figure 4.1: Tabulated demographic information on participant and control groups.



### 4.3 General Survey Results

#### Question 8. I am overworked in my role.

The response to this question in both groups was answered as a ‘strongly agree’ at the high end of the Likert scale in both pre and post-test results. Given that no intervention had occurred until after the pre-test, the strong response was reflective of some of the discourse expressed throughout the literature review validating that nurses working in aged and long term care feel and experience stress and burnout. There were no differences in the proportions of nurses from both groups that reported they felt overworked in their roles. Approximately 90% of all nurses in both intervention and control group reported they felt overworked in their roles pre and post-test the study. This data was deemed significant for the integrating analysis to follow.

**Fig 4.2: Question 8 result**

*Comparisons:*

Overworked	Intervention			Post-control vs Post-intervention		
	Pre (%)	Post (%)	<i>p</i>	Control (%)	Intervention (%)	<i>p</i>
No	11.0	8.3	0.544	11.9	8.3	0.533
Yes	89.0	91.7		88.1	91.7	
Total	100.0	100.0		100.0	100.0	

No changes in proportion of participants who responded as “overworked” post-intervention compared either with post-control ( $p > 0.05$ ) or with pre-intervention ( $p > 0.05$ ).

Overworked	Control			Pre-control vs Pre-intervention		
	Pre (%)	Post (%)	<i>p</i>	Control (%)	Intervention (%)	<i>p</i>
No	5.6	11.9	0.225	5.6	11.0	0.196
Yes	94.4	88.1		94.4	89.0	
Total	100.0	100.0		100.0	100.0	

No differences in proportion of participants who responded as “overworked” pre-control, compared either with post-control ( $p > 0.05$ ) or pre-intervention ( $p > 0.05$ ).

#### Question 9. I have been formally trained in the clinical leadership and management of care teams.

There were differences in proportions answering “Yes” for the three leadership questions between pre and post-intervention. That is, the numbers who agreed they were formally trained in leadership increased for the intervention group after the intervention (all  $p < 0.05$ ), but no such differences were found for the post-intervention group compared with post-control (all  $p > 0.05$ ). This data were deemed significant for the integrating analysis to follow.

**Fig 4.3: Question 9 result**

Leadership	Intervention			Post-control vs Post-intervention		
	Pre (%)	Post (%)	$p$	Control (%)	Intervention (%)	$p$
Yes, Clinical	45.1	67.7	0.004	64.1	67.7	0.706
Yes, Team	43.1	80.6	<0.001	63.2	80.6	0.064
Yes, Management	30.0	58.9	<0.001	51.3	58.9	0.471

**Question 10. I am confident with delegating tasks to my care staff.**

There were no differences in proportions of responses for both pre and post-test intervention or control groups. All nurses responded with confidence in regards to delegating tasks to staff. Although not significant for variance, it is noteworthy and discussed in the summary of this chapter

**Fig 4.4: Question 10 result**

*Comparisons:*

Further analysis was carried out by creating a new variable which, for each respondent, identified as a yes/no response if they were confident in delegation. Answers were coded as “yes” if either agree or strongly agree was chosen, and “no” if disagree or strongly disagree was chosen.

Confidence	Intervention			Post-control vs Post-intervention		
	Pre (%)	Post (%)	$p$	Control (%)	Intervention (%)	$p$
Yes, Clinical Skills Tasks	86.5	94.4	0.086	89.5	94.4	0.351
Yes, Administration Tasks	77.9	80.6	0.673	76.3	80.6	0.606

There were no changes in confidence for post-intervention compared with pre-intervention group (all  $p > 0.05$ ) or with post-control (all  $p > 0.05$ ).

Confidence	Control	Pre-control vs Pre-intervention
------------	---------	---------------------------------

	Pre (%)	Post (%)	<i>p</i>	Control (%)	Intervention (%)	<i>p</i>
Yes, Clinical Skills Tasks	85.5	89.5	0.560	85.5	86.5	0.847
Yes, Administration Tasks	80.6	76.3	0.625	80.6	77.9	0.705

There were no differences in confidence for pre-control compared with pre-intervention group or with post-control (all  $p > 0.5$ ).

### **Question 11. I am appreciated for the work I do.**

There were no differences in proportions of responses for both pre and post-test intervention or control groups. All nurses responded with confidence in regards to feeling appreciated for the work they do, however it was identified that all respondents felt less appreciated by the organisation in comparison to that of staff families and patients. Reflective of recorded ontology in the literature review, and although not significant for variance, it is noteworthy and discussed in the summary of this chapter

### **Question 12. I have a full understanding of the competency skills of my care staff.**

Respondents had to identify with two areas of understanding competency, being vocational, and clinical. Understanding improved with the post-intervention group, however there was no difference in the post-control group.

**Fig 4.5: Question 12 result**

Understanding	Intervention			Post-control vs Post-intervention		
	Pre (%)	Post (%)	<i>p</i>	Control (%)	Intervention (%)	<i>p</i>
Yes, Clinical skills	77.8	91.8	0.016	78.9	91.8	0.065
Yes, Vocational skills	65.8	81.5	0.020	62.2	81.5	0.031

### **Question 13. I have the learned ability and skill to effectively delegate work according to the Australian Nurses Midwives Board guidelines.**

This question identified significant improvement of learned ability to delegate effectively under the Australian guidelines for the post intervention group. However there were no differences in the respondents' pre and post-test control group.

**Fig 4.6: Question 13 result**

Effectively Delegate Work	Intervention			Post-control vs Post-intervention		
	Pre (%)	Post (%)	<i>p</i>	Control (%)	Intervention (%)	<i>p</i>
Yes	75.6	91.4	0.006	86.8	91.4	0.452
No	24.4	8.6		13.2	8.6	

Effectively Delegate Work	Control			Pre-control vs Pre-intervention		
	Pre (%)	Post (%)	<i>p</i>	Control (%)	Intervention (%)	<i>p</i>
Yes	86.6	86.8	0.968	86.6	75.6	0.072
No	13.4	13.2		13.4	24.4	

**Question 14. I have been formally and properly prepared for my role.**

Respondents had to identify with two areas of positive attitude; management, and clinical. A new variable was added to clarify with 'yes' and 'no' responses. Positive attitudes improved with the post-intervention group, however there were no differences in the responses from the post-control group.

**Question 15. There is a balance between clinical and non-clinical responsibility in my role.**

Respondents had to identify with three areas of positive attitude in relation to a balance, being administration, management, and clinical. A new variable was added to clarify with 'yes' and 'no' responses at each level. For the intervention group there was more balance for clinical and managerial post intervention, however there was no difference in the responses in administration. The control group showed no differences in responses from pre and post-test.

**Question 16. I am confident in writing care plans.**

Respondents had to identify with two areas of gaining confidence; assessment and planning. A new variable was added to clarify with 'yes' and 'no' responses. Confidence was gained and improved with the post-intervention group, however there was no difference in the responses from the post-control group. It is noteworthy that the baseline was already confident in all groups.

**Question 17. This role meets my expectations as an RN in aged care.**

Respondents had to identify with two areas of their team leaders' role; meeting expectation clinically and managerially. A new variable was added to clarify with 'yes' and 'no' responses. More expectations were met both clinically and managerially in the intervention group post-test, compared with the control group, however there was no difference between the pre and post-intervention responses. Noteworthy is the indication that all nurses responded positively to the pre and post-test surveys.

**Question 18. I have open communications with the management.**

There were no differences in the respondents' answers for both intervention and control groups in pre and post-test surveys. Responses were high and positive to open communications with management.

**Question 19. I have been formally trained to handle conflict and resolve issues well.**

Respondents had to identify with three areas of conflict in relation to role; staff conflict, resident conflict and family conflict. A new variable was added to clarify with 'yes' and 'no' responses at each level.

For the intervention group there was an increased number of respondents identifying with being trained post intervention, however there was no difference in the responses pre and post-test within the control group.

**Question 20. I trust the skill levels of my junior care staff.**

Respondents had to identify with three areas of trust: always, sometimes, and never. A new variable was added to clarify with 'yes' and 'no' responses at each level. For the intervention group there were an increased number of respondents having trust in their junior staff post-intervention, however there was no difference in the responses pre and post-test within the control group.

**Question 21. I am confident in my ability to challenge and manage policy.**

Respondents had to identify with two areas of challenging policy, being clinical and organisational. A new variable was added to clarify with 'yes' and 'no' responses. Confidence was gained and improved with the post-intervention group, however there was no difference in the responses from the post-control group. It is noteworthy that the baseline was already confident in all groups.

**Question 22. I have a full and confident understanding of the current legislation in delegation and supervision for nurses in aged care.**

Respondents had to identify, on a four point Likert scale, their degree of confidence in relation to understanding legislation. A new variable was added to clarify with 'yes' and 'no' responses for the question. For the intervention group there was more balance for clinical and managerial post-intervention, however there was no difference in the responses in administration. The control group showed no differences in responses from pre to post-test.

**Question 23. I am confident with the care funding instrument and the validation required.**

Respondents had to identify, on a four point Likert scale, their degree of confidence in relation to understanding the Aged Care funding instrument used in Australia. A new variable was added to clarify with 'yes' and 'no' responses for the question. More participants had confidence both post-intervention versus pre-intervention ( $p < 0.05$ ) and post-intervention versus post-control ( $p < 0.05$ ).

**Question 24. I would benefit from further training in leadership and management.**

Respondents had to identify, on a four point Likert scale, the level of their need in relation to gaining further leadership and management training. A new variable was added to clarify with 'yes' and 'no' responses for the question. More participants had identified their need for further training post-intervention versus pre-intervention ( $p < 0.05$ ), and post-intervention versus post-control ( $p < 0.05$ ). The control group showed no differences in responses.

**Question 25. I am confident in my skills in dealing with staff discipline and performance management.**

Respondents had to identify, on a four point Likert scale, their degree of confidence in relation to dealing with staff performance management. A new variable was added to clarify with 'yes' and 'no' responses for the question. More participants in the intervention group had improved their confidence post-intervention versus pre-intervention ( $p < 0.05$ ), and post-intervention versus post-control ( $p < 0.05$ ). The control group showed no differences in responses.

**Question 26. I have sound counselling skills when dealing with residents/clients/families.**

Respondents had to identify, on a four point Likert scale, their degree of confidence in relation to counselling skills. A new variable was added to clarify with 'yes' and 'no' responses for the question. More participants in the intervention group had improved their counselling skills post-intervention versus pre-intervention ( $p < 0.05$ ), and post-intervention versus post-control ( $p < 0.05$ ). The control group showed no differences in responses. However the baseline response was positive high.

**Question 27. I have had formal leadership skills training.**

Respondents had to identify, on a four point Likert scale, their degree of confidence in relation to leadership skills. A new variable was added to clarify with 'yes' and 'no' responses for the question. More participants in the intervention group had improved their leadership skills post-intervention versus pre-intervention ( $p < 0.05$ ), and post-intervention versus post-control ( $p < 0.05$ ). The control group showed no differences in responses.

**Fig 4.7: Question 27 result**

Workplace environment	Intervention			Post-control vs Post-intervention		
	Pre (%)	Post (%)	<i>p</i>	Control (%)	Intervention (%)	<i>p</i>
Yes, happy	81.1	80.9	0.964	81.1	80.9	0.980
Yes, effective	77.7	84.6	0.264	70.3	84.6	0.085

**Question 28. I have a happy and effective workplace environment.**

There were no differences in the responses to this question from all groups to both pre and post-test surveys. It is noteworthy that the respondents' identification with this question was positive and high.



**Fig 4.8: Question 28 result**

Workplace environment	Intervention			Post-control vs Post-intervention		
	Pre (%)	Post (%)	<i>p</i>	Control (%)	Intervention (%)	<i>p</i>
Yes, happy	81.1	80.9	0.964	81.1	80.9	0.980
Yes, effective	77.7	84.6	0.264	70.3	84.6	0.085

**Question 29. I have been formally trained in the clinical management of gerontic care issues.**

Respondents had to identify, on a four point Likert scale, their degree of confidence in relation to clinical management of gerontic care. A new variable was added to clarify with 'yes' and 'no' responses for the question. More participants in the intervention group had improved their confidence post-intervention versus pre-intervention ( $p < 0.05$ ), and post-intervention versus post-control ( $p < 0.05$ ). The control group showed no differences in responses.

**Fig 4.9: Question 26 result**

Clinical management	Intervention			Post-control vs Post-intervention		
	Pre (%)	Post (%)	<i>p</i>	Control (%)	Intervention (%)	<i>p</i>
Yes	41.1	70.6	<0.001	48.7	70.6	0.026
No	58.9	29.4		51.3	29.4	

**Question 30. I have been formally trained in communication styles and techniques.**

Respondents had to identify, on a four point Likert scale, their degree of confidence in relation to being trained in communication. A new variable was added to clarify with 'yes' and 'no' responses for the question.

More participants in the intervention group had improved their confidence post-intervention versus pre-intervention ( $p < 0.05$ ), and post-intervention versus post-control ( $p < 0.05$ ). The control group showed no differences in responses.

**Question 31. I spend more time on administration than nursing duties.**

There were no differences in the respondents' answers for both intervention and control groups in pre and post-test surveys. All groups identified that they spend more time on administration than nursing duties.

**Question 32. I need training in case management.**

This question required a true or false response. Fewer post-intervention participants needed training in case management than post-control group participants. The control group showed no differences in responses between the pre and post-test surveys.

**Question 33. I am planning a career in aged care.**

There were no differences in the respondents' answers for both intervention and control groups in pre and post-test surveys. All groups identified that they wish to have a long career in aged care and have a positive high response to the question.

**Question 34. I use quality auditing to meet best practice.**

This question required a true or false response. More post-intervention group than control group identified that they would use clinical auditing post the intervention. The

control group showed no differences in responses between the pre and post-test surveys.

**Question 35. I use a case conference method to review care services and improve care outcomes.**

This question required a true or false response. More post-intervention group than control group identified that they would use case conferencing post the intervention. The control group showed no differences in responses between the pre and post-test surveys.

**Question 36. I consider my role at work to be:**

The respondents had a choice to consider between being a nurse or a manager. All groups, in both pre and post-test surveys, identified themselves as nurses rather than managers. There were no differences in responses and it was noteworthy that there was a high response at baseline.

**Question 37. I am looking forward to a long career in aged care.**

There were no differences in the respondents' answers for both intervention and control groups in pre and post-test surveys. All groups identified that they wished to have a long career in aged care and had a positive high response to the question.

#### 4.4 Summary

Demographic analysis demonstrated that both participant and control groups were very similar and reflective of other current published literature. Given the current shortage of nurses globally and the rationales provided when reading broadly, having 50% of both groups made up of Overseas Trained Nurses (OTNs) indicates that this pattern will continue and more than likely increase as nurse numbers in Australia decline and

providers engage the 'scramble' for nurses in the future <sup>(37)</sup>. The mean average in age, that being 49 years old resonates with research findings that the nursing population is ageing in line with global statistics, and recruitment and retention of nurses will remain an issue of concern for aged or long term care nursing as it is not the registered nurses' preferred choice of workplace <sup>(12)</sup>.

One of the barriers presented during the facilitation of this research was the level of engagement of the participants within both groups and the desire to stay within the timeframe of the study, and commitment to completing the pre and post-test surveys. A number of the control group had changed their jobs and moved on to other care environments and consequently refused to continue in the study, or were difficult to manage. In the participant (intervention) group, the numbers were strong at the beginning of the study program, however a number of these nurses on completion of the training intervention had decided to move position and job, or could not engage in the post- test survey due to time or personal constraints. Investigations into a rationale acknowledged that this is common amongst healthcare professionals when recruited into participant groups in research. Although rarely cited and reported on in research, there is a distinct inclination for these subjects to remove, decline or avoid being research participants, particularly if the subject matter and inquiry contains personal and professionally linked attributes <sup>(11, 81)</sup>.

There was a strong significance in the improvement in confidence within the participant group relating to the questions that required the nurse to reflect on personal professional standing or knowledge and ability in relation to practice. Notably, when answering a question in regards to competency or standards of practice, the pre-test response sat in the positive or higher end of the Likert scale without significance. This can be assumed to be related to the nature of the nurse towards their individual licence

to practice, and responding in a negative or low end of the scale for the question would indicate the nurse was not competent or proficient.

Taking this case as hypothetical, nevertheless the participant group showed a significant increase and confidence to answer the question at a higher positive end of the scale post-intervention against the control group.

Question 8 was the first question in the survey that was not related to the collection of demographical statistical data and was identified as 'noteworthy', and asked the nurse if they felt overworked in their role. The strong pre-test survey response is clear that the workplaces have not improved for nurses in aged care from the beginning to the end of the study. This question was chosen as noteworthy for further investigation during the implementation of the qualitative interviews as a method of seeking some clarity on the understanding of the survey result. The results of the quantitative surveys underwent integration analysis process with the qualitative interviews analysis outcome, and is explained in **Chapter 6: Results Mixed Methods**.

The following chapter, Chapter 5, will be the explanation of results of the qualitative investigation using the live interviews undertaken in the web based virtual classroom with the participants groups. This investigation allowed a deeper understanding to the results of the survey monkey and provided a meaningful explanation of the experience that the intervention gave the nurse participant.

## Chapter 5: Results Qualitative

---

### 5.1 Introduction

*'You may have heard the world is made up of atoms and molecules, but it's really made up of stories. When you sit with an individual that's been here, you can give quantitative data a qualitative overlay'.*

*(William Turner)*

The previous chapter, was the presentation of the results of the quantitative methods used on both the participants and control groups utilising the pre and post-test survey questionnaire on the designated electronic survey monkey. This chapter is the presentation of the results of the qualitative methods undertaken to gain a deeper interpretation and understanding of the quantitative results and assist in providing the clarity for meaning of the significance.

Each of the ten groups of intervention (**IG1**) were asked if at least one person would like to participate in the collection of qualitative data by being involved in a live web-based interview session to answer some questions regarding their experience of the training course. A total of eight participants engaged with the opportunity and their answers were recorded for analysis. A series of seven questions was asked in relation to the nurses' experience of the training program, and its impact on their roles. Analysis was conducted utilising the Joanna Briggs Institute - Thematic Analysis Program (JBI-TAP).

### 5.2 Thematic Data Analysis

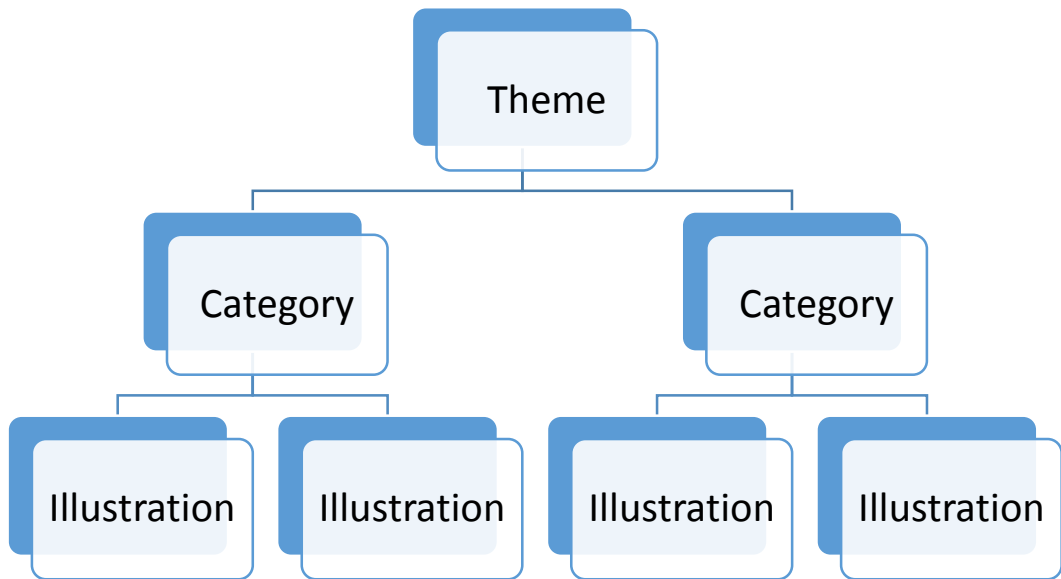
Each participant involved in qualitative data collection was identified as a 'Case' by using the first initial of the participant's name. Two pairs of the participants shared the

same first initial, so the second initial was used also, to uniquely identify their ‘Case’ responses to the questions during the recordings. A series of eight open ended questions was presented to the participants, which allowed free expression of their experience and reflection (Table 5.1). The responses to the questions were recorded in the live webinar, and then entered as text ‘Illustrations’ into the JBI – TAP software in order to establish ‘Categories’ that group different or similar ‘Illustrations’. Once the ‘Categories’ are known, the investigator can begin to read and re-read the ‘Illustrations, and ‘Categories’, to produce and identify ‘Themes’ that emerge, and present the qualitative outcome of the investigation interviews and data. (Figure 5.1)

**Table 5.1 Qualitative interview questions**

Q1	Was this training challenging for you, and why?
Q2	Has your understanding of clinical leadership changed since training began?
Q3	Has this training improved your understanding of your role as at work?
Q4	Has this course improved your leadership for the team?
Q5	Do you believe you have a better understanding of your team’s needs and how to support them at work?
Q6	Do you believe there has been an improvement to resident care outcomes since applying your leadership training?
Q7	Do you believe you have been supported in your role by your organisation?
Q8	Do you see a positive career for you in aged care?

Figure 5.1 JBI TAP Thematic Analysis Framework



### 5.3 Theme One: Leadership training is challenging in a positive way

Figure 5.2 Thematic Analysis Theme One.



The thematic analysis presented the theme that 'Leadership training for registered nurses is challenging in a positive way'. Although the impact of training was a personal challenge to the participants, they also felt the impact to be a positive experience in building personal and professional confidence.



Two categories were established from the illustrations; one being that 'The training course was a personal challenge' and the other, that the 'Training was also a positive experience' at the same time.

The illustrations collected from the participants demonstrated a paradoxical experience for the registered nurses. The majority of the participants were quick to respond to the question, demonstrating their feelings that the training had an impact that was a challenge for the individual person. The challenges ranged from the fear of engaging in new learning using the technology of web-based learning tools and having to complete written assignments, to personal challenges regarding time management and failure to complete the workloads.

*Participant L: 'This course was a challenge for me as time was an issue, other than that I enjoyed it immensely'.*

*Participant SN: 'yes it was challenging but I enjoyed the challenge as I was learning new things'.*

Paradoxical illustrations were identified in the responses as participants demonstrated that at the same time they were personally challenged by the impact that training was having on them.

*Participant R: 'This was challenging for me as I was already in my role without the knowledge, and did not appreciate the gap in my skills'.*

*Participant M: 'yes this course was a challenge for my confidence in learning new skills'.*

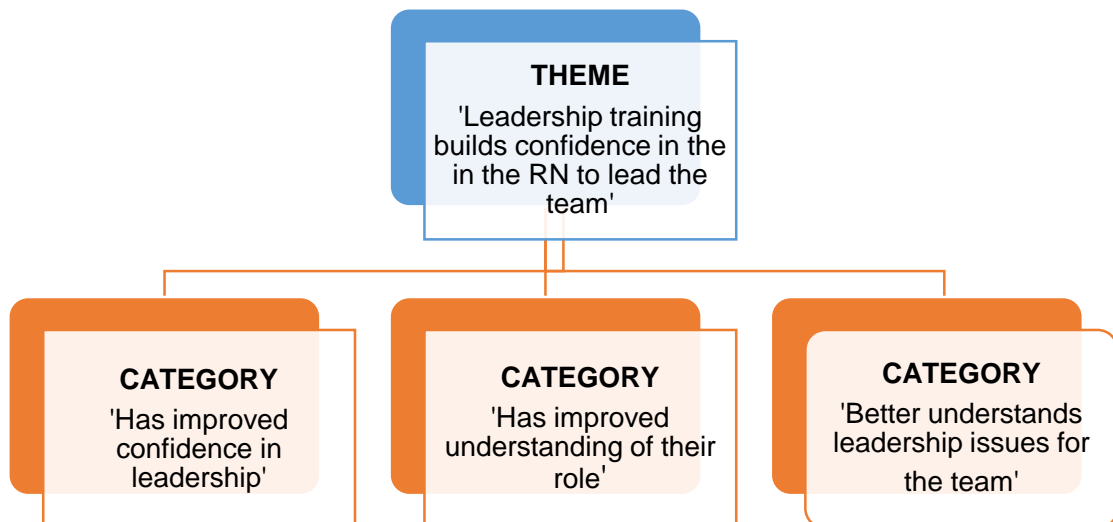
The registered nurses also felt a strong positive response towards learning new skills that would improve their performance in their role as team leaders and, at the same time, experiencing a positive feeling and one that was empowering their confidence during the course.

*Participant O: 'I am used to learning from Uni this way it was good for me and flexible. Some challenge for me was the new learning as I am post grad and need to build my confidence'.*

*Participant MN: 'was challenging but I enjoyed the experience of web based learning, it was new and refreshing. It was also challenging because it showed me how much I need to master in my role'*

#### 5.4 Theme two: Leadership training builds confidence in the RN to lead the team.

**Figure 5.3 Thematic Analysis Theme Two.**



The thematic analysis presented the theme that 'Leadership training builds confidence in the RN to lead the team'. The RN feels that clinical leadership training has improved their confidence in understanding leadership principles, there is a true link between

leading the team using both nursing and leadership skills, and that the training has enhanced their understanding of their role.

The categories of 'Has improved confidence in leadership', 'Has improved understanding of their role', and 'Better understands leadership issues for the team' were established from the illustrations.

The illustrations presented an experience that there was a strong improvement in the understanding of their individual roles as team leaders.

*Participant L: 'This course has given me more vision and passion for my role as RNTL and I can see a future in aged care. My role needs improvement and so does my skill sets'.*

*Participant SN: 'I believe the course has improved my confidence to lead the team when it is needed as I can identify when the team needs my direction'.*

The participants reflected on how they felt at the beginning of training, compared to how they felt at completion of the training.

All participants expressed an improvement in confidence to perform in the role, and a sense of clarity was noticed for participants to identify with focusing on team needs and leadership.

*Participant S: 'I think this course was great to open my eyes for this role. I was always struggling to see the light, and now I realise I was not focussed on leadership, and more on being a nurse. The role of RNTL means much more to me now.'*

*Participant SL: 'this course improved my knowledge of my role in understanding the people in my team and building my confidence to direct them in care work'.*

*Participant R: 'I have much more confidence to do my job every day. The course has allowed me to work on my weakness and that is in leading the care team. I can see that ROTD has improved much on the care overall and my team talks to me a lot more than before. My role as team leader is better.'*

Participants identified with an understanding of blending the skills they hold as registered nurses to strengthen their role as team leader at the same time, and vice-versa.

*Participant O: 'This course has improved my understanding of my role as a team leader, in that my nursing skills can be used to support care and direct the care worker. I am much clearer now on my critical thinking and taking the whole organisation and policy into account.'*

*Participant M: 'I feel the learning has showed me I need much more training in mastering the direction and leadership of the care workers. I have more confidence now but I feel that my clinical skills need some work too.'*

## 5.5 Theme Three: Leadership training has improved the knowledge and application of clinical leadership for the nurse.

**Figure 5.4: Thematic Analysis Theme Three.**



The thematic analysis mapped to the theme that 'Leadership training has improved the knowledge and application of clinical leadership for the nurse'. The RN feels that leadership training has improved their confidence in understanding clinical leadership principles, which leads to improved teamwork and communication, and this is now a reflective tool for the team leader.

Two categories were established; 'Has an improved knowledge of what is clinical leadership', and 'Has improved confidence in applying clinical leadership', Responses to questions again presented illustrations from personal reflections on experiences prior to the learning, and at the completion of the course. The illustrations presented a strong improvement in self confidence in the individuals' understanding of the principles of clinical leadership, and how to apply it in practice.

*Participant L: 'I believed it meant I am the RN so I have to make the decisions in care, now I know it means blending my clinical knowledge and skill with managing the team to do the care'.*

*Participant R: 'Doing the course allowed me to understand what I was missing. Clinical Leadership is harder than people think, it's easy to say you are one or do it well if it means a tick in the box for CNE. But doing requires skill and tact'.*

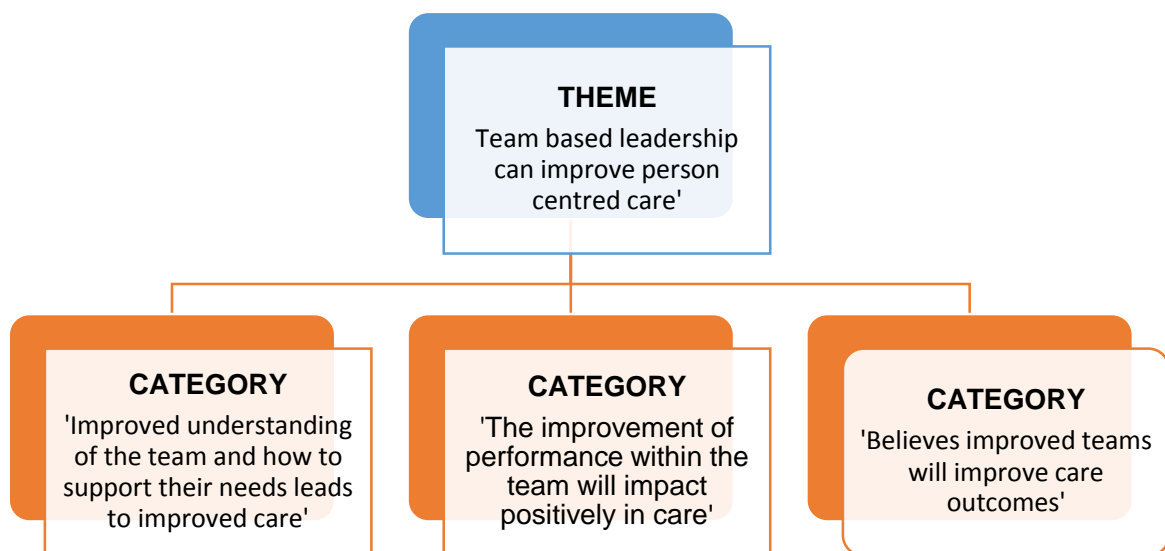
*Participant O: 'At Uni we learnt a lot about clinical leadership in the context of making nursing decisions.....It would have been good to learn the other aspects of management in leadership roles with staff and not just the patient .....It would have made the job easier to begin with'.*

*Participant MN: 'Before training the words meant nothing to me except another hat to wear at work. Now I am sure I am a clinical leader, but I do not know if others get it.....the workloads I mean'.*

Participant SN: 'I am afraid to admit that everyone talks about it and I didn't understand it so I just remained quiet. I now know what it all means and how to do it I now know that others may not get the concept as they are not leading well..... as I see it.

## 5.6 Theme Four: Team Based leadership can improve person centred care.

Figure 5.5: Thematic Analysis Theme Four.



The thematic analysis arrived with the theme that 'Team based leadership can improve person centred care'. Three categories were established from the illustrations from participants that 'Improved understanding of the team and how to support their needs leads to improved care' and 'The improvement of performance within the team will impact positively in care', and 'Believes improved teams will improve care outcomes'..

A common thread for the responses was that client goal attainment for the registered nurse is always or usually centred on direct intervention given by the registered nurse as a professional nurse.

The leadership training had identified a rationale that the registered nurse cannot do all the care and this was understood through applying their focus as a team leader through better understanding of the individuals in their teams and their needs in providing care services as directed in the care plans. This impact saw a change in focus for the registered nurse from measuring the outcome in care based on the direct application of care from the registered nurse, towards a stronger focus on the team needs by providing stronger support and improving communication from the leader in order to improve outcomes in care and service productivity and the indirect impact benefits.

*Participant O: 'I think that the care on the shift when I am in charge is improving as we seem to have less timeline issues and complaints are down. This is a good thing for the staff, but I think care can always be improved'.*

*Participant M: 'I think the care here is very good, but I think it can always improve. My residents are happy and they look good. The days seem to be improving all the time'.*

Participants also responded to this question with illustrations that demonstrated that they viewed care outcomes through the actions of direct intervention from the nurse applying the leadership training. The Illustrations demonstrated that it was a challenge for the nurse to step back from direct patient care, and focus on teamwork and leadership to delegate and direct that care. Some participants saw this as positive for care outcomes and some acknowledged they did not notice a direct impact on care outcomes, but that the improvement of performance within the team will impact positively in care.

*Participant MN: 'I think that the residents will benefit in the long run however I feel there is more work to be done to improve the care overall....more teamwork is my focus now because I have learnt I cannot do it all , I will lead the staff to do it the best they can'.*

*Participant L: 'I think that the care of the residents is improving as I see more being done for them and less time being wasted. I am very strict on timelines for the team and they seem to react well to my observations. I hope that the care is improving, perhaps I will audit it'.*

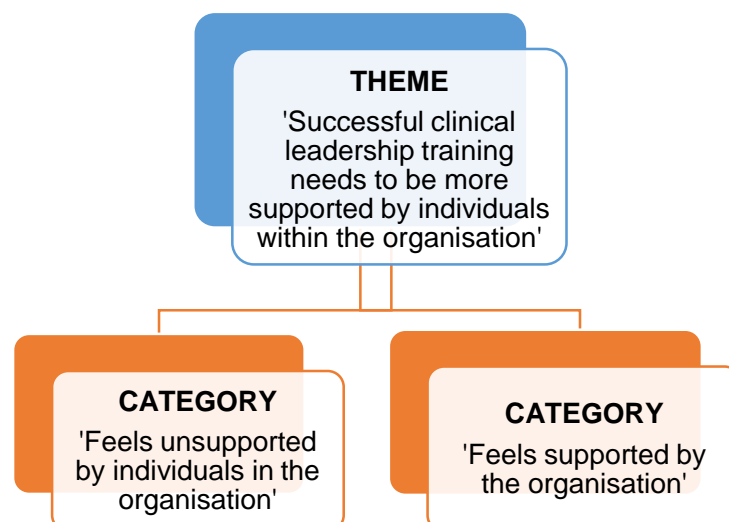
*Participant SN: 'I think that care needs to improve all the time, each resident is different, but I have noticed that the shift seem less frantic of late. I haven't looked at this in the course, I have been focused on the team'.*

*Participant R: 'I have not seen dramatic changes in care outcome for residents, but the team is improving all the time, and this will affect the residents in a positive way'.*

*Participant S: 'I think that the care is improving overall, I think the team works better and this has to be better outcome for the resident. I will look at this in future'.*

## 5.7 Theme Five: Successful clinical leadership training needs to be more supported by individuals within the organisation

**Figure 5.6: Thematic Analysis Theme Five**





The thematic analysis of the data produced the theme *'Leadership needs to be more supported by individuals in the organisation'*. The impact of leadership training has positively broadened the view of the registered nurse within the organisation, however it has narrowed the view of senior individuals in a negative way, as the registered nurse realises leadership is not understood as a shared culture, as some individuals are not trained in the skill.

Two categories were established; *'Feels supported by the organisation'* and *'Feels unsupported by individuals'*. Participants' responses and illustrations were again filled with paradoxical experiences that were a mix of positive feelings towards the organisation for supporting the training and skills development program, and yet negatively identified with a lack of support from individuals in senior roles within their organisation's structure. The participants provided 'Illustrations' that the organisation was supportive of role and career development, and was providing opportunity for growth, however many responses were paralleled with mixed emotions and reflections on the 'lack of support' and understanding for the role overall, and a 'lack of understanding' of its complexity and the leadership support required from senior individuals within the organisation.

*Participant L: 'The organisation is very supportive, this course has empowered me a lot, I have asked to be supported to become a Nurse Practitioner for the company and they have agreed to support my efforts and work towards a position in the future. I am excited'.*

*Participant MN: 'I feel the organisation has supported me in this learning, however there is much more they can do to action the advice that I now have to offer. They seem threatened by my confidence to lead care and challenge the status quo'.*

*Participant O: 'I feel the organisation has helped me a lot, as a grad and making transition this course has made it easier and I know they want me to succeed in my role.'*

*Participant SN: 'My organisation has supported me to do the course, but I think that support is only from a few. Other nurses need to do this training and the managers too. Our role is difficult and they don't listen at times.'*

*Participant SL: 'This organisation is supporting me as much as I think they can. Aged care is tough, but I feel the management understands this now. It would be good to see the manager do this training.'*

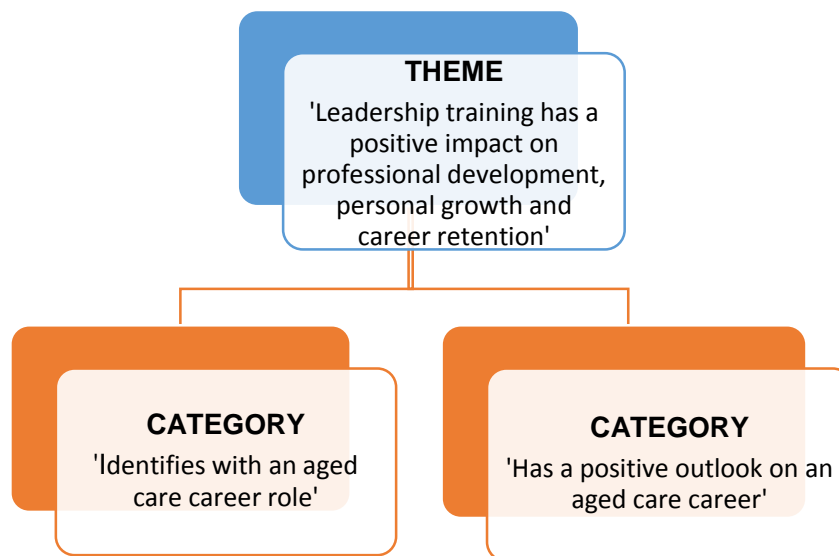
*Participant S: 'The fact that the organisation has allowed me to do this training is excellent support as I was getting lost and overwhelmed at times. I would have liked to be paid for the efforts as this was a lot of work on top of my job.'*

*Participant M: 'I feel that the organisation needs to understand the role we have is very important, they don't pay enough for the duties we are in control of , and some managers seem threatened when I challenge some situations with evidence and policy. I thank them for this course it has been good support for me.'*

*Participant R: 'My organisation is supporting me with this course, they seem to want me to do more in leading change in care. I think that the manager can improve on their understanding of the daily grind here, it's not easy, yet they demand so much for funding and accreditation, this distracts the team a lot.'*

## 5.8 Theme Six: Leadership training has a positive impact on professional development, personal growth and career retention.

**Figure 5.7: Thematic Analysis Theme Six**



The thematic analysis arrived with the theme that “Leadership training has a positive impact on professional development, personal growth and career retention’. Two categories were established from the illustrations from participants that ‘Identifies with an aged care career role’ and ‘Has a positive outlook on an aged care career’.

The illustrations presented a strong improvement on how the nurse identified with their role as a career professional within aged care. Participants expressed that an improved understanding of the individuals within their teams had increased their ability to lead and direct the nursing decisions for care. A common thread for the responses was that client goal attainment for the registered nurse was (in the past) always or was usually centred on direct intervention given by the registered nurse personally. The nurse now identifies with continuous education and professional growth, the change is empowering when understood and grounded with knowledge.

The positive responses are reflective of current literature that states nurses who work in aged care have a passion to do so, and this is a key indicator for recruitment and retention when considering growth pathways<sup>(1)</sup>.

*Participant L: 'I love aged care and I see much more for me in the role of NP I can make more changes and improve aged care at this level. I hope that my career is a long one now'.*

*Participant MN: 'This course has given me the confidence to see my career in aged care will be long and hopefully I can get better to become a facility manager, that where the change is needed, I see'.*

*Participant O: 'I feel that my career in aged care will be much different now I can see the ladder to success, and I need more education'.*

*Participant SN: 'I was going to retire soon but I think I can be better as a nurse leader to the care workers instead'.*

*Participant SL: 'I have much more confidence in my role and feel that my career in aged care has just begun. I have been here ten years already that tells me I have much more to do. I love my job now it's getting easier'.*

*Participant S: 'I am happy to say I will be having a longer career in aged care now I understand my role as RNTL better. This course has cleared so much up for me to think and plan myself'.*

*Participant M: 'I feel that my career is going to be better, I was thinking of going to be a midwife, but I can see more here in the future'.*

*Participant R: 'Before I thought I may not be good in this job. But now I see that I can build a career in team leadership care management, I think I want to become a nurse practitioner eventually'.*

## 5.9 Summary

Taking into account that the interview numbers were small, the illustrations that were presented from the interviews, demonstrated that the training course (the intervention)

had a positive impact overall on the participant registered nurses. The themes that were established are reflective of what is already known when reading the extent of qualitative results in previous studies. Nurses have appeared to gain a balanced and deeper appreciation of the impact that their clinical leadership has on the delivery of care through a multidisciplinary team, and has established or confirmed their role as the clinical team leader. The illustrations present a positive attitude to learning the skills of clinical leadership and leadership and management, and provide a positive outlook for the RN in continuing career paths in aged care and is a positive aspect for retention strategies in aged care environments and workplaces.

Completing this stage of the project was important in gaining an understanding of the impact and experience of the intervention on the participants groups. The next stage of the research was to now integrate the two methodological results for further and better particulars of the investigation. The thematic analysis of the qualitative interviews was extrapolated out of the TAP software and then mapped onto a table that enabled the framework for an integration analysis or triangulation (as a metaphor) for convergence with the significant variance identified in the quantitative results. The table is attached at the end of this thesis and labelled Appendix A.

The following chapter 6 is titled 'Results Mixed Methods' and will present the combination of the chapter 4 (results quantitative) and chapter 5 (results qualitative) as a result of being taken through a process of 'integrated analysis', or what is formally known to some scientists as a process of Triangulation. This process was undertaken to identify (if any) convergence of the results gave a significance and validation towards any of the hypothesis chosen in the introduction of this research and its methodology described in chapter 3: Methodology.

## Chapter 6: Results Mixed Methods

---

### 6.1 Mapping and Integrative Analysis

*‘The method of science is tried and true. It is not perfect, it’s just the best we have. And to abandon it, with its sceptical protocols, is the pathway to a dark age.’*

*(Carl Sagan)*

In the social sciences, the use of triangulation can be traced back to Campbell and Fiske (1959) cited in Jick (1979) <sup>(88)</sup> who developed the idea of "multiple operationism." They argued that more than one method should be used in the validation process to ensure that the variance reflected that of the trait and not that of the method. Thus, the convergence or agreement between two methods "...enhances our belief that the results are valid and not a methodological artefact" (Bouchard, 1976: p 268 cited in Jick). Triangulation in mixed methods is not new, however it is a delicate process to identify whether any of the results have congruency within the same paradigm. It was considered for this research that, rather than triangulation, an integration analysis of the data for convergence would be more suitable.

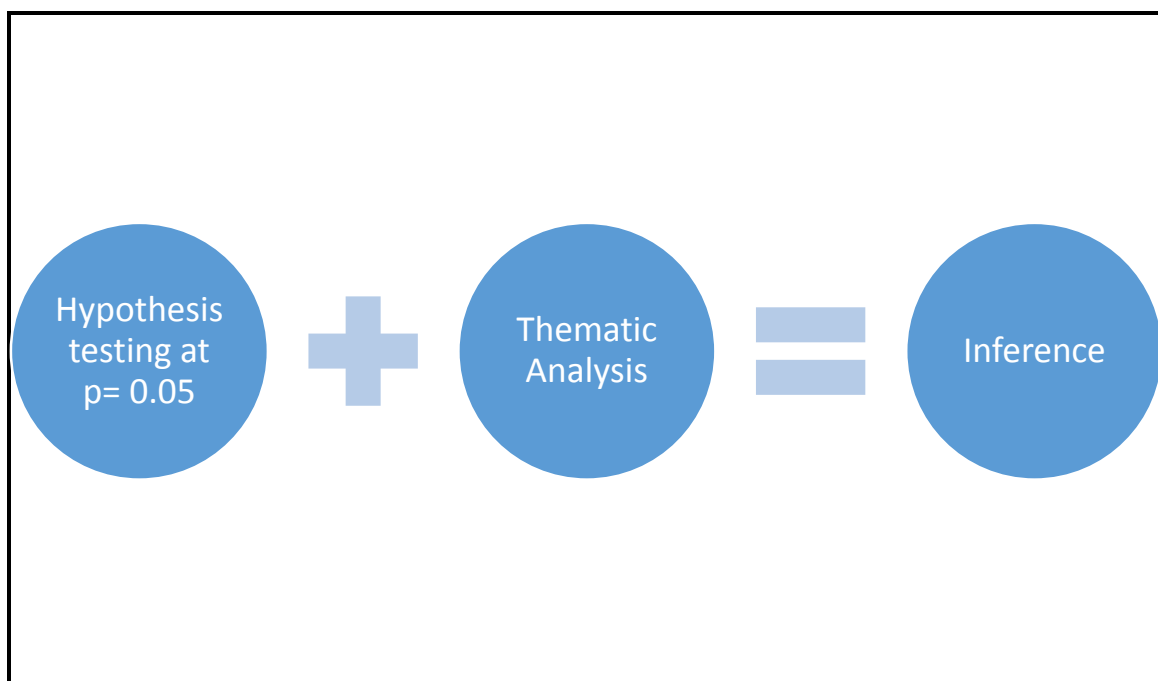
In this case, the weight given to either method of data should be underscored with the knowledge that the quantitative results were used largely to support or provide reference to the qualitative data. The surveys became more meaningful when interpreted in light of critical qualitative information, just as other statistics were most useful when compared with content analyses in the interview results.

Integration analysis or triangulation (as a metaphor), in this respect, can lead to a validity; that results are congruent and worth employing as a sequential mixed methods investigation of inquiry. The formula for data integration analysis was designed in a

table (Appendix C and figure 6.1) that enabled significance in the survey results to be colour-coded to match that of the theme generated from the thematic analysis.

On completion of the convergence analysis, the group was aligned to support or refute any of the hypotheses. One set of integrated data was mapped to the convergence of negative themes that did not support any hypothesis (Figure 6.6), however the training did have relevance for the participants to identify with poor organisational understanding and support for the RN role in aged care.

**Figure 6.1: Integrative analysis of mixed methods data.**



## 6.2 Finding One: Leadership Training is significant for the role identity of the RN in aged care.

The first finding was achieved through integrated analysis and mapping the questions from the pre and post-test surveys that showed a significant improvement, given that a decision was needed to balance the variances between a high pre-test answer in the

positive end of the responses to survey, with the significant higher post-test answers in the survey.

As explained in the results chapters, the health professional, when participating in research as a participant, will generally credit themselves as high in questions that are asked about professional standing and competency to practice. This was the case in both participant group and control group for the pre-test results, however the significance was only seen in the post-test result for the participant group and not in the control group. The significance is noticed when the participant group has answered the post-test survey with a higher validating mark on the Likert scale than in the pre-test score.

The results of the qualitative interviews provided an insight into understanding that although a challenging experience, the registered nurse participants found the training positive in that the registered nurse had established integrity with the role of team leader as an identity, giving reason to commit to the learning of new skills. Empowerment and confidence was established with the registered nurse that, as a team leader, there is a need to develop skills in leading a multidisciplinary team. Convergence with the first two themes has supported an inference to the hypothesis that: ***'The learning and development training will have a positive impact in developing positive attitudes to the role of the RN participant.'***



Figure 6.2: Convergence with theme One

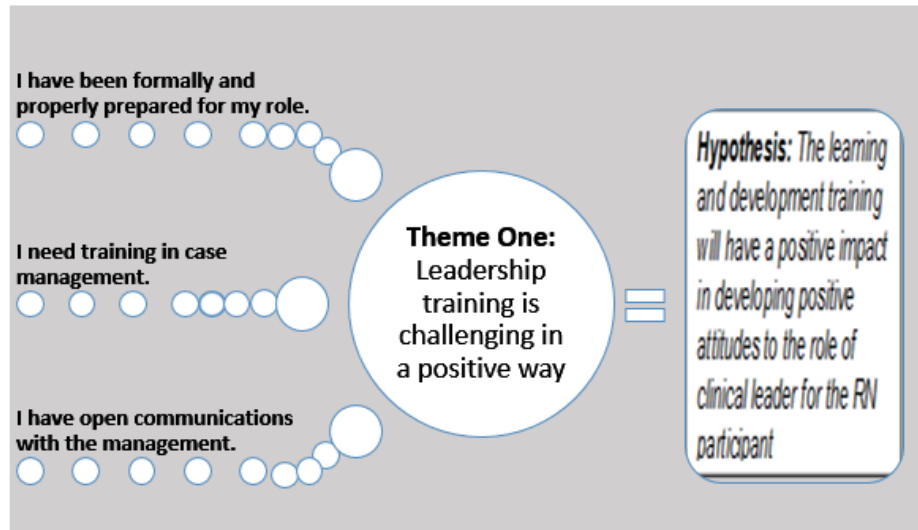
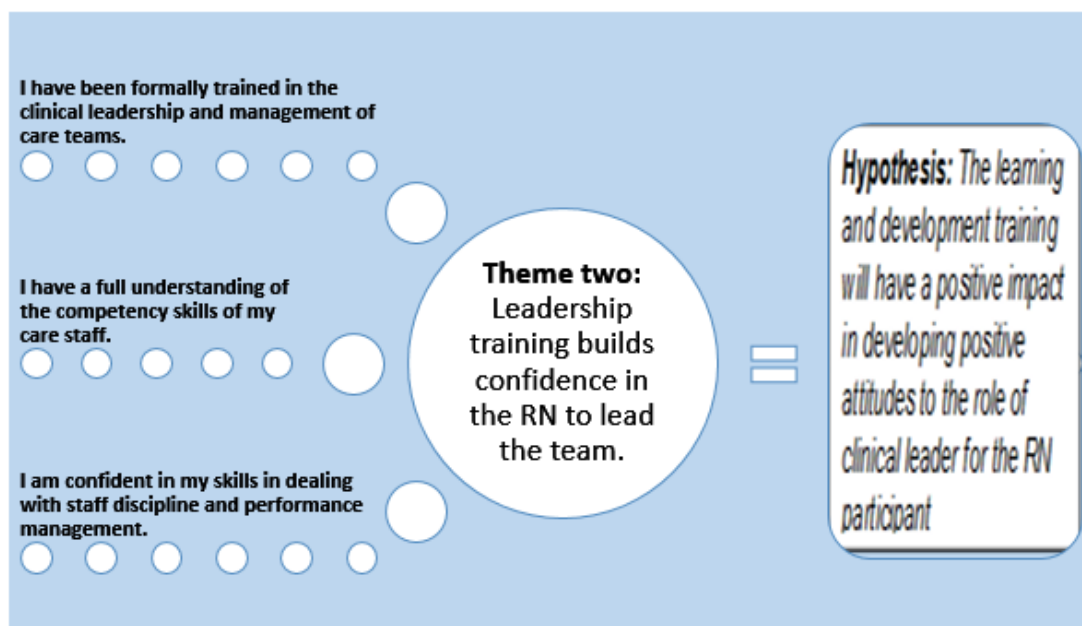


Figure 6.3: Convergence with Theme Two



### 6.3 Finding Two: Leadership training is a positive change agent for transmutation and getting the evidence into practice.

The second finding was also achieved through integration analysis and mapping the questions from the pre and post-test surveys that showed a significance in improvement. The questions from the quantitative survey that showed a significance in improvement for the participants group identified that the application of leadership

skills focused around working with the team. The results of the qualitative interviews provided an insight to understanding that learning the principles of clinical leadership improved the ability and confidence of the registered nurse to apply the skills in direct leadership of the team. There was a significant shift in the registered nurses to focus on the team performance and through meeting the team needs was attributing to improved outcomes and service delivery standards. Given the workplace scenarios of the typical participant in this case being the only registered nurse on the shift it is encouraging to see that the registered nurse has identified with applying clinical leadership to the multidisciplinary team members has built an improved process of communicating, established improved trust and lowered their stress levels in regards to achieving quality care outcomes. Convergence with the themes ‘Leadership training has improved the knowledge and application of clinical leadership for the nurse’, and ‘Person centred care teams lead to improved person centred care’ has supported an inference to the hypothesis that: ***‘The Improved skills training will have a positive impact in developing leadership skills in the RN Participant’***

**Figure 6.4: Convergence with Theme Three.**

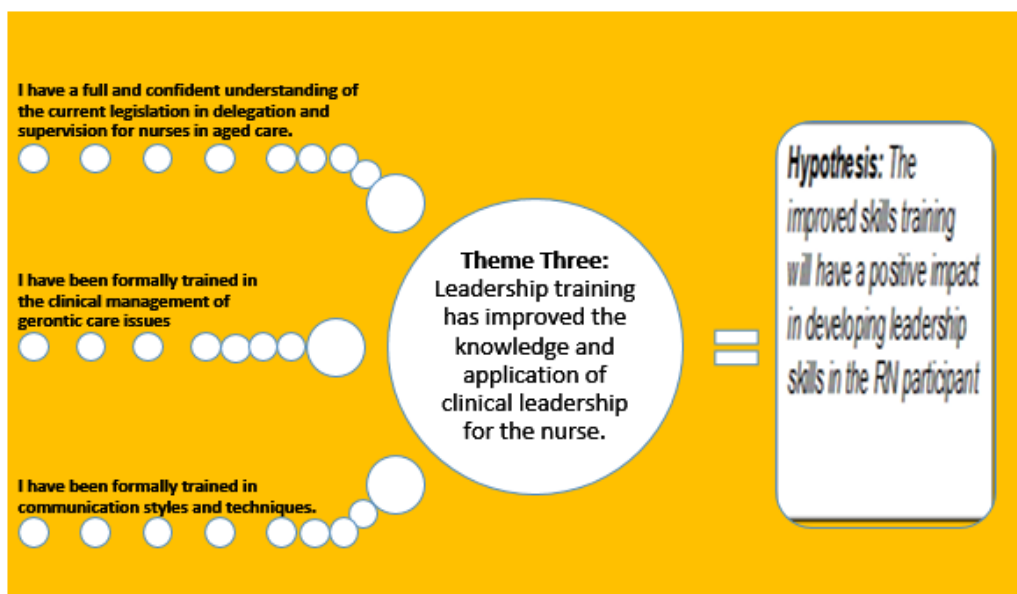
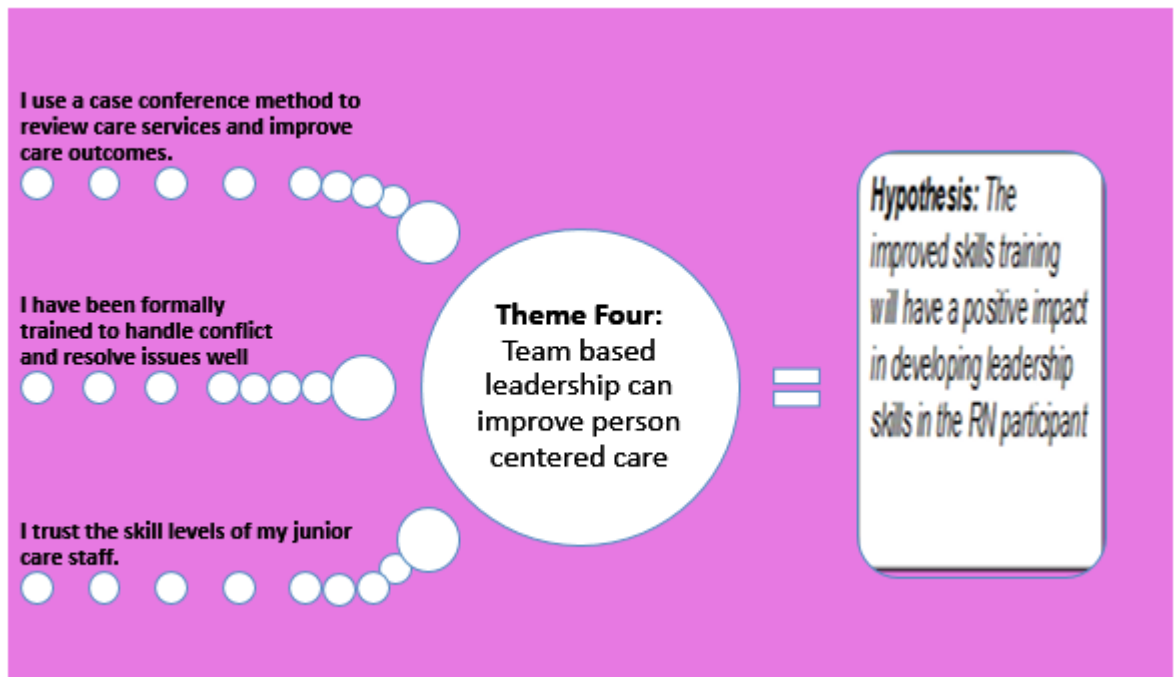


Figure 6.5: Convergence with Theme Four.



#### 6.4 Finding Three: Clinical leadership training should be a core principle for the organisation and valued as a key performance area

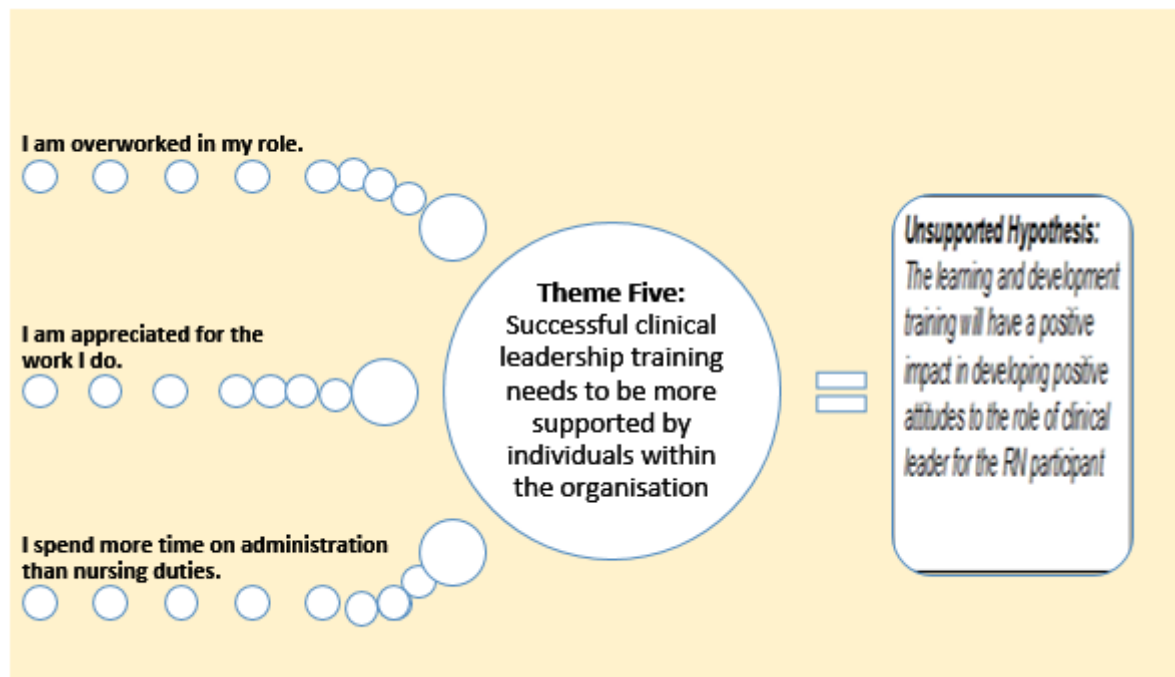
This third finding was again developed through the table of integrated analysis and mapping, however, identified a paradoxical or two phased variance that required some thought and analysis. The original question in the quantitative survey asked questions that enabled the registered nurse participants to reflect again on their experience, opinions and attitudes towards the role and its appreciation against scope of practice and accountability. The pre and post-test results identified that the registered nurse in all cases and groups felt that they were overworked in their role, placing a high end remark on the Likert scale. Other questions required segmented answers for feeling appreciated for the work they do, delineated by peers, patients and the organisation.

The post-test results showed that the registered nurse felt highly appreciated by patients/residents of their homes, however less appreciated by peers, and even further down the scale is appreciated by the organisation. The results of the thematic analysis

indicated that the registered nurse feels that applying the skills learnt in the training had improved their status, position, and appreciation from the work team, however certain individuals (management and colleagues) were not appreciative nor understanding of the clinical leadership required to achieve the organisational goals.

The registered nurses expressed that they felt supported and appreciated by the organisation for supporting and applying the training opportunity, however felt that this was symptomatic of improvement for accreditation results rather than cultural change in the organisation. It was interesting to note that in the participants' opinion or view this discourse is accepted by the registered nurse, as the 'compensation element' or reward is improved appreciation from the patient/resident and the frontline care team members as a matter of importance to personal professional satisfaction. Convergence with the theme 'leadership needs to be more supported by individuals within the organisation has not supported an inference to any of the hypothesis and as a strong negative is significant for future changes within the industry. This can be achieved through well trained clinical team leaders can assist in the transformation and change needed.

Figure 6.6: Convergence with Theme Five.



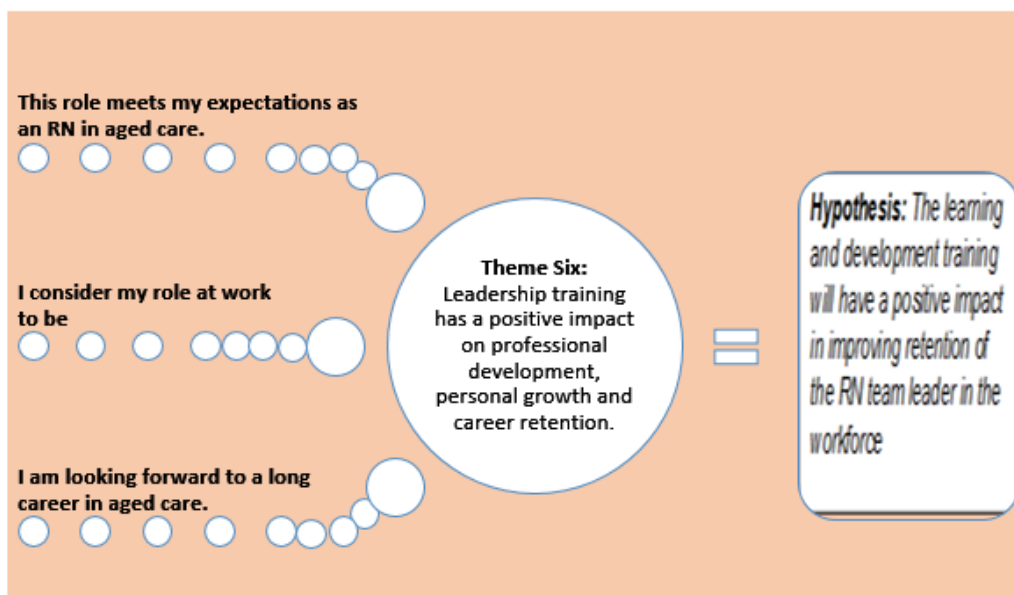
## 6.5 Finding Four: leadership training is essential for successful recruitment and retention and building healthy workplace environs.

On completing the integration analysis and mapping for convergence, the final finding was established. Questions from the quantitative results that were significant related to how the registered nurse perceived their professional standing and career aspects within aged care. Not surprisingly all participants and control groups had a high appreciation for their passion and commitment to working in aged care, that was also increased in the post test result for the participant group only.

All nurses in both intervention and control groups responded high on the Likert scale for identifying themselves as nurses and not managers within the organisation both pre and post-test results, however clinical leadership training had improved on this reflection for only the intervention group. There was a significance in the confidence that expectations of the role had improved for the post intervention group, and a boost in career aspects for the future was as a result of clinical leadership training.

Convergence with the theme 'leadership training has a positive impact on professional development personal growth and career retention', and has supported an inference to the hypothesis that: ***'The learning and development training will have a positive impact in improving the impact of retention of the RN in the workforce'***.

Figure 6.7: Convergence with Theme Six.



## 6.6 Discussion summary

It was important to conduct the integration analysis of the mixed methods results, particularly to enhance the interpretation of the quantitative data.

Part of the problem noticed in interpreting the results of surveys was respondent answer points on the Likert scale. Looking back, as one does in a research project, a design fault noticed was implementing a survey questionnaire and structuring the questions in order to obtain clarity in the statistical significance. As discussed in the previous chapter 4 on results quantitative, some questions in the survey needed to be re-graded into 'yes' and 'no' responses as a five point Likert scale was chosen and some questions had levels of responses within the Likert box choice, and participants

were inclined to 'sit on the fence' in the middle of the response line. A forced choice scale would be used in future projects to remove this distraction during data analysis. Notwithstanding this, it was positive to clearly establish that the intervention group had a significance of positive impact in areas of response that demonstrated and supported the hypothesis when needed. The disappointment in participant number reduction over the process of the project will need to be taken into consideration in future research that brings the health professional in as part of the experiment. Participants that did remove themselves from the project were engaged with informal inquiry as to an explanation and that respondents in general either moved on in their posts, or simply did not value the exercise and had other priorities to commit too.

It was intended to hold such a large group together for the entire journey, however this also provides insight to why so much nursing research is carried out on small groups and particularly as phenomenological qualitative methodologies and not strictly quantitative inquiry. Overall the qualitative inquiry and results were valuable to providing deeper understanding to the impact of the intervention. Investigation into attitudes, perceptions and opinions particularly about self, and professional standing in an organisation is limited when looking only at quantitative survey results.

The interviews allowed more expression and reflection from the participants and gave a great insight into what the registered nurse had experienced from the intervention of clinical leadership training and what their true opinion was.

As the researcher I was satisfied that the results were able to be interpreted with good feasibility, appropriateness, meaningfulness and effectiveness.

The following chapter is the final chapter of the thesis and will discuss the findings explained in the results of the study, as a reflection of the science utilisation and translation. This final chapter will provide the suggested science implementation

through presenting a tentative model of clinical leadership for registered nurses to improve outcomes in aged care. These recommendations are separated and directed to impact on the sector and its support services in aged care and the service organisations as a strategy for implementing the changes needed.



# Chapter 7: Discussion, Recommendations and Conclusion

---

## 7.1 Introduction

This final Chapter will include the discussion and recommendations in regards to the findings of the sequential mixed methods and the results of the whole research study. A recommendation will be applied at the end of each discussion that has been mapped against the JBI level of evidence according to the FAME (Feasibility, Appropriateness, Meaningfulness, and Effectiveness) scale to inform the strength of recommendation.

F – Feasibility; specifically:

- What is the cost effectiveness of the practice?
- Is the resource/practice available?
- Is there sufficient experience/levels of competency available?

A – Appropriateness; specifically:

- Is it culturally acceptable?
- Is it transferable/applicable to the majority of the population?
- Is it easily adaptable to a variety of circumstances?

M – Meaningfulness; specifically:

- Is it associated with positive experiences?
- Is it not associated with negative experiences?

E – Effectiveness; specifically:

- Was there a beneficial effect?
- Is it safe? I.e. is there a lack of harm associated with the practice?

The outcome of this study is a recommendation towards a tentative model of clinical leadership for registered nurses to improve outcomes in aged care. The recommendations are presented in sequential order as follows:

1. Industry and sector support strategy ( for the future of delivering aged care)
2. Organisational implementation strategy (for transforming the current workforce)

## Industry and sector support strategy (for the future delivery of aged care)

---

### 7.2 Discussion: The aged care industry and its sector support need to collaborate towards a strategy for the future needs of the ageing population and clinical leadership through nursing.

An ageing population is placing greater demand on the health services that is threefold. First and foremost is the demand on increased services for patients presenting with complex co morbidities within the ageing population and demographic. The burden on resources is at a critical level. The philosophy for ageing in Australia is focused on mixing traditional medical models with contemporary social models that create a motivation for 'Healthy ageing, 'Active ageing' and to encourage the elderly to 'Live longer, Live better' as a government reform slogan meets the consumer voice in a growing demand for choices of care in the twilight years. Government is reacting through reform changes, in order to balance the impacts on home and long term care and assisted living for the elderly.

Second fold is the demand on the workforce. As discussed in the previous chapters, an ageing population is also represented in the nursing workforce. As the nursing workforce is ageing, the global impact on the push and pull factors affecting the recruitment and retention strategies for nurses are major concerns of all healthcare industry stakeholders. Meeting the demand for increased services for the ageing population demands a strategy to meeting the workforce capacity to supply the needed expert nurses. Many of the nurses currently utilised in the aged care sector are demographically ageing as a cohort, and many of them will retire from the workforce and will need replacement.

Currently the multidisciplinary approach to aged care services is well practiced within Australia and overseas. This approach has found synergy with the increasing consumerism and person centred care philosophies that drive the reform as the population ages. Understanding that as humans we cannot live forever, the role of the nurse is becoming more important to the care needs of the elderly who can no longer live independently and require constant support, supervision or care in the activities of daily living. It is clear in the literature and established in practice that much of the care is provided by direct care workers under the supervision of a registered nurse. Immediately the nurse is placed in a positional clinical leadership role, required to lead a team and manage the care from numerous individuals, and usually without the skills set or knowledge of the Key Performance Area in clinical leadership.

Now is the appropriate time for the industry peak bodies and nursing as a professional peak body to collaborate and design a strategy that develops the educational model for supporting the establishment of specialised gerontic/geriatric nurse and underpinning the skills for the role of team leader and including an ongoing pathway to Geriatric Nurse Practitioner as represented in the USA and UK.

The issue of role identity for nurses has been investigated extensively throughout the past. As far back as 1954, where Lyal Saunders <sup>(89)</sup> writes to inform us that the nurse's role is changing and will continue to change forever more. One hundred years ago the nurse operated as an autonomous individual applying the practice as an entrepreneur using a fee for service to an individual or family, working long hours and on a one to one direct care basis. Fifty years ago the nurse moved more into institutionalised care facilities offering their skills as a service for salary. Mixed into a team of other nurses and colleagues the work became impersonal, time allocation was decreased and patient numbers increased as the organisation took the control of funding and resource allocation away from the autonomy of the nurse.

Today, especially in aged care, the registered nurse has moved away from the bedside and the role of a registered nurse is heavily contextualised to the clinical and practical supervision of care through the team that they operate in and reflecting what is a 'collective expectation' to ensure the patient/resident is 'nursed' and the nurse will integrate care with others in a higher more complex multileveled team. In general the result we currently see is that the registered nurse is usually professionally and personally challenged as interpretation of the role is often seen differently by the registered nurse to that of the individuals in the collective. The art of nursing directly to the care recipient in the aged care setting has been appositionally moved and this is grating at the core fundamentals of holistic direct patient care that nurses are still culturally trained in and hold strong value to. In order to develop the future of nursing in this emerging specialised field, undergraduate and post graduate education will be essential and will assist the recruitment of specialised nurses into aged care settings.

This doctoral study has identified that the intervention of clinical leadership training has a positive impact for the nurse even though there is a personal challenge to engage the learning program and develop new skills in order to meet the objectives in the role

<sup>(90)</sup>. The finding here is that clinical leadership is a Key Performance Area (KPA) of the nurse who holds the position of team leader and is responsible for delegation of the care through subordinate staff and professional colleagues.

Through the clinical leadership training the nurse learns the skills that are needed to make the role laudable and maintain the integrity to nursing values over the continuum of care. The function of nurses in the past has been highly important, not only to the care outcome but also to nurses themselves. Identifying the registered nurse as a specialist and professional partner within an aged care organisation will build the capacity for future care services.

The emerging geriatric/gerontic nurse role will be more significant if, by combining the old values in nursing with the new clinical leadership techniques, a nurse can reach full potential as a clinical leader in a multidisciplinary team <sup>(91)</sup>. Nurses will need to be empowered to aim for those potentialities, during undergraduate training or identifying a move toward their collective future as health professionals with confidence in both their professional aspirations and their abilities to influence change<sup>(14)</sup>. I therefore make the following recommendation for industry and sector support as a strategy towards a tentative model for clinical leadership to improve outcomes in aged care:

### 7.3 Recommendation:

- 1. Clinical leadership training is essential to the contemporary nurse role and should be grounded into the undergraduate nursing curricula and post-graduate nurse pathways; and**

**2. Leadership skills training should be incorporated into the key performance measurement for the role of the RN in the aged care setting to support the establishment of a specialist Gerontic Nurse role in Australia.**

Known in the literature <sup>(1)</sup> and validated in this research study is that people who work within aged care or geriatric care, have a passion to do so and are highly motivated for improved care outcomes. This is a key starting point for recruitment into the nursing workforce, and establishing common values between the aged care organisation and employee along with consumer of care services. One of those values has been established as 'clinical leadership' and leadership at all levels of the workforce. Transactional leadership is situational for care organisations, and the registered nurses role as clinical team leader is the key to transforming the team to meet the collective goal.

The values of nursing are a common thread for consumers and carers, and as such should be reflected in the educational development of nurses and the organisational structure and processes. The role of nurses has been specifically designed for them to be transformational leaders, in conducting their duties for clients, including the advocacy of values, education for informed choices, and planning care. Innovation is required by care organisations that blends nursing and nurses as a recruitment and retention strategy and empowers the service to continuously improve itself through nurse team leaders.

Registered nurses should be provided with a structured professional entry point including a clear role delineation when choosing to specialise in geriatric or long term care. The role of the nurse should also reflect their clinical leadership expectation as valued by the organisation and positional to the nurse's role. Nurses in geriatric or long

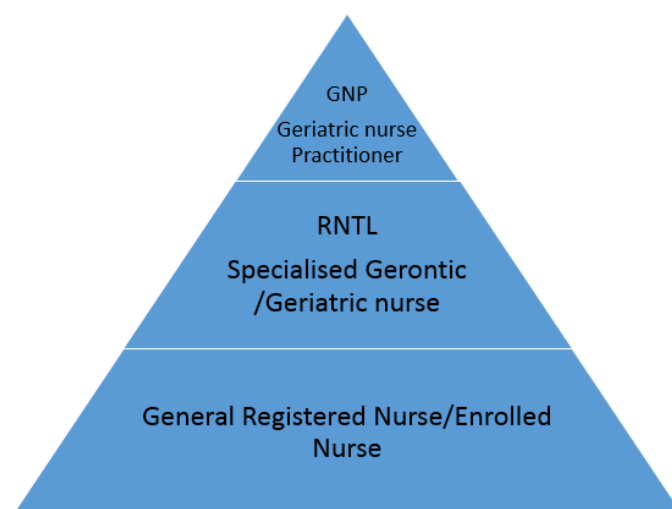
term residential care are best suited to be transformational team leaders and have a positive impact on care teams when trained well in clinical leadership.

Clinical leadership principles should be established as a key performance area (KPA) among all nurses and care service staff in order for them to transact and transform the best outcomes for clients and the organisation. I therefore make the following recommendation for workforce improvement:

## 7.4 Recommendations

1. **The establishment of the Registered Nurse Team Leader (RNTL) role** is recommended as the next nurse role in the tier of nursing within aged care, and includes both registered nurse (RN) and registered enrolled nurse (EN). This nurse requires skills in effective communication, counselling, competency assessment, conflict management, gerontic nursing skills to support clinical leadership and management of the care delivery through care workers. Preparing the quality data and care plan for collaboration in the case conference and under the direction of the GNP.
2. **The establishment of the Geriatric Nurse Practitioner (GNP) as clinical leaders of multidisciplinary teams within residential geriatric care is recommended.** This nurse has leadership skills sets in leading other nurses in clinical practice, and provides nurse practitioner directives and care treatments in complex clinical issues for multidisciplinary teams. Having the authority to diagnose and prescribe, the GNP is the leader of clinical decisions and a professional partner of the organisation.

**Figure 7.1 Suggested pathway and tiers of specialised nurses in aged care:**



## Organisational Implementation strategy (transforming the current workforce)

---

### 7.5 Discussion: Leadership training should be a core principle for the organisation and valued as a key performance area

Notwithstanding the need for the aged care industry and its sector support, such as the university and college education of nurses, the organisations that deliver care to the frail and vulnerable elderly are in need of transforming the current workforce to be better equipped for reform. As it stands, the phenomenon of leadership is already underway in the aged and long term care (LTC), despite the limited interpretation that exist within the literature (13, 16, 17, 51). Leadership is explained in numerous ways depending on the type of organisation and the value they give leadership itself, either as a quality in all staff, or a quality that is positional and status obtained such as in senior management.



Boldy et al (2006)<sup>(45)</sup> has provided a great insight to how aged care organisations can and should structure a model of leadership within their services, by looking at the leadership behaviours they wish to model. Clinical leadership is achieved through stages and applications of the characteristics of leadership principles and implemented through structured training for the registered nurse in charge of the healthcare team.

The first stage of leadership is driven by the organisation through first reviewing and disassembling the vision, mission and value statements of the organisation in partnership with the engagement, communication and feedback from all stakeholders in the team. This process is the beginning of '**values leadership**' and the principle of what it is that the team members value, and does it match the organisational ethos. This process builds the value in trust and the value of shared communication in regards to the understood and shared values across the organisation and is known as 'values leadership'.

Person centred care is one of the strong and most valued philosophy that is used to build a common goal in the aged care team. The philosophy is one of presenting "culture change" as a movement within the aged care sector, and one that creates a fundamental shift in thinking about how nursing homes should be and how care should be delivered to an individual <sup>(92)</sup>. Residential facilities are now vigorously marketing to the industry and community to be viewed not as institutions, but as person-centered homes offering long-term care services to the specific needs of an individual. Principles and practices are being shaped by shared concerns among consumer groups, policy makers, and providers regarding the value and quality of care offered in traditional nursing homes. Critical and comparative reviews on measuring person centered care outcomes using clinical tools <sup>(93)</sup> shows promise in improving quality of life as well as quality of care, and simultaneously addressing issues on high staff turnover. It is the issue of high staff turnover that is of concern to all stakeholders, as continuity in

designated carers and relationships in care are key issues that form care partnerships. Management can capitalise on the transformational power through nurse leaders to meet the key performance areas of regulation, reimbursement, public reporting, and other mechanisms that impact on the organisation.

Nurse leaders need to find ways to build open and transparent communications in which the team members' voices are heard and valued as a means of achieving continuous improvement as outlined by senior management. The registered nurse holds the critical and pivotal position that requires transformational leadership skills to interpret the direction of management, apply the nursing process, invoke cohesion in the team for person-centred care, and to lead change when antithesis is identified with the management goal <sup>(94)</sup>.

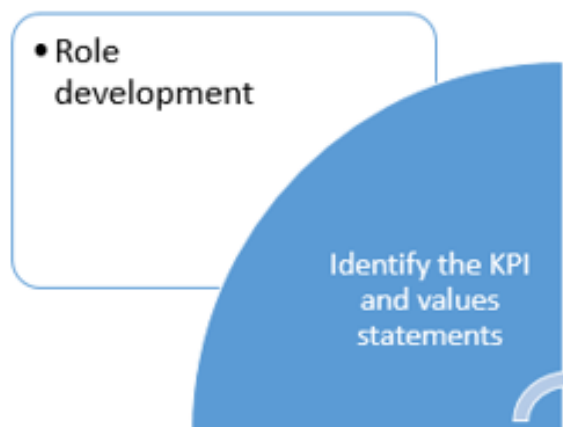
This skill is perhaps the biggest barrier in clinical leadership, as nurses are challenged when the conflict of interest is driven by compliance or organisational need, and the true value of care and best practice outcomes have been ignored. The true characteristics we value in providing care are lost when an organisation applies no person centeredness to the people that culturally lead the care team to provide person centred care, as it is a true contradiction in practice. I therefore make the following recommendation for organisational implementation and transforming the current workforce towards a tentative model for clinical leadership to improve outcomes in aged care:

## 7.6 Recommendation:

1. **Organisations should develop roles that demonstrate a person centred approach to staff and their careers, if they are to achieve the goals of person centred care.**

2. **Transformational leadership is an essential model for goal accomplishment in the philosophy of person centred care, utilising the role development of the registered nurse team leaders to transform both policy and practice.**

**Figure 7.1 Recommendation for organisational implementation strategy step 1:**



The second stage in the leadership development strategy is then identifying the facilitation approach and model they wish to apply to assist with change. Transformational leadership models are attractive and regularly validated options for nurse led teams, as the clinical leadership and clinical expertise is a driving force in meeting regulation and compliance and also establishing a valued input from numerous members of the team. Bass <sup>(95)</sup> explains "Transformational leadership occurs when leaders and followers raise one another to higher levels of shared values and motivations that result in a transforming effect on both leaders and followers".

‘Transformational leadership’ requires honed skills to motivate others through mentoring, communicating and challenging ideas including applications through learning opportunities or an imparting of knowledge from the leader to the team, or, from the team members to the leader. Hand in hand with transformational leadership is the ‘**transactional leadership**’ approach. Transactional leadership encompasses

the leader and the follower communicating and sharing their own self-interests, and setting goals of achievement for incentive or reward. Performance management is the tool currently used by leaders to identify weakness, or failure to reach goal or standards achievement, and allows the leader to engage and motivate or support towards reaching goal obtainment and getting the reward for the job well done <sup>(95)</sup>.

Academics writing about leadership capability frameworks discuss and recommend the **'Full range of leadership'** that includes leadership styles, behaviours, attitudes and management roles for organisational development and change as the transactional and transformational rubric can be applied to individuals within teams, teams as a whole and to organisations as a whole. Members of transformational teams learn to care about each other, they are mentored and encouraged to intellectually stimulate each other. Skills in 'transactional leadership' assist team leaders to inspire each member of the team, and to identify with the team's goals and construct pathways to higher performance. In general, transformational teams are high-performing and self-improving which is reflective of the national standards of nursing competency.

Senior management should have a core focus for the development of leadership and specifically clinical leadership through organisational policies and procedures that support and promote employee empowerment, creativity, and innovation and provide a sense of belonging to the same values and esprit de corps.

The organisational framework should include leadership training appropriate for the divergent levels of employee, meeting different skills sets for applying leadership that can be transformational at all levels within the organisation, and simultaneously working together, even in times of separation. This research has identified that clinical leadership training for the registered nurse in the role of team leader has a positive

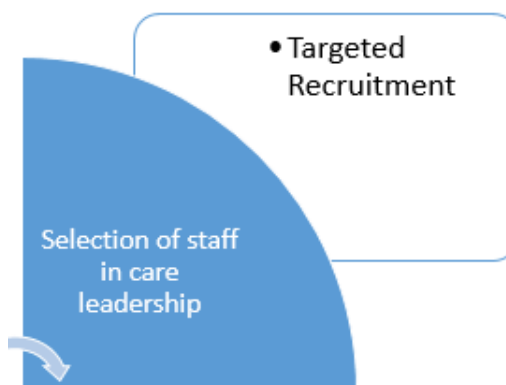
impact in empowering the nurse to motivate themselves to look for opportunity to share values and transform care as leaders.

Numerous authors have recommended that the industry would benefit from exploring the value of engaging with education providers for support to develop programs of learning that pay particular attention to clinical leadership knowledge and skills needed in aged care. The research in this study has effectively undertaken such a task with positive and conclusive results that have empowered and transformed the registered nurse. I therefore make the following recommendation for organisational implementation and transforming the current workforce towards a tentative model for clinical leadership to improve outcomes in aged care:

## 7.7 Recommendation:

1. **Clinical leadership principles should be adopted into the role of the RN team leader as a targeted recruitment.**
2. **Leadership principles should be adopted into the role of employees in aged care at multi-levels as a targeted recruitment.**

**Figure 7.2 Recommendation for organisational implementation strategy step 2:**



## 7.8 Discussion: Clinical leadership training is a positive change agent for transforming nurses and getting the evidence into practice.

Understanding that leadership is about the transformation of 'doing' what is necessary to lead and encourage others to 'get the job done', the nurse has a task at hand and numerous avenues to achieve the result. Those avenues are usually found in the sub-professionals or direct care workers in the team that are not as highly qualified as the registered nurse however, have the competency to learn new skills, apply autonomy and have input into the delivery of care as a team member. Through clinical leadership training the registered nurse learns the improved skills in communication, mentoring, and time management, then realising that these tools are key to empowering the team to apply quality to an individual's person centred care. Leadership is seen by nurses as 'visionary' and 'relationship based' <sup>(96)</sup> and the evidence in the literature has provided a strong theoretical description of the impact of leadership on care outcomes <sup>(43)</sup>, this suggests that leaders with relationship orientated values will utilise practice to improve communication flow, facilitate the interpersonal connections in the team, and provide a diverse cognitive perspective for care which in return will facilitate a positive patient outcome.

One of the major struggles experienced by nurses who work in residential aged care is to become complacent with holding a supervisory role and not be the direct care mechanism in every situation <sup>(1, 97)</sup>.

Perhaps it is the lack of understanding that they themselves are the vehicle of change and the relationships they build within their teams is essential for achieving, as a whole, what would have been usually achieved by only one. Nurses in residential or community aged care then have the organisation's cultural barriers to meander through in order to get productivity at an acceptable level. Through clinical leadership skills training the RN had established that the control and power to change the organisational

culture also sat in their hands through understanding the evidence based practice of clinical leadership and transforming the care.

Mentoring and supporting the needs of the team members is a positive way to develop cohesion within the team, and to achieve a mutual goal requires numerous skills and a confidence to transform the qualities that are known by the registered nurse as a professional into the other team members. During the qualitative interviews of this study, the registered nurse participants were eager to discuss that they themselves were empowered to see the changes in productivity and performance within the team, even though having to engage in conflict, manage performance and applying a discipline to the workplace was a challenge both personally and professionally.

Factors that once seemed too difficult and too hard to achieve due to confrontation and conflict of interests and values, were now seen as tools to improve and support the needs of the team members in reaching their own benchmarks at work. Improved attitudes to communication strategies using case conference frameworks was a measure of demarcation for the nurse leaders that brought the team together and provided continuity in care goals and enhanced the person centred approach that was mastered by the registered nurse as the clinical team leader and now shared as a valued philosophy amongst the team members.

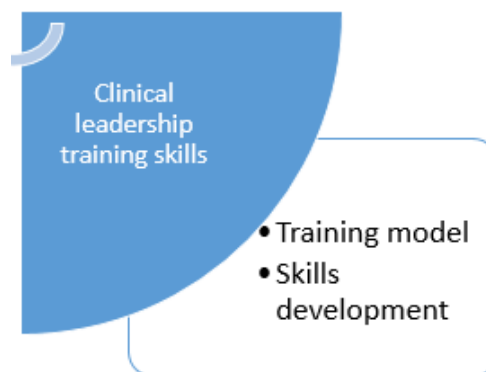
In the previous chapters, this dissertation addressed the contemporaneous issues within the literature that 'leadership' and 'management' although different in context, are usually intertwined and understood to be espoused. This domain of thinking is guided by the regulatory frameworks that provide accreditation, compliance and funding to the organisation. Accreditation is understood to be the bailiwick of the registered nurse's performance as quality and continuous improvement are known to be foundational to the nursing process<sup>(98)</sup>. It is paramount for both the organisation and

the registered nurse to build and perfect a professional partnership in clinical leadership of the aged care team through structured education and pathways for the specialised role. I therefore make the following recommendation for organisational implementation and transforming the current workforce towards a tentative model for clinical leadership to improve outcomes in aged care:

## 7.9 Recommendation:

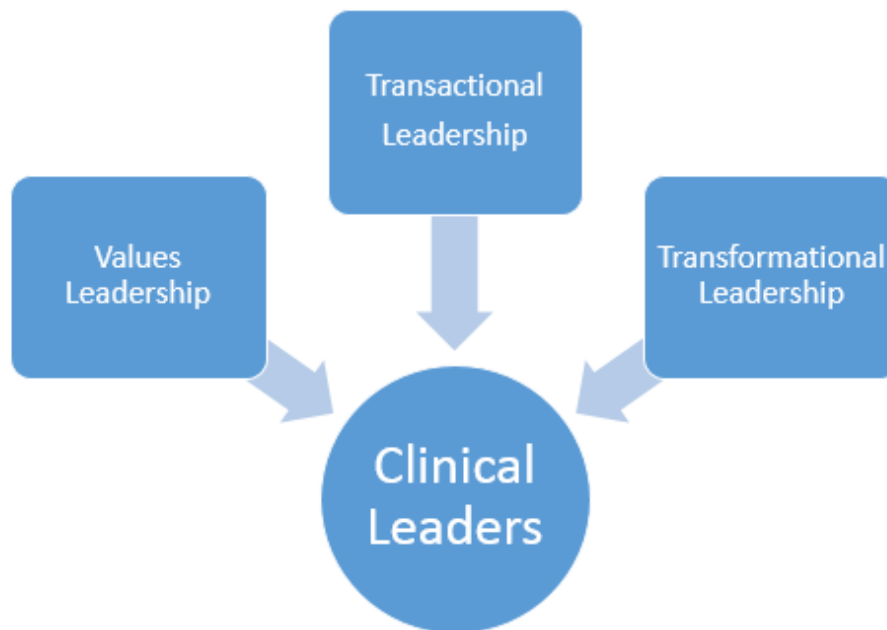
1. **Transformational clinical leadership should training be undertaken as a structured and supported learning pathway in aged care for the registered nurse.**

**Figure 7.3 Organisational implementation strategy step 3: Clinical leadership training**





**Figure 7.4 Organisational implementation strategy step 3.1: Clinical leadership training overview**



The details and contents of the structured clinical leadership training are provided in chapter 3 methodology specifically in section 3.18 Phase 2: Development of the intervention (the learning and development program). More research is needed in the specialised development of IPE courses in the future and should be considered as a priority within the aged care sector.

#### 7.10 Discussion: Clinical leadership training is essential for successful retention and building healthy workplace environs.

Recruitment and retention strategies that are collaborated between industry and nursing peak bodies and their support networks should provide opportunities for the general nurse or graduate nurse to also be contextually trained in leadership and management skills as a career pathway from General RN to specialised Gerontic/Geriatric RNTL to GNP in gerontic care. This process identifies gerontic nursing as a specialised skill and, with supported education and career advancements,

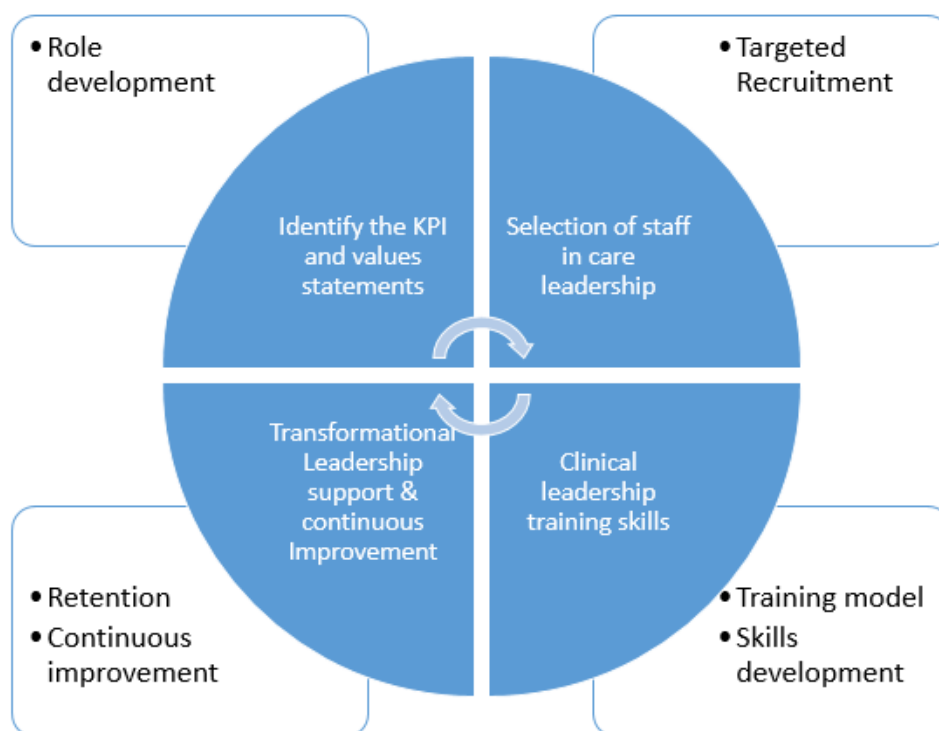
it would improve the choices for nurses wishing to transition careers or move into management.

Organisations would be well prepared for improved retention through valuing the registered nurse as a clinical leader and professional partner in the business, providing avenues for transformational and transactional leadership with support to the role through continuous improvement plans. It is recommended that structured learning and skills training is continuously undertaken by organisations to support transformational leadership and to provide and improve on a healthy workplace environment for establishing professional partnerships with the registered nurse in delivering quality aged care. Below is the recommended organisational strategy for implementation step 4, and the whole strategy for organisational implementation

**Figure 7.5 Recommended organisational implementation strategy step 4: Retention & continuous improvement**



**Figure 7.5 Recommendation towards a tentative model for clinical leadership in aged care: Developing clinical leaders in aged care.**



## 7.11 Conclusion

In concluding this research study, I examine the relationship of the outcomes and recommendations in line with the overall aims and objectives decided on at the beginning of the project. The aim of the study was to address the negative experiences being reported by nurses in the role of team leaders in aged care facilities through a clinical leadership and leadership training program designed as an intervention on the participants group. The intervention (the clinical leadership training) was designed to empower participants to become care team leaders and has proven to be a valid method of empowering and motivating the registered nurse in the role of clinical team leader.

Aged care nursing is a specialised field of nursing work. Given that it may not be the most preferred work sector for many, there are those that have the passion and skills

to devote their professional lives to the care of the sick, frail, and most vulnerable, and usually in very complex scenarios. As the population ages and the demands on healthcare change, so too will the impact on society. Nurses have played a role in a history that is well documented and filled with stories of leadership and change, as they have held the hand of society in partnership as it has evolved. As society continues to transform, so too does the healthcare industry. Looking from the outside in and the inside out from the aged care perspective, we currently have one of the best equipped professionals on the planet that should be utilised more effectively in transforming the care through clinical leadership, and that is the registered nurse. Nurses are instrumental in transformational leadership within the aged care sector. Clinical leadership is a missing ingredient that will transform nursing and nurses to be the change agent they want to see both for the nursing profession and improvement in the delivery of care to the elderly population. The strength of the recommendations in this research should be well investigated as positive options for improvement to the industry, its services and the care organisations.

This doctoral study has confirmed the hypothesis that clinical leadership training has a positive impact on registered nurses that work in residential aged care, and that targeted recruitment, training and retention assist with this process. Establishing clinical leadership is a transformational process for care teams and the nurse is well placed to be the transactional leader that transforms the individuals within the team and drives improvement for the organisation. Care service organisations can learn to value the importance of nurse clinical leaders, and support the role of the RN team leader and GNP with clear position descriptions, outlines of responsibility, and reflective pay parity to other nurse leaders and industry professionals. Nurses can learn that gerontic care is a specialised field and requires a skills set that is diverse and abstract from traditional nursing roles.

As the need for nursing care staff increases in our ageing population, we have the clear opportunity to build tomorrow's leaders today.

In closing I thank all those nurses for sharing this journey with me on the research study, as without nurses being the study subject, we cannot improve nursing for nurses and the rest of society. Throughout this thesis I have used a number of quotes from nurses and nurse leaders that I came across in reading the broad literature on this journey, and ones that resonated with me as a nurse myself. I end this dissertation with a quote of my own to add to the philosophical debate, and one that is true for validating Evidence Based Healthcare:

*'Never think that it is impossible, just do the research and you will discover the impossible is there'*

*(Drew Dwyer)*

## References:

---

1. Dwyer D. Experiences of registered nurses as managers and leaders in residential aged care facilities: a systematic review. *International Journal of Evidence-Based Healthcare*. 2011;9(4):388-402.
2. Fussell B, McInerney F, Patterson E. Experiences of graduate registered nurses in aged care: a case study. *Contemporary Nurse: A Journal for the Australian Nursing Profession*. 2009;33(2):210-23.
3. Nay R. RECRUITMENT AND RETENTION OF NURSES IN AGED CARE. *Australian Nursing Journal*. [Article]. 1998;5(8):30-.
4. Aberdeen S, Angus J. A Systematic Approach to Curricula Development for Aged-Care Leadership. *Educational Gerontology*. 2005;31(6):481-97.
5. Caruana E. Comprehensive systematic review of evidence on developing and sustaining nursing leadership that fosters a healthy work environment in health care. *Journal of Advanced Nursing*. [Article]. 2008;62(6):653-4.
6. Pearson A, Schultz T, Conroy-Hiller T. Developing clinical leaders in Australian aged care homes. *International Journal of Evidence-Based Healthcare (Wiley-Blackwell)*. 2006;4(1):42-5.
7. Kennedy R. 'How do we get the managers we need and the leaders we want?' A personal view. *Journal of Nursing Management*. 2008;16(8):942-5.
8. Furåker C. Registered Nurses' views on their professional role. *Journal of Nursing Management*. 2008;16(8):933-41.
9. Nay RG, S. Koch, M. Challenges for Australian Nursing in the International Year of the older person. *Geriatric Nursing*. [journal]. 1999 1999;20(1):14-7.
10. Chenoweth L, Jeon YH, Merlyn T, Brodaty H. A systematic review of what factors attract and retain nurses in aged and dementia care. *Journal of Clinical Nursing*. 2010;19(1-2):156-67.
11. Broyles LM, Rodriguez KL, Price PA, Bayliss NK, Sevick MA. Overcoming barriers to the recruitment of nurses as participants in health care research. *Qualitative health research*. 2011;21(12):1705-18.
12. Pearson A NR, Koch S, Ward C, Andrews C, & Tucker A. . Australian aged care nursing: A critical review of education, training, recruitment and retention in residential and community settings. . Canberra: Department of Education, Science and Training. 2001;.
13. Moiden N. Leadership in the elderly care home sector. *Nursing Management - UK*. 2002;9(8):24-8.
14. Grossman SC, Valiga TM. The new leadership challenge: Creating the future of nursing: FA Davis; 2012.
15. Jeong SY-S, Keatinge D. Innovative leadership and management in a nursing home. *Journal of Nursing Management*. [Article]. 2004;12(6):445-51.
16. Pearson A, Laschinger H, Porritt K, Jordan Z, Tucker D, Long L. Comprehensive systematic review of evidence on developing and sustaining nursing leadership that fosters a healthy work environment in healthcare. *International Journal of Evidence-Based Healthcare*. 2007;5(2):208-53.
17. Jeon Y-HM, Teri Chenoweth, Lynn. Leadership and management in the aged care sector: A narrative synthesis. *Australasian Journal on Ageing*. 2010;29(2):54-60.

18. Webster. Websters New World College Dictionary [Dictionary definition]. Cleveland, Ohio: Wiley & Sons publishing; 2010 [cited 2010 18, may 2010]. Available from: "<http://www.yourdictionary.com/registered-nurse>">registered.
19. Brown B, Crawford P, Darongkamas J. Blurred roles and permeable boundaries: the experience of multidisciplinary working in community mental health. *Health & Social Care in the Community*. 2000;8(6):425-35.
20. Weiner JM, Tilly J, Alexih LMB. Home and Community-Based Services in Seven States. *Health Care Financing Review*. [Article]. 2002 Spring2002;23(3):89.
21. Venturato L KU, Windsor C. Nurses experience of practice and reform in long term aged care in Australia: Implications for the retention of nursing personnel. *Journal of Nursing Management*. [journal]. 2007 2007;2007(15):4-11.
22. Cant RP, Foster MM. Investing in big ideas: utilisation and cost of Medicare Allied Health services in Australia under the Chronic Disease Management initiative in primary care. *Australian Health Review*. 2011;35(4):468-74.
23. Weston MJ, Falter B, Lamb GS, Mahon G, Malloch K, Provan KG, et al. Health care leadership academy: a statewide collaboration to enhance nursing leadership competencies. *Journal of Continuing Education in Nursing*. 2008;39(10):468-72.
24. Aroskar MA, Moldow DG, Good CM. Nurses' voices: policy, practice and ethics. *Nursing Ethics*. 2004;11(3):266-76.
25. Clarke E. Role conflicts & coping strategies in caregiving. A symbolic interactionist view. *Journal of psychosocial nursing and mental health services*. 2001;39(1):28-37.
26. Egenes KJ, Roux G, Halstead J. History of nursing. *Issues and trends in nursing: Essential knowledge for today and tomorrow*. 2009:1-26.
27. Alligood MR. Introduction to nursing theory: Its history, significance, and analysis. *Nursing theorists and their work*. 2006:3-15.
28. George Julia B. *Nursing theories: The base of professional nursing practice* 3rd edition. Norwalk, CN: Appleton and Lange. 1990.
29. Nursing A. Midwifery Council, 2006a. National competency standards for the registered nurse. AHPRA.
30. Dent S, Barnett M. *Nursing and midwifery workforce 2012*. 2013.
31. Buchan J, Kingma M, Lorenzo FME. International migration of nurses: trends and policy implications: International Council of Nurses; 2005.
32. Cheek J, Ballantyne A, Jones J, Roder-Allen G, Kitto S. Ensuring excellence: an investigation of the issues that impact on the registered nurse providing residential care to older Australians. *International Journal of Nursing Practice*. 2003;9(2):103-11.
33. Coombs MA. *Power and conflict between doctors and nurses: breaking through the inner circle in clinical care*: Psychology Press; 2004.
34. Galvin LC, Baudendistel D. Case management: a team approach. *Nursing Management*. 1998;29(1):28-31.
35. Anastasi J, Fox-Young S, Gorman D, McGrath P, Moxham L, Tollefson J. Collaborative voices: ongoing reflections on nursing competencies. *Contemporary Nurse*. [Article]. 2006 2006/07//;22(1):46.
36. Ebersole P, Touhy T. *Geriatric Nursing : Growth of a Specialty*. New York, NY, USA: Springer Publishing Company; 2006.
37. Francis K, Chapman Y, Doolan G, Sellick K, Barnett T. Using overseas registered nurses to fill employment gaps in rural health services: quick fix or sustainable strategy? *Australian Journal of Rural Health*. 2008;16(3):164-9.

38. Oulton JA. The Global Nursing Shortage: An Overview of Issues and Actions. *Policy, Politics, & Nursing Practice*. 2006 August 1, 2006;7(3 suppl):34S-9S.
39. Kimball B, O'Neil E. The Evolution of a Crisis: Nursing in America. *Policy, Politics, & Nursing Practice*. 2001 August 1, 2001;2(3):180-6.
40. Janiszewski Goodin H. The nursing shortage in the United States of America: an integrative review of the literature. *Journal of Advanced Nursing*. 2003;43(4):335-43.
41. Buntin MB, Damberg C, Haviland A, Kapur K, Lurie N, McDevitt R, et al. Consumer-directed health care: early evidence about effects on cost and quality. *Health Affairs*. 2006;25(6):w516-w30.
42. Low L-F, Yap M, Brodaty H. A systematic review of different models of home and community care services for older persons. *BMC health services research*. 2011;11(1):93.
43. Anderson RA, Issel LM, McDaniel Jr RR. Nursing homes as complex adaptive systems: relationship between management practice and resident outcomes. *Nursing Research*. 2003;52(1):12.
44. Baldwin KM. Elder case management by registered nurses. *Prof Case Manag*. 2013;18(1):15-22.
45. Boldy D, Horner B. Leadership in aged care. *Geriacton*. 2006;24(4):23.
46. Anthony MK, Standing TS. Changing Models of Care. *The Journal of Continuing Education in Nursing*. 2001;32:5.
47. Cherry B, Ashcraft A, Owen D. Perceptions of Job Satisfaction and the Regulatory Environment Among Nurse Aides and Charge Nurses in Long-Term Care. *Geriatric Nursing*. 2007;28(3):183-92.
48. Hasson F, Kernohan WG, Waldron M, Whittaker E, mclaughlin D. The palliative care link nurse role in nursing homes: barriers and facilitators. *Journal of Advanced Nursing*. 2008;64(3):233-42.
49. Karlsson I, Ekman SL, Fagerberg I. A difficult mission to work as a nurse in a residential care home - some registered nurses' experiences of their work situation. *Scandinavian Journal of Caring Sciences*. 2009;23(2):265-73.
50. Capezuti E, Taylor J, Brown H, Strothersiii H, Ouslander J. Challenges to implementing an APN-facilitated falls management program in long-term care☆. *Applied Nursing Research*. 2007;20(1):2-9.
51. Venturato L DL. Beyond Doing: Supporting clinical leadership and nursing practice in aged care through innovative models of care. *Contemporary Nurse*. [Journal]. 2010 2010;35(2):157-70.
52. Carryer J OHC, Blakely J. Experiences of nursing in older care facilities in New Zealand. *Australian Healty Review*. [journal]. 2010 2010;34(34):11-7.
53. Juthberg C, Sundin K. Registered nurses' and nurse assistants' lived experience of troubled conscience in their work in elderly care—A phenomenological hermeneutic study. *International Journal of Nursing Studies*. 2010;47(1):20-9.
55. Peel N, Bartlett H, McClure R. Healthy ageing: How is it defined and measured? *Australasian Journal on Ageing*. 2004;23(3):115-9.
56. Andrews G, Clark M, Luszcz M. Successful aging in the Australian longitudinal study of aging: applying the MacArthur model cross-nationally. *Journal of Social Issues*. 2002;58(4):749-65.
57. Kowalski K, Bradley K, Pappas S. Nurse retention, leadership, and the Toyota System Model: Building leaders and problem solvers for better patient care. *Nurse Leader*. 2006;4(6):46-51.



58. Chenoweth L, Jeon Y-H, Merlyn T, Brodaty H. A systematic review of what factors attract and retain nurses in aged and dementia care. *Journal of Clinical Nursing*. 2010;19(1-2):156-67.
59. Dumas LG, Blanks C, Palmer-Erbs V, Portnoy FL. Leadership in Nursing Homes--2009: Challenges for Change in Difficult Times. *Nursing Clinics of North America*. 2009;44(2):169-78.
60. Wilkinson JE, Nutley SM, Davies HTO. An Exploration of the Roles of Nurse Managers in Evidence-Based Practice Implementation. *Worldviews on Evidence-Based Nursing*. 2011;8(4):236-46.
61. Pearson AL, H. Porritt. K. Jordan, Z. Tucker, D. Long, L. . Comprehensive systematic review of evidence on developing and sustaining nursing leadership that fosters a healthy work environment in healthcare. *Int J Evid Based Healthc*. 2007; 5:45.
62. Teddlie C, Tashakkori A. A general typology of research designs featuring mixed methods. *Research in the Schools*. 2006;13(1):12-28.
63. Maxwell JA. *Qualitative Research Design: An Interactive Approach: An Interactive Approach*: Sage; 2012.
64. Holden MT, Lynch P. Choosing the Appropriate Methodology: Understanding Research Philosophy. *Marketing Review*. [Article]. 2004 Winter2004;4(4):397-409.
65. Fitzgerald B, Howcroft D, editors. Competing dichotomies in IS research and possible strategies for resolution. *Proceedings of the international conference on information systems*; 1998: Association for Information Systems.
66. Hanson WE, Creswell JW, Clark VLP, Petska KS, Creswell JD. Mixed methods research designs in counseling psychology. *Journal of counseling psychology*. 2005;52(2):224.
67. Sale JE, Lohfeld LH, Brazil K. Revisiting the quantitative-qualitative debate: Implications for mixed-methods research. *Quality and quantity*. 2002;36(1):43-53.
68. Babbie E. *Paradigms, theory and social research*. *The Practice of Social Research*, 11th edition Belmont, CA: Thomson Wadsworth. 2007:30-59.
69. Reinharz S, Rowles GD. *Qualitative gerontology*. New York [etc.]: Springer; 1988.
70. Cook TD, Reichardt CS. *Qualitative and quantitative methods in evaluation research*: Sage publications Beverly Hills^ eCA CA; 1979.
71. Firestone WA. Meaning in method: The rhetoric of quantitative and qualitative research. *Educational Researcher*. 1987;16(7):16-21.
72. Lockwood C, Oh EG, Sfetcu R. *Synthesizing Quantitative Evidence*: Lippincott Williams & Wilkins; 2011.
73. Merriam SB. Introduction to qualitative research. *Qualitative research in practice: Examples for discussion and analysis*. 2002:3-17.
74. Creswell JW, Klassen A, Plano Clark V, Smith KC. *Best practices for mixed methods research in the health sciences*. Bethesda (Maryland): National Institutes of Health. 2011.
75. Johnson RB, Onwuegbuzie AJ. Mixed Methods Research: A Research Paradigm Whose Time Has Come. *Educational Researcher*. 2004 October 1, 2004;33(7):14-26.
76. Jones R. Why do qualitative research? *BMJ: British Medical Journal*. 1995;311(6996):2.
77. Pearson A, Rittenmeyer L, Robertson-Malt S. *Synthesizing qualitative evidence*: Lippincott Williams Wilkins Medical Research; 2011.

78. Tashakkori A, Creswell JW. Editorial: Exploring the Nature of Research Questions in Mixed Methods Research. *Journal of Mixed Methods Research*. 2007 July 1, 2007;1(3):207-11.
79. Reichardt CS, Rallis SF. The Qualitative-Quantitative Debate: New Perspectives. *New directions for program evaluation*. 1994;61:1-98.
80. Kiesler S, Sproull LS. Response effects in the electronic survey. *Public Opinion Quarterly*. 1986;50(3):402-13.
81. Bosnjak M, Batinic B. Understanding the willingness to participate in online surveys—the case of e-mail questionnaires. *Online social sciences*. 2002;81:92.
82. Dugard P, Todman J. Analysis of Pre-test-Post-test Control Group Designs in Educational Research. *Educational Psychology*. 1995 1995/01/01;15(2):181-98.
83. Kish L. Sampling Organizations and Groups of Unequal Sizes. *American Sociological Review*. 1965;30(4):564-72.
84. Kenny DA. A quasi-experimental approach to assessing treatment effects in the nonequivalent control group design. *Psychological Bulletin*. 1975;82(3):345-62.
85. Tourangeau AE, Hall LM, Doran DM, Petch T. Measurement of nurse job satisfaction using the McCloskey/Mueller Satisfaction Scale. *Nursing Research*. 2006;55(2):128-36.
86. Barr H. Interprofessional education. *Educational strategies*. 2002:187.
87. Barr H, Freeth D, Hammick M, Koppel I, Reeves S. Evaluations of interprofessional education. London: United Kingdom Re view of Health and Social Care. 2000.
88. Jick TD. Mixing Qualitative and Quantitative Methods: Triangulation in Action. *Administrative Science Quarterly*. 1979;24(4):602-11.
89. Saunders L. The Changing Role of Nurses. *The American Journal of Nursing*. 1954;54(9):1094-8.
90. Gardner J. Leadership Development. *NASSP Bulletin*. 1989 March 1, 1989;73(515):73.
91. Sofarelli D, Brown D. The need for nursing leadership in uncertain times. *Journal of Nursing Management*. 1998;6(4):201-7.
92. Koren MJ. Person-Centered Care For Nursing Home Residents: The Culture-Change Movement. *Health Affairs*. 2010 February 1, 2010;29(2):312-7.
93. Edvardsson D, Innes A. Measuring Person-centered Care: A Critical Comparative Review of Published Tools. *The Gerontologist*. 2010 December 1, 2010;50(6):834-46.
94. Vogelsmeier A, Scott-Cawiezell J. A just culture: the role of nursing leadership. *Journal of Nursing Care Quality*. 2007;22(3):210-2.
95. Bass BM. Two Decades of Research and Development in Transformational Leadership. *European Journal of Work and Organizational Psychology*. 1999 1999/03/01;8(1):9-32.
96. Wong CA, Cummings GG. The relationship between nursing leadership and patient outcomes: a systematic review. *Journal of Nursing Management*. 2007;15(5):508-21.
97. Scott-Cawiezell J, Jones K, Moore L, Vojir C. Nursing home culture: a critical component in sustained improvement. *Journal of Nursing Care Quality*. 2005;20(4):341-8.
98. Vogelsmeier A, Scott-Cawiezell J. Achieving quality improvement in the nursing home: Influence of nursing leadership on communication and teamwork. *Journal of Nursing Care Quality*. 2011;26(3):236-42.

## APPENDIX A: Flyer for Control Group 2



### **RN Research Proposal Control Group Volunteers**

This year the organisation will be supporting the skills development of the RN Team Leaders with the implementation of a specialised course designed to provide the RN Team Leader with the essential skills to carry out the role within the facility.

The organisation is pleased to support the development of the RN as Team Leaders in order to meet the competing demands of the role.

The course will be subject to a research program that is being undertaken by Drew Dwyer as a process for the candidate in his PhD within the Joanna Briggs Institute. Drew is working towards a Doctorate in Evidence Based Healthcare and specifically empowering the role of the RN in the RACF.

To enable the research to be effective and validated there is a need to have a control group of 150 RN's from the organisations that will be asked to undertake a survey but will not be undertaking the course of study.

You are also be an RN who is not taking part in the training course and you have been asked to volunteer as a member of a control group to compare trained students against. The control group completes the same survey as the students, however does not do any training. The addition of a comparison group (control) helps determine whether any changes in the outcomes can be attributed to the intervention. The more similarly there is between the people who receive the intervention and those who do not, the more confidence there is that changes detected in the intervention group, but not the control group, were actually a result of the program or intervention. Thus, the comparison group (control) would be as similar to the intervention group in terms gender, race or ethnicity, socioeconomic status, and education, as possible.

Your expected time to participate in research surveys is approximately 45 mins for each of the 2 surveys.

If you are interested in taking part in the research control group please contact draw on Drew Dwyer, Education and development Manager, Frontline Care Solutions  
Email - [drew333@frontlinecaresolutions.com](mailto:drew333@frontlinecaresolutions.com)  
Telephone - 0437603632

Alternatively you can consult

Research Supervisor professor Alan Pearson AM, Joanna Briggs Institute, and Dr Anthony Puckett,

The University of Adelaide, AUSTRALIA 5005

Ph : +61 8 830 33644 e-mail: alan.pearson@adelaide.edu.au

The research component of the project is not mandatory and is on a voluntary basis for all in the control group and all who are doing the course. The organisation is asking all participants who are not in the course to consider assisting in the research as it will lead to better evidence for better practice in geriatric nursing.

Please contact your facility manager for details on registering your interest in either being in the control group or even doing the course.

Regards CEO

## APPENDIX B: Proposal Flyer for Intervention Group 1



### Aged Care Team Clinical Leadership Survey

#### PARTICIPATION INFORMATION SHEET

##### Introduction and invitation

you are invited to participate in a research project. Your role in this project will be as a member of either the control group or a student member of the course.

The research is being carried out to evaluate the success of a RN/Team Leader in residential aged care facilities course. Before you agree to participate could you please take time to read the following information in order to understand what the project involves and what is expected from you as a participant in either group?

Current changes in the best practice guidelines have emerged with the creation of a new role for the RN in the residential aged care sector. This new role is called the Multi-Disciplinary Health Care Manger (MDHTM) or Team Leader and is based on the evidence that to be most effective care delivery should take a collaborative approach. Industry has delegated that it is the RN who is best placed to adopt this role to lead and performance manage the team who deliver the services to residents and clients.

Your expected time to participate in research surveys is approximately 45 mins for each of the 2 surveys.

##### What is the purpose of the study?

The purpose of the study is:

- To gain an understanding of your knowledge base pre and post the learning
- to audit your learning outcomes resulting from the course
- to evaluate the effectiveness of this course on perceived change in participant nurse performance in the role of a Multi-Disciplinary Health Care Manger, by both the nurse and their care manager
- to evaluate whether RN are able to meet the Key Performance Indicators (KPI's) of the Multi-Disciplinary Health Care Manger (MDHTM) following the course
- to improve the performance of health teams and the outcomes of care
- to use the evidence gathered from participants on the Team Leaders course and their managers to validate an appropriate education program and a set of competencies that will fill the skills gap and satisfy the standards in accredited aged care
- to measure your satisfaction with the course and this type of education.

##### Why you have been invited?

As a health care practitioner who currently operates in the role of Team Leader within a CMC or Scalabrini residential aged care facility you have been invited to take part in a leadership course designed to educate you on the role of a Multi-Disciplinary Health Care Manger. This study wishes to evaluate the effectiveness of the course on your learning outcomes and your satisfaction with the course. As an RN/Team Leader you fit the demographics for this course and the study behind it.

You may also be an RN who is not taking part in the training course and you have been asked to volunteer as a member of a control group to compare trained students against. The control group completes the same survey as the students, however does not do any training. The control group is basically the comparison group that has not undergone any training, however completes the same survey.

##### Do I have to take part?

After reading this information sheet you can decide whether or not to participate. If you submit the questionnaire, this will be considered consent to participate. Questionnaires will be coded to conceal your identity and responses and the code will only be known to the investigators. Your name will not appear in any analysis or publication.

##### What will happen if I take part?

Prior to the start of the course, you will be asked to go to an internet web site to answer a number of questions which will take approximately 30 minutes to complete. At the conclusion of the course you will be asked to complete the same questionnaire along with a satisfaction survey. Then you will be asked at stages on the course to be involved in some interviews and answer some questionnaires delivered in person by the researcher. Three months after the conclusion of the course you will again be asked to complete the survey in the web portal again and complete the questionnaire, which will be mailed to you in a reply paid envelope. The results will be available in December 2012.

##### What are the disadvantages and risks of taking part?

There are no disadvantages or risks to taking part in the study. Participation or refusal to participate in the study will not affect your performance appraisal.

##### The possible benefits of taking part

While there are no direct benefits to you for taking part in this study, the information gathered may be used to identify the skills gaps that need to be filled with the appropriate learning and development.

Meeting this skills gap will allow the seamless integration of multi disciplinary services to aged care clients, and effectively manage care inline with legislation and accreditation standards.

The RN/Team Leader will gain confidence in the ability to use critical thinking and clinical judgment, give direction and delegate responsibilities for clients care needs and still meet the organisational requirements.

Finally, the study will inform future uptake of the course within Scalabrini villages.

##### Who has reviewed the study?

The study has been reviewed by the Ethics Committee, University of Adelaide, and the CMC and Scalabrini Villages Ethics Committee.

##### Contact for further information

If you have any questions or concerns regarding the study, you can contact the researcher. We will have a support service and a qualified counselor available to meet your needs. You may also contact the Chair of the Scalabrini Villages ethics committee.

Researcher - Drew Dwyer, Education and Development Manager, Frontline Care Solutions

Email - [drew888@frontlinecaresolutions.com](mailto:drew888@frontlinecaresolutions.com)

Telephone - 0437603632

Research Supervisor Dr Aye Aye Gyi, Research Fellow, Translation Science Unit, The Joanna Briggs Institute

The University of Adelaide, AUSTRALIA 5005

Ph : +61 8 830 33644 e-mail: [aye.aye.gyi@adelaide.edu.au](mailto:aye.aye.gyi@adelaide.edu.au)

Chair: Committee, Catholic Health Care Ltd, Scalabrini Ethics

Telephone - Chris Rigby @ Scalabrini or Fiona Kendall @CMC

I am providing acknowledgment for being provided information sheets in the research proposal conducted by Frontline Care Solutions

Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## APPENDIX C: Survey Questions

### APPENDIX D: Integrated Analysis Table for Convergence

Question	PG1 pre test		PG1 post test		Inference to Themes	Impact
	Positive	Negative	Positive	Negative		
<b>I am overworked in my role.</b>		Y		Y	Theme Five: Leadership needs to be more supported by individuals within the organisation	
<b>I have been formally trained in the clinical leadership and management of care teams.</b>		Y	Y		Theme two: Leadership training builds confidence in the RN to lead the team.	

I am confident with delegating tasks to my care staff.	Y		Y		Theme Four: Person centred care teams lead to improved person centred care	
I am appreciated for the work I do.	Y staff/Res	Y org	Y staff/Res	Y org	Theme Five: Leadership needs to be more supported by individuals within the organisation	
I have a full understanding of the competency skills of my care staff.		y	y		Theme two: Leadership training builds confidence in the RN to lead the team.	
I have the learned ability and skill to effectively delegate work according to the Australian Nurses Midwives Board guidelines.		y	y		Theme two: Leadership training builds confidence in the RN to lead the team.	
I have been formally and properly prepared for my role.		y	y		Theme One: Leadership training is challenging in a positive way	

<b>There is a balance between clinical and non-clinical responsibility in my role.</b>		y	y		Theme two: Leadership training builds confidence in the RN to lead the team.	
<b>I am confident in writing care plans.</b>	y		y		Theme Three: Leadership training has improved the knowledge and application of clinical leadership for the nurse.	
<b>This role meets my expectations as an RN in aged care.</b>	y		y		Theme Six: Leadership training has a positive impact on professional development, personal growth and career retention.	
<b>I have open communications with the management.</b>	y		y		Theme One: Leadership training is challenging in a positive way	
<b>I have been formally trained to handle conflict and resolve issues well</b>		y	y		Theme Four: Person centred care teams lead to improved person centred care	

<p><b>I trust the skill levels of my junior care staff.</b></p>		y	y		<p>Theme Four: Person centred care teams lead to improved person centred care</p>	
<p><b>I am confident in my ability to challenge and manage policy.</b></p>	y		y			
<p><b>I have a full and confident understanding of the current legislation in delegation and supervision for nurses in aged care.</b></p>	y		y		<p>Theme Three: Leadership training has improved the knowledge and application of clinical leadership for the nurse.</p>	
<p><b>I am confident with the care funding instrument and the validation required.</b></p>		y	y		<p>Theme Four: Person centred care teams lead to improved person centred care</p>	



<p><b>I would benefit from further training in leadership and management.</b></p>		y	y		<p>Theme Three: Leadership training has improved the knowledge and application of clinical leadership for the nurse.</p>	
<p><b>I am confident in my skills in dealing with staff discipline and performance management.</b></p>	y		y		<p>Theme two: Leadership training builds confidence in the RN to lead the team.</p>	
<p><b>I have sound counselling skills when dealing with residents/clients/families.</b></p>	y		y		<p>Theme Three: Leadership training has improved the knowledge and application of clinical leadership for the nurse.</p>	
<p><b>I have had formal leadership skills training.</b></p>	y		y		<p>Theme Three: Leadership training has improved the knowledge and application of clinical leadership for the nurse.</p>	

I have a happy and effective workplace environment.	y		y		Theme Four: Person centred care teams lead to improved person centred care	
I have been formally trained in the clinical management of gerontic care issues	y		y		Theme Three: Leadership training has improved the knowledge and application of clinical leadership for the nurse.	
I have been formally trained in communication styles and techniques.		y	y		Theme Three: Leadership training has improved the knowledge and application of clinical leadership for the nurse.	
I spend more time on administration than nursing duties.		y		y	Theme Five: Leadership needs to be more supported by individuals within the organisation	
I need training in case management.		y	y		Theme One: Leadership training is challenging in a positive way	

<b>I am planning a career in aged care.</b>	y		y		Theme Six: Leadership training has a positive impact on professional development, personal growth and career retention.	
<b>I use quality auditing to meet best practice.</b>	y		y		Theme Four: Person centred care teams lead to improved person centred care	
<b>I use a case conference method to review care services and improve care outcomes.</b>	y		y		Theme Four: Person centred care teams lead to improved person centred care	
<b>I consider my role at work to be</b>	Y nurse		Y nurse		Theme Six: Leadership training has a positive impact on professional development, personal growth and career retention.	
<b>I am looking forward to a long career in aged care.</b>	y		y		Theme Six: Leadership training has a positive impact on professional development, personal growth and career retention.	