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Leadership Practices of Nurse Managers in Saudi Arabian Hospitals: A Mixed-Methods Study

Abdulhafith Alharbi

BSN (Nursing Science), MSc (Nursing Leadership)

A thesis submitted to fulfil the requirements for the degree of Doctor of Philosophy

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Leaders must be close enough to relate to others, but far enough ahead to motivate them

(John C. Maxwell 2008)

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Publications, conferences and academic volunteering

Peer-reviewed article:

Alharbi, A, Rasmussen, P & Magarey, J 2021, 'Clinical nurse managers' leadership practices in Saudi Arabian hospitals: a descriptive cross-sectional study', *Journal of Nursing Management,* vol. 29, pp. 1454–1464, https://doi.org/10.1111/jonm.13302

Conference presentations:

- **Alharbi, A**, Rasmussen, P & Magarey, J 2019, 'Leadership practices of clinical nurse managers: a mixed methods study, (oral presentation, A. Alharbi), Research Conversazione 2019, University of Adelaide, South Australia, 23–26 September.

- **Alharbi, A**, Rasmussen, P & Magarey, J 2019, 'Leadership practices of clinical nurse managers: a mixed methods study' (oral presentation, A. Alharbi), 14th Florey Postgraduate Research Conference, University of Adelaide, South Australia, 1–3 September.

- **Alharbi, A**, Rasmussen, P & Magarey, J 2020, 'Leadership practices of clinical nurse managers: a mixed methods study' (oral presentation, A. Alharbi), 5th Saudi Scientific Symposium in Australia [virtual], Canberra, Australia, 12–13 September.

- **Alharbi, A**, Rasmussen, P & Magarey, J 2020, 'Leadership practices of clinical nurse managers: a mixed methods study' (oral presentation, A. Alharbi), Research Conversazione 2020, University of Adelaide, South Australia, 23–26 September.

Volunteering for academic committees

- Committee member of Health Sciences Postgraduate Association (HeSPA 2020), Faculty of Health and Medical Sciences, University of Adelaide.

- Committee member of Health Sciences Postgraduate Association (HeSPA 2021), Faculty of Health and Medical Sciences, University of Adelaide.

Abstract

Effective leadership of clinical nurse managers enables registered nurses to advance the profession of nursing and provide safe patient care. Therefore, there is a need for effective leaders and positive role models who can motivate, support and encourage others to develop professionally, so they can successfully engage with their roles in clinical settings to provide safe patient care.

This study explored the leadership practices of clinical nurse managers and their effectiveness in Saudi hospitals. A mixed-methods, explanatory sequential design was implemented involving clinical nurse managers and registered nurses in their wards. The quantitative phase of the research involved a cross-sectional study that used convenience sampling. The sample included 29 clinical nurse managers and 318 registered nurses who worked in the nurse managers' wards. The Leadership Practice Inventory – Self and the Leadership Practice Inventory – Observer instruments were used in this phase. The qualitative phase involved a hermeneutic phenomenological study that used purposive sampling. In this phase, in-depth interviews were conducted with 11 clinical nurse managers and 12 registered nurses.

The results from the first phase of the study indicate that there is a significant difference between the self and observer assessments of the transformational leadership practices of clinical nurse managers. There were also significant differences in the transformational leadership practices of Saudi and clinical nurse managers from other cultures. Ward experience of clinical nurse managers was statistically positively associated with higher ratings of "enabling others to act". Length of clinical nurse managers' experience was associated with "enabling others to act" and "encouraging the heart" practices.

The second phase of the study expanded on and contextualised the results gained from the first phase. Though the themes and subthemes from the clinical nurse managers and registered

nurses are presented as discrete elements, they are interrelated. Both groups expressed positive and negative perspectives of clinical nurse managers' leadership in the Saudi healthcare context. The eight common themes were lack of experience, cultural barriers for non-Saudis, poor leadership, barriers to good leadership, Saudis are better leaders, working as a team, the importance of clinical expertise and the critical need to develop leadership skills.

This research provides important evidence for policymakers regarding leadership behaviours of both Saudi and clinical nurse managers from other cultures. Also, this study offers important insights into challenges for clinical nurse managers. Implementation of well-structured, innovative and sustainable leadership development strategies for clinical nurse managers, and structured counselling and psychological services, can effectively support clinical nurse managers and promote improved leadership behaviours. Several important recommendations and insights are provided in this thesis for the advancement of nursing in the country, especially the leadership role of clinical nurse managers.

Thesis declaration

I certify that 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, in the future, be used in a submission for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint award of this degree.

I give consent to this copy of my thesis, when deposited in the University Library, being made available for loan and photocopying, subject to the provisions of the Copyright Act 1968. I also give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library catalogue and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

October 2022

Abdulhafith Alharbi Date

Dedication

It brings me great pleasure to dedicate this thesis to both my lovely mother and father, who have supported and encouraged me throughout my life and learning journey. In addition, I would like to express my gratitude to my wonderful sisters and brothers, who have always been supportive of me and whom I am extremely proud of.

To my loving wife Reem. I dedicate this thesis to you; it would not have been possible for me to complete this thesis without your constant support and love. Throughout my PhD journey, you were there for me, through ideas, every discussion, through all the agonies and joys. As much as I lived this PhD, you did too, and it is a shared achievement. From the bottom of my heart, I am grateful for your patience and belief in me.

To my beloved daughters Hanin and Bushra. You are my motivation, and I am thankful to be your father. Throughout the journey, you have been constant companions to me.

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In addition, I am grateful to Ms Kate Leeson for providing professional proofreading and copy-editing services for this thesis in accordance with Australian Standards for Editing Practice and the Guidelines on Editing Research Theses.

List of abbreviations

BSN	Bachelor of Science in Nursing
CBAHI	Central Board for Accreditation of Healthcare Institutions
CI	Confidence interval
CNM	Clinical nurse manager
CP	Challenging the Process Practice
CPD	Continuing professional development
EH	Encouraging the Heart Practice
EOA	Enabling Others to Act Practice
GAStat	General Authority for Statistics
GDP	Gross Domestic Product
IOM	Institute of Medicine
ISV	Inspiring a Shared Vision Practice
LPI	Leadership Practices Inventory
LPI-Observer	Leadership Practices Inventory Observer
LPI-Self	Leadership Practices Inventory Self-report
MENA	Middle East and North Africa
MLQ	Multifactor Leadership Questionnaire
MOC	Model of Care
MOH	Ministry of Health, Saudi Arabia
MW	Modelling the Way Practice
OPEC	Organization of the Petroleum Exporting Countries

OVR	Occurrence variance report
RN	Registered Nurse
SD	Standard deviation
SPSS	Statistical Package for the Social Sciences
SR	Saudi riyal
UN	United Nations
WHO	World Health Organization

Chapter 1: Introduction

1.1 Introduction to the study

Recently, the World Health Organization (WHO 2020b) reported on the state of the nursing profession and found a compelling need for change across the world and especially an improvement in nursing leadership. In their unique position, clinical nurse managers engage in activities across the entire clinical practice, because they are positioned between the front line and the system level (Duffield et al. 2019). In addition, clinical nurse managers are frontline leaders who manage wards and influence their staff's ability to deliver high quality care (McSherry et al. 2012; Trus et al. 2012). As a leader, a clinical nurse manager is "involved in providing direct clinical care, and … influences others to improve the care they provide continuously" (Cook 1999, p. 306) and ensures safe and efficient care in clinical settings (Xu 2017); in the nursing context, clinical nurse managers are leaders who guide registered nurses in their wards. This clinical leadership influences healthcare quality and patient outcomes (Daly et al. 2014; Sfantou et al. 2017; Wong 2015).

In Saudi Arabia, the nursing profession comprises a multicultural workforce with more than half of the nurses representing other cultures (Almutairi & McCarthy 2012; MOH 2017). However, one of the challenges facing nursing in the clinical area is leadership and supervision. According to Almalki et al. (2012), management and leadership issues are a concern for most nurses in the Saudi context, as they reported not receiving sufficient supervision from their nurse managers/supervisors. In addition, the nationality of a clinical nurse manager impacts the work environment and is one of the main concerns of registered nurses in the Saudi context (Saleh et al. 2018). Al-Yami et al. (2018) found that nationality was one of the strongest factors affecting organisational commitment in Saudi nursing. In addition, there are varying perceptions of the differences in leadership practices of Saudi clinical nurse managers and those

from other cultures depending on whether it is self-perception or observers' perceptions (Alharbi, Rasmussen & Magarey 2021). There is also a need to strengthen leadership practices at all levels in the Saudi nursing context (Alluhidan et al. 2020). In light of this, the study aims to understand and examine clinical nurse managers' leadership in more detail. The findings contribute to the body of knowledge regarding the current leadership practices of clinical nurse managers and their lived experiences of leading in multicultural workplaces. They also contribute knowledge to assist hospital administrators and government policymakers to develop strategies to improve clinical nurse managers' abilities and skills to enhance their leadership. There are also implications for other countries with different management demographics that aim to improve the leadership practices of their clinical nurse managers.

1.2 Saudi Arabian context

In the Middle East, Saudi Arabia occupies an area of over two million square kilometres of the Arabian Peninsula (General Authority for Statistics [GAStat] 2016). In addition, it shares borders with eight countries (Bahrain, Iraq, Jordan, Kuwait, Oman, Qatar, the United Arab Emirates and Yemen) and the country has two coastal borders, the Red Sea is to the west and the Arabian Gulf is to the east (Figure 1.1). King Abdulaziz bin Abdulrahman Al Saud, the founder of the Kingdom of Saudi Arabia, unified the Kingdom in 1932 (Mufti 2000). Saudi Arabia celebrates its national day on 23 September. The day of this celebration represents the unification of the Kingdom of Saudi Arabia and the establishment of the Kingdom by His Majesty King Abdulaziz bin Abdulrahman Al Saud. The kingdom is divided into thirteen administrative regions, each of which is divided into different governorates that differ in number from one region to another. Each governorate is divided into centres that are administratively connected to either the governorate or the emirate (GAStat 2016).

A national census was conducted for the first time in 1975, and the results of this survey were published two years later. According to the results, there was an estimated population of nearly 7 million people living in Saudi Arabia. According to the United Nations (UN), the population of Saudi Arabia had increased to 12 million by 1985 (Mufti 2000). In accordance with the most recent government survey conducted by the General Authority for Statistics in mid-2020 the population of Saudi Arabia is around 35 million, of which 58% was male and 42% female (GAStat 2021). Saudi Arabia is gaining importance internationally for two main reasons. First, the country is the birthplace of Islam, and it is home to two Muslim holy places, Makkah and Medina, which have thrived for over 14 centuries due to their spiritual and international influence (Mufti 2000). Second, the kingdom, one of the founders of the Organization of the Petroleum Exporting Countries (OPEC), is the largest exporter of oil in the world. The kingdom is the largest economy in the Middle East and North Africa (MENA) region, with 17% of the world's conventional oil reserves, and its oil reserves are the second largest in the world (OPEC 2021). Also, the oil and gas are contributing approximately 50% of the nation's GDP and 80% of its public revenues (OPEC 2021). Despite this, the General Authority for Statistics announced in a recent report that the Saudi GDP declined by 3.0% in the first quarter of 2021 compared to the same quarter of 2020. This was mostly due to the contraction in the oil sector of 11.7%; the non-oil sector recorded a positive growth rate of 2.9% (GAStat 2021). Therefore, the kingdom's leadership has made efforts to diversify the economy since 2015 by investing in additional sectors for the purpose of reducing reliance on natural resource and to work towards a sustainable and resilient society (Kingdom of Saudi Arabia 2016a).

Even though Saudi Arabia is a young country, its culture dates back thousands of years. Saudi Arabia's culture and traditions are mainly have formed and based on the beliefs and traditions of ancient Arabian cultures and has its primary roots in Islamic teachings (Gallagher & Searle 1985). Saudi Arabia is primarily a Muslim country, so its culture is derived from the Qur'an

and Sunnah (hadith). In addition, Saudi Arabian society is deeply rooted in Islamic traditions. Also, language plays a crucial role in cultural communication, but it also presents the beliefs and practices of individuals in a community. The Arabic language is the official language of Saudi Arabia, and it is the native tongue of the vast majority of Saudi Arabians in all 13 regions, although each region has its unique dialect, traditions, heritage and identity (Kingdom of Saudi Arabia 2016a). In addition to Arabic, English is a widely spoken language and it has been taught in schools and universities as a compulsory second language in recent decades (Elyas & Picard 2010; Harbi 2022; Alotaibi 2019). In the last forty years, Saudi Arabia has seen a significant increase in the number of English speakers (AlRawi, AlShurafa & Elyas 2022), because English is taught in the early years of schooling in the country (Shah & Elyas 2019).

Following the unification of the country, there has emerged a united Saudi cultural identity that has been influenced and shaped by a variety of factors over the years. Since the discovery of oil in 1938, the wealth generated by Saudi Arabia has had a dramatic impact on the Saudi people and culture (Gallagher & Searle 1985; WHO 2013). The result was the government provided free education, including tertiary education, and health care, and did not impose taxes (Luna 1998).

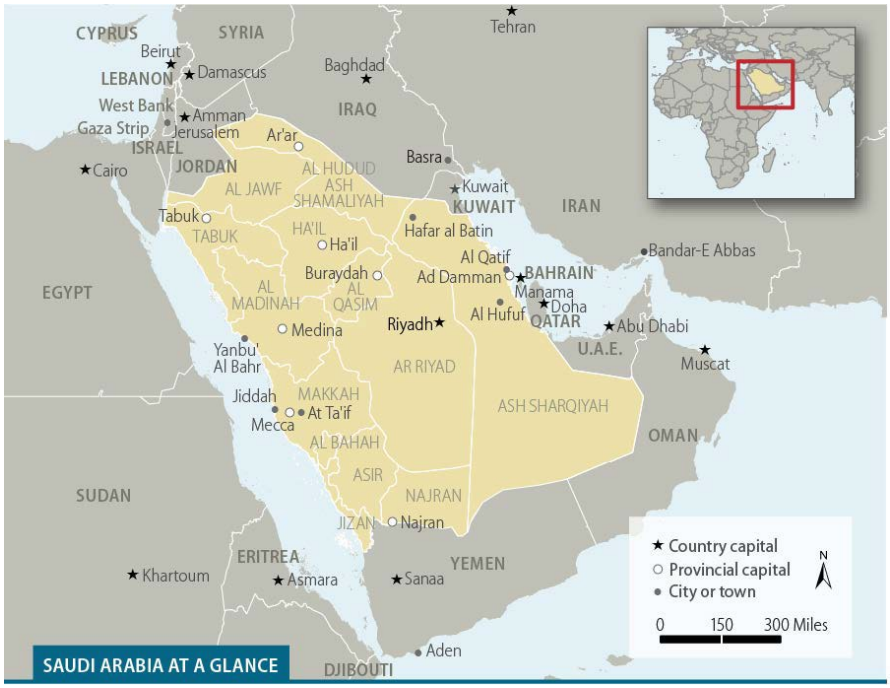

Figure 1.1: Saudi Arabia map (Source: Blanchard 2014)

Recently, the Vision 2030 plan and the National Transformation Program 2020 were introduced and began to be implemented across the country. Vision 2030 is evidence of the radical shift that the government has taken in order to reform the country on every level through its various sectors. This includes reforming the health sector by restructuring the sector and promoting public–private partnerships. More details are provided in the next section.

1.3 Healthcare system in Saudi Arabia

The Saudi Arabian government has been working to develop the nation's healthcare system at the primary, secondary and tertiary levels. In 1926, the country established a Health Department, which was its first organised health service provider (Mufti 2000). The healthcare system was established in Jeddah and Makkah, with the opening of two hospitals (Al-Rabeeah 2003). However, true improvement was not achieved until 1954, when the Ministry of Health was established (Al-Mazrou, Khoja & Rao 1995). As a result of oil revenue, massive

investments were also made in Saudi health infrastructure between 1966 and 1976 (Brown & Busman 2003).

The healthcare system in Saudi Arabia is divided into three sectors (Figure 1.2): the MOH, other government healthcare providers (e.g. military hospitals, university hospitals and royal hospitals), and the private sector (MOH 2017). In 2020, Saudi Arabia had 78,596 beds in 504 hospitals countrywide – that is, 22.4 beds per 10,000 of the population. In the same year, the total health budget reached 82 billion SR (8.1% of the overall government budget) (MOH 2022). Saudi Arabia's MOH is responsible for providing the majority of the country's health services. It funds 59.5% of all beds, followed by the private sector around 21.2% and the other government health sectors (approximately 19.3%) (MOH 2013). Health services are provided by the Ministry of Health free of charge to Saudi nationals and expatriates employed in government sectors. Other government health services are available to defined population groups. The Ministry of Education, for example, funds and operates university hospitals and provide health services solely to faculty members, students, employees and their dependents. Recently, the government has faced significant challenges owing to increasing healthcare costs, diminished oil revenues, changing demographics and improved life expectancy (Kingdom of Saudi Arabia 2021; Knight Frank 2018; Rahman & Salam 2021). Also, financial challenges such as rising healthcare costs are increasing at a faster rate than national incomes, and it costs much more to treat diseases than to prevent them in the first place (Kingdom of Saudi Arabia 2021). Furthermore, there are challenges related to the size, skills and participation of the workforce, effective recruitment that aligns with education, policies that are inconsistent with employers' practices within the healthcare sector, and the absence of a relationship between rewards and value-based health care (Kingdom of Saudi Arabia 2021). To address the workforce challenges, the government has set workforce initiative strategies. These include recruiting more health professionals, increasing the nurse-to-population ratio, promoting

Saudisation in medical and nursing roles, and increasing the retention rate of nursing staff (Kingdom of Saudi Arabia 2021). In an effort to increase quality and reduce costs, the government has strived to reforming the health sector in order to provide the best healthcare services to maintain and meet the social demands for quality improvement and reduce the government's burden in the health sector (Rahman 2020). Nevertheless, as part of the Saudi Vision 2030 plan, there has been a move to streamline the healthcare system by privatising public hospitals and introducing healthcare insurance coverage for both Saudi and non-Saudi nationals working in the country (Kingdom of Saudi Arabia 2016b). Privatisation is the process of transferring ownership of an enterprise from the government to either the for-profit or non-profit private sector (Ko et al. 2014).

Recently, the government has launched the new Model of Care program (MOC) to restructure the health sector and promote public–private partnerships. This was due to poor pathway management, inappropriate referrals, poor communication between healthcare providers, and between clinicians and their patients, variations in quality and delivery of care due to lack of standardised guidelines (MOH 2017). The MOC concept is based on international frameworks that proposed for the improvement of health systems, including the WHO health systems framework, the World Bank Group health systems framework, the Institute of Healthcare Improvement “Triple Aim” framework, and England’s National Health Service’s “Five Year Forward View” (MOH 2017). As a result of this initiative, the Ministry of Health has established health clusters in all regions of the country (Kingdom of Saudi Arabia 2021). A health cluster is an integrated network of healthcare providers run under one administrative structure that serves about one million people and allows medical professionals to move freely within the clusters (MOH 2017; Kingdom of Saudi Arabia 2021). These clusters facilitate patients’ access to the health system and transfer between care types.

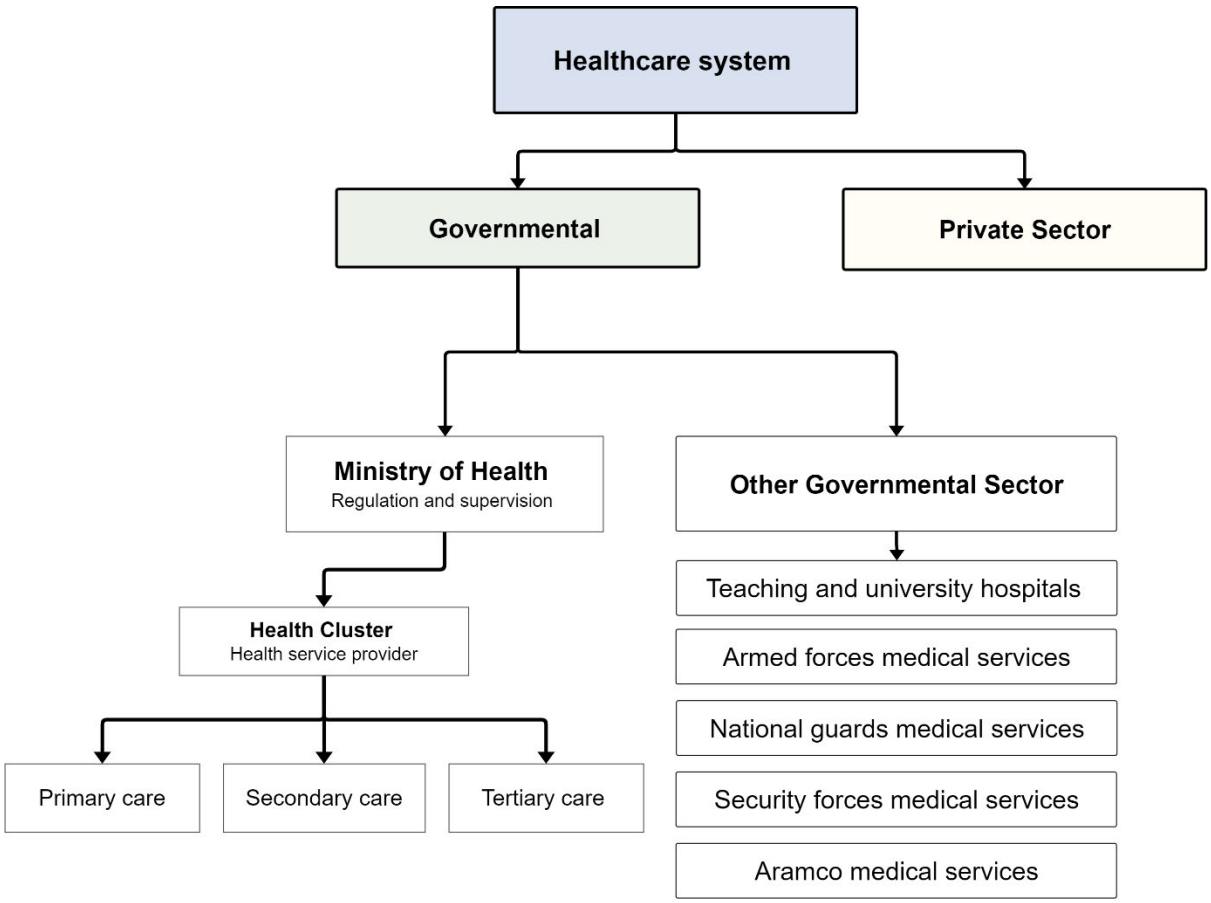

Figure 1.2: Saudi Arabia's current healthcare system (adapted from Khalil et al. 2018; Source: Kingdom of Saudi Arabia 2021)

1.4 Saudi Arabian nursing context

The nursing profession constitutes a large percentage of the healthcare workforce in most countries around world. Nursing in Saudi Arabia comprises a multicultural workforce with more than half of the nurses representing other cultures (Almutairi & McCarthy 2012; MOH 2018). A majority of nurses from other cultures working in the Ministry of Health are originally from India and the Philippines (Tumulty 2001). However, some are recruited from North and South America, Australia, the United Kingdom, Malaysia, South Africa and the Middle East (Aboul-Enein 2002; Mufti 2000; Luna 1998). In 2020, the health workforce in Saudi Arabia, the majority of whom are nurses, was around 196,701, out of which 42.9% were Saudi nationals

(MOH 2022). As a result, there were 25.4 MOH nurses per 10,000 population in 2020 (MOH 2022), a slight decrease of only 0.04% from 2017.

There are many challenges for the nursing profession in the country, such as nursing shortages, inadequate numbers of Saudi nurses, retention and increasing workloads (Alsadaan et al. 2021; Alluhidan et al. 2020). Furthermore, nursing faces the challenge of leadership and supervision in clinical settings. In the Saudi context, Almalki et al. (2012) found that nurses are concerned about management and leadership issues, since their supervisors and managers failed to provide them with adequate supervision. Further, the nationality of a clinical nurse manager influences the work environment and is an issue of concern for registered nurses (Saleh et al. 2018). According to Al-Yami et al. (2018), nationality was among the strongest factors affecting organisational commitment in the Saudi contex. Therefore, there is a need to determine the demographic and professional factors that influence clinical nurse managers' leadership (Saleh et al. 2018). There is also a critical need for effective leaders to efficiently manage the various nursing issues (Alsadaan et al. 2021) and to strengthen leadership practices at all levels in the Saudi nursing context (Alluhidan et al. 2020). The core of Saudi Vision 2030 is to understand the current situation and to find a path forward, in order to develop leaders and their staff to contribute to the development of hospitals' performance and growth (Kingdom of Saudi Arabia 2021).

1.5 Personal interest in the research

My interest in the phenomenon of clinical nurse leadership with the Saudi context is the result of my own observation of Saudi clinical nurse managers and those from other cultures. Being a university supervisor and instructor who has worked in different healthcare organisations over the past few years, I have seen clinical nurse managers' positive or negative effects on the motivation and performance of staff and others within the wards. I also observed that new

clinical nurse managers were motivated to take over the position with a desire to implement positive changes; however, after a few months, they became demoralised, causing some of them to leave the position. The reason for my initial interest in investigating this phenomenon was that, after I completed my master's degree in the UK, I found that there was a lack of knowledge about the effectiveness of clinical nurse managers' leadership despite Saudi nursing being considered multinational. There was a limited number of in-depth investigations of this topic, and no such study found has investigated the experiences of Saudi and from other cultures clinical nurse managers

1.6 Significance of the study

The findings of this study could assist policymakers at the Hail Health Cluster, the General Directorate of Hail Health Affairs, and the Saudi Ministry of Health to plan interventional and transformational change. It is anticipated that the results of the thesis may will attract the attention of health policymakers, healthcare providers and researchers those interested in supporting and implementing the strategies proposed in this study, in order to increase the number of well-prepared clinical nurse managers, foster cross-cultural leadership awareness, and promote a more positive working environment. Also, future studies can use the baseline information collected in this study to test the most effective interventions. This study will provide recommendations about how to enhance clinical nurse managers' leadership for the benefit of the nursing profession across the country.

1.7 Research questions

The principal aim of this research was to understand and examine clinical nurse managers' leadership practices and to explore in-depth the leadership effectiveness in healthcare institutions in Saudi Arabia.

The following three main questions, with sub-questions, were addressed:

1. What are clinical nurse managers' transformational leadership practices in healthcare institutions in Saudi Arabia?
    a. Is there a difference between self-reported clinical nurse managers' transformational leadership practices and those reported by registered nurses working in the clinical nurse managers' wards?
    b. Is there a relationship between clinical nurse managers' transformational leadership practices and their demographic variables (i.e. nationality, age and gender)?
    c. Is there a relationship between clinical nurse managers' transformational leadership practices and their professional variables (i.e. educational level, experience as a nurse, experience as a leader and experience in the current ward)?
2. What are nurses' experiences of the leadership of clinical nurse managers?
3. What are clinical nurse managers' perceptions of their own leadership?

1.8 Overview of the research process

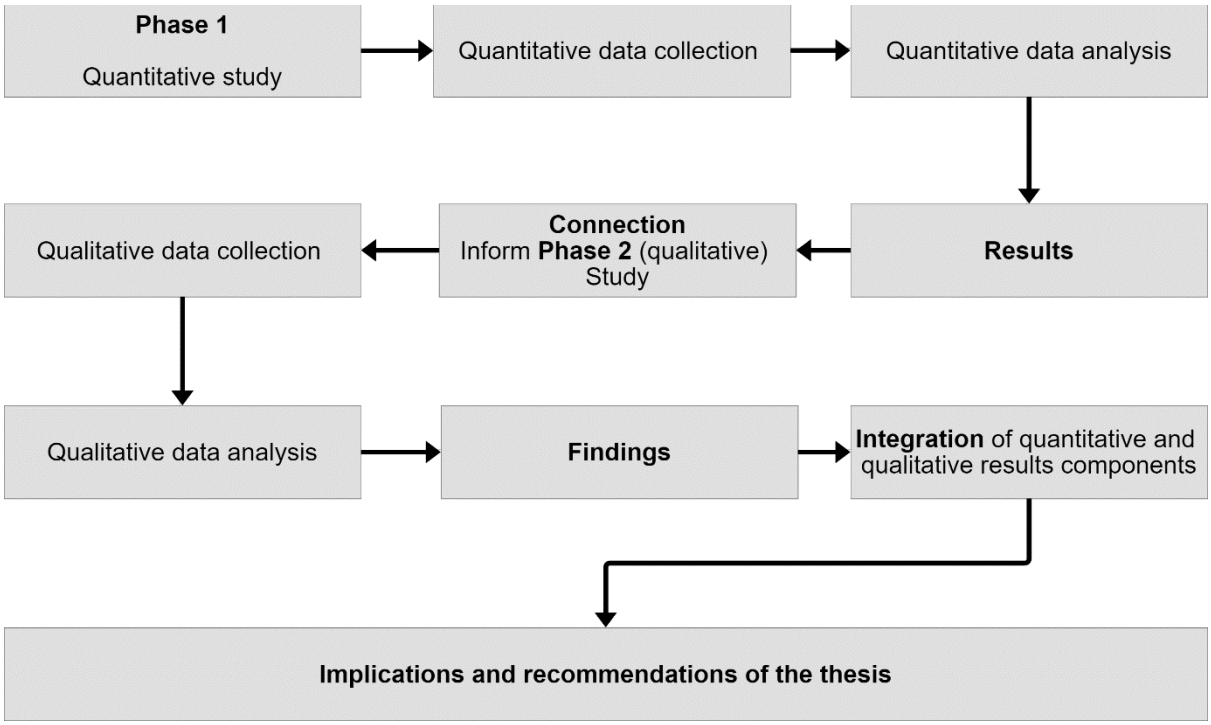

Figure 1.3: Outline of the study

1.9 Outline of the thesis

This thesis follows the principles of mixed-methods research, in that it reports the results of each component separately, and also integrated those results together to provide a holistic picture of the contemporary leadership practices of clinical nurse managers working in Saudi Arabian hospitals. This thesis reports the results of the research in nine chapters as follows.

Chapter 1 has provided an introduction to the study and an overview of Saudi Arabia and its socio-cultural life and people, as well as the health system and the health workforce. It also presented a comprehensive snapshot of the research aims, questions and thesis structure. Chapter 2 provided a critical evaluation of the literature about nursing leadership in clinical settings. Chapter 3 presented a comprehensive overview of the history of the research methodology as well as discussing the design utilised in this study.

Chapter 4 provided a detailed description of the quantitative methods used in the first phase of this study followed by the ethical considerations and ethics approvals. It also presented the methods used for sampling, data collection and analysis. Chapter 5 presents the results of the quantitative study.

Chapter 6 detailed the qualitative methods used in the second phase of this study. It also presented the methods used for sampling, data collection and analysis. Chapter 7 presented the findings and identified the themes from the qualitative study. Chapter 8 integrated the findings of the two studies and discussed both components. Chapter 9, as the conclusion chapter, summarised the core of this study. The unique characteristics of this study and its contribution to nursing leadership, particularly clinical nurse managers' effectiveness in the wards, are discussed. This included a discussion of the implications of the findings and recommendations for the future as well as the strengths and limitations of the study.

Chapter 2: Literature review

In the previous chapter, the topic of this research was introduced and the need for research on the topic was described. The current review critically evaluated the available literature discussing the leadership practices of clinical nurse managers. The cited studies and their findings were helpful in explaining and interpreting the results obtained, which were discussed in later chapters. This chapter was begun by explaining the strategy that was utilised to search for literature in relevant databases using appropriate search terms. Then, the leadership theories presented in the literature were discussed. Thereafter, the themes found in the literature that are relevant to this study were discussed under seven major headings: nursing leadership and healthcare systems, leadership styles in multicultural workplaces, different perspectives on clinical nurse managers' leadership, the demographic and professional factors relevant to leadership, the effectiveness of clinical nurse managers' leadership, the challenges confronting clinical nurse managers, and the influence of continuing professional development on nursing leadership. In conclusion, the discussion of this chapter was narrowed down by focussing on research gaps identified through the literature review.

2.1 Search strategy

Several databases were comprehensively searched in two phases. The first phase aimed to collect comprehensive seminal literature on the leading theories of leadership. The second phase collated literature relevant to the purpose of the study from the internet and within databases. The search engines and databases used were Embase, PubMed, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Scopus and Google Scholar. These databases were searched to provide an extensive coverage of peer-reviewed literature, including books, journals and conference papers (University of Adelaide 2018), As well as other articles that have been retrieved from the internet, that provided a substantial amount of

information on wide range of studies related to nurse managers' leadership. A combination of the following keywords was used for this search: leadership styles, clinical nurse manager, professional and demographics and organisational, nursing and patients' outcomes. A search terms were generated for each of these keywords based on the databases that were used. The search terms chosen for each database are shown in Table 2.1. Searches were conducted throughout the study from late 2018 to late 2022 and limited to literature in the English language. In addition, a systematic approach was used to review the available literature relevant to nurse managers' leadership practices to find peer-reviewed articles and gray literature to find unpublished research and theoretical literature (Aveyard 2019).

Table 2.1: Search terms for databases

CINAHL database			
Leadership	**Clinical nurse manager**	**Professional and demographic factors**	**Additional and related to the study**
			Organisational, nursing and patients' outcomes
MH Leadership + OR TI "leadership style*" OR AB "leadership style*" OR TI "leadership practice*" OR AB "leadership practice*" OR TI "leadership practise*" OR AB "leadership practise*" OR TI "leadership profile*" OR AB "leadership profile*"	MH Nurse Managers + OR TI "head nurs*" OR AB "head nurs*" OR TI "nurs* manager*" OR AB "nurs* manager*" OR TI "clinical manager*" OR AB "clinical manager*" OR TI "unit manager*" OR AB "unit manager*" OR TI "nurse leader*" OR AB "nurse leader*"	MH demographics + OR TI "experience*" OR AB "experience*" OR TI "age* gender*" OR AB "age* gender*" OR TI "nationalit*" OR AB "nationalit*" OR TI "multicultural" OR AB "multicultural"	MH Organisational outcomes + OR TI "nurse outcome*" OR AB "nurse outcome*" OR TI "patients outcome* patient outcome*" OR AB "patients outcome* patient outcome*" OR TI "adverse event*" OR AB "adverse event*" OR TI "patients safety" OR AB "patients safety"
PubMed database			
Leadership[mh] OR leadership style*[tiab] OR leadership	Nursing, Supervisory[mh] OR head nurse[tiab] OR nurse manager[tiab]	Demographic[mh] OR Professional*[tiab] OR	Organisational outcomes [mh] OR nurse outcome*[tiab] OR

practice*[tiab] OR leadership practise*[tiab] OR leadership profile*[tiab]	OR clinical manager[tiab] OR unit manager[tiab] OR nurse leader[tiab]	experience*[tiab] OR age*[tiab] OR gender*[tiab] OR nationalit*[tiab] OR multicultural*[tiab]	patients outcome*[tiab] OR patient outcome*[tiab] OR adverse event*[tiab] OR patients safety[tiab] OR patients safety[tiab]
Embase database			
De leadership OR leadership style*.ti,ab OR leadership profile*.ti,ab OR leadership practice*.ti,ab OR leadership practise*.ti,ab	Exp head nurse OR head nurse*.ti,ab OR nurse manager*.ti,ab OR unit manager*.ti,ab OR nurse leader*.ti,ab	Exp demographic OR demographic*.ti,ab OR professional.ti,ab OR experience*.ti,ab OR nationalit*.ti,ab OR multicultural*.ti,ab	Exp organisational outcome* OR organisational outcome*.ti,ab OR nurse outcome*.ti,ab OR patient* outcome*.ti,ab OR patient outcome*.ti,ab OR adverse event*.ti,ab OR patient* safety
Scopus database			
"Leadership" OR "leadership style*" OR "leadership style*" OR "leadership practice*" OR "leadership practice*" OR "leadership practise*" OR "leadership practise*" OR "leadership profile*" OR "leadership profile*"	"Nurse Managers" OR "head nurse*" OR "nurse* manager*" OR "clinical manager*" OR "unit manager*" OR "nurse leader*"	"demographics" OR "experience*" OR "experience*" OR "age*" OR "gender*" OR "nationalit*" OR "multicultural"	"Organisational outcomes" OR "nurse outcome*" OR "nurse outcome*" OR "patients outcome*" OR "patient outcome*" OR "adverse event*" OR "adverse event*" OR "patients safety" OR "patients safety"

2.2 Approaches to leadership theories

2.2.1 Leadership definition

There are many varied definitions and concepts of leadership which explicitly reflect the ideas underlying leadership theories. Several decades ago, Stogdill (1974) pointed out that “there are

almost as many different definitions of leadership as there are persons who have attempted to define the concept" (p. 7). There have been 65 classification systems developed over the last 60 years to describe the concept and dimensions of leadership (Fleishman, Zaccaro & Mumford 1991). Bass's proposed scheme (1990, pp. 11–20) is one such classification system that discusses and defines the concept of the leadership. In his unique book *Bass & Stogdill's handbook of leadership: theory, research, and managerial applications*, Bass (1990) argued that some leadership definitions focus on group processes. In this view, the leader plays a key role in collective change and action by embodies the collective will of the group (Bass 1990). Also, leadership can also be defined from the point of view of personality, suggesting that it is a combination of specific characteristics or traits that are present in some individuals (Bass 1990). Others consider leadership as an act or behaviour, or as a power relationship between the leader and followers (Bass 1990). Accepting leadership as a complex and multifaceted phenomenon necessitates familiarity with various theoretical and empirical perspectives of the different of theorists (Marriner-Tomey 1993). Katz and Kahn (1978) define leadership as "any act of influence on a matter of organisational relevance" (p. 334). Also, Rauch and Behling (1984) define leadership as "the process of influencing the activities of an organized group toward goal achievement" (p. 46). Similarly, Northouse (2021) defines leadership as "a process whereby an individual influences a group of individuals to achieve a common goal" (p. 3). In addition, Drath and Paulus (1994) define leadership as "the process of making sense of what people are doing together so that people will understand and be committed" (p. 4).

2.3 Leadership theories

Numerous studies on leadership have been conducted over many decades, giving rise to a number of leadership theories. According to Wart (2003), categorising all of the mainstream leadership literature into precise time periods is impossible; nevertheless, the prominent themes and interests can be captured for a heuristic summary. Wart depicted the main eras of leadership

theories and research, along with the associated major time frames and attributes (see Figure 2.1).

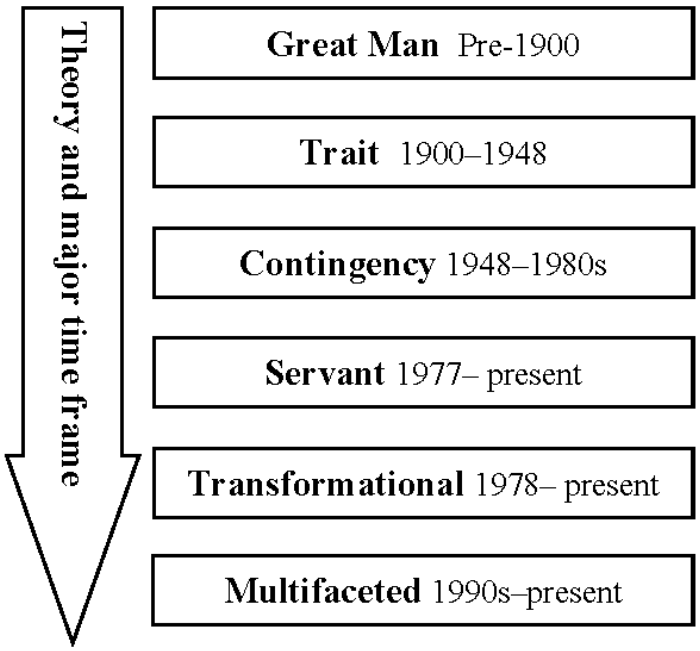

Figure 2.1: The eras of leadership theories (Source: Wart 2003)

2.3.1 Great man theory

Prior to the 1900s, and in the early attention of leadership research, the great man theory was one of the first systematic research attempts. This was as a result of the theory popularised in the 1840s by the Scottish author Thomas Carlyle, which is highlighted that great leaders are born, not made (Wart 2003; Spector 2016). Proponents of the theory usually focus on the rise of a great figure who had a significant influence on society, such as Napoleon or Martin Luther (Wart 2003). At that time, Carlyle reinforced the idea of the great man era that leadership is possessed by heroes with authority who are born to lead (Marshall 2010).

2.3.2 Trait theory

There was a growth and development of the great man theory (between 1900 and 1948) and this theory later referred to as the trait theory. Although the theory relies on the same premise is employed, however it is geared towards understanding and analysing the characteristics that are shared by leaders, including their physical, mental, and social (Zaccaro, Kemp & Bader 2018; Zaccaro 2007). There were a number of personality tests developed by researchers that were used to compare the results of people who were perceived to be leaders (Wart 2003). Researchers had compiled extensive lists of traits based on psychological studies brought by scientists in the 1940s (Bird 1940; Jenkins 1947). Some of the major criticisms of trait theory were, first, that the list of traits was so long, and second, the traits found were not powerful predictors in differing circumstances and situations (Wart 2003). Later, there is a scathing critique of pure trait theory published by Ralph Stogdill in 1948 that led the idea of such a theory to quickly fall out of favour as it failed to account for the complexities of leadership as being too one-dimensional (Stogdill 1948). In some situations, a person who shows leadership qualities and is a leader in one situation might not be able to take on that leader role in another. The next major thrust of theorists and researchers was to explore the context of the situation in which leaders operate to be able to identify patterns that are meaningful for developing theories.

2.3.3 Contingency (situational) theory

The contingency or situational theory emphasises the situations or circumstances that affect leaders. One early example was the leadership studies of Hemphill (Hemphill 1950; Hemphill & Coons 1957), which began by testing statements about leadership behaviour. Two types of behaviours were found to be particularly characteristic of effective leaders: consideration and initiating structure. The results of these and a series of similar studies have yielded useful theories, even if they are often simplistic and largely bimodal when combined with the

humanist movement revolution in the 1950s and 1960s (Argyris 1957; Likert 1959; McGregor 1960; Maslow 1965; Fiedler 1967; Fiedler & Chemers 1984; Fiedler, Chemers & Mahar 1977; Blake & Mouton 1964, 1965; Hersey & Blanchard 1977). The theory was developed further by Hersey and Blanchard (1977), who integrated situational leadership theory with the work on the impact of the power bases of leaders by Hersey, Blanchard and Natemeyer (1979). A key premise of situational theory is that different circumstances necessitate different types of leadership (Hersey & Blanchard 1977). It is important to realise, however, that these theories in general lack of scientific credibility due to attempted to explain too much with a limited number of variables (Wart 2003). There is only one exception in terms of major theories which is the model of Vroom's normative decision (Vroom & Yetton 1973; Vroom & Jago 1988a), which addressed a one-dimensional of leadership style, namely the role of participation, and seven problem characteristics were identified, as well as two types of cases (individual and group). (Wart 2003; Vroom & Yetton 1973; Vroom & Jago 1988a, 1988b). Despite these limitations, the situational perspective remains one of the cornerstones of most leadership theories that exist today (Wart 2003).

2.3.4 Servant theory

In his seminal works, Robert K Greenleaf (1970, 1977) introduced servant leadership theory with unusually substantial implications. Community is important to servant leadership because it offers a unique opportunity for people to interact face-to-face and experience interdependence, respect, trust, together with the growth of their personal potential (Greenleaf, 1970). Servant leaders start with the natural desire to serve others first, to ensure "highest priority needs are served first" (Greenleaf 1970, p. 4). A servant leader, according to Greenleaf, has a social responsibility to consider the needs of "have nots" as well as who are less fortunate (Northouse 2021, p. 229). Leader who are servant strives to eliminate inequities and social injustices if they exist (Graham 1991). According to Spears and Lawrence (2002), Greenleaf's

seminal works describe ten characteristics of the servant leader: "listening, empathy, healing, awareness, persuasion, conceptualisation, foresight, stewardship, commitment to the growth of people and building community" (pp. 5–8). The concept of servant leadership can be applied to all types of organisational structures; for instance, nurse managers who practice this leadership style should be aware the needs of their nurses through adopting the ten characteristics of the servant leader within their selves.

2.3.5 Transformational theory

In 1978, James Macgregor Burns' influential book on leadership was published. Burns was the first to propose a transformational theory of leadership. The transformational school built its reputation on vision and long-term organisational change (Burns 1978, 2012; Bass 1985; Bennis, Nanus & Bennis 1985; Tichy & Devanna 1986). According to Burns (1978), transformational leadership "raises the level of human conduct and ethical aspirations of both the leader and the led and thus has a transforming effect on both" (pp. 20). Burns (1978, p. 20) defined transformational leadership as "leaders and followers raising one another to higher levels of motivation and morality". Then, Bernard Bass (1985) advanced the idea of transformational leadership and identified four transformational leadership practices including: idealised influence, inspirational motivation, intellectual stimulation and individual consideration. Transformation "occurs when leaders broaden and elevate the interests of their employees, when they generate awareness and acceptance of the purposes and mission of the group and when they stir their employees to look beyond their own self-interest for the good of the group" (Bass 1990, p. 21). Posner and Kouzes (1988) developed the Leadership Practices Inventory to examine transformational leadership behaviour, which consists of five components: "*model the way*", "*inspire a shared vision*", "*challenge the process*", "*enable others to act*" and "*encourage the heart*". These will be covered in more detail in Chapter 4.

Figure 2.2: Elements of the Leadership Practices Inventory. (Source: Kouzes & Posner 2013) (Reproduced with permission: Alharbi, Rasmussen & Magarey, 2021)

Multifaceted theories emphasise integrating the major schools of thought, particularly those based on transactional theories, which include traits and behaviours that generally represent management interests, and also the transformational school which includes the visionary, entrepreneurial and charismatic schools (Wart 2003).

2.4 Nursing leadership and healthcare systems

Globally, leadership is known as one of the factors that contributes most significantly to shaping outcomes for professions and organisations in healthcare systems, particularly in nursing (Fowler et al. 2021; Rosser et al. 2020; McCay et al. 2018; Cummings et al. 2018; Gemeda & Lee 2020; Singh 2020; Clavijo-Chamorro et al. 2021). The literature revealed that the leadership of clinical nurse managers has a strong influence on nurses, the work environment, and nursing and organisational outcomes, as well as in providing a supportive

environment and culture for the implementation of evidence-based practice (Bianchi et al. 2018; Clavijo-Chamorro et al. 2021). Several nursing leadership studies have been conducted in the Middle East and North Africa (MENA) across different settings. Some studies have been conducted in Saudi Arabia (AbuAlRub & Alghamdi 2012; Alshahrani & Baig 2016; Al-Yami et al. 2018; Alsadaan 2018; Alghamdi et al. 2018; Saleh et al. 2018; Harb et al. 2022), some examined the impact of nursing leadership styles in Jordan (Abdelhafiz et al. 2016; Alloubani et al. 2019), and some studies were conducted in Egypt (Al-Yateem et al. 2021; Abou-Ramadan & Eid 2020; Moustafa Saleh et al. 2021). Other studies have focused on nursing leadership in Bahrain (Isa 2012; AlHashmei & Hajee 2013), Kuwait (AlFadhalah & Elamir 2019, 2021; AlFadhala et al. 2020), Iran (Ebrahimzade et al. 2015; Bahadori et al. 2018; Hamidifar 2010; Asiabar et al. 2020; Kalateh Sadati et al. 2021) and Turkey (Demirhan 2020; Kül & Sönmez 2021; Sahan & Terzioglu 2022). The World Health Organization's (2020b) recently report *State of the world's nursing* described a profound shortage of human resources for health, particularly in nursing. Leadership in nursing is an important aspect of strengthening the nursing workforce and improving the quality of nursing practice (WHO 2020b; IOM 2011). In addition, the behaviours of clinical nurse managers play an important role in nursing outcomes, as well as in the work environment (Page, Halcomb & Sim 2021). Stoddart et al. (2014) found that clinical nurse managers are expected to be effective and ultimately responsible for the quality of care delivered to patients. They also have a particularly important role to play in the implementation of evidence-based practice by fostering a supportive culture and work environment (Bianchi et al. 2018). Thus, clinical nurse managers are expected to adopt an effective leadership style in the wards they manage.

The role of the clinical nurse manager is that of a frontline leader who manages wards and influences the ability of the staff to provide patient care of the highest standard (McSherry et al. 2012; Trus et al. 2012). It is the responsibility of the clinical nurse manager to be "involved

in providing direct clinical care, and … influences others to improve the care they provide continuously" (Cook 1999, p. 306) and ensures safe and efficient care in clinical settings (Xu 2017). Clinical nurse managers are leaders who serve as guides for registered nurses on their wards (Alharbi, Rasmussen & Magarey, 2021), provide higher level leadership and coordinate activities within the nursing wards (Jackson & Nowell 2021). In Saudi context, the clinical nurse manager role (also called Head Nurse) assists with the administration and coordination of staff and patient care administration as well as they may provide nursing care to patients as required to maintain clinical skills (Hospital document, personal communication, 13 January 2023). This is different to Australia where these roles can be undertaken by two different registered nurses such Clinical Nurse Consultant and Nurse Unit Manager. A primary focus of Clinical Nurse Consultant role in Australia is to coordinate clinical practice in a particular the clinical specialty (Queensland Health 2015, 2020). While the Nurse Unit Manager role focuses on coordination of clinical practice, human and or materials resources (Queensland Health 2015, 2020). Combining these different responsibilities of the clinical nurse manager role in Saudi context may impact the role locally. Recently during the COVID-19 pandemic, their role has been more important as it has included managing patient care transitions and finding solutions to the new challenges of nursing practice (Jackson & Nowell 2021; Freysteinson et al. 2021). Clinical nurse managers play a crucial role in creating a healthy work environment and fostering nurses' resilience (Shirey 2006; Labrague et al. 2018; Mollahadi et al. 2021; Wei et al. 2019), and their role is widely regarded as one of the most vital yet challenging within any healthcare organisation (Moore, Sublett & Leahy 2016).

2.5 Leadership styles in multicultural workplaces

Increasingly, diversity is becoming an important aspect of workplaces in the Saudi healthcare sector. As mentioned earlier, the health sector in Saudi Arabia is heavily reliant on expatriate workers: approximately 60% of the health workers are not Saudi nationals (WHO 2020a). In a

workforce that comprises diverse cultures, religions and educational backgrounds, it is particularly important for leaders to provide outstanding leadership to nurses in order to provide quality care, create a positive work environment, and achieve the organisation's goals. Leaders play a pivotal role in shaping the contexts in which groups work (Maxwell 2017). Globally, there has been a growing number of studies in recent years which have attempted to create a better understanding of an effective leadership style in multicultural workforce settings (Casida & Pinto-Zipp 2008; Raithel, Van Knippenberg & Stam 2021; Mills et al. 2019; Mahadevan 2017; Lindheim 2020; Saleh et al. 2018; Suliman 2009; El Amouri & O'Neill 2014). A study from New Jersey, United States found that nurse managers from different ethnicities, such as African American, Asian, Caucasian and Hispanic, who lead nurses have the ability to balance flexibility and stability, which is essential to maintaining organisational effectiveness (Casida & Pinto-Zipp 2008). Findings from a study conducted in the south-western United States in multiple organisations, including healthcare organisations, concluded that leaders contribute to the performance of teammates in settings that are characterised by diverse ethnicities and nationalities (Raithel et al. 2021). A study conducted in the southern United States with managers from multicultural backgrounds found that nurse managers' leadership styles affected the reporting of negative acts such as bullying in the workplace; however transformational leadership was associated with a 22% decrease in bullying reports (Mills et al. 2019). A cross-sectional study by El-Amouri and O'Neill (2014) conducted in the United Arab Emirates with nurse managers from different nationalities, such as Arab, Asian and European, found that there are variations in leadership styles, but that key attributes of transformational and transactional leadership can be used to enable a collaborative approach that can be used to build staff capacity to provide culturally competent care. Moreover, a cross-cultural scoping review found that an unsupportive leadership style was an important cause of bullying in the nursing profession across different cultural clusters (Karatuna, Jönsson &

Muhonen 2020). A recent study from eastern Saudi Arabia found that nurses expressed dissatisfaction about the preferential leadership style displayed by some of their nurse managers because of nationality bias (Saleh et al. 2018). Another study in Saudi Arabia conducted by Suliman (2009) indicated that the nationality and intention of the nurses and nurse managers in terms of their intention to stay or to leave influenced how they perceived transformational leadership as a dominant style. A recent study conducted in eastern Saudi Arabia by Alsadaan (2018) found there was no significant difference across nationalities on transactional, laissez-faire leadership factors, but there were significant differences regarding idealised influence (transformational leadership). The mean score for Saudi nurse managers was higher than that of their Indian and Filipino counterparts. A more recent study from the USA found that when the leader is a foreigner, cultural diversity has a positive effect on team performance, however, when the leader is local and has a less tenure, it has a negative effect on team performance (Raithel et al. 2021). Overall, the leadership styles of nurse managers in multinational workplaces differ. A possible explanation for the variation could be the differences in socioeconomic and demographic factors in the populations studied.

2.6 Different perspectives on clinical nurse managers' leadership

The majority of the literature describes clinical nurse managers' leadership from a single perspective, either from clinical nurse managers' own perspective (Goh, Ang & Della 2018; Sammut & Scicluna 2020; Zampieron et al. 2013; Heuston et al. 2021; Charosaei et al. 2020) or from the perspective of observers, who are usually their nurses (Magbity, Ofei & Wilson 2020; Heuston et al. 2021; Goh, Ang & Della 2018; Firestone 2010; Andrews et al. 2012; Casida & Parker 2011; Sammut & Scicluna 2020; Pishgooie et al. 2019), whereas some studies examine dual perspectives (Zampieron et al. 2013; Goh et al. 2018; Sammut & Scicluna 2020; Heuston et al. 2021; Charosaei et al. 2020). The purpose of this review was to examine studies that have investigated the leadership of clinical nurse managers from two different

perspectives: first how clinical nurse managers perceive their own leadership, then how registered nurses perceive the leadership of their managers.

2.6.1 Clinical nurse managers' self-perceptions of their leadership

Leadership self-perceptions provide insight into the way clinical nurse managers view themselves as leaders. In addition, nurse managers' perceptions of their leadership are crucial in order to evaluate the alignment with the perceptions of the registered nurses. The perceptions of nurse managers have been examined in several previous studies using survey-based methods (Goh et al. 2018; Sammut & Scicluna 2020; Zampieron et al. 2013; Heuston et al. 2021; Charosaei et al. 2020).

A study conducted by Goh et al. (2018) in Singapore examined the leadership styles of nurse managers from the perspective of nurse managers. This study used the Multifactor Leadership Questionnaire (MLQ) to collect data from four nurse managers and 111 registered nurses. The results of the study showed that clinical nurse managers displayed both transactional and transformational leadership behaviours, as well as a lesser degree of laissez-faire leadership behaviours. Another study conducted by Sammut and Scicluna (2020) in the Republic of Malta compared the perceived leadership practices of charge nurses from the perspective of charge and staff nurses. This study used the Leadership Practices Inventory and collected data from 151 charge nurses and 1950 registered nurses. The study found that both staff nurses and charge nurses thought that the charge nurses demonstrated transformational leadership behaviours such as enabling others to act. A study conducted by Zampieron et al. (2013) in Italy compared different leadership styles of nurse managers based on the perceptions of nurse managers and their nurses and assistants. This study used the change, production, employee leadership model developed by Ekvall and Arvonen (1991, 1994). It collected data from 21 clinical nurse managers, 406 registered nurses and 96 assistants. The results of the study showed that the

leadership styles the nurse managers preferred were in the change and production domains. A recent study conducted by Heuston et al. (2021) to compare the self and observer perceptions of clinical nurse managers in the USA found that nurse managers described their leadership practices as transformational, which was different from nurses' perceptions. A study conducted by Charosaei et al. (2020) involved 45 nurse managers including matrons, supervisors, head nurses and 315 nurses and paramedics in Iran. The study identified the perceived and preferred perceptions of nursing personnel and managers about nurse managers' leadership styles and compared them with each other. The results showed that nurse managers scored their leadership higher than nurses and paramedics did.

2.6.2 Registered nurses' perceptions of clinical nurse managers' leadership

It is possible that self-perceptions may cause leaders to overestimate their level of leadership. Assessing nurses' perceptions of their ward managers' leadership is vital to identifying fit or disagreement with leaders' leadership self-perceptions. Nurses' perspectives on leadership are considered to be an important factor to take into consideration, since the nurses contribute to assessing the leadership of clinical nurse managers and may result in improving that leadership, promoting nursing excellence and retaining registered nurses (Andrews et al. 2012). Several research studies have used a survey-based approach to understand nurses' perceptions of their managers' leadership (Magbity et al. 2020; Heuston et al. 2021; Goh, Ang & Della 2018; Firestone 2010; Andrews et al. 2012; Casida & Parker 2011; Sammut & Scicluna 2020; Pishgooie et al. 2019). A recent study conducted to compare the self and observer leadership perceptions of clinical nurse managers by Heuston et al. (2021) found that clinical nurse managers received lower ratings from nurses for their leadership practices. Also, a study by Firestone (2010) revealed that the mean scores for staff responses concerning their managers' leadership behaviours were lower than the mean scores for the managers' self-assessment. Both studies (Firestone 2010; Heuston et al. 2021) were conducted to understand the

transformational leadership practices of nurse managers in the USA. A study conducted by Goh et al. (2018) in Singapore evaluated the leadership styles of nurse managers as perceived by registered nurses working in their wards in an acute tertiary hospital. The study found that registered nurses tended to rate their managers lower than nurse managers' self-perceptions in terms of transformational leadership. A study conducted by Magbity et al. (2020) in Ghana examined clinical nurse managers' leadership styles from nurses' perceptions. This study used the MLQ leadership tool to collect data from 250 registered nurses. The results of the study showed that nurses perceived that nurse managers demonstrated participatory and transformational leadership styles. A study conducted by Pishgooie et al. (2018) in Iran investigated nurse managers' leadership from nurses' perceptions. This study used the MLQ leadership tool to collect data from 1617 registered nurses. The study found that nurses perceived that the nurse managers demonstrated transactional leadership styles.

It is evident that some previous studies have assessed self-perceptions of clinical nurse managers' leadership, and some have examined nurses' perspectives (Magbity et al. 2020; Heuston et al. 2021; Goh, Ang & Della 2018; Firestone 2010; Andrews et al. 2012; Casida & Parker 2011; Sammut & Scicluna 2020; Pishgooie et al. 2019) and far fewer have investigated nurse managers' leadership from a dual perspective (Goh et al. 2018; Sammut & Scicluna 2020; Zampieron et al. 2013; Heuston et al. 2021; Charosaei et al. 2020). Most of the dual perspective studies found that nurse managers had higher perceptions of their own leadership than their nurses did (Heuston et al. 2021; Charosaei et al. 2020; Zampieron et al. 2013; Sammut & Scicluna 2020; Goh et al. 2018). The majority of previous studies reported significantly lower registered nurses' observer ratings of clinical nurse managers' leadership than the managers' self-reports. However, one study found that nurses' perceptions were higher than those of their nurse managers. A possible explanation for this variation could be a perception gap between leaders and their registered nurses. There is a possibility that these perception gaps could

negatively impact the effective collaboration between leaders and their registered nurses, affecting the provision of patient care. In spite of this, a number of studies conducted to assess nurses' and nurse managers' perceptions of nurse managers' leadership neglect to measure the perceptions of nurse managers and nurses from the same team/ward. Thus, the results may not accurately reflect nurse managers' leadership practices.

2.7 Demographic and professional factors relevant to leadership

The nursing workforce in Saudi Arabia is considered a multicultural workforce because more than half of working nurses come from different cultures (MOH 2018; Almutairi & McCarthy 2012). As mentioned earlier, few studies have been conducted on clinical leadership practices and demographic characteristics in the Saudi nursing context. In one Saudi study Saleh et al. (2018) recommended that more research is needed to investigate the influence of demographic and professional factors on clinical nurse managers' leadership. In this section the focus of the review is understanding research to date in the area of demographic and professional factors relevant to clinical nurse managers' leadership worldwide. This includes research on clinical nurse managers who practise a transformational style and the effect on their leadership of demographic and professional factors such as age, total experience and length of time in their current position (Raup 2008; Lappalainen, Härkänen & Kvist 2020). Researchers have identified a need for transformational clinical nurse managers in the nursing context (Suliman 2009). Factors affecting leadership styles have been categorised as internal and external environments, understanding and experience (Cook 2001). The internal environment focuses on the beliefs and values of individual leaders, and the external environment focuses on organisational structures and the dominant culture. In addition, understanding refers to the understandings of individual leaders, while experience focuses on what an individual leader can bring to the post. A review of the literature that investigates these factors follows.

2.7.1 Demographic factors and leadership practices

Most of the studies reviewed here investigated nursing leadership practices and their association with organisation, nursing and patient outcomes as well as demographic factors, but with less attention on demographic factors. There is evidence to suggest that demographic factors play a role in shaping the leadership behaviours of leaders within an organisation. A recent study conducted in east Saudi Arabia by Alsadaan (2018) found there was no significant difference across nationalities on transactional, laissez-faire leadership factors, but there was a significant difference across nationalities on idealised influence attributed of transformational leadership. The mean score for Saudi nurse managers was higher than that of their Indian and Filipino counterparts. In contrast, another Saudi study by Shahin, Abdrbo and Bayoumy (2018) found that Saudi nationality negatively affects nurses' leadership behaviour. A more recent study from the USA found that when the leader is a foreigner, cultural diversity has a positive effect on team performance, however, when the leader is local and has a less tenure, it has a negative effect on team performance (Raithel et al. 2021).

In previous studies of Saudi nursing leadership, less attention has been given to age, and the findings reported in the available literature regarding age's effect on leadership practices are inconsistent. Globally, older age is the factor that is most commonly positively associated with good nursing leadership (Budak & Özer 2018; Clavelle et al. 2012; Fardellone et al. 2014; Herman et al. 2017; Yoon, Kim & Shin 2016). However, other studies have found no relationship between leadership and the age of the nurse (Al-Dossary, Kitsantas & Maddox 2016; Cao et al. 2015; Jang & Oh 2019; Moon, Van Dam & Kitsos 2019; Özden et al. 2017; Prado-Inzerillo, Clavelle & Fitzpatrick 2018). Focusing on this aspect, a study conducted by Budak and Özer (2018) in Turkey explored personal factors that influence clinical leadership. This study used the Clinical Leadership Scale developed by the UK National Health Service to collect data from 1218 physicians and nurses. The study found that there are statistically

meaningful correlations between older age and leadership characteristics such as personal qualities, abilities to work with others, ability to improve services, and ability to set directions. A study conducted by Herman et al. (2017) in the USA explored the effects of age on transformational leadership practices. This study used the Leadership Practices Inventory – Self developed by Kouzes and Posner (1995) to collect data from 261 registered nurses. The results showed that chronological age was associated with leadership self-ratings, with those aged from 60 to 69 years having significantly higher self-ratings than the rest of the participants for every LPI-Self leadership practice. In contrast, a study conducted by Jang and Oh (2019) in Korea explored the impact of ethical leadership on job satisfaction as perceived by nurses. This study used the Ethical Leadership at Work Questionnaire and general characteristics such as age and collected data from 263 registered nurses. The results showed that there was no statistically significant correlation between age and ethical leadership. Another study conducted by Al-Dossary, Kitsantas and Maddox (2016) in Saudi Arabia assessed the influence of residency programs on nurses' leadership abilities. This study used the Clinical Leadership Survey developed by Patrick et al. (2011) and general characteristics such as age, and collected data from 98 registered nurses. The results showed that nurses' age was not a significant predictor of the total clinical leadership skills score.

Some studies have examined the influence of clinical nurse managers' gender on their leadership practices (Budak & Özer 2018; Moon et al. 2019; Özden et al. 2017; Moradpour, Abedi & Bahonar 2017; Shirazi et al. 2016; Alghamdi et al. 2018). A study conducted by Budak and Özer (2018) in Turkey explored personal factors that influence clinical leadership. The study found that there is a statistically significant positive relationship between being female and leadership characteristics such as abilities to work with others, and ability to manage and improve services. A study conducted by Moon et al. (2019) in Australia measured the leadership styles of nurse managers working in a healthcare organisation in regional Australia.

This study used the Multifactor Leadership Questionnaire (MLQ) and general characteristics such as gender. The study found that female nurse managers displayed a higher level of passive/avoidant leadership. A study conducted by Moradpour et al. (2017) in Iran investigated the relationship between self-leadership and resistance to organisational change. This study used Houghton and Neck's self-leadership questionnaire and general characteristics such as gender and collected data from 120 managers, supervisors and matrons (nursing managers). The results showed that gender does not influence the development of self-leadership skills. Another study conducted by Shirazi et al. (2016) in Iran examined the effectiveness of a multifaceted workshop that focused on fostering a supportive leadership style on the performance of head nurses in leadership roles. This study used the Developmental Leadership Model (Hersey & Blanchard 1979), Hersey and Blanchard's situational theory, and general characteristics such as gender. Data were collected from 110 head nurses and 621 nurses. The results showed that there was a statistically significant change in supportive leadership behaviour scores among males but not females after the intervention. Another study conducted by Alghamdi et al. (2018) in Saudi Arabia compared nurse/manager dyads' perceptions of the managers' transformational leadership style. This study used the MLQ leadership tool and general characteristics such as gender, and collected data from 308 nurses. The study found that both genders of subordinates who worked under a supervision of a male manager rated their managers' leadership style as more transformational than those who worked under a female manager. Inconsistencies in the findings about these key demographic characteristics and their relationship with leadership can be explained in part by the diversity of contexts, cultures and settings, as well as by the difference in the proportion of male and female participants, as the participants in most previous studies have been predominantly female.

Some studies have investigated clinical nurse managers' educational level and leadership behaviours, practices and/or styles (Alsadaan 2018; Alshammari 2014; Dunham-Taylor 2000;

Spano-Szekely et al. 2016; Suliman 2009; Moon et al. 2019; Cao et al. 2015; Echevarria, Patterson & Krouse 2017). A study conducted by Cao et al. (2015) in China described nurses' perceptions of their professional practice environment. This study used the Professional Practice Environment Scale developed by Erickson et al. (2004), and general characteristics such as qualifications. Data were collected from 573 nurses using paper-based and online questionnaires. The results showed that there was a significant statistical correlation between highest nursing qualification and supportive leadership and handling conflict in the work environment. A study conducted by Spano-Szekely et al. (2016) in the USA examined the relationship between nurse managers' transformational leadership and emotional intelligence. This study used the MLQ leadership tool, and general characteristics such as qualifications, and collected data from 148 nurse managers. The results showed a significant correlation between transformational leadership and the education level of nurse managers. A study conducted by Moon et al. (2019) measured the leadership styles of nurse managers working in a healthcare organization in regional Australia. The results showed that transformational leadership is strongly associated with nurses managers' educational level, which generally increased with a higher qualification. In contrast, a study conducted by Echevarria et al. (2017) in the USA examined the relationship between nurse managers' education, leadership experience, and their transformational leadership. This study used the MLQ leadership tool, and general characteristics such as qualifications, and collected data from 148 nurse managers. The results showed no significant differences in transformational leadership among nurse managers with different levels of education. In addition, a study conducted by Jang and Oh (2019) in Korea explored the impact of ethical leadership on job satisfaction as perceived by nurses. The results showed no significant association between transformational leadership and nurses' education levels. A study conducted by Alsadaan (2018) involved 283 nurses and 121 nurse managers including such as: head nurses, charge nurses and evening/night supervisors.

The study examined nursing leadership in the Eastern Province of Saudi Arabia using the MLQ leadership tool, and general characteristics such as qualifications. The results showed no significant differences in mean scores across education levels for transformational and transactional leadership styles. Also, the study found that nurses with diplomas reported a higher level of passive/avoidant leadership than nurses with bachelor's degrees.

2.7.2 Professional factors and leadership practices

In previous studies of nursing leadership, attention has been given to professional factors such as years of nursing experience, leadership experience in nursing and experience in the current position, and the findings regarding these factors' effect on leadership practices have been inconsistent. The factor that has been studied most often to predict leadership practices is the years of nursing experience (Alsadaan 2018; Cao et al. 2015; Fardellone et al. 2014; Gilmartin 2014; Gutiérrez-Rodríguez et al. 2019; Herman et al. 2017; Jang & Oh 2019; Lawson et al. 2019; Prado-Inzerillo et al. 2018; Sabbah et al. 2020). Some studies have considered experience in leadership roles within the nursing profession (Clavelle et al. 2012; Echevarria et al. 2017; Gottlieb & Gøtzsche-Astrup 2019; Kelly, Wicker & Gerkin 2014). In addition, some studies have considered experience in the current position (Budak & Özer 2018; Fardellone et al. 2014; Moon et al. 2019; Yoon, Kim & Shin 2016).

A recent study conducted in Spain by Gutierrez-Rodriguez et al. (2019) involved 277 specialist nurses and advanced practice nurses. The study assessed the distribution of advanced competences such as leadership and consultancy and their association with general characteristics of nurses' professional profile such as years of nursing experience. The results showed no significant association between leadership and consultancy and years of nursing experience. A Korean study conducted by Jang and Oh (2019) similarly found no significant correlation between ethical leadership and years of nursing experience. Furthermore, a study

conducted by Sabbah et al. (2020) in Lebanon found no significant correlation between perceptions of leadership styles and length of nursing work. A study conducted by Lawson et al. (2019) in the USA explored whether significant associations exist between patient satisfaction and leadership style. The results showed that informal leaders had greater professional experience than their counterparts who were not regarded as informal leaders, resulting in a higher level of job satisfaction. A study conducted by Alsadaan (2018) in Saudi Arabia showed a significant correlation between one of the transactional leadership factors which is management-by-exception passive with length of experience. The study found that nurse managers with more than 10 years of experience scored the highest mean on this factor.

Some studies reveal that experience in leadership roles within the nursing profession has a relationship with leadership practices (Clavelle et al. 2012; Echevarria et al. 2017; Gottlieb & Gøtzsche-Astrup 2019; Kelly et al. 2014). A study conducted by Gottlieb and Gøtzsche-Astrup (2019) in Denmark involving 177 charge nurses and 3,497 subordinates did not reveal any correlation between leadership experience and subjective measures. A study from the USA found there was no significant correlation between a predictor and a response variable, which suggests that transformational leadership is not associated with leadership experience (Echevarria et al. 2017). In contrast, another study from the USA found a positive relationship between the number of years as a frontline leader and leadership practices (Kelly et al. 2014). In a study conducted by Clavelle (2012), a highly significant relationship was observed between years of leadership experience and the Leadership Practices Inventory score, such as for the practice *inspire a shared vision*.

2.8 Effectiveness of clinical nurse managers' leadership

2.8.1 The influence of clinical nurse managers' leadership on nursing outcomes

The existing literature has indicated that nursing leadership practices have an important influence on nursing staff outcomes, such as workplace empowerment, job satisfaction and nursing practice, in developed and developing countries. It is important to note that nursing leadership can have a positive or negative impact on staff outcomes (AbuAlRub & Alghamdi 2012; Alharbi et al. 2020; Al-Yami et al. 2018; Asif et al. 2019; Boamah et al. 2018; Dall'Ora et al. 2020; Majeed & Fatima 2020; Malloy & Penprase 2010; Falatah & Salem 2018; Lamb et al. 2018; Cummings et al. 2018; McCay et al. 2018; Wu et al. 2020; Wang et al. 2021; Raso, Fitzpatrick & Masick 2020; Zaghini et al. 2020; Kim et al. 2018; Labrague et al. 2020; Magbity, Ofei & Wilson 2020; Uslu Sahan & Terzioglu 2022; Pishgooie et al. 2018; Kodama et al. 2016; Mansyur et al. 2022; Alkarabsheh et al. 2022; Suliman et al. 2020; Hall, White & Morrison 2022).

Findings from a study conducted in Australia revealed that nurse managers who demonstrate effective leadership had higher job satisfaction for their nurses (Duffield et al. 2011). A study conducted in the United States found that a transformational leadership style significantly influenced the psychosocial work environment for registered nurses (Malloy & Penprase 2010). A Canadian study found that transformational leadership increased workplace empowerment, which consequently enhanced nurses' job satisfaction (Boamah et al. 2018). Another study conducted in Canada indicated that leadership could enhance nursing practice by increasing the level of professionalism (Lamb et al. 2018). Findings from a study conducted in Spain revealed that a direct and positive impact on the structural empowerment of nurses when a nurse manager exhibited transformational leadership, which, in turn, has a positive influence on their engagement (García-Sierra & Fernández-Castro 2018). Another study conducted in Spain indicated that nurse manager leadership ability and support of nurses were

associated with dimensions of burnout such as emotional exhaustion and depersonalisation. The authors found that, when nurses lack leadership and support, this leads to increased emotional exhaustion and depersonalisation (Sillero & Zabalegui 2018). A study conducted in the United States found that transformational leadership protects against emotional exhaustion but does not protect against depersonalisation; it also promotes feelings of personal accomplishment (Madathil et al. 2014). The results from a study conducted in South Korea revealed that clinical nurse managers' leadership and support of nurses had an influence on missed nursing care (Kim et al. 2018). Evidence from a review revealed that positive correlations with nurses' job satisfaction were highest with transformational styles, while transactional styles showed both positive and negative correlations, and the passive-avoidant and laissez-faire styles were negatively correlated with job satisfaction (Specchia et al. 2021). A recent review study by Kiwanuka and colleagues (2021) indicated that transformational and exemplary leadership practices have the potential to positively impact the outcomes such as the intent to stay and job satisfaction of the nursing workforce. This review also found that studies have shown a connection between nursing leadership and both outcome and structural measures (Kiwanuka et al. 2021). Another review study indicated that effective leadership plays an important role in preventing burnout for nurses, including in emotional exhaustion, structural disempowerment and depersonalisation (Dall'Ora et al. 2020).

A study conducted in the Philippines found that nurses who worked with a transformational nurse manager reported higher job satisfaction and lower intentions to leave nursing (Labrague et al. 2020). In contrast, nurses would be less satisfied with their jobs, greater levels of stress, frequent absenteeism and a greater desire to leave nursing when they worked for a nurse manager with toxic leadership (Labrague et al. 2020). A study conducted in Ghana found that nurse managers' leadership style was one of the factors impacting nurses' turnover intentions, as the study found that effective leadership styles such as participative or transformational

leadership decrease turnover intention for nurses; however, the likelihood of turnover intention increases with autocratic and laissez-faire leadership styles (Magbity et al. 2020). A Jordanian study found a positive relationship between transformational leadership styles of nurse managers and nurses' job satisfaction (Abdelhafiz et al. 2016). However, they also found that passive-avoidant leadership resulted in negative consequences (Abdelhafiz et al. 2016). A cross-sectional study conducted in Saudi Arabia found that nurses' job satisfaction levels are positively influenced by nurse managers' transformational leadership styles; however transactional leadership has a negative effect on their satisfaction (AbuAlRub & Alghamdi 2012). Another Saudi cross-sectional study indicated that nurse managers' transformational leadership was the most important factor contributing to nurses' organisational commitment (Al-Yami et al. 2018). Another Saudi study examining the relationship between nurses' work environments and their job satisfaction, emotional exhaustion and intent to leave the profession reported that nurse manager leadership and support for their nurses were positively related to nurses' job satisfaction (Alharbi et al. 2020). A recent Saudi descriptive study found that nurse managers' leadership practices positively influenced their staff nurses' organisational resilience and their job involvement (Abd-El Aliem & Abou Hashish 2021). According to a recent Saudi review study, nurse manager leadership is one of the determinants of nurse turnover (Falatah & Salem 2018). Overall, nurse managers' leadership influences nurses' performance and turnover intention in developed and developing countries. The presence of effective leadership enhances the work environment, commitment to the organisation and job satisfaction of nurses. Conversely, a lack of effective leadership is linked to increased turnover intention, emotional exhaustion and depersonalisation among nurses.

2.8.2 The influence of clinical nurse managers' leadership on patient outcomes

The influence of nurse managers' leadership on patients' outcomes was examined in the literature, with a focus on indicators such as patient safety and satisfaction, and adverse events,

for example hospital-acquired infections, medication errors, and mortality rate (Murray & Cope 2021; Wong et al. 2013; Murray et al. 2018; Wong & Giallonardo 2013; Bahadori et al. 2018; Boamah et al. 2018; Zaghini et al. 2020; Cziraki 2020; Lappalainen et al. 2020; Ogbomeh 2018). Also, nurse managers' behaviours can have impact on building a culture of safety on the wards (Campbell et al. 2021; Lee, Hyunjie & Sang 2022). These studies found that nurse managers' leadership practices influenced patients' outcomes; this section reviews these studies.

Two cross-sectional studies conducted in Canada found that a nurse manager's transformational and authentic leadership decreases the frequency of adverse patient outcomes caused by nurses (Boamah et al. 2018; Wong & Giallonardo 2013). A study conducted in Italy showed that when nurses have a negative perception of their nurse manager's leadership it leads to an increase in counterproductive work behaviours, which, in turn, negatively impacts patients' perceptions of the quality of care they receive (Zaghini et al. 2020). A descriptive study conducted in the United States found that when nurse managers demonstrate transformational leadership the incidence of adverse events such as patient falls is reduced (Ogbomeh 2018). In a study conducted in eastern Finland, a transformational leadership style of nurse managers was found to have a positive relationship with medication safety (Lappalainen et al. 2020). An Iranian study found that wards managed by nurse managers who demonstrated transformational leadership were rated better on patient satisfaction than other wards (Bahadori et al. 2018). A study conducted in Oman found that nurses whose managers exhibited authentic leadership typically reduced the incidence of adverse events (Labrague et al. 2021). A cross-sectional study conducted in Greece indicated that, when nurses indicated that medication errors occurred frequently or very frequently as a safety indicator, their manager's leadership qualities scored lower (Moisoglou et al. 2020). A qualitative study conducted in Finland examining nurse managers' leadership actions following adverse events

found that there is a need to prevent future adverse events by nurse managers (Liukka, Hupli & Turunen 2018). The researchers concluded that, in order for staff to understand why such errors occur, clinical nurse managers should emphasise the importance of discussing adverse events with their nurses. Also, nursing wards should create a blame-free culture by encouraging nurses to report and discuss adverse events. A study conducted in Canada found that nurse managers' empowering behaviour has indirect effects on nurses' assessment of adverse events (Cziraki 2020). A review study found that positive relational leadership styles lead to higher levels of patient satisfaction, lower rate of patients mortality, and fewer medication errors (Wong et al. 2013).

2.9 Challenges confronting clinical nurse managers

Generally, the nursing leadership literature recognises that nurse managers' roles have expanded, diversified, and often contain multiple roles and responsibilities that challenge clinical nurse managers (Pilat & Merriam 2019; Kauffman 2020; Kath et al. 2013; Hutchison & Purcell 2010; O'Brien-Pallas et al. 2010; Hand et al. 2021). Furthermore, it acknowledges that unpreparedness of and lack of support from clinical nurse managers in leadership roles can result in voiced concerns, ambiguous expectations and challenges for these professionals (Kitson et al. 2011; McCallin & Frankson 2010; Pilat & Merriam 2019; Saaweh 2018; Townsend et al. 2012; Manion et al. 2021; Kauffman 2020; Moore, Sublett & Leahy 2016; Keys 2014; Saifman & Sherman 2019; Arakelian & Rudolfsson 2021). This section addresses the concerns expressed by these professionals, their ambiguous expectations, and the challenges they face.

A study conducted by Kitson et al. (2011) in Australia found that only a few clinical nurse managers felt prepared to assume leadership responsibilities, and most expressed concerns about inconsistent support from their organisations. Another Australian study conducted by

Townsend et al. (2012) examined the career development of clinical nurse managers. They collected data from 14 nurse managers. The results indicated that most nurse managers fell into the role by accident, had no career paths planned for management, and were not supported by their employers, who left them to either "sink or swim" (p. 213). A study conducted by Kath et al. (2013) in the USA and Canada found that clinical nurse managers reported higher stress levels than the midpoint in the scales, and role overload, organisational constraints and role ambiguity were identified as predictors of stress, which in turn resulted in reduced job satisfaction, intentions to leave and mental health symptoms. Another US study conducted by Keys (2014) examined Generation X nurse managers' attitudes about professional success, professional fulfilment, and environments that favour loyalty and long-term commitment. The study collected data from 16 nurse managers. The results showed that nurse managers wished for success, but they felt ill prepared for the nurse manager role. A study conducted by Moore et al. (2016) in the USA explored nurse managers' perspectives regarding the nurse manager role. A total of 13 nurse managers were interviewed for their study. The results indicated that they experienced a lack of role orientation, mentorship to guide them and foundational knowledge. Another US study conducted by Saifman and Sherman (2019) sought to understand how nurse managers make sense of their lived experiences in the role by exploring their experiences of being a nurse manager. They collected data from 25 nurse managers in a qualitative phenomenological study with an interpretive approach. The results indicated a wide variation in the manner in which new managers were orientated to the role. Some received formal training and mentorship, whereas others did not. Also, the study found that nurse managers are more satisfied with superiors who are responsive to their needs and respond to their questions promptly. However, the study also found that nurse managers were acutely aware of the challenges of managing change resulting from unexpected additions to their role responsibilities. Another qualitative study conducted by Arakelian and Rudolfsson (2021) in

Sweden investigated why nurse managers leave their employment. They collected data from seven nurse managers. The results indicated that functioning cooperation between the superior and a nurse manager was necessary for them to be able to continue to work, but some felt they had lost trust in their superiors and received insufficient support from them. A recent Spanish study conducted by Membrive-Jiménez et al. (2021) examined nurse managers' burnout levels and prevalence. The study found high levels of neuroticism, depression, and anxiety among nurse managers. Consequently, nurse managers may lack authority and leadership (Membrive-Jiménez et al. 2021). A recent Australian study conducted by Manion et al. (2021) examined the opportunities for clinical nurse managers to develop professionally, the effectiveness of these opportunities, and the nurses' perceptions of their abilities to perform their duties in the role. The study found that the participants felt unprepared for the role of clinical nurse manager, and identified a lack of support and opportunity for structured development.

In addition to the challenges and difficulties faced by nurse managers under normal circumstances, the recent COVID-19 pandemic presented nurse managers with further challenges such as a lack of staff, conflict management, management of uncertainty, lack of pandemic preparedness and leadership challenges (Mollahadi, Mokhtari Nouri & Moradian 2021; Vázquez-Calatayud et al. 2022; Gab Allah 2021; White 2021). A recent US study conducted by White (2021) examined the experiences of nurse managers during the outbreak of COVID-19. The study found challenges such as leadership issues, long working hours, and dealing with and supporting staff who were witnessing human suffering and death, was often draining. Another qualitative study conducted in Spain by Vázquez-Calatayud et al. (2022) found that frontline nurse managers faced challenges such as complexity in staff management due to absenteeism caused by COVID-19 and communication problems with staff regarding the guidelines to be followed. In a study conducted in South Africa by Moyo et al. (2021), nurse managers faced challenges including limited staff, more administrative work and stigma

and discrimination from colleagues because they were working in COVID-19 wards. Another recent study conducted by Hand et al. (2021) in the USA explored nurse managers' perspectives regarding the nursing leadership and management that should be emphasised post-COVID-19 pandemic. The study found that there is a need for more evidence regarding leadership preparedness, particularly with regard to the effectiveness of the crisis leadership structures, so that nurse leaders can utilise their unique strengths and perspectives to their maximum potential in crisis situations.

2.10 The influence of continuing professional development (CPD) on nursing leadership

Evidence has shown that healthcare organisations that support continuing education and CPD increase the effectiveness of healthcare professionals' leadership practices, especially in the nursing profession (Jackson & Manley 2022; Mlambo et al. 2021; Curtis et al. 2011; Ingwu et al. 2019; Goudreau et al. 2015; Frasier 2019; AbuAlRub & Nasrallah 2017; Galuska 2014). CPD and leadership are related to each other, as CPD is most effective when it is supported by effective enabling leadership and a positive working environment (King et al. 2021). Thus, it has been shown that through the provision of leadership training content in the activities related to CPD and training programs, nurse managers are able to improve their leadership abilities and competencies (AbuAlRub & Nasrallah 2017; Galuska 2014). In a cross-sectional study by Frasier (2019), nurse manager participants reported increased self-awareness following a pilot leadership program, and registered nurses reported improvement in managers' use of effective leadership behaviours. A quasi-experimental and correlational study conducted over a 90-day period by LaCross, Hall and Boerger (2019) found that, after participating in the program, participants reported that they were more prepared for transitioning to nurse manager roles and demonstrated more leadership behaviours. As such, leadership training should be considered as part of nurse managers' CPD to enhance their leadership skills. No evidence was found

about the leadership training that clinical nurse managers working in Saudi hospitals had received to advance their skills as leaders.

2.11 Research gaps identified from the review of the literature

This literature review has presented evidence of the critical importance of nursing leadership both globally and regionally, the influence of nursing leadership on nursing outcomes and patient outcomes, and the challenges of nursing leadership. In the Saudi context, limited research has been conducted on clinical nurse managers' leadership and nurses' perceptions of their ward managers' leadership. However, previous studies have concentrated primarily on including all clinical nurse managers, deputy clinical nurse managers and supervisors to enable an understanding of nurse managers' leadership (Alsadaan 2018; Suliman 2009). As of these groups have different positions and tasks, these results may not provide an accurate picture of clinical nurse managers' leadership in the wards. No study conducted in Saudi Arabia has examined the leadership practices of clinical nurse managers from their own perspectives and that of the nurses they manage in the wards. Also, the Leadership Practice Inventory instrument had not been used in the Saudi nursing context until this study, which produced the first journal article on this subject (Alharbi et al. 2021). Furthermore, of the 18 leadership tools that were evaluated for this research, this instrument was the only one with robust psychometric properties and ease of use (Huber et al. 2000). It was validated quantitatively (Afam 2012; Nash 2009; Posner 2016) and evaluated qualitatively using developed criteria for judging psychometric soundness and ease of use (Huber et al. 2000). According to Afam (2012) internal reliability for the LPI has found ranging between 0.95 to 0.97, and (Posner 2016) found that scores in different published studies were ranging 0.61 to 0.97. It was chosen not only because it had not been used in previous Saudi studies on nursing leadership but also because it provides robust psychometric and other features, such as peer and observer evaluations. Most Saudi nursing leadership studies have used the Multifactor Leadership Questionnaire (Avolio & Bass

1995) as a tool. That instrument has been criticised for its conceptual framework, and the lack of clarity regarding its factor structure, transformational subscales and psychometric properties (Antonakis 2012; Van Knippenberg & Sitkin 2013; Yukl 1999; Judge & Piccolo 2004; Batista-Foguet, Esteve & van Witteloostuijn 2021), and there is a need for a new theory of transformational leadership and contingent reward that takes into account the five dimensions (Boamah & Tremblay 2019). The Multifactor Leadership Questionnaire has attracted several other criticisms globally (Batista-Foguet, Esteve & van Witteloostuijn 2021; Rafferty & Griffin 2004) and in the Saudi context (Alsadaan 2018; Alshammari 2014). However, some of these studies had only a few participants or and participants had a different role responsibility to look at the quality of the study.

Studies have shown that the nationalities of clinical nurse managers play a significant role in the adoption of a preferential leadership style in the Saudi context, as perceived by their nurses (Saleh et al. 2018), and that a dominant unfair leadership style based on race exists in Saudi hospitals (Alshareef 2019). However, to the best of the researcher's knowledge, no attempt has been made to explore the potential differences between Saudi and clinical nurse managers from other cultures vis-à-vis the effectiveness of leadership. Furthermore, no Saudi study on nursing leadership utilising explanatory sequential mixed methods has been identified to date. No previous studies have examined what kind of leadership development is available to clinical nurse managers. There is also a strong need for future research studies designed to measure the value of continuing professional development in the workplace (King et al. 2021), and those to investigate the effective leadership preparedness in ordinary and pandemic circumstances (Hand et al. 2021).

2.12 Summary

This chapter has highlighted issues in relation to clinical nurse managers' leadership practices in healthcare systems, which have been examined in previous studies. The literature suggests that there are differences in the perceptions between nurse managers and the registered nurses regarding nurse managers' leadership practices. This review also revealed that most studies on clinical nurse managers' leadership practices have identified that they can have both positive and negative influences of nurse managers' leadership practices on nurses and on patients' outcomes. The review also made it clear that there are challenges confronting clinical nurse managers under both normal and pandemic circumstances in providing optimal and effective leadership environments. There has been limited research comparing clinical nurse managers' leadership and nurses' perceptions of their ward managers' leadership and the effectiveness of that leadership in clinical settings. Moreover, few studies have been conducted in Saudi Arabia, demonstrating the critical importance of conducting the current study in the Saudi context to contribute to the advancement of clinical nursing leadership and the profession in general. In the next chapter, the methodology used by this study to answer the research questions will be discussed.

Chapter 3: Methodology

The most suitable research design for a study is one that leads to logical and consistent conclusions and generates results that allow for appropriate and easy interpretation of the data. A mixed-methods approach with both quantitative and qualitative methods is the most appropriate design for exploring a complex research topic (Creswell & Clark 2017). A mixed-methods approach with a comprehensive and sequential research design was chosen in this study to better address the research questions and improve the scope and depth of the understandings generated by the research being undertaken. The findings generated by the different methods were combined in a bid to present a holistic and clear picture of the current leadership practices of clinical nurse managers in multicultural workplaces in Saudi hospitals.

3.1 Mixed-methods approach

The work of Campbell and Fiske (1959) on triangulation in the first half of the twentieth century is credited with the beginnings of the mixed-methods approach. Previously, researchers were using either quantitative or qualitative studies and designing each study separately (Johnson, Onwuegbuzie & Turner 2007). As the century progressed and research methods developed, the mixed-methods approach came to be recognised as a distinct approach associated with the pragmatic worldview (Patton 1990; Morse 1991; Rorty 1990; Rossman & Wilson 1985). Researchers are increasingly aware that using a single method may be insufficient for answering a variety of research questions in order to address complex research problems and find solutions (Leech & Onwuegbuzie 2009). Mixed-methods research has been formally defined as collecting and combining diverse types of research data (quantitative and qualitative) in one study to produce a comprehensive understanding of the research problem (Andrew & Halcomb 2009; Creswell & Creswell 2017; Zhang & Creswell 2013). Creswell and Creswell (2017, p. 4) define mixed-methods research as follows:

> Mixed methods research is an approach to inquiry involving collecting both quantitative and qualitative data, integrating the two forms of data, and using distinct designs that may involve philosophical assumptions and theoretical frameworks. The core assumption of this form of inquiry is that the integration of qualitative and quantitative data yields additional insight beyond the information provided by either the quantitative or qualitative data alone.

The fundamental aspects of effective mixed-methods research in nursing include both the collection and analysis of different types of data sets and the use of rigorous techniques during the analysis of relevant data according to each method's conventions (Andrew & Halcomb 2009).

Mixed-methods research is the preferred approach of many researchers because of its many strengths (Halcomb & Hickman 2015). The researcher can use narratives and terms to add meaning to the numerical data and study results; likewise, researchers have an added advantage in that they can use numbers to increase the precision of narratives and words. Moreover, the researcher can formulate and test a theory. The researcher can append insights and techniques that might be omitted if a single-method approach were applied. Mixed-methods research also allows for the simplification of results, making the results concise and unambiguous (Creswell & Clark 2017). The researcher can present the comprehensive knowledge that is needed to inform practice and theory due to the incorporation of both quantitative and qualitative data (Creswell & Creswell 2017). Mixed-methods research also considers the participants' opinions and perceptions, thus ensuring that the findings are based on their experiences.

Mixed-methods research promotes scholarly interaction as studies done using this approach are more diverse and widen the scope of the study by fostering interaction with qualitative and quantitative scholars (Halcomb & Hickman 2015). Moreover, mixed-methods research offers flexibility and is adaptable to various study designs such as randomised tests and observational studies to deliver additional information gathered in qualitative research. Furthermore, mixed-

methods research gathers rich and comprehensive data and reflects the natural collection of information by integrating qualitative and quantitative data (Halcomb & Hickman 2015; Creswell & Creswell 2017).

With mixed-methods research, the researcher can utilise the advantages of one research method to mitigate the weaknesses of the other approach, and mixed-methods research is beneficial when exploring contradictions between the qualitative findings and quantitative results (Creswell & Clark 2017). Additionally, mixed-methods research is useful in situations that involve techniques that simultaneously or chronologically employ both quantitative and qualitative aspects with similar or distinct samples and the integration of data when collecting, analysing or discussing the data. Hence, when a researcher achieves a conclusion using mixed methods of research, they are in a better position to present a substantial conclusion.

Although mixed-methods research presents some benefits, it also has some drawbacks. Creswell and Garrett (2008) suggest the use of both quantitative and qualitative methods should remain distinct due to their incompatibility and the consequent difficulties inherent in integrating the two approaches. Additionally, combining the two approaches is difficult due to the complexities inherent in utilising multiple approaches and frameworks. Additionally, difficulties may arise if where one method's results contradict the results of the other method (Salehi & Golafshani 2010; Creswell & Creswell 2017). Nonetheless, Risjord, Dunbar and Moloney (2002) assert that research findings improve when mixed methods are employed. Thus, if one method is not sufficient to answer the research questions, another method might help.

3.1.1 Pragmatism and mixed-methods research

There are different philosophical worldviews that allow the researcher to shape and guide their scientific inquiry. These worldviews are typically guided by epistemological assumptions

about what constitutes knowledge, or "a way of understanding and explaining how we know what we know" (Crotty 1998, p. 3), as well as ontology, which deals with the nature of knowledge and reality as "the study of being" (Crotty 1998, p. 10). Positivist/post-positivist worldviews (usually associated with the quantitative approach) (Creswell & Creswell 2017), constructivist (typically associated with the qualitative approach) and pragmatic (associated with the mixed-methods approach) are popular examples of philosophical worldviews (Crossan 2003; Creswell 2003; Creswell & Creswell 2017; Tashakkori & Teddlie 2003, 2010; Teddlie & Tashakkori 2009).

The theory of pragmatism was founded by philosopher Charles Sanders Peirce (1839–1914) late in the nineteenth century. Early in the twentieth century, the approach was developed and formulated in the works of pragmatists James (1842–1910), Mead (1863–1931), and Dewey (1859–1952). The word "pragmatism" comes from the Greek word "pragma", which means "action", which is the core concept of pragmatism (Pansiri 2005). Instead of letting a theory to drive a researcher's understanding of an idea, pragmatism focuses on the exploration of ideas based on their possible consequences, both practically and empirically (Creswell & Creswell 2017; Johnson & Onwuegbuzie 2004). Pragmatism focuses on practical rather than idealistic or rationalistic approaches (Frega 2011). When compared to other paradigms or worldviews, for example post-positivism, where an issue's understanding is guided by its antecedents' assumptions, pragmatic thinking draws attention to and investigates the problem itself and its consequences (Creswell & Creswell 2017). Several authors have discussed how pragmatics evolved and how it applies in mixed-methods research (Creswell & Creswell 2017; Johnson & Onwuegbuzie 2004; Murphy & Murphy 1990; Patton 1990; Robson 2002; Rorty 1990; Tashakkori & Teddlie 2003, 2010; Teddlie & Johnson 2009; Teddlie & Tashakkori 2009).

In mixed-methods research, pragmatism emphasises the importance of the research questions, which guide the selection of the method that should be able to address the study problems

appropriately without being constrained by either method's philosophical underpinnings (Tashakkori & Teddlie 2003); thus, researchers are not required to completely commit to a specific method (Robson 2002) but are free to focus on the two different approaches to inquiry (Morgan 2014). According to Sieber (1973), integrating quantitative and qualitative approaches to combine their advantages and disadvantages may be the most efficient way to overcome the disadvantages. Pragmatism is not aligned to any one philosophy but considers subjective and objective assumptions to be crucial to comprehending a phenomenon or problem. In this view, research should be driven by consequences, and researchers can choose the methods which work best for them in order to answer their research question. In fact, pragmatism believes in the existence of two worlds, one external to the mind and the other internal to the mind (Legg 2014, p. 212). It is not reasonable to assume that these two worlds follow the same set of rules or adhere to the same set of realities. Pragmatism acknowledges that what we think we know now may not be the case in the future.

3.1.2 Leadership studies and mixed-methods research

Most leadership research has predominantly relied and continues to rely on a single research method such as using surveys (Bass & Avolio 1994; Kouzes & Posner 1995). This is despite the fact that several of the surveys employed to assess leadership practices focus on what a leader is doing, with few or no details explaining why these actions are being taken. Mixing methods by combining quantitative and qualitative approaches has been recommended to obtain a broader view of leadership (Berson 1999; Parry & Bryman 2006; Antonakis, Avolio & Sivasubramaniam 2003) to advance the study of leadership (Hunt & Conger 1999). By integrating the approaches, it is possible to address both the *what* and the *why* of leadership practices (Conger 1998). In addition, combining the approaches facilitates exploring the topic from various angles and obtaining more meaningful, reliable and rich findings (Creswell et al. 2011). A mixed-methods design was used for this study to collect quantitative and qualitative

data that would facilitate the interpretation and understanding of the research questions about current leadership practices and the lived experience of clinical nurse managers working in multicultural workplaces in Saudi hospitals.

3.2 Different types of mixed-methods design

In recent years, mixed-methods studies have experienced a renaissance and a researcher can employ mixed methods in a variety of designs. According to Tashkori and Tidland (2010), different mixed-methods designs that a researcher might use in conducting research have been discussed in the literature. Two general types of mixed-methods research can be distinguished: basic mixed-methods and advanced or complex methods (Andrew & Halcomb 2009; Creswell & Creswell 2017; Fetters, Curry & Creswell 2013). In mixed-methods research, there are three types of basic designs: convergent parallel, exploratory sequential, and explanatory sequential mixed methods. However, for this approach to be successfully applied, researchers need to understand the procedures and options that accompany each design as described in the following sections.

3.2.1 Convergent parallel mixed-methods design

The most common of these designs is the convergent (Creswell & Creswell 2017). It employs various methods to ensure that the results obtained are applicable to a wide range of populations. The design employs diverse methods that complement one another by collecting both qualitative and quantitative data and by analysing the same dimensions simultaneously and comparing and confirming the results (see Figure 3.1), which may reveal whether the results are convergent or divergent (Andrew & Halcomb 2009). This design is suitable for a brief data collection period and gives equal priority both to the qualitative and quantitative data (Teddlie & Tashakkori, 2003). However, the greatest challenge of this design is merging the

numeric quantitative data with the textual qualitative data and integrating the results (Creswell & Clark 2017; Creswell & Creswell 2017).

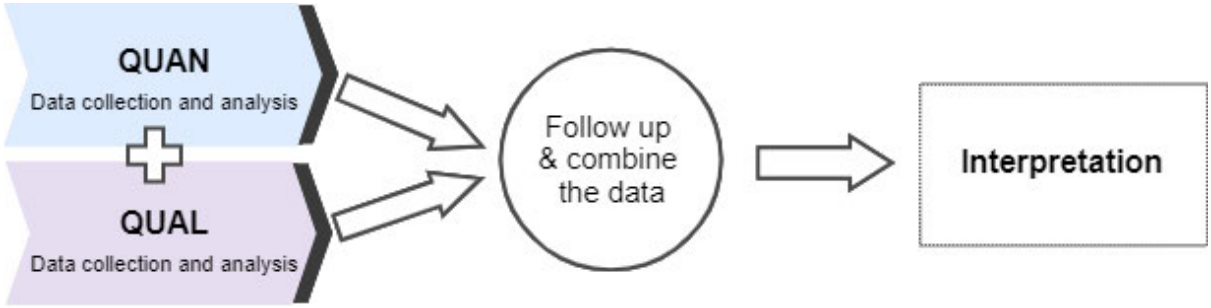

Figure 3.1: Illustration of convergent mixed-methods design (Source: Creswell & Creswell 2017)

3.2.2 Sequential exploratory mixed-methods design

In this design, the first phase uses qualitative data collection and analysis to inform the second phase of quantitative data collection and analysis (Greene et al. 1989). This design is the best way to develop better measurement by knowing what subjects and aspects of the issue should be under investigation (Creswell & Creswell 2017) or to generalise results to diverse groups (Morse 1991). However, in order to collect and analyse data in both phases sequentially, researchers using this design require a significant amount of time. Moreover, the development of quantitative research questions based on qualitative results may present a challenge to researchers (Andrew & Halcomb 2009; Creswell & Clark 2017).

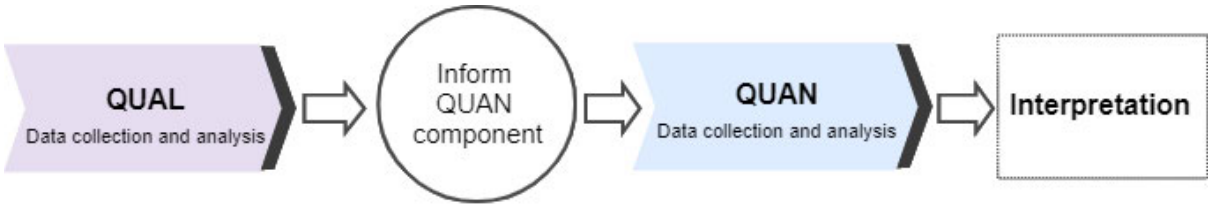

Figure 3.2: Illustration of sequential exploratory mixed-methods design (Source: Creswell & Creswell 2017)

3.2.3 Sequential explanatory mixed-methods design

In this design, the researcher obtains and analyses the quantitative data, then subsequently collects qualitative information in another stage of the research. The qualitative data collected in the second stage are linked to the results of the initial quantitative stage (Creswell & Creswell 2017; Gorard & Taylor 2004; Morse 2009). A sequential explanatory design is beneficial when exploring a phenomenon as in-depth interviews can be conducted to follow up and explain the quantitative results.

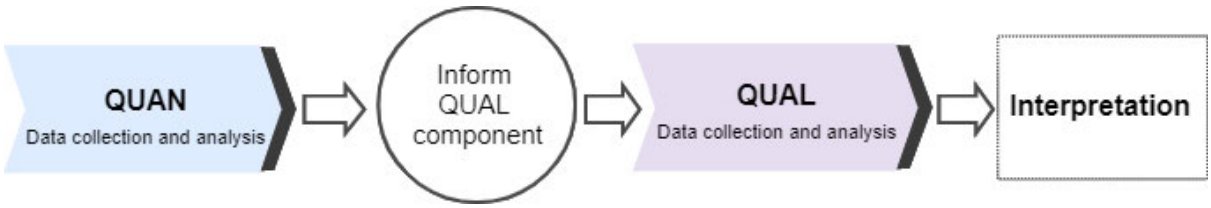

Figure 3.3: Illustration of sequential explanatory mixed-methods design (Source: Creswell & Creswell 2017)

3.3 Considerations for selecting a mixed-methods design

Researchers must consider several factors when designing procedures and plans for their research. These factors range from the broad assumptions behind the study to the detailed scholarly methods including data analysis and collection (Morse 2009). To decide which method to use, researchers must assess the extent of their knowledge, skills, and experiences in utilising both quantitative and qualitative methods prior to deciding which methods they will use (Teddlie & Tashakkori 2003; Creswell & Clark 2017; Creswell & Creswell 2017). Also, the researcher must consider several issues when deciding on the research approach. According to Andrew and Halcomb (2009), there are three aspects of the design of a mixed-methods study that should be addressed explicitly: the interaction between the two types of data, the priority or timing of each method, and integrating the results. Also, considering that the qualitative components cannot be fully developed until the first phase component is complete, the study

which is may need to be approved by an ethics committee or institutional review board a second time for the qualitative phase (Creswell & Plano Clark 2011).

3.3.1 Interaction between the research phases

This aspect concerns the extent of interaction between quantitative and qualitative data that may interact with each other at any stage of the research process, including the collection, analysis, and interpretation of data. The two research phases may be completely separate until the results have been interpreted, as in a convergent and parallel design, or have earlier interactions (Andrew & Halcomb 2009; Morgan 2007). This current study has two stages of interaction: the results gained from the first phase of the study were used to build the design of the second phase of the study; and in the interpretation stage, the findings were integrated. This was due to the nature of the study design used, in which the second phase of the study was designed based on the results of the first phase (Andrew & Halcomb 2009; Creswell & Creswell 2017)

3.3.2 Method priority

In the context of research, "priority" refers to the weighting given to the qualitative and quantitative components (Andrew & Halcomb 2009; Morgan 2007). The priority given to each of the research components can be equal or unequal. Explanatory research, such as the current study, usually prioritises the quantitative study, while qualitative methods are mainly used to provide clarification and substantiation the findings generated from the quantitative study (Andrew & Halcomb 2009; Morgan 2007). However, both the quantitative and qualitative approaches were equally weighted and prioritised for this current study, and it required nearly the same amount of time and effort to plan, implement, and analyse data for both studies, in spite of the fact that the qualitative study took longer than expected due to the COVID-19 pandemic. Furthermore, there was equal contribution from both methods to the findings of the

study, despite the qualitative study's role in providing further explanations for the quantitative results and an insight into clinical nurse managers' leadership and challenges.

3.3.3 Integration

This aspect of integration refers to the process of combining the study data at any early or later stage of the research process, whether it is during data collection, analysis or interpretation (Andrew & Halcomb 2009; Fetters, Curry & Creswell 2013; Tashakkori & Teddlie 2010). This study collected and analysed quantitative and qualitative data separately. As mentioned earlier, the results of the first phase drove the data collection plan for the second phase; this is referred to as interaction or connection rather than integration. In addition, Plano Clark (2019) emphasised that a researcher must identify points of integration of the study when using mixed-methods research. The integration of this study occurred at the discussion stage. According to Doyle, Brady and Byrne (2016, p. 630), effective integration in a mixed-methods study should result in "a whole greater than the sum of its parts". Chapter 8 will cover the data integration in detail.

3.4 Design employed in this study: Mixed-methods sequential exploratory design

A mixed-methods sequential explanatory design involving the use of two sequential phases of collection and analysis of data was employed in this study (see Figure 3.4). The researcher obtained and analysed quantitative data, then conducted a second phase in which the qualitative information was collected and analysed (Andrew & Halcomb 2009; De Vaus 2001). In addition, the qualitative data obtained in the second phase were closely related to and explained in depth the results from the initial quantitative phase.

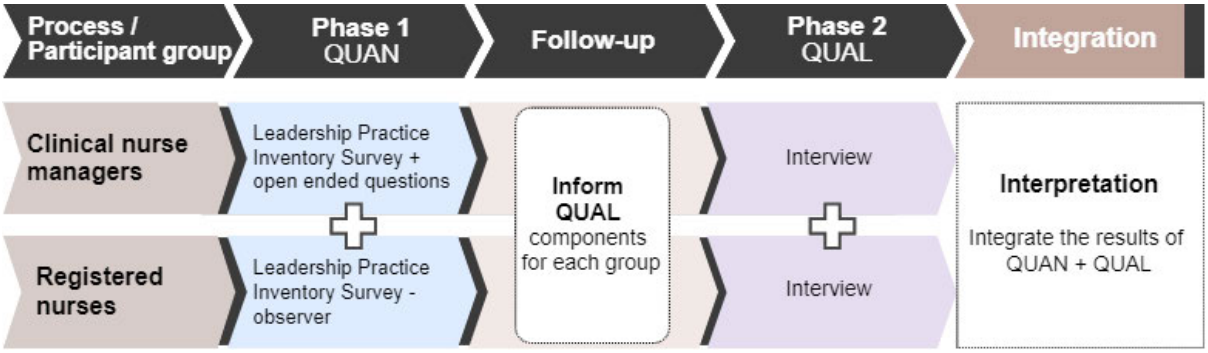

Figure 3.4: Sequential explanatory mixed-methods design used in this study (adapted from Creswell & Creswell 2017)

3.4.1 Quantitative phase using a survey

The survey method has been defined as "the collection of information from a sample of individuals through their responses to questions" (Check & Schutt 2012, p. 160). Survey research allows the researcher to recruit participants, collect data and utilise different methods of instrumentation (Ponto 2015). According to Creswell and Creswell (2017), survey research provides "quantitative or numeric description of trends, attitudes or opinions of a population by studying a sample of that population" (p. 12). Surveys are useful in descriptive or exploratory studies (De Vaus 2001; Creswell & Creswell 2017). Surveys are commonly used in cross-sectional research. It has been widely used in diverse disciplines such as health sciences, especially in the nursing context (Polit & Beck 2017), for instance, nursing leadership studies in clinical areas (Ross et al. 2014; Silva et al. 2017; Herman et al. 2017). Utilising a cross-sectional design has many advantages for researchers: it is not time-consuming, is inexpensive and uses few resources to conduct the study (Levin 2006; Setia 2016; Wang & Cheng 2020). However, there are also downsides of conducting a cross-sectional study, such as the inability to make a causal inference, non-response bias and difficulty interpreting identified associations (Levin 2006; Setia 2016; Wang & Cheng 2020). In this current mixed-

methods study, phase one employed a cross-sectional survey through two types of self-administered questionnaires to collect quantitative components from the participants at one point in time. More details about this phase are discussed in the next chapter.

3.4.2 Qualitative phase using interviews

The individual interview is a qualitative data collection method commonly used in social science research. The interview usually gathers data through verbal communication between the interviewer and the interviewee (Mathers, Fox & Hunn 1998). The second phase of this study used qualitative methods through interviewing two groups of participants (clinical nurse managers and their registered nurses) to collect qualitative data to provide a better understanding of the leadership experience of clinical nurse managers in the workplace, which led to a better understanding of the results found in phase one (the quantitative study). The qualitative approach used in the second phase of the study is based on phenomenological research, which enables the researcher to focus on the study of an individual's lived experiences (van Manen, 1990; Neubauer, Witkop & Varpio 2019; Byrne 2001; Rodriguez & Smith 2018). This phase is discussed in more detail in Chapter 6.

3.5 Summary

Mixed-methods research refers to using both quantitative and qualitative research techniques and is utilised in studies that require a more thorough comprehension of the issue being explored. Mixed-methods research gives the researcher an expanded understanding of the research topic and allows for the utilisation of quantitative and qualitative techniques. The key benefit of mixed-methods research is that it enables the researcher to understand the research topic more comprehensively. Additionally, pragmatism contributes to how the research techniques are combined. The combination of various research techniques should aim at providing the best opportunity for answering the research questions. In the current study, two

sets of data were collected, using surveys and interviews with two groups of participants for each, to provide a deep understanding of the current leadership practices and lived experience of clinical nurse managers working in multicultural workplaces in Saudi hospitals.

Chapter 4: Methods for the quantitative study

4.1 Introduction

This chapter presents the methods that were used for the collection and analysis of quantitative data from the study. The aim of this component was to explore and understand the current leadership practices of clinical nurse managers in Saudi Arabian hospitals using the Leadership Practice Inventory – Self (LPI-Self) and Leadership Practice Inventory – Observer (LPI-Observer) tools. This phase of the study employed a cross-sectional survey through two self-administered questionnaires to collect quantitative components from the participants at one point in time. According to Creswell and Creswell (2017) survey research provides "quantitative or numeric description of trends, attitudes or opinions of a population by studying a sample of that population" (p. 12). This is useful in descriptive or exploratory studies (De Vaus 2001; Creswell & Creswell 2017).

4.2 Research population and sample

The target population for this study was CNMs and RNs in Saudi Arabian hospitals; the accessible population was CNMs (n = 40) and RNs (n = 715) working in the three main hospitals located in Hail city, in the north of Saudi Arabia. A non-probability convenience sampling technique was utilised for this research. This method has been widely used in previous health studies for several reasons, firstly because the sampling period is not lengthy and thus will save time. Secondly, it is cost effective to implement. Thirdly, it provides the researcher easy access to the participants and the participants have easy access to the researcher. Lastly, the geographical proximity of the three hospitals to the researcher made it the preferred method. Thus, for all these reasons a convenience sample was considered an appropriate method for this research. According to Schneider et al. (2013) and Etikan et al. (2016), the advantages of a convenience sample are proximity to the researcher, easy

accessibility for participants and the collection of data from readily available participants with the least amount of cost. Conversely, a convenience sampling method can be a source of bias, as the sample may not be representative of the total population (Polit & Beck 2012). Bias is defined as "influence that produces distortion or error" (Polit & Beck 2017, p. 161). Thus, a potential threat to the validity of this study is selection bias, as randomisation of participants was not feasible (Pedhazur & Schmelkin 1991). To avoid this bias, only respondents who met the inclusion criteria in this study were selected. The inclusion criteria for participants were: CNMs who had at least six months' experience as a CNM in their current ward, and RNs who had worked for at least six months under the direction of their current CNM at the time of data collection. The exclusion criteria were CNMs and RNs who had not had at least six months working in their current ward, and deputies of CNMs. According to Patino and Ferreira (2018), establishing inclusion and exclusion criteria is critical in order to achieve a high-quality research protocol. The sample size was calculated using the G*Power 3.1.9.7 software (Faul et al., 2007; Faul et al., 2009). The G*Power suggested that we would need 276 participants to detect a moderate effect size of Cohen ' s d = 0.63, with power = 0.85 and alpha = 0.05 (two-tailed test).

4.3 Site and setting

This study was conducted in the three main hospitals in the Hail region in the north of Saudi Arabia. The first hospital selected was the King Khalid Hospital with a capacity of 280 beds, the second was Hail General Hospital with a capacity of 245 beds, and the third and final selected hospital was Maternity and Children Hospital with a capacity of 135 beds. These hospitals collectively serve approximately 716,021 people who live in the Hail region (MOH 2018). They are funded and supported by the Saudi Ministry of Health (MOH), the largest single healthcare provider in Saudi Arabia, providing about 60% of health care across the

country (MOH 2018). All these hospitals provide healthcare services to Saudi citizens free of charge.

4.4 Study instruments

Three tools were used to collect data for the purpose of this study. Demographic and professional variables were developed to examine the association with transformational leadership practices. The Leadership Practice Inventory – Self (LPI-Self) and Leadership Practice Inventory – Observer (LPI-Observer) (Table 4.1) developed by Kouzes and Posner (2017) were selected over others for use in this study for reasons that have been outlined earlier and used with permission (see Appendix A). A number of scale and subscale scores were created using responses to the Leadership Practices Inventory questionnaires.

Table 4.1: Description of instruments used in the study

Instrument name	**Number of items and scale**		
	Number of items	**Scale**	**Total possible score**
LPI-Self	30	1–10	300
LPI-Observer	30	1–10	300

4.4.1 Demographic and professional variables

For CNM participants, the demographic variables consisted of fourteen items. Items one to six covered gender, age, current work ward, experience in nursing practice, period of experience in the current ward and highest academic nursing qualification achieved. Items seven to nine covered nationality and period of experience as a CNM (including overseas experience as a CNM). Items ten to fourteen were open-ended questions. Item ten covered the leadership skills participants believed were essential for CNMs. In general, CNMs with training were expected to be better leaders (covered by item eleven). Item twelve sought information on perceptions

of the role of CNMs. Item thirteen covered the leadership skills participants believed were critical elements for CNMs. Item fourteen covered the support offered to CNMs by institutions to help them develop as nursing leaders. For RN participants, the demographic variables covered the first six aspects mentioned above.

4.4.2 Leadership Practices Inventory – Self (LPI-Self) and LPI-Observer

The LPI-Self (Appendix B) generates an overall Leadership Practices Inventory score and 5 subscale scores, being: a *model the way* (MW) score, *inspire a shared vision* (ISV) score, *challenge the process* (CP) score, *enable others to act* (EOA) score, and *encourage the heart* (EH) score, with a total of 30 items on a 10-point Likert scale ranging from 1 (almost never) to 10 (almost always). This allowed the participants to evaluate themselves through 30 statements to understand the practices in which they most often engage. A score of 1 (almost never) indicates that the participant almost never engages in the practice, while a score of 10 (almost always) indicates that the participant almost always engages in the practice. Kouzes and Posner (2017) elucidate that the LPI has five subscales, and each subscale score ranges from 6 to 60, and the overall leadership scale score ranges from 30 to 300.

The LPI-Observer (Appendix C) contained the same scale, subscales and scores as described above (with minor changes to statements in the third part), allowing the participant to evaluate their CNMs through 30 statements to understand the practices in which his/her manager most often engages. The definitions and scores for scale and subscale practices for both versions are given in Table 4.2.

Table 4.2: The definitions and scores for scales and subscales of both versions of the Leadership Practice Inventory (LPI)

Variable	Conceptual definition	Operational definition		
		Number of items	Computation	Interpretation of scores
Leadership Practices Inventory score	Overall transformational leadership practices	30	Sum of the 1 (almost never) to 10 (almost always) response rating for all 30 items	30 = low 300 = high
Model the Way (MW) score	Model the way practice of leadership	6	Sum of the 1 (almost never) to 10 (almost always) response rating for items 1, 6, 11, 16, 21 and 26	6 = low 60 = high
Inspire a Shared Vision (ISV) score	Inspire a shared vision through leadership	6	Sum of the 1 (almost never) to 10 (almost always) response rating for items 2, 7, 12, 17, 22 and 27	6 = low 60 = high
Challenge the Process (CP) score	Challenge the process practice of leadership	6	Sum of the 1 (almost never) to 10 (almost always) response rating for items 3, 8, 13, 18, 23 and 28	6 = low 60 = high
Enable Others to Act (EOA) score	Enable others to act practices of leadership	6	Sum of the 1 (almost never) to 10 (almost always) response rating for items 4, 9, 14, 19, 24 and 29	6 = low 60 = high
Encourage the Heart (EH) score	Encourage the heart practice of leadership	6	Sum of the 1 (almost never) to 10 (almost always) response rating for items 5, 10, 15, 20, 25 and 30	6 = low 60 = high

4.4.3 Leadership Practices Inventory subscales statements

According to Kouzes and Posner (2017), the five leadership practices are covered by six unique statements for each practice. The first practice is *model the way* which incorporates *"sets a personal example of what is expected"*, *"makes certain that people adhere to the principles and standards that have been agreed upon"*, *"follows through on promises and commitments"*, *"asks for feedback on how his/her actions affect people's performance"*, *"builds consensus around the organisation's values"* and *"is clear about his/her philosophy of leadership"*. The second practice is *inspire a shared vision* (ISV), described as one which *"talks about future trends influencing our work"*, *"describes a compelling image of the future"*, *"appeals to others to share a dream of the future"*, *"shows others how their interests can be realised"*, *"paints a 'big picture' of group aspirations"* and *"speaks with conviction about the meaning of work"*. The third practice is *challenge the process* (CP), which *"seeks challenging opportunities to test skills"*, *"challenges people to try new approaches"*, *"actively searches for innovative ways to improve what we do"*, *"asks what can we learn?"*, *"identifies measurable milestones that keep projects moving forward"* and *"takes initiative in anticipating and responding to change"*. The fourth practice is *enable others to act* (EOA) which *"develops cooperative relationships"*, *"actively listens to diverse points of view"*, *"treats people with dignity and respect"*, *"involves people in the decisions that directly impact their job performance"*, *"gives people choice about how to do their work"* and *"ensures that people grow in their jobs".* The fifth practice and final practice is *encourage the heart* (EH), which *"praises people for a job well done"*, *"expresses confidence in people's abilities"*, *"makes sure that people are creatively recognised for their contributions to the success of our projects"*, *"recognises people for commitment to shared values"*, *"tells stories of encouragement about the good work of others"* and *"gets personally involved in recognising people and celebrating accomplishments".*

4.5 Ethical considerations

Ethics approval for this research was granted by the Human Research Ethics Committee of the University of Adelaide with approval number H-2019-049, and from the Institutional Review Board – Hail, Saudi Arabia with log number 2019-8 (see Appendix D).

The National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council et al. 2018) was utilised as the framework to protect the participants of this study. All participant information was combined and anonymised; only the principal researcher and his supervisors at the Adelaide Nursing School of the University of Adelaide had access to the anonymised data. Further, the utmost care was taken to ensure that no personal identifying details were revealed about CNMs. Participant identifiers such as ward names were coded, and age and experience data were combined to ensure that the participants' privacy and confidentiality were maintained.

Participant information sheets outlined all information regarding the study such as the study's aims, participants' rights, the researcher's contact details, and ethical considerations. Participation was entirely voluntary and anonymous to maintain the participants' privacy. In addition, the participant information sheet stated that completed and returned questionnaires implied informed consent to participate in the study.

The quantitative phase of the study contained two forms of data: hard copy questionnaires and a digital copy of data. Hard copy questionnaires were kept in a locked cabinet accessible only to the researcher. The digital version of the data was secured on the researcher's computer (protected by a password) and his university cloud account – the researcher was the only person who had access to the digital data. Furthermore, during the study period, all completed questionnaires were stored in a secure box and collected by the researcher daily in order to reduce the risk of the box being breached (based on the ethics committee's recommendations).

All anonymised hard and digital copies of the data will be kept for five years following the study (when publication and dissemination take place), then the data will be permanently deleted under the guidance of the University of Adelaide's IT department, and all hard copy materials will be destroyed confidentially, as per the University of Adelaide's Research Data and Primary Materials Policy.

4.6 Data collection procedure

In the first instance, data collection commenced after obtaining the required ethics approval from the University of Adelaide and the Institutional Review Board – Hail. The researcher then approached administrators in each individual hospital for approval to conduct the study. The researcher pointed out the benefits of the research study, outlined the data collection plan and assured administrators that, by participating in the study, neither their employees nor the care provided for patients would be adversely affected. The hospitals' administrators referred the researcher to the nursing office directors (responsible for nursing staff) to discuss the data collection plan and time schedules and clear instructions to participants, to ensure that the data would be of quality as possible (Polit & Beck 2012). The plan for data collection was then agreed, and the process to protect participants' identities was provided by the researcher. Because of the need for anonymity, secure boxes were placed in every ward for nurses and in the Nursing Administration Offices for Clinical Nurse Managers, ensuring that they were not accessible to anyone except the researcher.

The questionnaire package consisted of the cover letter, which was an invitation to participate, the participant information sheet and the questionnaire, including the demographic items and the LPI items. These were distributed to participants using hard copies rather than email. In a study by Nulty (2008) comparing the response rates of paper-based and web-based questionnaires, there was a higher response rate for paper questionnaires. In Saudi Arabia, a

high response rate is only possible with paper-based questionnaires (Meyer et al. 2022). In addition, an online survey was not feasible because not all participants had regular access to email, which may have adversely affected the questionnaire response rate. For these reasons, the researcher preferred to utilise a hard copy questionnaire.

The researcher attended one of the monthly nursing office meetings in each selected hospital. He introduced himself and gave a brief overview of the research to the CNMs. He then attended a handover in the wards of selected hospitals and delivered a session of 5–10 minutes. This was to recruit the RNs and to provide them with an overview of the research to ensure that they had a clear understanding of it. Then the researcher approached the nursing office supervisor (who was not involved in the study) to place posters on the staff noticeboard to invite the RNs and CNMs to participate. In addition, packages including hard copies of the questionnaire were made available at the reception desk in each ward. In order to ensure anonymity, the RNs were instructed to put their completed questionnaire in the secure boxes available in each ward, which were locked with a key held only by the researcher.

Since there were only 40 clinical nurse managers, the questionnaire packages were sent to CNMs by the Nursing Administration Offices, to ensure that the CNMs completed the correct questionnaire. They were asked to put their completed questionnaire in secure boxes in the Nursing Administration Office in their hospitals. The researcher checked these secure boxes daily and collected the completed questionnaires. In addition, reminder posters were placed on the nursing staff noticeboard of each ward by the nursing office supervisor in each hospital two weeks after distribution of the questionnaires.

4.7 Data analysis

Two types of analysis were conducted on the data using different software: statistical analysis using the Statistical Package for the Social Sciences (SPSS) version 26, and content analysis using NVivo 12™.

4.7.1 Statistical analysis

SPSS version 26 was used to analyse the data. A descriptive statistical analysis was used to describe and explore the demographic and professional data of the sample using percentages, means, frequencies and standard deviation. Prior to conducting the inferential analysis of leadership practices of CNMs as self-reported and reported by RNs working in the CNMs' wards, computation was performed for outcomes (one subscale at a time); the five composite leadership practices were scored out of 60 and a total score was computed. This was also performed for predictors (one at a time): ethnicity, age, gender, education level, nursing experience and management experience (for CNMs only). This process was conducted first with CNMs and then with RNs. An independent t-test was performed for the outcomes (one subscale at a time): of the five composite leadership practices to identify the differences in self-reports of nurse managers' leadership practices and observer-reports of leadership practices by registered nurses. Then, an independent t-test was performed to identify the differences between Saudi clinical nurse managers and clinical nurse managers' leadership practices from other cultures (self-reports and observer reports). After that, linear regression was used to analyse the outcomes (one model at a time) of the five composite leadership practices and the total score, and the predictors (one at a time) gender, age, nationality, nursing experience, management experiences and education level.

4.7.2 Content analysis

NVivo software version 12 was utilised to analyse the data. A content analysis method was used to analyse five open-ended questions about the essential and critical leadership skills of CNMs and descriptions of CNMs' current roles. Through NVivo, the analysis identified the leadership training courses and workshops provided by participants' institutions and the continuing professional development offered to support the development of CNMs as nursing leaders.

The approach to content analysis can be divided into three types: conventional, summative, and directed (Hsieh & Shannon, 2005). Traditionally, coding categories are derived from the text data in conventional content analysis as a whole. For a directed analysis, a theory or relevant research results are used as a starting point for initial coding. While in summative content analysis, keywords and content are counted, compared, then interpreted to reveal context. In the open-ended questions of the current study, content analysis was conducted in a summative manner, in which the context of the text was analysed through counting identified codes across the transcripts to elucidate the text's contextual meaning (Hsieh & Shannon, 2005).

4.8 Summary

In this chapter, an overview of the methods that were employed for the study's quantitative component have been presented. It provided an overview of the sample, the locations, and the types of instruments that were used in the data collection, the data collection procedures, the software used for data analysis, and the ethical considerations. The results of the quantitative component of the study will be presented in the next chapter.

Chapter 5: Results of the quantitative phase of the study

5.1 Introduction

This chapter presents the results of the questionnaires distributed to clinical nurse managers and the registered nurses who worked on their wards. It begins by summarising the response rate and the demographic and professional characteristics of the participants. It then presents a descriptive and inferential analysis of the leadership practices of clinical nurse managers as self-rated, as well as those rated by registered nurses working in the clinical nurse managers' wards. Finally, the results of the open-ended questions that were asked of clinical nurse managers are presented.

5.2 Response rate

A convenience sample of clinical nurse managers (N = 40) and registered nurses (N = 715) with at least six months' experience in their wards in the three biggest hospitals in the north of Saudi Arabia (specifically in Hail City) were eligible to participate in the study. A total of 29 out of 40 clinical nurse managers' questionnaires were returned, while 372 of 715 registered nurses' questionnaires were received, with response rates of 72.5% and 50.6%, respectively. All questionnaires were screened for eligibility for analysis. There were no issues with the clinical nurse managers' questionnaires, and all were adequately completed by the participants. The screening resulted in the exclusion of 31 questionnaires of the 372 returned by registered nurses because they were incomplete, while another 23 were excluded because the participants had less than six months' experience and were therefore not eligible to participate. Ultimately, 29 clinical nurse managers' questionnaires and 318 registered nurses' questionnaires (with response rates of 72.5% and 44.5%, respectively) were valid, as shown in Table 5.1.

Table 5.1: Response rate by participants

Participant's role	Number of questionnaires				
	Distributed	Returned	%	Valid	%
CNMs	40	29	72.5%	29	72.5%
RNs	715	372	50.6%	318	44.5%

5.3 Demographic characteristics of the participants

The demographic characteristics of the participants are presented in Table 5.2. Most of the clinical nurse managers and registered nurse participants were female, at 89.7% and 94.3%, respectively. The majority of both groups were aged between 26 and 35 years (75.9% and 82.1%, respectively). For clinical nurse managers, the nationality split was almost equal between Saudi (51.7%) and non-Saudi (48.3%). Most clinical nurse managers had between 5 and 10 years' nursing experience (n = 13, 44.8%), while the majority of registered nurses had 1–5 years' nursing experience (n = 165, 51.9%). Most clinical nurse managers had 1–5 years' experience (n = 14, 48.3%), while there were no clinical nurse managers who had more than 10 years of experience. More than half (n = 27, 62.1%) of the clinical nurse manager participants had not held this position elsewhere before working in their current role. Most clinical nurse managers (51.7%) had between 1 and 5 years' experience in their current ward, while only 17.3% of clinical nurse managers had between 5 and 10 years' experience at the time of data collection. Most of the registered nurses (52.8%) had 1–5 years' experience in their current ward, while only 4.1% had more than 10 years. The most common highest qualification held by both clinical nurse managers and registered nurse respondents was a bachelor's degree (62.1% and 82.7%, respectively).

Table 5.2: Demographic characteristics of the participants

Variables	CNMs		RNs	
	N	(%)	N	(%)
Gender				
Female	26	89.7%	300	94.3%
Male	3	10.3%	18	5.7%
Overall	29	100%	318	100%
Age (years)				
≤ 25	0	0	20	6.3%
26–35	22	75.9%	261	82.1%
36–45	2	6.9%	29	9.1%
≥ 46	5	17.2%	8	2.5%
Mean age (SD), range	34.8 (8.2), 26–55		30.3 (4.9), 24–52	
Nationality				
Saudi	15	51.7%	N/A	N/A
Non-Saudi	14	48.3%	N/A	N/A
Overall	29	100%	N/A	N/A
Experience as RN				
6–12 months	0	0	9	2.8%
1–5 years	4	13.8%	165	51.9%
5–10 years	13	44.8%	107	33.6%
>10 years	12	41.7%	37	11.6%
Mean experience as RN in months (SD), range	132.5 (77.7), 22–360		75.7 (52.6) 6–288	
Experience as a CNM				
6–12 months	8	27.6%	N/A	N/A
1–5 years	14	48.3%	N/A	N/A
5–10 year	7	24.1%	N/A	N/A
>10 years	0	0	N/A	N/A
Mean experience as CNM in months (SD), range	39.2 (31.1), 6–108		N/A	
Clinical nurse manager elsewhere				
Yes	2	34.5%	N/A	N/A
No	27	62.1%	N/A	N/A
Overall	29	100%	N/A	N/A
Experience in the current ward				
6–12 months	9	31%	97	30.5%
1–5 yrs	15	51.7%	168	52.8%
5–10 yrs	5	17.3%	40	12.6%
>10 yrs	0	0	13	4.1%
Mean experience in current ward in months (SD), range	33.8 (29.2), 6–108		39.2 (36.7), 6–180	
Highest qualification				
Diploma	10	34.5%	51	16%

BSN	18	62.1%	263	82.7%
MSN	1	3.4%	4	1.3%

Abbreviations: CNMs = clinical nurse managers. RNs = registered nurses. BSN = Bachelor of Science in Nursing. MSN = Master of Science in Nursing. N/A = not applicable.

5.4 Internal consistency and reliability analysis of the Leadership Practices Inventory (LPI)

The Cronbach's alphas for the LPI scale and subscales of the clinical nurse managers/registered nurses are shown in Table 5.3. The total LPI-Self had high internal consistency (α = .97). The strongest internal consistency scores for the LPI-Self composite scales were for *Model the Way* (α = .90), followed by both *Enable Others to Act* and *Encourage the Heart* (α = .89). The composite scales for *Inspire a Shared Vision* and *Challenge the Process* had acceptable reliability (α = .85 and α =.83, respectively). The total LPI reported by the registered nurses had high internal consistency (α = .97). Internal consistency scores for the LPI registered nurse–reported composite scales were as follows: *Model the Way*, α = .85, *Inspire a Shared Vision*, α = .86, *Challenge the Process*, α = .85, *Enable Others to Act*, α = .84, and *Encourage the Heart*, α = .84. Since all of these Cronbach's alphas are greater than .7, the items from the LPI scale and subscales were deemed internally consistent and fit for use in the subsequent analysis.

Table 5.3: Cronbach's alphas

Scale/subscale	**Item no.**	**Cronbach's alphas**	
		CNMs *(n = 29)*	**RNs** *(n = 318)*
Leadership Practices Inventory	**30**	.97	.97
Subscale			
Model the Way	6	.90	.85
Inspire a Shared Vision	6	.85	.86
Challenge the Process	6	.83	.85
Enable Others to Act	6	.89	.84
Encourage the Heart	6	.89	.84

5.5 Leadership practices of clinical nurse managers as self-rated and reported by registered nurses

All participants were asked to rate the leadership practices of the clinical nurse managers. The clinical nurse managers rated their own practices and the registered nurses rated the practices of the manager on their ward. In Table 5.4, descriptive statistics are presented for the LPI scale and subscale scores self-reported by clinical nurse managers and reported by registered nurses. Two key observations were made from the findings: self-reported leadership practices were scored consistently higher than the scores provided by registered nurses in all leadership practices, and the highest self-reported scores were *Enable Others to Act* with a mean of 8.1, followed by *Encourage the Heart* with a mean of 7.7. The lowest practice score rated by the clinical nurse managers was for *Challenge the Process* with a mean of 7.4. In comparison, registered nurses observed clinical nurse managers to be most engaged in *Enable Others to Act* with a mean of 6.8, followed by *Model the Way* with a mean of 6.7. The lowest practice score was for *Inspire a Shared Vision*, with a mean of 6.6.

Table 5.4: Leadership practices of CNMs: Self-reported vs. as reported by RNs

Leadership scale/subscale	**CNMs** *(n=29)* *Mean (SD)*	**RNs** *(n=318)* *Mean (SD)*
Leadership Practices Inventory score	45.8 (9.2)	40.2 (9.1)
Subscale		
Model the Way	7.5 (1.8)	6.7 (1.6)
Inspire a Shared Vision	7.4 (1.6)	6.6 (1.6)
Challenge the Process	7.4 (1.5)	6.6 (1.5)
Enable Others to Act	8.1 (1.4)	6.8 (1.6)
Encourage the Heart	7.7 (1.6)	6.6 (1.6)

Descriptive statistics are presented in Table 5.5 for the LPI scale and subscale scores for the leadership practices of both Saudi clinical nurse managers and clinical nurse managers from other cultures, as self-reported. The leadership practices' overall scores were rated consistently higher by clinical nurse managers from other cultures than by Saudi clinical nurse managers. The leadership practice found to be most common for clinical nurse managers from other cultures was *Enable Others to Act*, with a mean of 8.6, followed by *Model the Way* and *Encourage the Heart*. Saudi clinical nurse managers also saw themselves as engaged in *Enable Others to Act*, with a mean of 7.7, followed by *Challenge the Process* and *Encourage the Heart*.

Table 5.5: Leadership practices of Saudi CNMs vs. CNMs from other cultures (as self-reported)

Leadership scale/subscale	**Saudi CNMs** *(n=15)* *Mean (SD)*	**CNMs from other cultures** *(n=14)* *Mean (SD)*
Leadership Practices Inventory score	43.4 (10.3)	48.5 (7.3)
Subscale		
Model the Way	6.8 (1.9)	8.1 (1.4)
Inspire a Shared Vision	7.1 (1.7)	7.8 (1.4)
Challenge the Process	7.2 (1.8)	7.7 (1.1)
Enable Others to Act	7.7 (1.6)	8.6 (1.1)
Encourage the Heart	7.2 (1.8)	8.1 (1.4)

In contrast, registered nurses scored Saudi clinical nurse managers' leadership practices consistently higher than those of clinical nurse managers from other cultures. The practice they found to be most common was *Enable Others to Act*, with a mean of 6.9 for Saudi clinical nurse managers, while the practice rated lowest by the registered nurses was *Inspire a Shared Vision*, with a mean of 6.3 for clinical nurse managers from other cultures, as shown in Table 5.6.

Table 5.6: Leadership practices as reported by RNs for Saudi and CNMs from other cultures

Leadership scale/subscale	**RNs reported for Saudi CNMs** *(n=159)* *Mean (SD)*	**RNs reported for CNMs from other cultures** *(n=159)* *Mean (SD)*
Leadership Practices Inventory score	41.1 (9.0)	39.2 (9.1)
Subscale		
Model the Way	6.9 (1.6)	6.6 (1.6)
Inspire a Shared Vision	6.8 (1.6)	6.3 (1.6)
Challenge the Process	6.8 (1.5)	6.4 (1.6)
Enable Others to Act	6.9 (1.6)	6.8 (1.7)
Encourage the Heart	6.8 (1.6)	6.5 (1.6)

5.6 Leadership Practices Inventory individual items

5.6.1 Leadership Practices Inventory: Individual items from clinical nurse managers' and registered nurses' perspectives

The following tables break down each practice category into specific leadership behaviours as perceived by the respondents. Table 5.7 presents the individual items of the LPI from the perspective of clinical nurse managers and registered nurses. The clinical nurse managers scored *I treat others with dignity and respect* as the highest, with a mean of 8.48 (SD = 1.95). The second highest-scored leadership behaviour was *I develop cooperative relationships*, with a mean of 8.28 (SD = 1.99). These two items were scored highly on the 8-point scale by the clinical nurse managers and corresponded to the *Enable Others to Act* practice. The two leadership behaviours rated lowest by clinical nurse managers on the 6-point scale were *I take initiative in anticipating and responding to change*, with a mean of 6.76 (SD = 2.38), and *I ask for feedback on how my actions affect people's performance*, with a mean of 6.86 (SD = 1.92). These were the two items scored lowest by the clinical nurse managers and corresponded to *Challenge the Process* and *Model the Way*, respectively.

The two leadership behaviours rated highest by registered nurses in the 6–7 point scale range were *Enable Others to Act* and *Model the Way*. The highest-rated leadership behaviour, *He/she treats people with dignity and respect*, had a mean of 7.03 (SD = 2.57). The second highest-scored leadership behaviour, *He/she makes certain that people adhere to the principles and standards that have been agreed upon*, scored closely behind at 6.98 (SD = 2.14). The two behaviours rated lowest by registered nurses on the 6-point scale were *Model the Way* and *Inspire a Shared Vision*. The behaviour given the lowest rating by registered nurses was *He/she asks for feedback on how his/her actions affect people's performance*, with a mean of 6.39 (SD = 2.33). The second lowest was *He/she talks about future trends influencing our work*, with a mean of 6.44 (SD = 2.21). Surprisingly, both clinical nurse managers and registered nurses rated the behaviour *Asks for feedback on how his/her actions affect people's performance* as low.

Table 5.7: Leadership Practices Inventory individual items from CNMs' and RNs' perspectives

Item #	Item description	CNMs *(n = 29)* Mean (SD)	RNs *(n = 318)* Mean (SD)
Model the Way practice (6 items)			
1	Sets a personal example of what is expected	7.38 (2.55)	6.48 (2.26)
6	Makes certain that people adhere to the principles and standards that have been agreed upon	7.52 (1.84)	6.98 (2.14)
11	Follows through on promises and commitments	7.52 (2.55)	6.92 (2.07)
16	Asks for feedback on how his/her actions affect people's performance	6.86 (1.92)	6.39 (2.33)
21	Builds consensus around organisation's values	7.72 (2.20)	6.85 (2.07)
26	Is clear about his/her philosophy of leadership	7.97 (2.29)	6.86 (2.06)
Inspire a Shared Vision practice (6 items)			
2	Talks about future trends influencing our work	7.52 (2.21)	6.44 (2.21)
7	Describes a compelling image of the future	7.41 (1.93)	6.63 (2.02)
12	Appeals to others to share a dream of the future	7.34 (2.05)	6.52 (2.23)
17	Shows others how their interests can be realised	7.28 (1.57)	6.54 (2.10)
22	Paints "big picture" of group aspirations	7.41 (2.19)	6.52 (2.12)
27	Speaks with conviction about meaning of work	7.83 (2.49)	6.86 (2.15)
Challenge the Process practice (6 items)			
3	Seeks challenging opportunities to test skills	7.38 (2.02)	6.45 (2.17)
8	Challenges people to try new approaches	8.03 (1.82)	6.70 (1.96)
13	Actively searches for innovative ways to improve what we do	7.38 (2.29)	6.61 (2.10)
18	Asks "What can we learn?"	7.48 (1.63)	6.65 (2.05)
23	Identifies measurable milestones that keep projects moving forward	7.62 (2.17)	6.82 (2.00)
28	Takes initiative in anticipating and responding to change	6.76 (2.38)	6.67 (2.00)
Enable Others to Act practice (6 items)			
4	Develops cooperative relationships	8.28 (1.99)	6.97 (2.23)

9	Actively listens to diverse points of view	8.21 (1.44)	6.75 (2.13)
14	Treats people with dignity and respect	8.48 (1.95)	7.03 (2.57)
19	Involves people in the decisions that directly impact their job performance	7.69 (1.58)	6.64 (2.01)
24	Gives people choice about how to do their work	8.24 (1.64)	6.91 (2.04)
29	Ensures that people grow in their jobs	7.86 (1.97)	6.78 (2.15)
Encourage the Heart practice (6 items)			
5	Praises people for a job well done	8.24 (1.97)	6.84 (2.21)
10	Expresses confidence in people's abilities	7.62 (2.06)	6.77 (2.02)
15	Makes sure that people are creatively recognised for their contributions to the success of our projects	7.34 (2.33)	6.55 (2.29)
20	Recognises people for commitment to shared values	7.45 (2.02)	6.61 (2.05)
25	Tells stories of encouragement about the good work of others	7.66 (2.07)	6.59 (2.00)
30	Gets personally involved in recognising people and celebrating accomplishments	7.86 (1.99)	6.62 (2.24)

5.6.2 Leadership Practices Inventory: Individual items from Saudi and clinical nurse managers from other cultures

Table 5.8 presents the individual items of the LPI from the perspective of Saudi and clinical nurse managers from other cultures. Saudi clinical nurse managers gave a high score to the items *I actively listen to diverse points of view,* and *I give people choice about how to do their work*, with means of 8.3 (SD = 1.6) and 8.1 (SD = 1.8), respectively. These were the two items scored most highly on an 8-point scale by Saudi clinical nurse managers and corresponded to *Enable Others to Act*. The two leadership behaviours rated lowest by Saudi clinical nurse managers, on the 6-point scale, were *I ask for feedback on how my actions affect people's performance,* with a mean of 6.4 (SD = 2.2), and *I set a personal example of what is expected*, with a mean of 6.5 (SD = 3.0). These were the two items scored lowest by the Saudi clinical nurse managers and corresponded to *Model the Way*.

The two leadership behaviours rated highest by clinical nurse managers from other cultures, on the 9-point scale, came from the *Enable Others to Act* and *Encourage the Heart* practices. The highest-ranked leadership behaviour, *I treat people with dignity and respect*, was rated at 9.4 (SD = 1.2). The second highest-scored leadership behaviour – *I praise people for a job well done* – scored closely behind at 9.1 (SD = 1.4). The two behaviours rated lowest by clinical nurse managers from other cultures , on the 6- and 7-point scales, came from *Challenge the Process* and *Model the Way*. The behaviour rated lowest by clinical nurse managers from other cultures was *I take initiative in anticipating and responding to change*, with a mean of 6.9 (SD = 2.5). The second lowest was *I ask for feedback on how my actions affect people's performance*, with a mean of 7.4 (SD = 1.5). Both Saudi and clinical nurse managers from other cultures rated the behaviour *I ask for feedback on how my actions affect people's performance* in the lowest place.

Table 5.8: Leadership Practices Inventory: Individual items from Saudi CNMs and CNMs from other cultures

Item #	Item description	Saudi CNMs *(n = 15)* Mean (SD)	CNMs from other cultures *(n = 14)* Mean (SD)
Model the Way practice (6 items)			
1	Sets a personal example of what is expected	6.47 (2.99)	8.36 (1.55)
6	Makes certain that people adhere to the principles and standards that have been agreed upon	6.87 (1.55)	8.21 (1.92)
11	Follows through on promises and commitments	6.87 (2.5)	8.21 (2.51)
16	Asks for feedback on how his/her actions affect people's performance	6.40 (2.19)	7.36 (1.49)
21	Builds consensus around organisation's values	7.40 (1.95)	8.07 (2.46)
26	Is clear about his/her philosophy of leadership	7.07 (2.73)	8.93 (1.14)
Inspire a Shared Vision practice (6 items)			
2	Talks about future trends influencing our work	7.07 (2.57)	8.00 (1.71)
7	Describes a compelling image of the future	7.40 (1.76)	7.43 (2.17)
12	Appeals to others to share dream of the future	7.27 (2.34)	7.43 (2.78)
17	Shows others how their interests can be realised	6.93 (1.75)	7.64 (1.33)
22	Paints "big picture" of group aspirations	7.27 (1.75)	7.57 (2.65)
27	Speaks with conviction about meaning of work	6.93 (2.86)	8.79 (1.62)
Challenge the Process practice (6 items)			
3	Seeks challenging opportunities to test skills	7.13 (2.56)	7.64 (1.27)
8	Challenges people to try new approaches	7.93 (2.18)	8.14 (1.40)
13	Actively searches for innovative ways to improve what we do	6.73 (2.68)	8.07 (1.59)
18	Asks "What can we learn?"	7.27 (1.98)	7.71 (1.20)
23	Identifies measurable milestones that keep projects moving forward	7.67 (1.83)	7.57 (2.56)
28	Takes initiative in anticipating and responding to change	6.67 (2.38)	6.86 (2.47)
Enable Others to Act practice (6 items)			

4	Develops cooperative relationships	7.67 (2.25)	8.93 (1.49)
9	Actively listens to diverse points of view	8.27 (1.62)	8.14 (1.29)
14	Treats people with dignity and respect	7.60 (2.16)	9.43 (1.15)
19	Involves people in the decisions that directly impact their job performance	7.53 (1.88)	7.86 (1.23)
24	Gives people choice about how to do their work	8.13 (1.84)	8.36 (1.44)
29	Ensures that people grow in their jobs	7.00 (2.23)	8.79 (1.12)
Encourage the Heart practice (6 items)			
5	Praises people for a job well done	7.40 (2.13)	9.14 (1.35)
10	Expresses confidence in people's abilities	7.20 (2.42)	8.07 (1.54)
15	Makes sure that people are creatively recognised for their contributions to the success of our projects	6.53 (2.64)	8.21 (1.62)
20	Recognises people for commitment to shared values	7.40 (2.06)	7.50 (2.06)
25	Tells stories of encouragement about the good work of others	7.60 (1.80)	7.71 (2.40)
30	Gets personally involved in recognising people and celebrating accomplishments	7.27 (2.21)	8.50 (1.55)

5.6.3 Leadership Practices Inventory: Individual items from registered nurses for Saudi and clinical nurse managers from other cultures

Individual items of the LPI, from the perspective of registered nurses, for Saudi and clinical nurse managers from other cultures , are presented in Table 5.9. The two leadership behaviours rated highest by registered nurses for Saudi clinical nurse managers, on the 7-point scale, were *He/she makes certain that people adhere to the principles and standards that have been agreed upon*, with a mean of 7.2 (SD = 2.2), and *He/she builds consensus around the organisation's values*, with a mean of 7.1 (SD = 2.0). These two items were scored highly by the registered nurses for Saudi clinical nurse managers and correspond to the *Model the Way* practice. The two leadership behaviours rated lowest by registered nurses for Saudi clinical nurse managers, on the 6-point scale, were *He/she sets a personal example of what is expected*, with a mean of 6.4 (SD = 2.3), and *He/she talks about future trends influencing our work*, with a mean of 6.5 (SD = 2.3). These were the two items scored lowest by the registered nurses for Saudi clinical nurse managers and corresponded to *Model the Way* and *Inspire a Shared Vision*, respectively.

The two leadership behaviours rated highest by registered nurses for clinical nurse managers from other cultures, in the 6–7 scale range, both came from the *Enable Others to Act* practice. The highest-rated leadership behaviour, *He/she treats people with dignity and respect*, was rated with a mean of 7.2 (SD = 2.6). The second highest-scored leadership behaviour, *He/she develops cooperative relationships*, was scored closely behind at 7.0 (SD = 2.4). The two behaviours rated lowest by registered nurses for clinical nurse managers from other cultures, in the 6-point scale, came from the *Model the Way* and *Inspire a Shared Vision* practices. The behaviour rated lowest by registered nurses for clinical nurse managers from other cultures was *He/she asks for feedback on how his/her actions affect people's performance*, with a mean of 6.1 (SD = 2.3) The second lowest ranking was given by registered nurses for clinical nurse

managers from other cultures for *He/she shows others how their interests can be realised* with a mean of 6.2 (SD = 2.2).

Table 5.9: Leadership Practices Inventory: Individual items from RNs for Saudi and CNMs from other cultures

Item #	Item description	RNs reported for Saudi CNMs *(n= 159)* Mean (SD)	RNs reported for CNMs from other cultures *(n= 159)* Mean (SD)
Model the Way practice (6 items)			
1	Sets a personal example of what is expected	6.43 (2.27)	6.54 (2.25)
6	Makes certain that people adhere to the principles and standards that have been agreed upon	7.18 (2.21)	6.79 (2.06)
11	Follows through on promises and commitments	6.95 (2.00)	6.90 (2.15)
16	Asks for feedback on how his/her actions affect people's performance	6.68 (2.34)	6.10 (2.29)
21	Builds consensus around organisation's values	7.08 (2.02)	6.62 (2.09)
26	Is clear about his/her philosophy of leadership	6.88 (2.14)	6.83 (1.98)
Inspire a Shared Vision practice (6 items)			
2	Talks about future trends influencing our work	6.47 (2.29)	6.41 (2.12)
7	Describes a compelling image of the future	6.99 (2.02)	6.26 (1.96)
12	Appeals to others to share dream of the future	6.75 (2.00)	6.28 (2.42)
17	Shows others how their interests can be realised	6.86 (1.95)	6.23 (2.20)
22	Paints "big picture" of group aspirations	6.72 (2.13)	6.33 (2.10)
27	Speaks with conviction about meaning of work	7.08 (2.11)	6.65 (2.18)
Challenge the Process practice (6 items)			
3	Seeks challenging opportunities to test skills	6.53 (2.16)	6.36 (2.20)
8	Challenges people to try new approaches	7.02 (2.00)	6.38 (1.87)
13	Actively searches for innovative ways to improve what we do	6.80 (2.11)	6.42 (2.08)
18	Asks "What can we learn?"	6.85 (1.91)	6.45 (2.17)
23	Identifies measurable milestones that keep projects moving forward	6.92 (2.04)	6.71 (1.95)
28	Takes initiative in anticipating and responding to change	6.93 (1.85)	6.41 (2.12)

Enable Others to Act practice (6 items)			
4	Develops cooperative relationships	6.98 (2.10)	6.97 (2.36)
9	Actively listens to diverse points of view	6.98 (2.13)	6.53 (2.12)
14	Treats people with dignity and respect	6.87 (2.56)	7.19 (2.57)
19	Involves people in the decisions that directly impact their job performance	6.75 (1.89)	6.53 (2.12)
24	Gives people choice about how to do their work	7.01 (2.06)	6.81 (2.03)
29	Ensures that people grow in their jobs	6.87 (2.16)	6.69 (2.15)
Encourage the Heart practice (6 items)			
5	Praises people for a job well done	7.00 (2.20)	6.69 (2.21)
10	Expresses confidence in people's abilities	6.92 (2.09)	6.62 (1.95)
15	Makes sure that people are creatively recognised for their contributions to the success of our projects	6.89 (2.29)	6.22 (2.26)
20	Recognises people for commitment to shared values	6.84 (2.05)	6.37 (2.03)
25	Tells stories of encouragement about the good work of others	6.60 (2.05)	6.57 (1.95)
30	Gets personally involved in recognising people and celebrating accomplishments	6.81 (2.19)	6.43 (2.27)

5.7 Univariate analysis

5.7.1 Differences between self-reported and observer-reported

Independent t-tests were conducted for the five composite leadership practices and total scores to evaluate the differences between clinical nurse managers' and registered nurses' perspectives about the leadership practices of the clinical nurse managers. Leadership practices were measured as quantitative and continuous variables. Independent t-test results showed a statistically significant difference in the Leadership Practice Inventory's overall scores for clinical nurse managers' self-reports (M = 45.8, SD = 9.2) compared with registered nurses' observer reports (M = 40.2, SD = 9.1), (t (345) = 3.2, p = .001). There was a statistically significant difference in *Model the Way* between the observations of clinical nurse managers and registered nurses. Clinical nurse managers (M = 7.5, SD = 1.8) had a mean MW score higher than registered nurses' observations (M = 6.7, SD = 1.6), (t (345) = 2.3, p = .020). The *Inspire a Shared Vision* practice also showed a statistically significant difference, with clinical nurse managers (M = 7.4, SD = 1.6) returning a higher mean *Inspire a Shared Vision* score than registered nurses' observations (M = 6.6, SD = 1.6), (t (345) = 2.7, p = .006).

Challenge the Process practice was rated significantly differently between clinical nurse managers and registered nurses, with clinical nurse managers (M = 7.4, SD = 1.5) reporting a higher mean *Challenge the Process* score than registered nurses (M = 6.6, SD = 1.5), (t (345) = 2.6, p = .009). There was also a significant difference in *Enable Others to Act* between clinical nurse managers and registered nurses. Clinical nurse managers (M = 8.1, SD = 1.4) had a mean *Enable Others to Act* score higher than registered nurses (M = 6.8, SD = 1.6), (t (345) = 4.0, p < .001). *Encourage the Heart* practice also showed a statistically significant difference between clinical nurse managers and registered nurses. Clinical nurse managers (M = 7.7, SD = 1.6) had a mean EH score higher than registered nurses' observations (M = 6.6, SD = 1.6), (t (345)

= 3.3, p = .001). This indicates that clinical nurse managers rated themselves more highly on all leadership practices than registered nurses, as reflected by the overall and subscale scores (Table 5.10).

Table 5.10: Independent t-tests to examine differences in leadership practices of clinical nurse managers as self-reported vs. reported by registered nurses

Leadership scale and subscale	**CNMs – self** *(n = 29)* Mean ± SD	**RNs – observer** *(n = 318)* Mean ± SD	t-test	p-value
Leadership Practice Inventory overall scale	45.8±9.2	40.2±9.1	3.2	.001**
Model the Way	7.5±1.8	6.7±1.6	2.3	.020*
Inspire a Shared Vision	7.4±1.6	6.6±1.6	2.7	.006**
Challenge the Process	7.4±1.5	6.6±1.5	2.6	.009**
Enable Others to Act	8.1±1.4	6.8±1.6	4.0	<.001***
Encourage the Heart	7.7±1.6	6.6±1.6	3.3	.001**

Abbreviations: CNMs = clinical nurse managers. RNs = registered nurses

* p ≤ 0.05, ** p ≤ 0.01, *** p ≤ .001

5.7.2 Differences in leadership practices between Saudi clinical nurse managers and clinical nurse managers from other cultures (self-report)

The mean Leadership Practices Inventory score for Saudi clinical nurse managers (M = 43.4, SD = 10.3) was lower than the mean of clinical nurse managers' scores from other cultures (M = 48.5, SD = 7.3), (t (27) = -1.5, p = .380). Independent t-test results showed a significant difference in the self-reported *Model the Way* scores between Saudi clinical nurse managers (M = 6.8, SD = 1.9) and clinical nurse managers from other cultures (M = 8.1, SD = 1.4), (t (27) = -2.0, p = .047). This indicates that Saudi clinical nurse managers rated themselves lower in this practice than their counterparts from other cultures. There was no significant difference

in the *Inspire a Shared Vision*, *Challenge the Process*, *Enable Others to Act* and *Encourage the Heart* ratings, as shown in Table 5.11.

Table 5.11: Independent t-tests to examine differences in leadership practices between Saudi and clinical nurse managers from other cultures

Leadership subscale	**Saudi CNMs** *(n = 15)* Mean ± SD	**CNMs from other cultures** *(n = 14)* Mean ± SD	t-test	p-value
Leadership Practices Inventory overall score	43.4±10.3	48.5±7.3	-1.5	.380
Model the Way	6.8±1.9	8.1±1.4	-2.0	.047*
Inspire a Shared Vision	7.1±1.7	7.8±1.4	-1.1	.597
Challenge the Process	7.2±1.8	7.7±1.1	-0.7	.120
Enable Others to Act	7.7±1.6	8.6±1.1	-1.7	.143
Encourage the Heart	7.2±1.8	8.1±1.4	-1.5	.360

Abbreviation: CNMs = clinical nurse managers
* $p \leq 0.05$

5.7.3 Differences in leadership practices between Saudi and clinical nurse managers from other cultures (observer report)

The registered nurses' reported results showed a statistically significant difference in three transformational leadership practices between Saudi and clinical nurse managers from other cultures (see Table 5.12). Differences in *Inspire a Shared Vision* (t = 2.4, p = .014), *Challenge the Process* (t = 2.2, p =.025), and *Encourage the Heart* practices (t = 2.0, p = .044) were reported by the registered nurses. This indicates that Saudi clinical nurse managers were rated higher for *Inspire a Shared Vision*, *Challenge the Process* and *Encourage the Heart* than their counterparts from other cultures. There were no statistically significant differences in registered nurses' observations for *Model the Way* and *Enable Others to Act*.

Table 5.12: Independent t-tests of clinical nurse managers' leadership practices assessed by registered nurses for Saudi CNMs vs. CNMs from other cultures

Leadership subscale	**RNs assessment of Saudi CNMs** *(n = 159)* Mean ± SD	**RNs assessment of CNMs from other cultures** *(n = 159)* Mean ± SD	t-test	p-value
Leadership Practices Inventory	41.1±9.0	39.3±9.1	1.8	.811
Model the Way	6.9±1.6	6.6±1.6	1.3	.697
Inspire a Shared Vision	6.8±1.6	6.3±1.6	2.4	.014*
Challenge the Process	6.8±1.5	6.4±1.6	2.2	.025*
Enable Others to Act	6.9±1.6	6.8±1.7	0.6	.811
Encourage the Heart	6.8±1.6	6.5±1.6	2.0	.044*

Abbreviation: CNMs = clinical nurse managers, RNs = registered nurses
* $p \leq 0.05$

5.8 Clinical nurse managers' demographics, professional variables and leadership practices

The demographic and professional predictors were compared to test the differences and the associations between the five leadership practices and selected characteristics. Linear regressions were conducted for outcomes (one model at a time): the five composite leadership practices and total score, and predictors (one at a time): gender, age, nationality, nursing experience, management experiences and education level. Upon inspection of histograms, it was found that all the composite scores and the total score were normally distributed, and the assumptions of regressions met the requirements. The results were presented: estimates, 95% confidence intervals, comparison p-values and global p-values. Further, to adjust for multiple comparisons, a Bonferroni correction was applied to each group of linear regressions. The research is exploratory and adjustments for multiple comparisons are generally conservative; therefore, only non-adjusted p-values are reported in this chapter.

5.8.1 Association between leadership practices and age

Linear regressions were conducted to establish whether the LPI scale and subscale scores were significantly associated with the clinical nurse managers' ages, and no significant associations were found (estimate = 0.20, 95% confidence interval (CI): -0.19, 0.60, p = .32), as presented in Table 5.13.

Table 5.13: Linear regression analysis to examine age predictors of clinical nurse managers' leadership practices

Predictors	**Leadership scale/subscale**	***Scores versus potential predictors (CNMs = 29)***				
		B	SE	95% confidence interval		p-value
				Lower	Upper	
Age	**Leadership Practices Inventory**	.202	.2026	- 0.195	0.600	.32
	Model the Way	.047	.0402	- 0.032	0.125	.25
	Inspire a Shared Vision	.024	.0354	- 0.046	0.093	.50
	Challenge the Process	.016	.0342	- 0.051	0.083	.63
	Enable Others to Act	.043	.0308	- 0.018	0.103	.16
	Encourage the Heart	.039	.0368	- 0.033	0.112	.28

Abbreviation: CNMs = clinical nurse managers
Note: Dependent variables were leadership practices, one at a time for predictor
* $p \leq 0.05$

5.8.2 Gender differences in leadership practices

The mean Leadership Practices Inventory score for male clinical nurse managers was lower than for female clinical nurse managers by 1.04 units (estimate = -1.04, 95% CI: 0.85, -11.84), although this difference was not statistically significant. There were no significant differences between males and females across leadership practices, as determined by linear regressions (Table 5.14).

Table 5.14: Linear regression analysis to examine gender predictors of clinical nurse managers' leadership practices

Predictor	***Scores versus potential predictors*** *(n = 29)*			
	Leadership scale/subscale	**Comparison**	**Estimate (95% CI)**	**p-value**
Gender	**LPI overall score**	Males vs females	-1.04 (0.85, - 11.84)	.850
	Model the Way	Males vs females	0.006 (-2.15, 2.16)	.995
	Inspire a Shared Vision	Males vs females	0.038 (-1.82, 1.90)	.968
	Challenge the Process	Males vs females	-0.121 (-1.92, 1.67)	.894
	Enable Others to Act	Males vs females	-0.574 (-2.23, 1.08)	.496
	Encourage the Heart	Males vs females	-0.217 (-2.18, 1.74)	.828

*Significant result: p-value ≤ .05

5.8.3 Association between leadership practices and experience

There was no significant association between Leadership Practices Inventory scores and the clinical nurse managers' overall nursing experience. There was a statistically significant association between the *Enable Others to Act* score and the clinical nurse managers' experience in their current ward (p = .032). For every one-month increase in experience in the current ward, the mean EOA score increased by 0.018 (estimate = 0.018, 95% CI: 0.002, 0.034). There were no statistically significant differences in other leadership practices, as shown in Table 5.15.

Table 5.15: Linear regression analysis examining clinical nurse managers' overall nursing experience and experience in the ward as predictors

Predictor	**Leadership scale/subscale**	***Scores vs potential predictors (CNMs = 29)***				
		B	SE	95% confidence interval		p-value
				Lower	Upper	
Nursing experience	**LPI overall score**	.012	.0217	-0.031	0.054	.594
	Model the Way	.003	.0043	-0.006	0.011	.504
	Inspire a Shared Vision	.001	.0038	-0.007	0.008	.854

Predictor	Leadership scale/subscale	*Scores vs potential predictors (CNMs = 29)*				
		B	SE	95% confidence interval		p-value
				Lower	Upper	
	Challenge the Process	.000	.0036	-0.007	0.007	.940
	Enable Others to Act	.004	.0033	-0.003	0.010	.273
	Encourage the Heart	.002	.0039	-0.006	0.010	.583
Experience in the current ward	**LPI overall score**	.094	.0558	-0.016	0.203	.093
	Model the Way	.013	.0114	-0.009	0.036	.244
	Inspire a Shared Vision	.015	.0097	-0.004	0.034	.111
	Challenge the Process	.014	.0094	-0.004	0.033	.130
	Enable Others to Act	.018	.0084	0.002	0.034	.032*
	Encourage the Heart	.017	.0102	-0.003	0.037	.090

Abbreviation: CNMs = clinical nurse managers
Note: Dependent variables were leadership practices, one at a time for predictors
* $p \leq .05$

5.8.4 Association between leadership practices and experience as a clinical nurse manager

Linear regression was conducted to establish whether the LPI scale and subscale scores were significantly associated with experience as a clinical nurse manager. The results indicated that *Enable Others to Act* and *Encourage the Heart* had statistically significant positive associations with experience as a clinical nurse manager ($p = .041$ and $p = .034$, respectively). For every one month increase in experience, the mean EOA score increased by 0.016 (estimate = 0.016, 95% CI: 0.001, 0.032), and the mean EH score increased by 0.020 (estimate = 0.020, 95% CI: 0.001, 0.038). There was no statistically significant difference in other leadership practices, as shown in Table 5.16.

Table 5.16: Linear regression analysis to examine clinical nurse managers' experience as a predictor

Predictor	Leadership scale/subscale	*Scores vs potential predictors (CNMs = 29)*				
		B	SE	95% confidence interval		p-value
				Lower	Upper	
Experience as a CNM	**LPI overall score**	.089	.0523	- 0.013	0.192	.089
	Model the Way	.015	.0106	- 0.006	0.036	.152
	Inspire a shared vision	.012	.0092	- 0.006	0.030	.189
	Challenge the Process	.011	.0089	- 0.006	0.028	.216
	Enable Others to Act	.016	.0079	0.001	0.032	.041*
	Encourage the Heart	.020	.0093	0.001	0.038	.034*

Abbreviation: CNMs = clinical nurse managers
Note: Dependent variables were leadership practices, one at time for predictors
* $p \leq .05$

5.8.5 Leadership practices and education level

Linear regression was used to compare the mean scores for leadership practices and educational level of diploma and Bachelor of Science in Nursing (BSN). Since a low number of participants reported holding an education level of Master of Science in Nursing (MSN), it was combined with BSN. That is, level of education was divided into two categories, diploma and degree. All assumptions of the regression were examined and met. Histograms indicated that leadership practice scores were normally distributed and that there were no outliers. There were no statistically significant differences in leadership practice scores between the educational levels (diploma and BSN) means as examined (estimate = -2.70, 95% CI: -9.55, 4.15, p = .440), as presented in Table 5.17.

Table 5.17: Linear regression analysis to examine clinical nurse managers' qualifications as predictors

Predictor	Leadership scale/subscale	Comparison	Estimate (95% CI)	p-value
Education level	**LPI overall score**	Diploma vs BSN	-2.70 (-9.55, 4.15)	.440
	Model the Way	Diploma vs BSN	-0.57 (-1.94, 0.80)	.408
	Inspire a Shared Vision	Diploma vs BSN	-0.53 (-1.71, 0.64)	.377
	Challenge the Process	Diploma vs BSN	-0.14 (-1.29, 1.01)	.810
	Enable Others to Act	Diploma vs BSN	-0.14 (-1.20, 0.92)	.794
	Encourage the Heart	Diploma vs BSN	-0.85 (-2.08, 0.36)	.169

*Significant result: $p \leq .05$

5.9 Results of open-ended questions

The clinical nurse manager questionnaire included qualitative components about essential leadership skills and asked for a description of the respondents' current role. The study identified the leadership training courses and workshops that had been provided by their institutions and the continuing professional development (CPD) offered to support the development of clinical nurse managers as nursing leaders. Open-ended questions were used to elaborate their points of view. The number of responses to each open-ended question varied and was analysed using the summative approach of the content analysis method (Hsieh & Shannon 2005); data were managed using NVivo 12^{TM} software.

Elo et al. (2014) discussed how to prepare, organise and report content analysis results in an understandable manner to improve the trustworthiness of a study. These concepts were considered during the data analysis by the principal researcher and his supervisors to ensure participant representation. Several studies have discussed rigour in qualitative research, including the similarities and differences between content and thematic analyses. When new knowledge concerning the studied phenomenon emerges, it confirms the quality of the findings

(Krippendorff 2004; Vaismoradi, Turunen & Bondas 2013). A total of 194 responses were provided.

5.9.1 Essential leadership skills of clinical nurse managers

A total of 21 (75%) of 29 participants responded to the open-ended question, "What do you think are the essential leadership skills of a clinical nurse manager?" The responses focused on the need for good communication skills, decision-making skills, flexibility, courage and willingness to take risks. Thirteen (23%) participants identified communication skills as the most important skill for clinical nurse managers to have to be effective leaders. According to one respondent, "The essential leadership skill of a clinical nurse manager is communication; they should be able to communicate well with their staff." Nine (16%) participants' responses suggested that motivation skills were the most essential leadership skills for clinical nurse managers. According to one of these respondents, "The clinical nurse manager can motivate their staff and provide reliable feedback when evaluating what they do." Nine (16%) participants identified decision making as the most essential leadership skill, and seven (13%) respondents reported that adaptability was the most important skill: "They should be flexible and have the courage and willingness to take risks." The results are shown in Table 5.18.

Table 5.18: Frequency and percentage of identified categories from responses to open-ended Question 1

Open-ended question component	**Identified categories**	**Frequency** *Out of 56 responses n (%)*	**Participants' responses**
Essential leadership skills of clinical nurse managers	Communication skills	13 (23)	"The essential leadership skill of a clinical nurse manager is communication; they should be able to communicate well with their staff" (Participant 2).
	Motivation skills	9 (16)	"The clinical nurse manager can motivate the staff and provide

			reliable feedback when evaluating what they do" (Participant 8).
	Decision making	9 (16)	"The clinical nurse managers should make decisions with wisdom and justice in teamwork" (Participant 9).
	Adaptability	7 (13)	"The clinical nurse managers should make decisions with wisdom and justice in teamwork" (Participant 9). "They should be flexible and have the courage and willingness to take risks" (Participant 9).

5.9.2 Leadership training courses and workshops provided to clinical nurse managers

The participants were asked to provide details about training courses and workshops provided by their institutions to support nurse leadership. A total of 18 (62%) of participants responded to the question, "Have you undertaken any leadership training courses or workshops?" Most responses indicated that training was not received. Seven (39%) of those 18 participants indicated YES, they have received leadership training. In addition, eleven (61%) of participants answering the question indicated NO, they had not received leadership training in their institutions. According to one respondent, "No, but I would like for my hospital to provide leadership training courses that will help me manage my ward and lead my staff'". See Table 5.19.

Table 5.19: Frequency and percentage of identified categories from responses to open-ended Question 2

Open-ended question component	**Response Y/N**	**Frequency** *Out of 18 responses n (%)*	**Participants' responses**
Leadership training courses or workshops	Yes	7 (39)	-

	No	11 (61)	"No, but I would like for my hospital to provide leadership training courses that will help me manage my ward and lead my staff" (Participant 6). "No, I was not offered any leadership courses prior to accepting this position" (Participant 27).

5.9.3 The current roles of clinical nurse managers

A total of 21 (75%) of participants responded to the question, "How would you describe your role as a clinical nurse manager?" The total of 46 responses highlighted their roles in managing the ward, influencing and motivating nursing staff, and being fair to the staff and providing them autonomy. Sixteen responses (35%) indicated that "managing the ward" in terms of organising, budgeting and supervision is the primary responsible role of clinical nurse managers in the ward. According to respondents: "As a clinical nurse manager I can do what it takes to be a responsible manager in my area" … by "organising the department work" … being "responsible for supervision" … and organising "ward budgeting and requests to the hospital store". Nine responses (20%) indicated that influencing and motivating the nursing staff is one of the key roles of a clinical nurse manager. According to one respondent: "The clinical nurse manager is responsible for motivating nurses as often as they can and influencing them to be better followers or staff" (Participant 18). This included "Helping nurses with procedures" … "justice between all of the staff; and giving them the right to decide" … and "listening to the staff problems". Moreover, five responses (11%) indicated that clinical nurse managers are responsible for "providing a safe patient care environment". According to respondents: "The clinical nurse manager is responsible" … "to support the work of the health team" … which may "contribute to optimal patient outcomes", as presented in Table 5.20.

Table 5.20: Frequency and percentage of identified categories from responses to open-ended Question 3

Open-ended question component	**Identified categories**	**Frequency** *Out of 46 responses n (%)*	**Participants' responses**
Role of clinical nurse managers	Managing the ward	16 (35)	"As a clinical nurse manager, I can do what it takes to be a responsible manager in my area" (Participant 2). "Organising department work" (Participant 12). "Responsible for supervision" (Participants 8 & 25). "Ward budgeting and requests to the hospital store" (Participant 8).
	Influencing and motivating nursing staff	9 (20)	"The clinical nurse manager is responsible for motivating nurses as often as they can and influencing them to be better followers or staff" (Participant 18). "Helping nurses with procedures" (Participant 27). "Justice between all staff and giving them the right to decide"; and "Listening to staff problems" (Participant 28).
	Patient care environment	5 (11)	The clinical nurse manager is responsible "to support the work of the health team" ... "contribute to optimal patient outcomes" (Participants 7 & 12).

5.9.4 Critical elements of clinical nurse managers' role

The participants were asked to list up to five critical elements of nursing leadership. A total of 18 (62%) of participants responded to the question, "What are the critical elements of the clinical nurse manager role?" A total of 37 responses focused on the need for supervision (i.e. advising and accountability), optimising patient outcomes, responsibility for clearly communicating expected standards of care and listening skills. Eleven responses (30%) indicated that "supervision" in terms of supervising, advising and accountability is a critical

element of the role of clinical nurse managers in the ward. According to respondents: "Supervision of nursing staff in the ward" … "ward management and advising" … "New staff orientation" … and "accountability" are critical elements of the role. Six (16%) respondents indicated that "optimising patient outcomes" is one of the key critical elements of the role of clinical nurse manager. According to respondents, "overall patient care", "direct development in patient care", "optimising patient care" and "emphasis on high-quality care" contribute to this critical element of the role. Moreover, six (16%) indicated that clinical nurse managers should be an "effective communicator". According to one respondent, "The clinical nurse manager is responsible for clearly communicating expected standards of care and being a good listener". See Table 5.21.

Table 5.21: Frequency and percentage of identified categories from responses to open-ended Question 4

Open-ended question component	**Identified categories**	**Frequency** *Out of 37 responses n (%)*	**Participants' responses**
Critical elements of clinical nurse managers' role	Supervision	11 (30)	"Supervising nursing staff in the ward" (Participants 1 & 11). "Ward-management and advising" (Participant 25). "New staff orientation" (Participant 9). "Accountability" (Participant 9).
	Optimising patient outcomes	6 (16)	"Overall patient care" (Participant 1). "Direct development in patient care" (Participant 5). "Optimising patient care" (Participant 7). "Emphasis on high-quality care" (Participant 8).
	Effective communication	6 (16)	"The clinical nurse manager is responsible for clearly communicating expected standards of care and being a good listener" (Participants 14 and 18).

5.9.5 Continuing professional development offered to support clinical nurse manager leadership development

The participants were asked to provide details about continuing professional development provided by their institutions to support the clinical nurse managers as nursing leaders. A total of 18 (62%) of participants responded to the question: "What continuing professional development is offered by your institution to support the development of clinical nurse managers as nursing leaders?" The responses indicated that there were some courses and conferences available in the hospitals to support clinical nurse managers' leadership development, but no additional continuing professional development–related details were provided by the participants. See Table 5.22.

Table 5.22: Frequency and percentage of identified categories from responses to open-ended Question 5

Open-ended question component	**Identified categories**	**Frequency** *Out of 37 responses n (%)*	**Participants' responses**
Continuing professional development offered to support clinical nurse manager leadership development	Courses	7 (28)	No additional continuing professional development–related details were provided by the participants
	Conferences	5 (20)	
	Programmes	5 (20)	
Operational definition: **Course:** Lectures on a specific subject, such as code blue, emergency management and time management. **Program:** Short lesson activities regarding clinical practices such as infection control			

5.10 Summary

The study results identified a significant difference in the Leadership Practice Inventory's overall scores for clinical nurse managers' self-reports (M = 45.8, SD = 9.2) compared with registered nurses' observer reports (M = 40.2, SD = 9.1), (t (345) = 3.2, p = .001). This indicated that there were significant differences between clinical nurse managers' image of their transformational leadership performance and registered nurses' perception of the same. Further, significant differences were found in the self-reports and observer reports for Saudi clinical nurse managers and clinical nurse managers from other cultures. This indicated that there are differences between Saudi and non- Saudi clinical nurse managers' transformational leadership practices. Notably, the clinical nurse managers in this study had been in their positions for less than 10 years and most of them for less than 5 years; therefore, they were relatively inexperienced. Also, the results indicated that some professional development courses were available, but most clinical nurse managers did not receive training to develop their leadership skills.

Chapter 6: Methods for the qualitative study

6.1 The research design

The second phase of the study used an interpretive phenomenological method, hermeneutic phenomenology informed by Heidegger (1962), in order to explore and understand clinical nurse managers' experiences as leaders in clinical settings and to explore nurses' experiences of the leadership practices of clinical nurse managers. For the purposes of the study, the researcher sought the essence of both the experiences of the clinical nurse managers and registered nurses regarding the leadership practices of clinical nurse managers. An interpretive phenomenological approach was chosen over a descriptive one as it emphasises the "meaning of the meaning of the text" (Matua & Van Der Wal 2015, p. 24). Moreover, interpretive phenomenology enables the researcher not only to describe the clinical nurse managers and registered nurses' experiences, but also to interpret their experiences to gain a deeper understanding of the phenomenon (van Manen 1990; Matua & Van Der Wal 2015; Polit & Beck 2017). In addition, through an interpretative approach, researchers can deliberately make use of past knowledge to gain new insights through their research (Sorsa, Kiikkala & Åstedt-Kurki 2015). According to Polit and Beck (2017), interpretive phenomenology is a particularly useful method for researching and interpreting the lived experiences of humans in a detailed and meaningful way. For these reasons, the interpretive method was chosen for this phase of the study to gain useful and valuable insights into the meaning of the phenomenon.

Two phases of data collection were undertaken during this qualitative study. The first was semi-structured interviews with the clinical nurse managers about their leadership in the clinical settings. The second was semi-structured interviews regarding nurse managers' leadership practices with registered nurses working in the clinical nurse managers' wards. The interview has become the most common method of data collection in the field of nursing (Andrew &

Halcomb 2009; Doody & Noonan 2013; Mitchell 2015). According to Polit and Beck (2017), the semi-structured interview is a useful qualitative method used by researchers to obtain detailed information from participants in their own words about the phenomenon under study. It allows the researcher to delve deeply in order to explore the thoughts, feelings and beliefs of participants about a specific topic (van Manen 1990; DeJonckheere & Vaughn 2019).

6.2 Research questions

The results from the quantitative data (phase one) of this study informed the phenomenological study (phase two). A list of questions was generated to investigate in this latter phase. Phase one of the study indicated the importance of exploring the leadership practices of clinical nurse managers working in Saudi workplaces. Also, there were differences between clinical nurse managers' perceptions of their own transformational leadership practices and the observations of these by the registered nurses working in their wards. In addition, there were differences in the transformational leadership practices of Saudi and clinical nurse managers from other cultures. Further, there were differences in transformational leadership practices between experienced and inexperienced clinical nurse managers. In addition, clinical nurse managers frequently referred to some leadership skills in the open-ended questions in previous phase with no explanation. Finally, while some courses were available, most of the clinical nurse managers did not receive training to develop their skills. For this reason, the findings from phase one were the issues to explore further in phase two. This has implications not only for clinical nurse managers but also for the work environment of nurses in Saudi Arabian hospitals.

6.3 Ethics approval

Processes were undertaken to gain ethics approvals prior to the commencement of this phase, with approvals obtained from the University of Adelaide's Human Research Ethics Committee, South Australia and the Institutional Review Board, Hail, Saudi Arabia (see Appendix E).

Documents for the research included: an invitation poster; an invitation letter for each group (Appendix F); a participant information sheet for each group (Appendix G); a demographic survey for each group (Appendix H); and a consent form for each group (Appendix I).

6.4 Researcher preparation

In interview-based research, the researcher is considered the primary instrument for research data collection (Sorrell & Redmond 1995; Merriam & Tisdell 2015). Adequate preparation for interviews encourages rigour and helps to avoid pitfalls for novice researchers, such as inadequate depth of questioning (Banner 2010). An intensive discussion regarding phenomenological interview techniques was undertaken with the supervisory team. The researcher then conducted an interview with one supervisor while the other evaluated this process. The evaluation outcome was discussed to consider all aspects that would be useful and valuable in conducting a phenomenological interview. The researcher then interviewed one of his colleagues who had nearly finished his PhD studies about his experiences as a student in Australia. Finally, the researcher interviewed another colleague who had previous experience in clinical wards using the research questions. These steps gave the researcher a better understanding of how to conduct this kind of research in order to get the required depth of information about clinical nurse managers' leadership practices in Saudi hospitals.

6.5 Site and setting

The study was conducted in the same three MOH hospitals in Hail City, Saudi Arabia which were selected in the first phase, described in Section 4.3.

6.6 Participants and selection

A purposive sampling method was applied in this phase to recruit participants from the clinical nurse manager and registered nurse groups. This sampling method widely used by researchers to select individuals or settings likely to elucidate a phenomenon of interest (Polit & Beck

2017). This method of sampling is non-probability in that the researcher decides whether to include a particular individual in the sample group depending on certain criteria, which that who can provide the insight into the research question being investigated (Creswell & Creswell 2017). Qualitative purposive sampling was used in this phase to identify suitable clinical nurse manager participants who were working as heads of department and their registered nurse participants in the three participating hospitals during the study period. Only clinical nurse managers and registered nurse groups in selected hospitals who meet criteria were included. The target clinical nurse manager participants were clinical nurse managers in the selected hospitals who had at least six months' experience in clinical wards as a manager, who were looking to explore their experiences as nursing leaders in a clinical setting. In the selected hospitals, registered nurse participants with at least six months' experience in clinical wards, were targeted to explore their experiences of the leadership practices of their clinical nurse managers.

6.7 Recruitment process

After receiving ethics approvals, the researcher contacted the administrators of the selected hospitals seeking their support and approval to facilitate the data collection process in their hospitals. Firstly, the researcher emailed to the selected hospitals' administrators and provided the referral letter from the Institutional Review Board – Hail, ethics approvals, posters, invitation letters and participant information sheets. The researcher sent emails to hospital directors, which were then forwarded to nursing directors to ask the nursing office supervisors to send an invitation letter and participant information sheet to potential participants. The researcher also asked the nursing directors to place the posters on the nursing noticeboard in each ward in the selected hospitals. These documents included a contact number for the principal investigator. Potential participants were asked to contact the researcher via his phone

number or email if they were interested in participating, or if they had any queries, and to decide on an appropriate time to conduct the interview.

There were 11 clinical nurse managers who contacted the researcher and expressed an interest in participating and sharing their experiences. All the clinical nurse managers replied and completed the consent form and demographic survey prior to being interviewed. The purpose of the demographic survey was to gather descriptive data about the participants being interviewed, but no identifying information was published. Each participant was given the right to choose a suitable time for an interview while taking into account the time differences between Australia and Saudi Arabia. There were 17 registered nurses who contacted the researcher and expressed an interest in participating in the study. They were sent a consent form and demographic survey to be completed prior to being interviewed then returned to the researcher. Twelve of the 17 registered nurses replied, indicating that they were willing to participate.

Data for this phase of the study were collected through in-depth interviews with clinical nurse managers and registered nurses working in their wards, between September 2020 and December 2020. Due to the COVID-19 pandemic and travel restrictions across the world, the interviews were conducted online through Zoom ™ (Zoom Video Communications, Inc) instead of face to face as originally planned. Zoom ™ interviews have been found to be highly satisfactory for interviewing nurses in place of other methods (Archibald et al. 2019). Several nursing studies conducted during COVID-19 used Zoom ™ interviews (Khatatbeh et al. 2021; Doherty et al. 2022; Holm, Ohr & Giles 2021) and virtual interviews are considered a suitable method for research in the future (Irani 2019; Holm, Ohr & Giles 2021).

6.8 Interviews

Each interview was initiated once the signed consent form was received. The researcher briefly introduced himself and explained the purpose of the research. The researcher used an interview protocol (Appendix J) to ensure that the same basic process was followed with each person. Each participant was informed that the interview would be recorded for research purposes only. In addition to this, a copy of each transcript was sent to participants later for their verification.

Semi-structured interviews were held through the online Zoom platform at a time and place that is convenient for each clinical nurse manager and registered nurse participants, with a unique link and password provided to ensure confidentiality. Semi-structured interviews enabled the researcher to gain a thorough understanding of the participants' experiences and to delve deeply into them (Bowling 2014; DeJonckheere & Vaughn 2019). A separate questions guide was developed for the clinical nurse managers and registered nurses based on the results of the previous study (See Appendix K). The decision to conduct individual interviews using open-ended questions was taken to encourage clinical nurse managers to talk freely and provide rich information about the main results found from phase one and to share their experiences as leaders in clinical settings. In addition, this method also allowed registered nurses to talk freely and therefore provide rich information about their experiences of the leadership practices of clinical nurse managers in their hospitals.

6.9 Data analysis

Once the interviews were completed, the data analysis processes were commenced immediately. The data analysis process was guided by van Manen's method, which was used as a framework for the analysis and interpretation of this study. van Manen's framework was chosen because it combines the features of descriptive and interpretive phenomenology (Polit & Beck 2017). The recorded interviews were played and re-played then transcribed verbatim.

Any identifying information about the participants or their institutions were coded when the interview was transcribed. The researcher kept track of the participants' tone of voice, their reactions, as well as his own reactions to their stories and words, in the field notes. NVivo 12^{TM} software was used to manage the data analysis process. Van Manen's method, which guided the data analysis process of the study is a six-step "methodical structure" (1990, p. 30), as follows.

6.9.1 Turning to the phenomenon

Van Manen describes the first step as turning toward the phenomenon, explaining: "It is always a project of someone: a real person, who, in the context of particular individual, social, and historical life circumstances, sets out to make sense of a certain aspect of human existence" (van Manen 1990, p. 31). Accordingly, the first step of this research was to explore the clinical nurse managers' and the nurses' experiences of the clinical nurse managers' leadership practices, while keeping in mind the researcher's interest in this topic and from where it developed. The researcher's interest came from his experiences as a university supervisor in Saudi hospitals; the lack of appropriate knowledge of managers in Saudi Arabia and nurses' experiences of their clinical nurse managers' leadership; and the phase one results which indicated the importance of understanding certain aspects of leadership and the effectiveness of clinical nurse managers' leadership while considering the multinational Saudi nursing context. This first step also involves the formulation of the research question. Consequently, the researcher's interest brought to the forefront the experience of clinical nurse managers and their registered nurses, as a phenomenon, in order to explore it. The research question for CNMs was: "What are clinical nurse managers' perceptions of their own leadership?" and the research question for RNs was: "What are nurses' experiences of the leadership of clinical nurse managers?"

6.9.2 Investigating experience as we live it

Van Manen explains the second step as investigating experience as we live it, stating that "the best way to enter a person's life world is to participate in it" (van Manen 1990, p. 69). The researcher conducted semi-structured, in-depth interviews to seek clinical nurse managers' and nurses' experiences of their clinical nurse managers' leadership practices. In this step, during the interviews the researcher had to deeply engage with the participants' stories in order to allow reflection on the richness of the data being collected. The clinical nurse manager participants were asked to describe their experiences in their leadership position and their experience of their colleagues' leadership. Then the registered nurse participants were asked to describe their experiences of their clinical nurse managers' leadership practices, to tell the story in their own words and to describe the difference between Saudi and clinical nurse managers from other cultures, and also between experienced and inexperienced clinical nurse managers when managing their wards.

6.9.3 Reflecting on the essential themes which characterise the phenomenon

Van Manen describes the third step as "a thoughtful reflective grasping of what it is that renders this or that particular experience its special significance" (van Manen 1990, p. 33). In this step, it is very important to listen to the audiotaped interviews again and to read, then re-read, the participants' words in order to obtain as clear a grasp as possible of the essential structure. The researcher should use three steps "toward uncovering or isolating thematic aspects of a phenomenon", namely an approach that is holistic, selective and detailed (van Manen 1990, p. 92). In this study, the researcher selected expressions and phrases from participants while re-reading verbatim transcripts of their interviews to develop sub-themes and themes that gave meaning to the phenomenon under investigation.

6.9.4 Describing the phenomenon: The art of writing and rewriting

Explaining the fourth step, van Manen (1990, p. 7) states that "hermeneutic, phenomenological research is fundamentally a writing activity". In this step, the researcher is responsible for making evident to the reader the feelings, attitudes and thoughts of the participants, in this case the clinical nurse managers and registered nurses, about their experiences through the art of writing and rewriting.

6.9.5 Maintaining a strong and oriented relation to the phenomenon

In this fifth step, van Manen argues that researchers must maintain their belief in the integrity of the phenomenon under investigation. In this step, the researcher should avoid becoming distracted and remain focused on the research questions, which in this phase of the study were: "What are clinical nurse managers' perceptions of their own leadership?" and "What are nurses' experiences of the leadership of clinical nurse managers?" The researcher's aim here was to deliver a text of value which gives the reader a legitimate and "real" experience from the clinical nurse managers' and nurses' perspectives.

6.9.6 Balancing the research context by considering the parts and the whole

In this sixth and final step, van Manen points out the researcher's need for "organising one's writing" (van Manen 1990, p. 168) so as to uniquely reflect the nature of the phenomenon under investigation.

6.10 Trustworthiness in this research

It is imperative to ensure the quality of phenomenological research in the nursing context (De Chesnay 2014). Rigour is essential and must be considered to determine whether qualitative data is accurate and believable (Andrew & Halcomb 2009; Polit & Beck 2017; Morse 2015). The five criteria for rigour in the qualitative phase are credibility, transferability, dependability

and confirmability (Lincoln & Guba 2000; Ajjawi & Higgs 2007), and authenticity (Guba & Lincoln 1994).

6.10.1 Credibility

According to Lincoln and Guba (1985) the first criterion of rigour is *credibility*, which refers to the level of confidence in and truthfulness of the data. According to this criterion, the researcher should assess the truth value of their study through prolonged engagement to obtain adequate representation. The researcher should use triangulation, which involves comparing data collected through multiple methods to draw conclusions about truth and to validate the data (Polit & Beck 2017). Triangulation involves methods such as analysing the data from audio-recorded interviews and field notes. In this study, field notes were used as a further source of data to identify code names, dates, times, codes of the hospitals where the interviews were conducted and the appropriate communication channel for each participant. The researcher also kept field notes during each interview as another source of data to allow further reflection from a different perspective. Moreover, credibility is further enhanced through informants' feedback by each participant reviewing and verifying the transcript of their interview to ensure that it is an accurate account (Birt et al. 2016). The transcripts were verified by emailing them to each participant for checking. This was done not to add information, but to verify that it was an accurate account of their experiences.

6.10.2 Transferability

The second criterion of the Lincoln-Guba framework is *transferability*, which refers to the applicability or transferability of a study's findings to other settings or groups. In this study "thick description" was chosen, which involved presenting a deeply detailed account of clinical nurse managers and nurses' experiences so that readers can judge the work's potential application to other contexts. As recommended by Lincoln and Guba (1985), using thick

description strengthens and enhances transferability. Transferability will be assessed by those reading the publications and presentations from this research.

6.10.3 Dependability

The third criterion is *dependability*, which refers to the stability and consistency of findings over time. The researcher decided to use strategies to increase the dependability and consistency of the study's findings, including ensuring technical accuracy in recording interviews, adopted a step-by-step process in data analysis, and by carefully checking transcripts with the audio-recordings to ensure they did not contain mistakes. According to Creswell (2003), indications of the consistency of a researcher's approach during the study process will ensure dependability and accuracy.

6.10.4 Confirmability

The fourth criterion is *confirmability*, which refers to objectivity, and whether the data accurately reflects participants' experiences. Before considering this criterion, the researcher will seek to achieve the criteria of credibility, transferability and dependability, which will then establish the confirmability of the study. According to Guba and Lincoln (1989) and Koch (2006), when credibility, transferability and dependability are achieved, the confirmability of study will be established.

6.10.5 Authenticity

The fifth and final criterion is authenticity, which refers to whether the data is fair and faithful, and shows a range of different realities, to evaluate the quality of the study's outcomes outside the methodological dimensions (Guba & Lincoln 1994; Polit & Beck 2017). To establish authenticity, the researcher engaged in several activities to ensure that the results would be accurate and credible, not only from the clinical nurse managers' and nurses' experiences, but

also paying attention to the larger implications of the research. Subsumed by the criterion of trustworthiness, authenticity is concerned with the value of the topic of study, and also with the potential benefit of the study to society (James 2008). As described by Lincoln and Guba (1985), there are five categories of authenticity to be considered: fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity. Each category of authenticity is reflected in the current inquiry, which draws attention to several potential changes, such as a change in participants, systems or power structures. The researcher's interest is in how to leverage the larger implications of the research and create better outcomes by providing recommendations to health institutions regarding how to promote and enhance the leadership of clinical nurse managers. Clinical nurse managers are the "frontline leaders" of clinical care, and thus their involvement in leading the staff may impact the quality of care.

6.11 Ethical considerations

As outlined in Section 6.3, ethics approval for this phase was granted by the Human Research Ethics Committee of the University of Adelaide. Ethics approval was also granted by the Institutional Review Board, Hail, Saudi Arabia, where the study was conducted. The National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council et al. 2018) was utilised as the framework to protect the ethical integrity of the study data. All participant information was coded; only the principal researcher and his supervisors at the Adelaide Nursing School, University of Adelaide had access to coded data. The privacy and confidentiality of participants was upheld throughout the research process. Prior to conducting each interview, participant information sheets were provided which outlined all the information regarding the study, such as the study aims, participants' rights, the researcher's contact details and ethical considerations, then a consent form was signed by each participant

and the researcher. Further, the utmost care was taken to ensure that no personal identifying details were revealed about participants.

The qualitative phase of the study included data in an electronic format, such as recordings of audio interviews, field notes and verbatim transcripts in the form of Microsoft Word documents. Any hard copies were kept in a locked cabinet accessible only to the researcher. The data were secured on the researcher's computer (protected by a password) and his university cloud account – the researcher was the only person who had access to soft copy data. Furthermore, the electronic data will be permanently deleted after five years and all hard copy material will be destroyed, in line with the University of Adelaide's Research Data and Primary Materials Policy.

6.12 Summary

This chapter has discussed the methods used for this qualitative phase of the study. This phase was informed by hermeneutic phenomenology, which emphasises the use of reflective interpretations of data, particularly textual data, to understand human experiences (van Manen 1990, 1999). In order to prepare for this phase, a series of processes were followed, such as receiving ethics approvals, preparing and training the researcher, and recruiting participants. Then the interviews were conducted in a manner that was respectful of participants and their cultures and ideas and that allowed them to express themselves freely. Furthermore, the data analysis was carried in such a way that maintained the results' credibility and, as outlined above, ensured that the findings are reliable, trustworthy and transferrable to other research settings. The findings from the participants' interviews are presented in the next chapter.

Chapter 7: Findings from the qualitative study

This chapter presents the findings of the interviews with the two groups of study participants. It deals with the lived experience of eleven clinical nurse managers who worked as leaders in clinical settings in Saudi workplaces and twelve registered nurses who worked under their direction in order to make sense out of their lived experiences about the leadership of clinical nurse managers. As entered their world, the researcher, too, became a passionate and curious researcher, caring about their experiences, feelings and interactions as they recounted their unique experiences to create a perception of the reality they lived. My interpretations of their experiences are based on Gadamer's view that interpretation is "a 'fusion of horizons,' a dialectical interaction between the expectations of the interpreter and the meanings in the text" (Polkinghorne 1983, p. 226). First, the findings of the group of clinical nurse managers are presented, then the group of registered nurses. Clinical nurse managers interview durations ranged from 27 minutes to 87 minutes, with a median interview time of 59 minutes. While registered nurses interview durations ranged from 22 minutes to 57 minutes, with a median interview time of 41 minutes. Interviewing was conducted in English. Nevertheless, some explanations were given in Arabic when necessary in order to allow the participants to share their experiences. Both groups of participants in this study were eager to share their experiences. They all had a broad range of knowledge and backgrounds that they shared through their stories. Each participant contributed a unique perspective to the interview data; however, they all shared and expressed similar experiences and feelings. These distinctions and similarities formed the themes presented in this chapter.

7.1 Process of interpretation

The interpretation of themes and subthemes was based on a phenomenological hermeneutic analysis. A Heideggerian approach to research focuses more on uncovering meanings than on

describing experiences the way Husserlian research does (Walsh 1996). Nevertheless, Heidegger reminds us that in order to understand how something is actually lived, we must return to the facts of existence. However, Heidegger also stated that a truth is an interpretable reality, so there is no such thing as a fact that is uninterpreted. Also, Heidegger insisted in order to interpret the phenomena, one must remain grounded in terms of the interpretation, that is, in the truth and existence of the things themselves:

> Our first, last, and constant task is never to allow our fore-having, fore-sight, and fore-conceptions to be presented to us by popular conceptions, but rather to make the scientific theme secure by working out these fore-structures in terms of the things themselves. (Heidegger 1962, p. 195)

van Manen has explained Heidegger's notion of hermeneutic interpretation:

> The notion of hermeneutic understanding for Heidegger was not aimed at re-experiencing another's experience but rather the power to grasp one's own possibilities for being in the world in certain ways. To interpret a text is to come to understand the possibilities of being revealed by the text. (van Manen 1990, p 180)

Based on van Manen's (1990) hermeneutic approach, participants' lived experiences were analysed, a phenomenological data interpretation process described by van Manen as a "dynamic interplay among six research activities" (p. 30) in order to "transform lived experience into a textual expression of its essence" (p. 36). The six activities were explained in detail in Chapter 6. The researcher immersed himself in the transcripts while interpreting the themes and subthemes until he believed that he understood how the clinical nurse managers felt about their leadership and working in their position. Following this, how the registered nurses felt about working with their clinical nurse managers and their managers' leadership practices was also analysed and understood. Finally, the researcher attempted to comprehend how these two perspectives interrelate to each other.

7.2 Clinical nurse manager participants

The clinical nurse manager participants represented a range of cultures and backgrounds. The majority were Saudis (n = 7) (with n = 4 non-Saudis), which matches the proportions reported in the first phase. The researcher used field notes (Dowling 2007; Groenewald 2004) in each interview to keep a record of each participant's interactions. Table 7.1 describes each CNM participant in this study using a pseudonym to ensure their identity is kept confidential.

Table 7.1: Description for each CNM participant in the study

Participant	Description
Khalid	Khalid was a Saudi in his early thirties who had a bachelor's degree from overseas. He had over a decade's experience as a nurse and considerable experience as a clinical nurse manager in his current ward. Prior to working on his current ward, he was a clinical nurse manager in another ward for one year, but he had not been a clinical nurse manager overseas. He participated in the first phase of the study and was very excited to participate in the qualitative phase to express his point of view about clinical nurse managers' leadership and their current situation in the hospital.
Amita	Amita had over a decade of experience as a nurse and was in her early thirties. She was non-Saudi with a bachelor's degree in nursing. She did not have much experience as a clinical nurse manager either in her current ward or others. She had not been a clinical nurse manager overseas. She participated in the first phase of the study and was very excited to express her opinions and experiences about her leadership practices and the current situation of clinical nurse managers' leadership in a multicultural workplace. She felt it was hard to work in a place outside your own culture, particularly when your colleagues can make a decision autonomously, but you may not.
Saud	Saud had over a decade's experience as a nurse and was in his early forties. He was a Saudi with a master's degree from overseas. He had less than ten years' experience as a clinical nurse manager. He had not been a clinical nurse manager overseas. He was not able to participate in the first phase of the study due to special circumstances. He was very excited to participate, saying that he had enough experience to express his opinions and experiences about his leadership that might be beneficial for the next generation of clinical nurse managers. He was very focused on events in the hospital, the relationships between clinical nurse managers, and the important role played by the director of nursing.
Ali	Ali was a Saudi in his mid-thirties with a bachelor's degree from his home country. He had over a decade's experience as a nurse and did not have much experience as a clinical nurse manager in his current ward or previously. He had not been a clinical nurse manager overseas. He was excited to participate in this phase after taking part in the first phase of the study and to express his views about clinical nurse managers' leadership and their

	current position in the hospital. He argued that communication is vital and clinical nurse managers are a conduit of communication.
Amira	Amira was in her late twenties and had been working as a nurse for about five years at the time of the interview. She was a Saudi who did not have much experience as a clinical nurse manager in her current ward. She had not been a clinical nurse manager overseas. She expressed a strong interest in participating in the study to relate her experience and express concerns about leadership practices and the current situation. When she commenced in her role, she struggled to lead the team because it was her first time.
Mohammad	Mohammad was a Saudi in his late twenties who had a bachelor's degree in nursing. He had between two and four years' experience as a nurse and less than three years' experience as a clinical nurse manager in his current ward. He had not been a clinical nurse manager overseas. He expressed his happiness to share what he had learned about leadership practices and the current situation of clinical nurse managers in the hospital, while telling of his own experiences of being a clinical nurse manager. However, he contended that there is a need to improve the leadership of clinical nurse managers.
Fahad	Fahad was a Saudi who had two to three years' experience as a nurse and was in his mid-twenties. He had a bachelor's degree in nursing. On his current ward, he had less than two years' experience as a clinical nurse manager and no experience as a clinical nurse manager in any other wards. He participated in the first phase of the study and expressed an interest in sharing his experiences and opinions about his leadership practices. He felt that he and most of the clinical nurse managers had been "thrown" into the position, so he believed they needed support from other clinical nurse managers.
Ashmita	Ashmita was a non-Saudi her early thirties who had been working as a nurse for a decade at the time of the interview. She had a bachelor's degree in nursing. She had two to three years' experience as a clinical nurse manager in her current ward and about three years' experience as a clinical nurse manager in different wards. Prior to working in Saudi Arabia, she did not have any management experience overseas. Having taken part in the first phase of the study, she was excited to be able to express her opinions about clinical nurse managers' leadership and about their current position. She felt that communication is crucial and clinical nurse managers need to maintain a good relationship with staff in order to be able to utilise their abilities.
Ahmad	Ahmad was a non-Saudi in his mid-thirties with a bachelor's degree in nursing. He had a decade's experience as a nurse, three years' experience as a clinical nurse manager in his current ward, and about four years' experience as a clinical nurse manager in other wards. He had not been a clinical nurse manager overseas. He was enthusiastic about sharing his experiences and opinions about the leadership practices and the current situation of clinical nurse managers in the hospital. He was uncomfortable with some of the behaviour of his colleagues when dealing with staff. He emphasised the leadership principle of not only taking care of staff professionally, but also personally. However, like some of the other participants, he said that there is a need to improve the leadership of clinical nurse managers.
Hamad	Hamad was a Saudi in his early thirties with a bachelor's degree in nursing. He had less than a decade's experience working as a nurse and about three years as a clinical nurse manager in his current ward. He was very interested in participating in the study and

	expressing his perceptions regarding the clinical nurse managers' leadership practices and their current situation in the hospital he was employed at. He felt he was not ready to be in this position. He felt lack of listening to staff can lead to problems and he emphasised the importance of collaboration.
Sara	Sara was a Saudi in her early thirties who had been working as a nurse for more than a decade at the time of the interview. She had a diploma in nursing. She had less than a decade's experience as a clinical nurse manager in her current ward and the same experience as a clinical nurse manager in general. She did not have any management experience overseas.

7.2.1 Major themes

The 11 participants willingly shared their experiences of being clinical nurse managers in Saudi workplaces with staff from multicultural backgrounds. A number of similar ideas were revealed as a result of reading and rereading each of the participants' data. Data was then grouped together when moving between the "parts" (the transcripts of the eleven clinical nurse manager participants) to a holistic picture of the data (van Manen 1990). There were 10 major themes that emerged from the data analysis, namely: *thrown in the deep end; a manager not a leader; collaborative trust; nurses do not understand the clinical manager role; nurses know what a good leader is; Saudis are more effective leaders; working in a culture that is not their own; without good communication, nothing can be done; barriers to leadership development; and CNMs need specifically designed leadership development strategies*. Each of these major themes includes a number of subthemes (See Figure 7.1). The themes and subthemes from the participants' stories are described here in a traditional linear format. The experience of leadership in Saudi workplaces with staff from multicultural backgrounds is a such complex phenomenon in which the identified themes and subthemes are intertwined with each other, and the interpretation chapter addresses this complexity further.

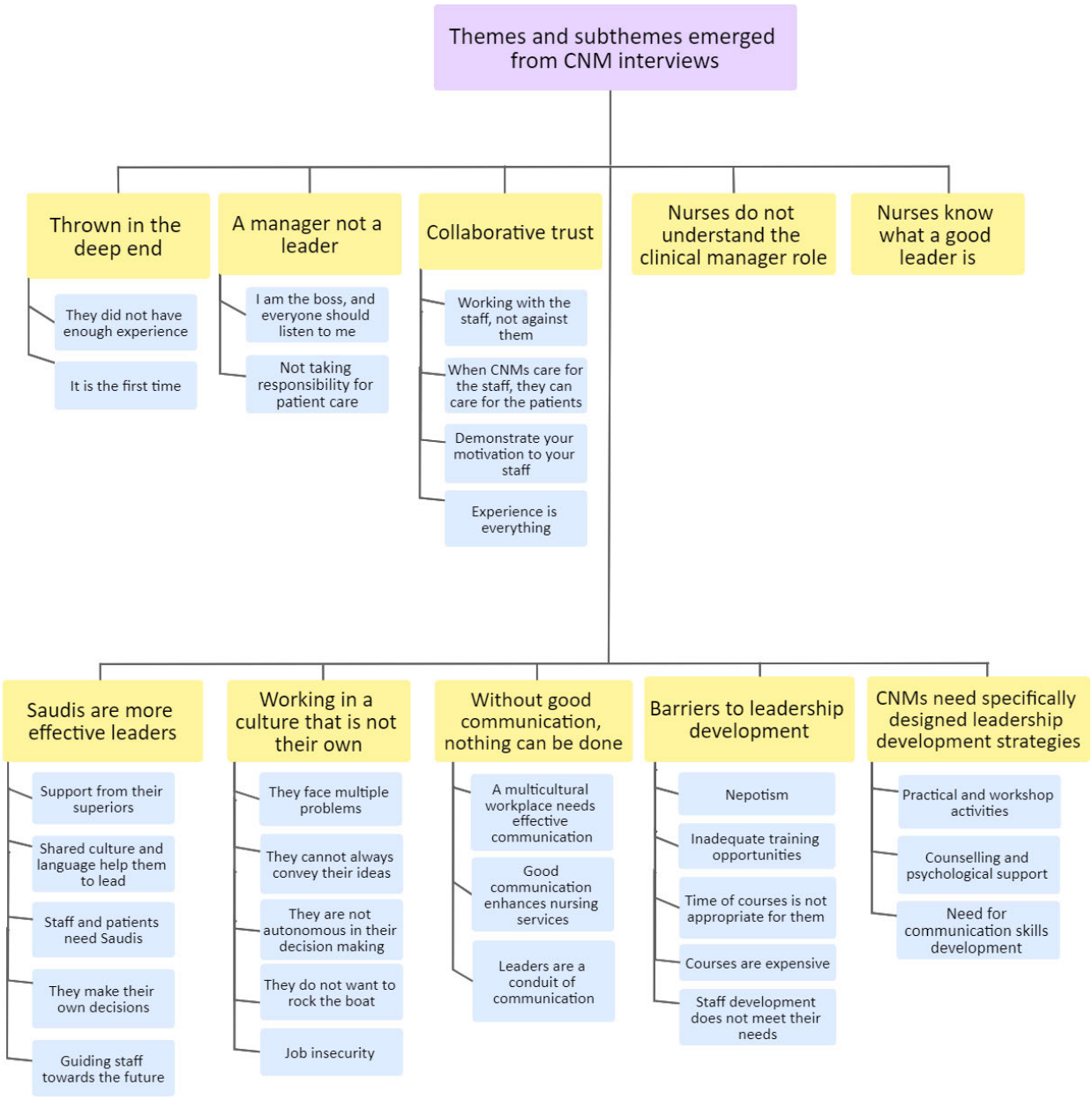

Figure 7.1: Themes and subthemes that emerged from clinical nurse manager interviews

7.2.1.1 Thrown in the deep end

This theme focuses on how the participants described being clinical nurse managers, the ways in which they did not understand what the position involved, and the concerns that informed their decision to become a CNM. Most found themselves suddenly appointed to the position

with inadequate notification from their superiors. This theme is therefore about inexperienced nurses being appointed to the role and highlights the difficulties and uncertainties when managers with no experience are trying to lead staff on a ward.

They did not have enough experience

In this subtheme, the participants talked about when they first assumed their position as a CNM, with most lacking significant experience as nurses in the ward prior to becoming ward leaders. The participants spoke about these sudden appointments and how they felt they did not know much about ward administration procedures or how to deal with new nursing staff. Some expressed the opinion that their nursing experience was not sufficient to qualify them for the CNM position and that they were set up for failure as a consequence of their appointment.

For example, Hamad described concerns from early in his career, revealing that he felt he was not ready to be a CNM. He faced difficulties on the ward because of the sudden appointment as well as his lack of experience:

> *Do not place the nurse as head of the ward suddenly; this is what happened for me. … I did not know many things. I did not know most of the ward procedures, and I had a new staff nurse. I did not know how to deal with it. … I was placed in the position early with no experience or notification.* (Hamad, p.1 L: 11-14)

Mohammad explained that he was appointed as a CNM just months after becoming a registered nurse: "*Actually, in the beginning, I started after seven months of experience [as] staff in the same department. In the beginning, it was so difficult because I didn't have experience"* (Mohammad, p.1 L: 7-9). Sara supported this view, feeling that the majority of staff have limited nursing experience before being appointed to leader positions: "*Most of my [CNM] colleagues don't have experience but are appointed very quickly to the position"* (Sara, p.3 L: 48).

Ali felt that anything less than three years of experience is not enough to qualify for a CNM position: "*I had no more than three years' experience. I think the clinical nurse manager needs more experience – at least five years – to be in the position"* (Ali, p.3 L: 49-50). Consequently, a quick appointment to the position may lead a CNM to fail in managing their staff, as Ali continued:

> *One clinical nurse manager was appointed after one year or less in our hospital. Then they changed her after a couple of months. She did not succeed; I think she faced many problems understanding her responsibilities. She stepped down, and the nursing director returned her to her assignment as a staff nurse.* (Ali, p.3 L: 50-54)

The comments related to this subtheme highlight the difficulties faced when appointments are made with inadequate experience and the ongoing repercussions of that. The next group of comments illustrates how being appointed with little or no experience impacts a CNM's ability to lead.

It is the first time

In this subtheme, participants described the difficulties they faced due to their sudden appointment to CNM positions. They felt it was difficult to lead because it was the first time they had assumed such a role, with some participants describing their confusion about leadership practices in the beginning. Some felt that this uncertainty and confusion meant they had no option but to seek support and assistance from others.

Amira said that she faced difficulties in the beginning and struggled with leadership: "*I have two years' experience as clinical nurse manager in my ward. It was difficult, a little difficult to lead, because it was [the] first time for me"* (Amira, p.1 L:6-7). Ahmad felt similarly, adding that he was uncertain about leadership at the start. He said: "*I think in the beginning, maybe in the beginning, I was confused about my leadership principles"* (Ahmad, p.1 L: 9-10).

Fahad also faced initial difficulties, which prompted him to seek support from others:

> *At the beginning, it's difficult because it's [the] first time, and I will call somebody for support. I will ask somebody for … help. I will take some opinions from others [who] have practice and experience as [a] clinical nurse manager.* (Fahad, p.1 L: 12-14)

7.2.1.2 A manager not a leader

Within this theme, some participants expressed dissatisfaction with a number of CNM colleagues whom they described as looking down on staff nurses and considering themselves better than everyone else. For example, some participants described colleagues who were overly punitive with staff, punishing or reprimanding them for the simplest incident or mistake. Some also felt that CNMs try to lead nurses with commands, implying that they must be obeyed, and that some colleagues only do managerial work without taking any responsibility for patient care.

I am the boss, and everyone should listen to me

This subtheme covers participants' descriptions of their colleagues who do not listen to or help the nursing staff. One participant, Ahmad, spoke about CNMs taking investigative action against nurses for the smallest mistake:

> *I don't think my colleagues are good in leadership; they think themselves better than anyone else. They think they are the boss. I can give you an example. I have a friend who is a clinical nurse manager. One of his staff forgot the glucometer device beside the patient. When he heard about this, he called her and made an [occurrence variance report]. I do not think it should be like this; he should just talk to her nicely and professionally. When I told him [I thought] it was wrong, he said, "I am the boss, and everyone should listen to me." We should talk to our staff, not only give commands, you know, especially if a mistake is not big. It is just a glucometer device. It's not causing harm to the patient.* (Ahmad, p2 L: 50-57)

Hamad felt that CNMs often think their instructions absolutely must be followed. He said:

> *Some of my colleagues think that, as clinical nurse managers, our word must be heard [by] the staff. I think this wrong; it is big mistake. They think the staff should do what they say or it means they are against you, but this is wrong.* (Hamad, p4 L: 85-87)

In a similar vein, Amira described CNM colleagues who do not help their staff, leading to a lack of teamwork: "*The nurses may have rated some clinical nurse managers lower [as leaders] because they do not help or listen to their staff. They do not work as one group"* (Amira, p3 L: 50-51).

Not taking responsibility for patient care

Some of the participants had experience of CNM colleagues who do not believe their work involves patient care, feeling instead that their role is purely managerial. For example, Khalid recounted one CNM arguing with the nursing director about their responsibilities:

> *I ... met the clinical nursing manager of another ward in my hospital, and he was arguing with the nursing director about his job description. The nursing director mentioned that his job is care for the patients. He was arguing that is not his job; his work is to observe and lead his staff and to manage the ward, not to provide care.* (Khalid, p.4 L: 147-156)

Amita supported that sentiment, also noting that some of her colleagues only do managerial tasks. She said: "*Clinical nurse managers have some work specifically for their position, such as scheduling or managerial work, but some of them will do only that work"* (Amita, p.6 L: 204-205).

7.2.1.3 Collaborative trust

This theme focuses on participant testimonies relating to how trusting each other, respecting every teammate, and working collaboratively towards the same goal can positively impact the

workplace. For example, some participants felt that working with other staff, rather than against them, improves ward outcomes and that taking feelings into account and attempting to help others, in turn, contributes to good patient care. Some emphasised how important it is for clinical nurse managers to motivate themselves in order to be able to then motivate their staff in the mission of achieving ward goals. Most participants also stated that experience is everything when it comes to knowing the capacities and feelings of staff, meeting their needs, and improving the ward's day-to-day functioning.

Working with the staff, not against them

In this subtheme, participants talked about the significance of CNMs working with their staff, emphasising that careful listening can change a ward for the better. Some participants felt that working as a friendly team facilitates better ward management and that maintaining a good relationship with the nursing staff fosters cooperative trust that allows CNMs to take advantage of staff capabilities within the ward. Some were also of the opinion that it is better to engage staff in everything within the ward or they may fail over time. Not listening to staff can drive them to leave the profession, be absent, or seek a different CNM who appreciates them.

Ashmita reported her CNM experience of building relationships with staff in order to benefit from their abilities:

> *I think we should manage a good relationship [with] all the members of our team. If we do not have a solid relationship with all team members, we cannot [achieve] collaborative trust. ... So, if we have a solid or good relationship with our members, we can use all the capabilities of each member.* (Ashmita, p.2 L: 17-22)

Similarly, Mohammad emphasised the need to involve the staff:

> *As a clinical nurse manager, we are one [with] the ward, and we are a part of [the nursing staff]. If we do not teach and involve our staff in everything in our ward, for sure we will fail with time.* (Mohammad, p.12 L: 402-403)

Amita said that working with and encouraging the nursing staff should precede a CNM's expectations of productivity:

> *Sometimes when there are fewer patients and the staff ratio is higher, some clinical nurse managers give the staff days off or something else. I know one clinical nurse manager who gives encouragement to the staff to improve their work in the ward. He posts [words of gratitude] on the ward board, and he gives some gifts to the staff.* (Amita, p.3 L: 50-53)

Saud agreed when relaying his own experience of dealing with nurses:

> *You cannot manage the unit alone without the cooperation of your team, because you are working as a team. So, if your team cannot cooperate with you, I'm sure while managing the unit, some trouble will [ensue] in the ward. So, managing the ward – it's not only the responsibility of the clinical nurse manager, but it will also be the responsibility of all team [members] in this ward.* (Saud, p.10 L: 296-300)

To achieve this level of cooperation, Mohammad thought that it was important to have regular meetings to share what is happening with staff:

> *Actually, we have [a] ward meeting at the end of each month, so I share what is happening during the month. Then, I share my opinion, and I hear their opinions. By the end, I will [make] a good decision that will support the department … with the knowledge of all the staff.* (Mohammad, p.12 L: 408-411)

Hamad's view supported the above comments, and he added that not listening to nurses can drive them to be absent or seek another CNM:

> *As a head nurse, you must hear your staff. The staff are [people] who are able to improve your ward. … It is not reasonable that all those who are transferred to other wards or all those who have absences are the ones with problems. Why?*

> *Because when they are transferred to another ward, they do not have absences, and there are no problems with them. We have to care about our staff.* (Hamad, p4 L: 88-94)

When CNMs care for the staff, they can care for the patients

In this subtheme, participants voiced opinions about the importance of CNMs caring for nursing staff by getting acquainted with the problems they might be facing. Regardless of whether the issues are professional or personal, CNMs endeavouring to help solve them will have a positive impact on staff and encourage them to provide the best of what they have to offer to the ward and their patients. This may improve the general level of care provided.

Ahmad, for example, recounted his experience of helping to resolve an issue faced by one of the nurses on his team:

> *She was in trouble in her personal life, and I thought it's not my business to interfere, but I discovered later that it was affecting her work in that department. ... So, we – just me and her – we talked about that issue. And, thankfully, we did find a solution. Then she was focused on her work and gave the patients ... good care. I understand the leadership principle that, not only professionally, even sometimes personally, [you] can intervene if ... any one of your staff has a problem. So, not focusing only on the professional side – the personal side also need[s] ... attention.* (Ahmad, p.2 L: 21-31).

Khalid spoke about his experience as a CNM during the pandemic when his staff had to work with COVID patients:

> *It was difficult for my staff to work in the COVID-19 ward, so I encouraged [them to work] in isolation rooms. They felt that they were doing something important [for] the patients; it's a very real responsibility in their workplace.* (Khalid, p.11 L: 367-369)

Hamad thought it was important for CNMs to have regular meetings with staff to allow them to discuss and resolve problems and that this leads to the provision of high-quality patient care:

> *Every two to three months, I personally decided to specify a day [for] an open meeting for our department. Anyone who has problems, wants to share a point of view, is upset about something, or has complaints; I am here for them. I can solve it to improve our ward [and] provide good care.* (Hamad, p.12 L: 212-217)

Amita spoke more specifically about the importance of taking care of the staff to enable them to take care of the patients:

> *When I was staff, I knew that if the head nurse would not help, the work could not be done properly. So, when I do head nurse duty, I always try to help the staff with their work. If the doctor made an order, I would help the staff carry out the order. I tell them to be with the patients and to give them the good care they need. I will also do other work [and] requests on [their] behalf. I could tell by their efforts that I was doing a good thing.* (Amita, p.6-7 L: 206-2011)

As Khalid spoke about the positive influence he could have on his staff as leader, he said it made them more confident about their own work, helping them to provide the best possible care:

> *When you influence staff through your leadership practices, you will be a good guide for your staff, so they will feel comfortable in their ward. They will be confident about their work [and] provide care because you are influencing them to do something good.* (Khalid, p.13 L: 415-417)

Demonstrate your motivation to your staff

Participants talked about the importance of motivating nursing staff and showing appreciation for their achievements as this will reflect positively on their efforts and encourage them to strive to complete future tasks well and on time. Indeed, some participants believe that "*motivation is the basis of leadership*" (Khalid). When the CNM is motivated, it helps the nurses stay motivated too.

Khalid said that motivation should be the foundation of CNM leadership:

> *Without motivation, your ward will not [function] as you plan, and I can say that motivation is the basis of leadership. When your staff [is] not motivated, they will feel like [there is] damage inside themselves. So as a leader, you have to always demonstrate your motivation to your staff. The motivation is like renewing them every day.* (Khalid, p.14 L: 421-425)

Saud also stressed the importance of motivating nursing staff so that they can take on many different tasks or issues.

> *In the ward, we have a different [method of motivating] staff members: If [we] give them a specific assignment, [and] they do it … on time, I will announce [it to] our group: "Ok, you did well. Thanks … for completing your assignment on time." So, it will motivate [them] in the future to complete tasks on time. So, sometimes [it's] like this, and sometimes, even [a] simple gift to staff will be good motivation. And sometimes, if you label the staff [member], like she's the best member staff this week, it can be taken as an example of motivation. So, the staff will increase their power to [resolve] issues.* (Saud, p.10 L: 305-312)

Experience is everything

In this subtheme, participants stressed CNMs' experience as key to several aspects of ward and staff management. They observed, for example, that an experienced manager is, by definition, knowledgeable and therefore understands how to deal with difficult situations on the ward. To be a good leader, you have to understand what your staff members are going through, and some also felt that those with experience are better able to deal with and cooperate with staff despite different cultures and nationalities. Experienced CNMs will also be able to assign tasks according to nurses' clinical ability and skill, which could have a positive effect on patient care.

Hamad felt that previous experience can make you a good leader:

> *An experienced clinical nurse manager can know everything in the ward, has communicated with a lot of staff, and has dealt with different nationalities and cultures and with problems of all kinds. I see that he can be more cooperative with staff than less experienced head nurses.* (Hamad, p.20 L: 352-356)

Relatedly, Saud pointed out that experience can give you valuable insight into staff capabilities and needs:

> *If you have many years of experience in the department, you will know what the staff need. I remember that when I was assigning [cases to] the staff, I knew my staff well, I knew their abilities. So, I would assign the staff to particular cases based on their experience and based on their clinical practice skills.* (Saud, p.9 L: 255-258)

Amita thought that her experience as a nurse had prepared her to anticipate the challenges ahead and handle them in the best possible way: "*I know that what we are doing is tough, so, when I became a clinical nurse manager, I [knew] … all the problems they are facing. I am managing it. So, I think I understand it well"* (Amita, p.1 L:9-12).

Ali pointed out that experience can help CNMs better understand how nursing staff feel in different circumstances, while those with less experience may not be able to comprehend all eventualities:

> *I think those who have experience will understand the staff's situation very well, because they were in [that position] before, and they have long-term experience that allows them to understand the feelings of the staff when encouraging them, punishing them, or giving them feedback. But a less experienced head nurse might not have gotten the chance to understand all these circumstances. The staff nurses need encouragement, and really, if they get encouragement, their efforts will increase.* (Ali, p.7 L: 200-207)

Khalid agreed with the above, stressing that experience allows you to deal with different situations. He recounted how he managed a staff shortage during COVID-19:

> *When you have more experience, you know how to deal with different situations. … [If you are] still new in your position as a head nurse, you can't deal with all situations, and you will have to ask for help. I will give you an example. During COVID-19, we [had] a shortage of staff in our ward. So, for myself, I used to manage my work. Even [when] I had only 12 staff members, I could manage. If I didn't have enough staff, I changed their duty from 8 hours every day to 12*

> *hours. So, I have managed the situation already. It depends on your experience and how you can convince your staff to do this as well as [on] how you encourage and motivate your staff to change their work hours from 8 to 12. This is related to the head nurses themselves, their experience, and how [they can] convince their staff in these situations.* (Khalid, p.10-11 L: 340-350)

Amita added that experience can increase a CNM's awareness of ward policies and protocols:

> *Experienced clinical nurse managers know the ward, the policy and the protocol. They know everything, so they can handle everything easily. But less experienced head nurses are still learning. So, they want to learn step by step. There may be some delay, or they might go to somebody for help, which will create a delay. But experienced head nurses know everything, so they can easily handle everything with the staff and department.* (Amita, p.5 L: 154-159)

Moreover, Khalid felt that experience helps CNMs encourage and engage their staff in any situation. They also know when to say thank you:

> *Experienced clinical nurse managers are always aware of how to engage their staff in the current situation, how to encourage them, and also how to thank them. Let's say, you should not say thank you all the time for nothing to gain their satisfaction or something! No, when you become expert, you know that you must not say thank you to your staff all the time. Let them feel that when they do something well, I will give you a reward.* (Khalid, p.11 L: 362-367)

Saud said that experience enables CNMs to handle the problems that arise because they may have encountered them before:

> *If you have more experience in your ward, at least you will know how to react because you will have reflected on your practice in the previous years. So, you can actually deal with a new difficulty happening in the ward; you know how to solve it because you have met this issue before: "Yeah, I solved the issue this way." So, experience in the ward is very important because you will know how to deal with difficulties … and how to motivate and enable your staff to solve the issue with confidence.* (Saud, p.7 L: 234-239)

Fahad expressed the view that experience is important for understanding everything that is happening in the ward: "*As leader, every day, you are learning something. So, those [with] seven, eight, or ten years [of experience], it is easy for them because they have faced and tried everything, and now they know everything in the ward"* (Fahad, p.9 L: 279-281).

Mohammad recounted how an experienced CNM fostered his own growth:

> *When I came, there was one non-Saudi head nurse who was in the ward for about nine years. She was a clinical nurse manager and worked before as deputy, so it was her way of collaborating … and she knew how to do that. So, I learnt from her those things and how to collaborate very well with all the staff.* (Mohammad, p.10 L: 321-324).

7.2.1.4 Nurses do not understand the clinical manager role

Some participants indicated that RNs do not always understand the role of the CNM and consequently do not recognise the possibility of work overload, stress and other difficulties. As a result, some nurses tend to give CNMs lower leadership ratings than they perhaps deserve.

Saud, for example, talked about nurses lacking detailed knowledge about the CNM's responsibilities, which may have affected the leadership ratings: "*When the staff rate the nurse managers, I think they are not aware of the responsibilities of the clinical nurse managers, and they are not aware of the difficulties which the clinical nurse managers [experience]"* (Saud, p.2 L: 53–57). Statements from Amita, Ali and Fahad support Saud's perspective that misunderstanding the responsibilities of CNMs might lead RNs to inaccurately describe their leadership. Amita said: "*We have so much work, so maybe the staff [think] that the clinical nurse managers are not doing that much work"* (Amita, p.2 L: 48–49). Ali felt that "*the understanding of leadership, the understanding of the staff [about] leadership, there is responsibility for leadership in the ward. This may be [that] the staff don't have experience*

with leadership, so they evaluated the clinical nurse managers like this" (Ali, p.2 L: 33–36).

Relatedly, Fahad said:

> *Clinical nurse managers experience stress, and they have many things to do. And they have many [responsibilities] – the staff, the patients, the physicians, the nursing office and pharmacy. They also have [responsibility to] the store because every week we request [supplies]. I need to manage what we want … for the next week. So the staff may think the clinical nurse managers do not have responsibility for staff.* (Fahad, p.2 L: 33–38)

7.2.1.5 Nurses know what a good leader is

In contrast, some participants indicated that RNs recognise good leaders. Nurses encounter and work with multiple CNMs, and so participants felt they had enough experience of leadership to understand it. They also felt that nursing staff themselves face particular problems during shifts, giving them a good understanding of the qualities of an effective leader.

Khalid and Hamad both felt that nurses have sufficient experience to give their CNMs an accurate rating:

> *I think the staff nurse [rating] is maybe right somehow, and it is more correct than the clinical nurse managers' rating of themselves … because maybe they used to [be managed] by someone else before, I mean, have an experience with some other clinical nurse managers, maybe in another department, and they know about this … it's difficult to rate yourself, so I think when [others rate] you, it will be more accurate than [what you have] done yourself.* (Khalid, p.3 L: 121–123, 129–133)

> *The registered nurses can see [ratings] clearly because they are the ones in this situation, and they experience the most problems in the ward, not the head nurse. The staff members are the ones who work during all the shifts: morning, afternoon and night. I think they are more accurate in their evaluation than the head nurses themselves. If the head of the department is excellent in leadership, then all the shifts will go very well, but if the morning shift is excellent but the afternoon and night shifts are not, the head nurse's leadership is not perfect.* (Hamad, p.4 L: 94–100)

7.2.1.6 Saudis are more effective leaders

Participants strongly felt that being Saudi makes it easier for a CNM to lead a ward, particularly in collaborating with doctors and talking to patients. One factor that seems to help Saudi CNMs is support from those above; participants felt Saudi managers have more authority due to their better relationships with their superiors and administrative departments. In addition, sharing a culture and language helps them exercise more effective leadership than their counterparts from other cultures since they can more easily communicate with staff, patients, visitors and staff in other departments.

The participants also expressed a feeling that Saudi CNMs have a greater ability to guide staff towards the future because they are more keenly aware of Saudi Arabia's Vision 2030. The participants further suggested that staff and patients feel they need Saudi CNMs because their attention and feedback are valued more than that of their counterparts from other cultures. They also felt that patients and relatives will cause fewer problems for Saudi CNMs.

Support from their superiors

Participants considered Saudi CNMs to have greater authority because of their relationships with those above them in the hospital and the lack of barriers between them and various administrators. Ali, for example, said: "*Saudi clinical nurse managers have more authority because of their relationships with others, administration and head nurses"* (Ali, p.3 L: 65–66). He also thought that senior management accorded more credibility to the views of Saudi CNMs: "*The hospital director or the nursing director; they are more interested in the Saudi head nurses or in their comments and recommendations. Really, this is the truth. I observe it in our hospitals"* (Ali, p.5 L: 162–167).

Shared culture and language help them to lead

Some participants felt Saudi CNMs are better able to lead because of similarities with other staff and with patients in terms of culture and language. They are also able to form closer relationships with staff in other departments and units, new staff and visitors.

Ali pointed out that Saudi CNMs benefit from this shared culture:

> *There is a difference between Saudi and non-Saudi [clinical nurse managers] because [of] the culture. It helps Saudis lead and manage very well, especially in our hospital. ... Understanding the language also helps them. There is no barrier between them and the administration, let's say.* (Ali, p.3 L: 63–64, 66–67)

Saud supported these comments, emphasising the importance of clear communication with staff, administrators and visitors:

> *Saudi head nurses can communicate easily, especially with other departments, [such as] medical supply stores, or new staff. Most other departments and new staff have poor English language skills. So, if non-Saudi head nurses do not communicate ... fluently with them, they will not understand what the head nurses need from them. Then, miscommunications will happen. So, communication when there is a Saudi head nurse will be easy with other departments and even with other [staff and visitors]. So, this will facilitate their work within the ward, like when you are dealing with patient watchers and visitors. So, it will be easy. But non-Saudis will face [difficulties], and they will have issues regarding communication.* (Saud, p.2 L: 101–111)

Staff and patients need Saudis

Some participants felt that RNs value the encouragement they receive from Saudi CNMs more than that from managers from other cultures. Further, the participants also felt that patients and relatives prefer Saudi CNMs and will create fewer problems when they are in charge.

Ali believed that staff see Saudi CNMs as more valuable: "*Encouragement from the Saudi head nurse is more important than from non-Saudi nurses, because staff see the value [of] Saudis more than [of] non-Saudi head nurses"* (Ali, p.5 L: 160–161). Amita supported this and expanded on it: "*If Saudi head nurses are there, patients and their relatives will not make more problems. They are okay with Saudis. I feel that"* (Amita, p.3 L: 53).

They make their own decisions

Some participants felt that Saudi CNMs are better able to trust their own decisions and are in a position to do a number of things that non-Saudis cannot. The participants also expressed the idea that Saudi CNMs are more likely to discuss decisions with their superiors.

Mohammad, for example, thought that the Saudi managers in his hospital are stronger leaders: "*As Saudi head nurses, we maintain strict order sometimes, and we take action without asking anyone if the action is correct. Non-Saudis might have a different leadership style than us, but we are stronger in action and leadership"* (Mohammad, p.5 L: 124–127). Mohammad continued this theme, stating that Saudi CNMs always make their own decisions because they know what is required and what needs to be done to meet those demands. He said: "*As Saudi head nurses, we fight for our opinions because we are the ones working and suffering in the department, so we know what's supposed to be done. So, we describe the plan, and we hear the feedback"* (Mohammad, p.6 L: 194–196).

Sara expressed a similar view: "*I think there is a difference between Saudis and non-Saudis in the clinical field, as Saudi clinical nurse managers have the power to make some decisions that non-Saudis cannot"* (Sara, p4 L: 110–112). Amita's opinion was that Saudi CNMs make strong decisions that are likely to be accepted by senior management:

> *If a Saudi head nurse were there, they would make some decisions of their own. But the non-Saudi head nurses are afraid that if they do something or if they*

> *make a decision, the nursing office, quality department or CNE [Continuing Nursing Education] department might not accept it. But if a Saudi makes some decisions, they will be accepted by [their] superiors. .. .I feel that.* (Amita, p.4 L: 106–109)

Khalid also pointed out that Saudi CNMs make strong decisions because they are not afraid of losing their jobs: "*Saudis are not worried about losing their job or something like that, so they can take more action than non-Saudis"* (Khalid, p.5 L:180–181). Ali added that Saudi managers want to understand what is going on and be able to make changes to their decisions instead of just following orders:

> *Saudi clinical nurse managers discuss the benefits of changing decisions or, if there has been a change, they ask if it is [for] our benefit, [if it] is what we need. So, they like to understand rather than simply following commands*. (Ali, p.5 L: 136–139)

Guiding staff towards the future

Participants talked about Saudi CNMs knowing they will be in Saudi Arabia in the future, and having greater knowledge about the future of the nursing profession in the country. Saudi CNMs are also better aware of Vision 2030, and the participants believed that they will therefore be able to work more effectively towards that future.

Khalid observed that Saudi CNMs are less likely to be planning a location change than their counterparts from other cultures, making them more focused on the organisation's future:

> *Saudi clinical nurse managers already know they are staying here and are not planning to change their job, unlike non-Saudis who sometimes go to other countries. They may not be thinking about the future of the organisation. But [a] Saudi head nurse [will] focus on the organisation; they are thinking 10 years, 20 years ahead, and they are trying to improve because they know that they will be here in the country.* (Khalid, p.8 L: 250–254)

Ali stated that Saudi CNMs consider how the staff and ward could benefit: "*Saudi clinical nurse managers are thinking about their and the staff's [benefits]: they are thinking about the feedback and how the outcomes will improve the ward"* (Ali, p.5 L: 143–144). Saud thought that Saudi managers are more aware of the current state of the nursing profession as well as the country's vision for the future of the profession. He said:

> *Saudi head nurses might have more knowledge about the future of the nursing profession in Saudi Arabia! They have a vision for Saudi 2030, so it will be easy for a Saudi head nurse to guide the staff towards this vision, unlike a non-Saudi.* (Saud, p.6 L: 166–169)

Mohammed explained that, as a Saudi CNM, he always attends meetings, so he knows what the ward needs to improve their work in the future: "*As Saudi head nurses, we ask to be in the meetings [too], not just the nursing director, because we know how to deal with our department and patients and how to make our work better in the future"* (Mohammad, p.6 L: 196–198). In a similar way, Khalid felt that Saudi CNMs are more capable of empowering their staff and making RNs more effective practitioners in the future: "*I think Saudi clinical nurse managers empower staff and try to make them more skilled and organised and more – I mean, to make them better for the future"* (Khalid, p.9 L: 272–273).

Ashmita observed that Saudi CNMs seem more focused on future plans. She said: "*As non-Saudis, we focus on the ongoing process [in] certain situations. We are thinking about the present situation, how to deal with it. But maybe, when it comes to thinking about future plans, Saudis [are] better"* (Ashmita, p.10 L: 344–345).

7.2.1.7 Working in a culture that is not their own

This theme focuses on participants' descriptions of CNMs working in a culture that is not their own. Participants sometimes felt that CNMs from other cultures face multiple additional

problems, such as being questioned by superiors, patients and relatives, and they also described being subjected to their anger more frequently.

Managers from other cultures can, the participants suggested, find it difficult to convey their ideas, primarily because not all of them can communicate in Arabic, and some participants also felt that clinical nurse managers from other cultures cannot be independent in their decision making because they just follow orders without discussion. Relatedly, participants felt that leaders from other cultures do not want to rock the boat and that most plan to return to their own or another country. Some participants were of the opinion that job insecurity may affect the leadership practices of CNMs from other cultures.

They face multiple problems

With reference to this subtheme, one participant spoke about the difficulties that CNMs from other cultures can encounter with various stakeholders. Amita said: "*If there is a non-Saudi head nurse, they can face so many problems. But if Saudi head nurses were there, the superior would not ask them for more"* (Amita, p.3 L: 50). She also explained that patients can get annoyed by a CNM from other culture: "*If there is a non-Saudi head nurse, patients will get angry, and the patients' relatives will ask so many questions"* (Amita, p.3 L: 52).

They cannot always convey their ideas

Difficulties in communication were often attributed to managers from other cultures being unable to express themselves in Arabic. Participants believed that the cultural and language differences between CNMs from other cultures and new Saudi nurses may lead to an inability to communicate effectively.

For example, Amita talked about a situation that occurred when she was trying to inform a Saudi nurse about vacations during the pandemic:

> *At the beginning of [the] COVID-19 pandemic, all [vacations were] on hold here. One new staff member is asking for a vacation, and I'm explaining to him that all requests are on hold. But I cannot communicate well because he doesn't understand English. He says everything in Arabic, [and] he cannot understand English very well. So, I can't explain much about this as I'm not an Arabic speaker. There is a communication problem. So I asked a Saudi staff member to translate everything to this other staff member. I don't know what he actually understood, but he agreed anyway. I feel that if I could have relayed my message, I could have explained everything my own way and maybe he could understand much better than with a translator. But there are some problems in communication; that is the truth.* (Amita, p.7 L: 190–200)

Khalid felt similarly that CNMs from other cultures face difficulties describing their ideas due to their inability to communicate in Arabic: "*Saudi and non-Saudi clinical nurse managers communicate differently. Non-Saudis cannot always communicate in Arabic, so they cannot always convey their ideas. This may affect their leadership practices in the clinical area"* (Khalid, p.5 L: 161–169). In addition, Ali thought that managers from other cultures might have difficulty asking for help due to the language barrier. He said: "*Non-Saudi head nurses have to contend with barriers [in] administration departments, such as language barriers. Similarly, they sometimes have difficulty asking for support from other departments and administration departments"* (Ali, p.3 L: 70-72).

They are not autonomous in their decision making

In this subtheme, participants felt that CNMs from other cultures do not show autonomy in their decisions; instead they simply follow orders given by their superiors without discussion. Amita explained this problem:

> *If the nursing office, quality department or CNE [Continuing Nursing Education] send information or orders to clinical nurse managers, non-Saudi clinical nurse managers would follow the orders with no discussion. ... But if they would decide, no, their [superior] will not accept it – so they don't say anything. They will only obey orders. So, the staff might think there is some*

> *difference in the leadership of [non-Saudi] head nurses.* (Amita, p.4 L: 102–105)

Mohammed spoke about managers from other cultures being afraid and unable to make decisions:

> *Actually, as I have [experienced], there are many differences. Most doctors, unfortunately, will deal with the clinical nurse managers, especially non-Saudis, with a lack of respect. They will sometimes [issue] orders for anything. They will let the head of the ward do doctors' work. The Saudis – they can take action, and they can make decisions. But non-Saudis are sometimes afraid. You know, they came to this country, and sometimes they are afraid of the doctor's position or of the doctor's loud voice. But Saudis are better than non-Saudis [at] dealing with all other healthcare professionals, not only with doctors.* (Mohammad, p.3 &4 L: 99–108)

They do not want to rock the boat

Some participants felt that CNMs from other cultures do not want to cause any issues because they do not have plans to stay long in Saudi Arabia. Indeed, participants felt that most intend to return to their home or travel to another country.

Ali explained his view that managers from other cultures do not want to create problems: "*Non-Saudis clinical nurse managers came here only to get a job and are planning to go back one day to their country or to another country. They don't want any problems. They only like to follow"* (Ali, p.5 L: 148–150). Continuing this theme, Ali added that managers from other cultures are likely to accept orders even if they have no idea what the results are going to be: "*Non-Saudis will agree to the orders even if they don't know what the outcome will be. ... I think they are only following their superiors"* (Ali, p.5 L: 141–142).

Mohammad observed that managers from other cultures seem to always be asking for their supervisor's guidance: "*Some non-Saudis follow the old leadership style, which means, as you*

know, if they do something as the head nurse, they must come back to the supervisor. They consider all that routine" (Mohammad, p.5 L: 122–123). He continued:

> *Actually, as I saw, when they [do] rounds [in] the department. Non-Saudi clinical nurse managers will be – sorry to say this – they will be in the picture, just standing and listening to the opinions of the hospital director, nursing director and medical director. They will not share their opinion but only do the action. Then they will say [the team] must be like that*. (Mohammad, p.6 L: 189–194)

Job insecurity

This subtheme focuses on the idea that job insecurity may significantly impact the leadership practices of CNM from other cultures.

Ali noted that managers from other cultures seem more concerned about their jobs than Saudi managers, and that is why they do not want to create any issues:

> *Non-Saudi clinical nurse managers have contracts that need to [be renewed] early, so they don't want any problems with their superior. The Saudis, I think, are not thinking about their contracts and salaries. So, let's say they are feeling [safer] than non-Saudis. They will focus on their goals.* (Ali, p.5 L: 150–154)

Khalid and Sara agreed on this point too:

> *Non-Saudis are sometimes afraid to do something, to create something new and to have new ideas. They might think that someone will not agree or that they will lose their job over it.* (Khalid, p.5 L: 161–169)

> *Non-Saudis are afraid because they think about losing their job.* (Sara, p. L: 117)

Fahad felt that the leadership practices of CNMs from other cultures could be affected by some of the differences in salary and working hours:

> *Non-Saudis have to deal with some differences in their salaries. [They receive] lower salaries than Saudis, and Saudis also have extra days off – not the same number as non-Saudis. For example, Saudis get eight days off per month, and non-Saudis get six days, and their salary is different. So, a non-Saudi head nurse would be so tired that it may affect their leadership practices.* (Fahad, p.5 L: 112–117)

7.2.1.8 Without good communication, nothing can be done

This theme focuses on the different ways in which participants expressed that nothing can be achieved without good communication. The participants indicated that effective communication is critical in multicultural workplaces in order to provide proper nursing care and that clinical nurse managers are an important conduit of communication in that context.

A multicultural workplace needs effective communication

Participants' statements under this subtheme describe how good communication is particularly vital for success when there are many different languages and cultures to deal with; being able to communicate effectively is crucial.

Amita said that, because various languages and cultures are involved on the ward, communication is essential: "*Communication skills are important because there are so many different languages and different cultures. So, if the communication is not good, we can't do our work properly"* (Amita, p.7 L: 181-183). Ashmita agreed, saying: "*Communication plays a major role in leadership practices because we will have to face different individuals that have particular characters"* (Ashmita, p.17 L: 576). More specifically, Ali felt that clinical nurse managers with limited communication skills have difficulty getting along with their staff and other health professionals: "*Whoever cannot communicate very well will have difficulty managing their staff and even communicating with their superiors, with speciality physicians, and with all colleagues around them"* (Ali, p.7 L: 221-225).

Good communication enhances nursing services

In addition to the need for effective communication with individuals from different cultures, as outlined in the previous subtheme, the statements in this subtheme emphasise that good communication by leaders is particularly vital to enhancing nursing services on the wards. Saud, for example, described how effective communication supports the delivery of nursing care:

> *Communication with staff is very important because it facilitates work [and] promotes nursing services in the ward. Your message will reach the staff. Also, it could effectively help to solve many expected issues in the future, many difficulties. So, communication should be clear with all staff … because if there is miscommunication, everyone will be in trouble. Like, for example, if I want to explain … some criteria of moving a patient from the unit to the X-ray department, like the patient needs precautions. If they do not get your message, of course, many difficulties and many errors can happen and [might] affect patient safety.* (Saud, p.10 L: 284-291)

Khalid also emphasised the importance of effective communication in being able to provide good care:

> *I think communications skills are some of most important skills that leaders should have. Without good communication, nothing can be done. Communication involves the relationship between the staff themselves and between the staff and the clinical nurse manager. You get feedback through communication, and you need to improve yourself through the feedback. When you have good communication with staff, you have a good chance of improving yourself and your staff to provide good care. Yes, I think this is why communication is very important.* (Khalid, p.12 L: 381-385)

Mohammed added that effective communication by clinical nurse managers is essential because it will allow them to understand their staff's situations. He said:

> *Communication skills are important because, as you know, when most nurses come to their duties, you will be able to observe in their faces or their eyes if a*

> *member of staff is not rested today or their mood is bad. I will try to change their assignment; for example, I will give them a comfortable assignment and try to ask, "What happened? Do you need anything?" I will get good feedback from leading this way, and they will feel that there is someone caring for them. Then the staff, if they have something to say, will say it to you first. This kind of communication is important.* (Mohammad, p.11 L: 360-368)

Ashmita supported this comment, adding that effective communication is essential to understanding staff's capabilities:

> *When we communicate with a particular person, we can understand their emotions and their capability. After assessing their capability or their emotions … we can give a particular sort of task or guidance. So without communication skills, we can't do good leadership.* (Ashmita, p.17 L: 577-580)

Leaders are a conduit of communication

In the previous two subthemes, the emphasis was placed on the importance of communication skills in a multicultural workplace to promote nursing care. In the following statements, the participants indicated that the role of a clinical nurse managers includes facilitating this kind of communication between the nurses and their superiors or other health professionals. For example, Ali talked about the importance of clinical nurse managers providing staff with feedback, comments and information about issues discussed during hospital administration meetings:

> *During the monthly leaders' meeting, as a head nurse, you know all the information that was discussed during the meeting. Some head nurses are interested in giving their staff meeting feedback, comments and issues. But some units really are not! And I think this is the responsibility of the head nurse because he's the one from the team in that meeting. … I think this is an example of that communication between the administration of the hospital and the staff [and] how the message will be transferred from them to the staff – it's from the head nurses!* (Ali, p.7 L: 227-233)

Mohammad added that he ensures his staff clearly understand any feedback from the hospital administration: "*If there is an opinion or feedback from the hospital director, nursing director or medical director about our ward or about our needs, I give the staff [this information] clearly"* (Mohammad, p.12 L: 411-412).

7.2.1.9 Barriers to leadership development

This theme is focused on the participants' descriptions of workplace barriers to developing their leadership. In particular, nepotism is a concern when directors choose who to appoint to a clinical nurse manager position as there are no clear evaluation criteria. Participants also indicated that inadequate leadership training opportunities are a problem, with several expressing dissatisfaction with the available courses. They also complained that courses are often run at times that are not appropriate for them to attend. In addition, the participants feel that the development opportunities provided to staff do not sufficiently meet the needs of those assigned a clinical nurse manager position.

Nepotism

Many participants were concerned about bias during CNM selection in their hospitals and also felt there were no clear criteria for evaluating the work on CNMs. Saud expressed concern regarding the lack of a transparent selection process when selecting the head of a ward. He said:

> *It depends on the nursing director when he chooses the staff as head nurse, and we have the culture, so, you know sometimes the rules will be affected by the culture. And you understand what I mean by this one ... I mean when the director of nursing chooses the head nurse [and] you ask him based on what? He says, "I saw him as active". What is meant by "active"? So, this is maybe because the director of nursing is not following clear criteria.* (Saud, p.4 L: 86-89)

Similarly, Sara expressed her belief in the importance and necessity of justice when evaluating the work of different clinical nurse managers:

> *I think the director of nursing needs to be fair about how to deal with all clinical nurse managers. Some of my colleagues did not work well but they got a good evaluation by the director of nursing. Why? This is not fair*. (Sara, p.17 L: 510, 511)

Inadequate training opportunities

In this subtheme, participants stated that a lack of lectures, courses and workshops specific to the work of clinical nurse managers was a barrier to furthering their leadership skills. Fahad, for example, explained that he had not received any kind of clinical nurse manager training that had enabled him to update his knowledge. He said: "*In the last three years, there have been no specific lectures or courses for clinical nurse managers [but] sometimes we need to update or refresh our knowledge. We are human [and] likely to forget"* (Fahad, p.23 L: 765-769). Amita agreed, stating: "*I didn't get anything until now"* (Amita, p.7 L: 218).

In accordance with the above, Ashmita felt that if clinical nurse managers were not provided with the opportunity to refresh their leadership skills, it would impact their ability to lead. She said:

> *If the head nurse is not getting a chance to update their knowledge about leadership, that's why they'll get a low rating [in leadership practices]. If we just do our work and go home like that, if we continue as though it is routine, we cannot get a chance to update our leadership knowledge.* (Ashmita, p3 L: 95-98)

Saud also stated that there was no specific training provided for clinical nurse managers: "*I'm not sure about any specific lecture or course for head nurses. I did not see any specific course for the head nurse in our hospital*" (Saud, p.11 L: 352-353).

Time of courses is not appropriate for them

Participants also expressed dissatisfaction with the timing of available lectures and their inability to attend due to their work schedule and being unable to leave their ward. Training being scheduled during work hours is one of the obstacles preventing Hamad and his colleagues from being able to attend:

> *Most of the courses are in the morning shift; it is during our work time. So, during work time, you do not know what will happen in your ward. It will be crowded. Do I have a [staff] shortage? Will the nursing administration office allow me to attend? I see that the first obstacle is the time of the courses which is not appropriate for us.* (Hamad, p.26 L: 450-453)

The following statements from Mohammad, Ashmita and Amita are all in agreement with the above, describing that they are unable to participate in courses due to their timing:

> *Most of the courses really we don't attend. Even for me, sometimes, if I [get] a lecture schedule … when I will be busy in the ward, I can't leave because I think to be in my department during [busy times] is better than attending a course. I cannot leave the situation in my ward.* (Mohammad, p.13 L: 429-433)

> *If we get enough time, we … attend the courses. But because of the workload, or sometimes problems with time management, we won't be able to participate.* (Ashmita, p.21 L: 716-718)

> *Maybe [my colleagues] cannot leave the ward when the lectures or courses are available. That's why they can't go. … I heard that all lectures were on workdays, so … they are also working. Head nurses only get weekends off and there are no lectures, nothing on weekends*. (Amita, p.7 L: 219 and 227- 229)

Courses are expensive

The emphasis in the above subthemes is on the lack of adequate training opportunities and dissatisfaction with the timing of what is available. Here, participants indicated that some of the courses and lectures are expensive. Ali related that "*some available courses are not free*

and are expensive" (Ali, p.8 L: 266). Similarly, Khaled said that he was interested in a workshop on healthcare quality but that he was unable to attend because of the high cost: "*There was a workshop about [becoming a] Certified Professional in Healthcare Quality. It's about health quality. It was expensive, about SR 4000* [AUD 1400]. *I was not able to attend"* (Khalid, p.15 L: 495-497).

Staff development does not meet their needs

Additionally, some participants talked about the development opportunities for staff being insufficient to meet their needs as a clinical nurse manager, although they had varying perspectives on why this is such an issue. Khalid suggested that some of the training provided will have no use in the future in terms of promotion: "*Some courses when you take it, there is no use for it in the future for promotion. [Colleagues] may be thinking about the benefits in the future [and whether] they will use it or not"* (Khalid, p.14 L: 476-478). He described one particular training course at his hospital that colleagues did not seem to be interested in: "*There was one seminar recently about leadership, and not all clinical nurse managers were there because they thought it was useless"* (Khalid, p.15 L: 484-486).

The lack of interest in courses could perhaps be related to the repetition of training materials, as Ashmita described: "*Because of repeated courses, ... conducting them again and again, [clinical nurse managers] will not attend. They will omit that one"* (Ashmita, p.21 L: 721-723). Ahmad explained that the way the training is delivered does not meet clinical nurse managers' needs: "*I feel the way they present the courses to us [is] so boring. It's like taking the paper in one hand and just reading from it, and so it's not like an active workshop"* (Ahmad, p.10 L: 340-342).

7.2.1.10 CNMs need specifically designed leadership development strategies

This theme is focused on the participants' expressed need for leadership development strategies specifically designed to improve CNMs' leadership. Despite participants being individually interviewed, most of them emphasised the importance of implementing strategies and policies to improve CNMs' leadership in hospitals, for example through practical activities, communication development and sharing their experiences in workshops.

Practical and workshop activities

In this subtheme, the participants talked about strengthening leadership practice by participating in practical activities, such as interactive workshops that focus on skills development or counselling and wellbeing support for CNMs.

Ashmita felt that clinical nurse managers should strengthen their leadership abilities through practical activities rather than theory:

> *In all the courses, they are telling you theories ... but if they are providing you [with information about] how you do it in a practical fashion, that is a different thing, so if they're faced [with a] particular situation, how they will act, then [you] can understand that.* (Ashmita, p.22 L: 750-752)

The following statements from Mohammad and Ali support Ashmita's point:

> *I think the leadership courses [are] better as workshops, ... to share head nurses' experience with colleagues from other departments or even [other] hospitals.* (Mohammad, p.14 L: 473-475)

> *We should take some leadership training, like management and leadership and team building, something like this in [a] practical way would help.* (Ali, p.8 L: 272-273)

Counselling and psychological support

One participant expressed the need for psychological support from their organisation to enhance teamwork and foster the positivity that could facilitate better leadership: "*My opinion is [that] to lead with good teamwork, we need positive thinking, maybe some need some counselling or emotional support. ... If they include ... that, it's very nice"* (Ashmita, p.22 L: 752-756).

Need for communication skills development

Some participants also talked about developing their leadership practice through enhancing their communication with their staff and patients. There were multiple extracts supporting this theme, such as the following examples:

> *We need courses about communication skills. I think it's really important, the communication behaviour between the head nurse and staff, [among the] staff, head nurse to head nurse, and also between staff and patients. I think there is some weakness in communication, and there are some gaps that need to be covered through the training.* (Khalid, p.15 L: 512-515)

> *We need a course [in] personal communication to focus on how to have good communication with your staff.* (Ahmad, p.10 L: 357-358)

> *I think we need courses such as communication skills [and] time management and understanding quality improvement tools or quality improvement projects that should be shared. Head nurses know what the tools are; they should know. The standards, they should understand the ... accreditation standards*. (Ali, p.8 L: 269-272)

7.3 Registered nurse participants

The registered nurses (n = 12) who took part in this study represented a range of cultures and backgrounds. The majority were Saudis (n = 7), which matches the proportions reported in the clinical nurse managers' interviews. Field notes were used to record each participant's

interactions (Dowling 2007; Groenewald 2004). Table 7.2 describes each participant using a pseudonym to ensure their identities remain confidential.

Table 7.2: Registered nurse participants' demographics

Participant (pseudonym)	**Gender**	**Nationality**	**Age**	**Experience**		**Qualification**
				Nursing	Current ward	
Fares	Male	Saudi	26 - 35	5– 10 years	< 5 years	BSN
Tisha	Female	Non-Saudi	26 - 35	1– 5 years	< 5 years	BSN
Faisal	Male	Saudi	26 - 35	5– 10 years	< 5 years	BSN
Saleh	Male	Saudi	26 - 35	5– 10 years	< 5 years	BSN
Saad	Male	Saudi	26 - 35	5– 10 years	< 5 years	BSN
Nawal	Female	Saudi	26 - 35	1– 5 years	1– 5 years	BSN
Majeed	Male	Saudi	26 - 35	5– 10 years	1– 5 years	BSN
Suliman	Male	Saudi	26 - 35	5– 10 years	5– 10 years	BSN
Nasser	Male	Saudi	26 - 35	5– 10 years	5– 10 years	BSN
Ebtisam	Female	Saudi	26 - 35	1– 5 years	1– 5 years	BSN
Nawaf	Male	Non-Saudi	26 - 35	5– 10 years	1– 5 years	BSN
Bandar	Male	Saudi	26 - 35	5– 10 years	< 5 years	BSN

7.3.1 Major themes

The 12 registered nurses willingly shared their experiences of working with clinical nurse managers in Saudi Arabian workplaces for this study. The process of reading and rereading the interview data revealed a number of similarities in the ideas that were expressed, and the data was then grouped in a process of moving from the parts (the interview transcripts of the twelve registered nurse participants) to a holistic picture. There were 11 major themes that emerged from the data analysis, namely *collaborative relationships are required to lead; they stand by*

the staff; we are not supported; lack of mentorship; they do not have the experience to lead; relationship bias; they are knowledgeable and give us confidence; Saudis are better able to lead in their own country; cultural barriers for leaders from other cultures; good leadership from Filipino leaders; and preparing the staff for future leadership. Each of these major themes includes a number of subthemes (Figure 7.2). The experience of working with clinical nurse managers in Saudi workplaces from multicultural backgrounds is a such complex phenomenon in which the identified themes and subthemes are intertwined with each other, and the interpretation chapter addresses this complexity further.

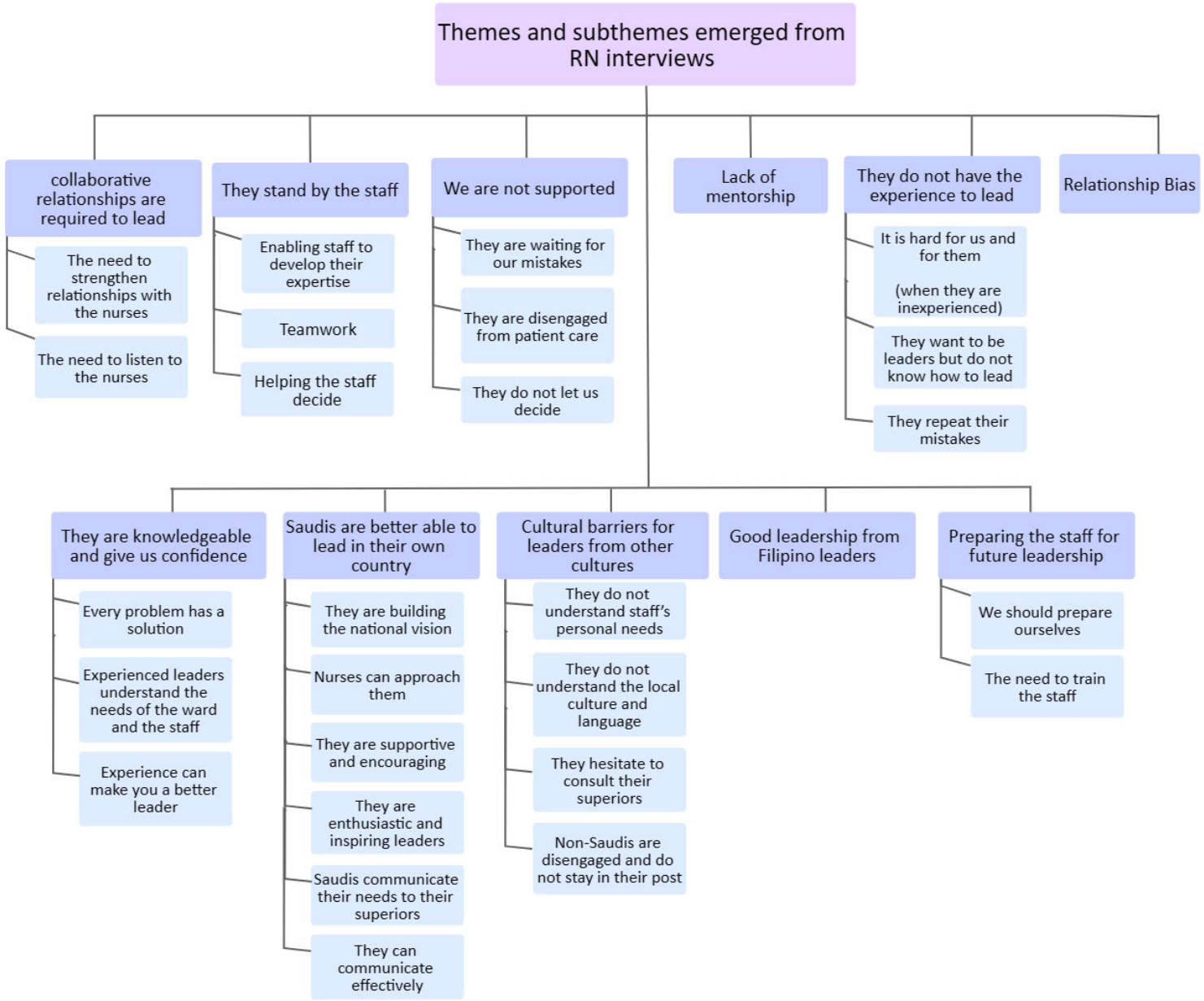

Figure 7.2: Themes and subthemes that emerged from registered nurses' interviews

7.3.1.1 Collaborative relationships are required to lead

The nurses expressed the feeling that the clinical nurse managers must build an exemplary collaborative relationship with them in order to strengthen leadership on the wards and that CNMs need to listen to the nurses' perspective.

The need to strengthen relationships with the nurses

Many participants thought that a friendly relationship between CNMs and staff is important as well as strengthening that relationship through fortnightly or monthly meetings to discuss their needs or difficulties on the ward. Tisha, for example, stressed the importance of a good working relationship: "*They should have a good friendly relationship with their staff; that is the first thing we want. Also, they should have good communication [skills]"* (Tisha, p.8 L: 256–257).

Saleh talked about the possibility of arranging regular meetings with the staff in order for the CNM to know what they need and resolve any challenges they are facing:

> *They should [schedule] a quick meeting of 30–45 minutes every two weeks … to talk to the staff, ask us about our needs or [the] challenges we face and take our [input on improving] our ward and the work environment in general*. (Saleh, p.7 L: 221–223)

Fares supported the above comment, explaining: "*I think it's a good thing to have a monthly meeting with the staff … to strengthen relations with them"* (Fares, p.7 L: 230–231).

The need to listen to the nurses

In this subtheme, some participants highlighted the importance of leading employees in a way that enables them to share their thoughts. Fares described:

> *I would say to some clinical nurse managers: "We know that you have experience and good skills, but some of your staff might have a different*

> *perspective. They might see things that you don't see, and they could give you their advice or opinion. It's better to listen to them."* (Fares, p.7 L: 426–429)

7.3.1.2 They stand by the staff

This theme focuses on participants' experiences of working with their managers and how some of their clinical nurse managers are eager to develop their nurses' skills. Some clinical nurse managers were described as always willing to share information and best practice with their staff for the common goal of providing excellent patient care, while others felt some clinical nurse managers allow their staff to decide their own duties by assigning the shifts that nurses request to help them do the best work for their patients.

Enabling staff to develop their expertise

The statements under this subtheme emphasise the importance of clinical nurse managers' efforts to enable their staff to develop their skills and expertise, particularly in light of the challenges a nursing professional may face at the beginning of their career. This includes standing by the nurses and encouraging them to overcome obstacles as well as improving their abilities.

Saad described the difficulties he faced at the beginning of his nursing career in dealing with various documentation and how he had a clinical nurse manager who supported him during those difficult times:

> *I had a challenge doing the nursing and ward documents because they were new to me. My clinical nurse manager came and put her chair next to me and showed me and explained everything. … I [then] understood many things, and I thought it was so difficult for me because it was the first time. That's why I think my clinical nurse manager is a leader because she gave me her time and showed me how to do everything correctly.* (Saad, p.2 L: 46–50)

Saad added:

> *Some clinical nurse managers let the staff work on their tasks by themselves and observe … and encourage them. If the staff have any obstacles, they will stand by the staff and show them the right path to do their tasks.* (Saad, p.1 L: 26–28)

Faisal endorsed this perspective, adding that his clinical nurse manager is eager to develop Faisal's expertise:

> *Our clinical nurse manager was directing us and seeing what we needed ... because she had experience and knowledge, and I remember she said to me [you have Basic Life Support] and you need to get [Advanced Cardiac Life Support]. She said, "I will support you and explain to you everything", and I got it in a few months. Then, she asked me why [not] get [Advanced Trauma Care for Nurses] and [she] taught me. I passed this course … because she had experience. So, she [wants] the staff [to] be knowledgeable.* (Faisal, p.10 L: 323–329)

Teamwork

Under this subtheme, participants talked about the importance of the clinical nurse managers' capacity for teamwork. The staff felt that they needed to be kept informed and updated about decisions being made for the ward. Additionally, participants mentioned occasions when clinical nurse managers stepped in to protect their staff when there was a request beyond their remit.

Nawal provided her opinion about the ways in which her clinical nurse manager shares information about the ward with the staff: "*Our clinical nurse manager always shares with us [information on] which one is better [and also provides] any updates about our ward's needs … to work together and provide excellent care"* (Nawal, p.3 L: 80–81). Tisha added that her clinical nurse manager models good teamwork in the way she provides assistance to her staff:

> *If doctors ask us to do something that we are not allowed to do according to policy – that's happened with me – then I just talk with her. I told her I can't do anything [that's] not allowed by policy. Then, she had a good talk with the doctors.* (Tisha, p.1 L: 16–20)

Helping the staff decide

Participants conveyed in various statements the importance of clinical nurse managers guiding the nursing staff to make their own decisions, for example through choosing the best shifts, and how this has a positive effect on the ward as well as on the care provided to patients.

As an example, Nawal mentioned that her clinical nurse manager gave staff the chance to decide which shift was most convenient: "*My clinical nurse manager gives us a sheet to record which shift is suitable for each nurse, and she [tries] to assign the requested shift to everyone, if possible; she [is] really helpful"* (Nawal, p.1 L: 28–29). Faisal concurred, adding that this can help them give the best possible care: "*[The] clinical nurse manager asks us what the appropriate shift [is] for each nurse. This reflects positively on all staff, [helping them] do the best work for our ward and patients"* (Faisal, p.3 L: 89–90).

7.3.1.3 We are not supported

In contrast to the above themes, some participants felt that clinical nurse managers were not supportive and perhaps that they were just waiting for them to make mistakes. Relatedly, statements in this theme indicated that the participants thought that the clinical nurse managers did not always involve themselves in patient care or allow staff to make decisions on their own.

They are waiting for our mistakes

Some participants felt that some of their clinical nurse managers are waiting for staff to make mistakes. In this theme, the nurses felt that they were not being supported to overcome difficulties by some of the managers, who were instead waiting for errors to put in occurrence variance reports (OVRs).

Saleh spoke about his experiences working with some unsupportive clinical nurse managers, saying: "*Most clinical nurse managers see themself as better than the staff, do not understand*

our needs, and [do] not encourage; they are waiting for our mistakes" (Saleh, p.2 L: 63–64). Faisal made similar comments:

> *When I am worried about a particular procedure – for example, an intubation or a central venous catheter – and when I talk to him, he may cause a problem and write an OVR. … He did not help, did not direct, did not motivate me to overcome these [challenges].* (Faisal, p.7 L: 218–221)

They are disengaged from patient care

One participant stated that some clinical nurse managers in their hospital do not help staff by participating in patient care because they are always doing administration. Faisal said: "*Some clinical nurse managers [are] just doing managerial work [that] does not help us with the patients' care"* (Faisal, p.1 L: 19–20).

They do not let us decide

In this similar subtheme, some participants felt that their clinical nurse managers do not let staff make decisions about, for example, daily assignments or shift duties. Participants observed that some staff might prefer activities they actually like rather than those they are randomly assigned.

Majeed said: "*Our clinical nurse manager does not give us a chance to decide our daily assignments, which I think is important because some staff may prefer something they like to do"* (Majeed, p.1 L: 19–20). Suliman, Nasser and Faisal strongly supported the above:

> *I think they need to give the staff what they want – [a] particular shift or assignment that I'm sure will help us because everyone wants to work in their convenient shift or tasks.* (Suliman, p.9 L: 309–311)

> *Some clinical nurse managers think they should fight and make trouble with the staff by not giving what they want.* (Nasser, p.1 L: 45)

> *I think some of our clinical nurse managers think like this: "I am the manager of the ward, and the staff must listen to me, and there is no discussion."* (Nasser, p.2 L: 49–50)

> *Some clinical nurse managers don't have the art of leadership. For example, if I ask him [for] days off on Monday and Tuesday, and not the weekend, he will be stubborn and put me on the weekend [days off]. He did not help me.* (Faisal, p.5 L: 151–153)

7.3.1.4 Lack of mentorship

The statements in this subtheme that some participants perceive a lack of mentorship from their CNMs, that is, they feel they have not been adequately taught or guided in the right direction.

For example, Saleh felt that CNMs should explain errors to their staff: "*[The] clinical nurse manager should teach the staff and let us know our mistakes, [showing] us the right direction"* (Saleh, p.6 L: 182-183). Nawal agreed with this statement, noting that new staff are eager to advance their knowledge: "*Some of [the] clinical nurse managers in our hospital should know how to deal with staff. ... I am referring to knowing how [to manage] experienced staff and new staff differently, because [the latter] are more interested in learning"* (Nawal, p.5 L: 120-121). He also expressed frustration at having been assigned to a particular area without explanation of how it worked:

> *I remember when I was appointed to the emergency [ward], my clinical manager put me in the triage section. ... I was suffering and made errors in sorting the cases because I was new and the procedure was not explained.* (Nasser, p.1 L: 30-33)

Ebtisam also spoke about CNMs being unable to manage their staff properly: "*I have worked with some clinical nurse managers who were not able to direct us correctly"* (Ebtisam, p.7 L: 203).

7.3.1.5 They do not have the experience to lead

Some participants felt that the majority of the CNMs in their hospitals lacked the (clinical) experience to lead the nursing staff, and some stated that some managers want to lead but are unable to do so because they are unaware of their own weak points. Participants also described CNMs frequently repeating the same mistakes.

It is hard for us and for them (when they are inexperienced)

In this subtheme, CNMs were described as lacking the experience required to manage wards effectively and not being familiar with some of the procedures. In the participants' opinion, this makes life on the ward challenging for both managers and staff.

Tisha, for instance, emphasised the importance of having sufficient experience: "*They need good experience in clinical area. Then, they can be a good clinical nurse manager. There is really a lack of experience"* (Tisha, p.3 L: 65-66). Suliman and Faisal made similar comments:

> *Most of our clinical nurse managers do not have [experience]. …We do not have more experienced clinical nurse managers … [but] I do not know why.* (Suliman, p.7 L: 251-252)

> *Those who do not have experience [worry] when dealing with a new issue [as] they are not sure [if] it's [the] right decision or not.* (Suliman, p.8 L: 259-260)

> *Experience is very important. Some clinical nurse managers lack experience, so they are not familiar with some procedures. [This is] very hard for us and for them too.* (Faisal, p.10 L: 316-318)

Nawaf pointed out that this inexperience also affects staff evaluations: "*I feel some clinical nurse managers are unfair [during] the annual evaluation because they do not have enough knowledge and experience. [Their] evaluation is unfair [on the] staff"* (Nawaf, p.3 L: 99-101).

They want to be leaders but do not know how to lead

Some participants felt that their CNMs wanted to lead but did not behave appropriately, while others believed that their CNMs could not recognise their own leadership shortcomings.

For example, Nawaf stated: "*Most clinical nurse managers do not see their weak points [in] some of their leadership practices when they are leading us"* (Nawaf, p.1 L: 22-23). Nawal concurred, asserting that CNMs do not always have the knowledge to be leaders: "*I can say they want to be leaders, but sometimes, they don't know how to lead. … [They] should improve their skills"* (Nawal, p.5 L: 124).

They repeat their mistakes

One participant observed that his CNM repeatedly makes the same mistakes and also felt that he might not be receiving the support he needs from his superiors to develop his skills. Saleh said:

> *I feel there is no support for clinical nurse managers because sometimes [they] repeat their mistakes. … I mean, they [are] not assigning the right staff member to the right task.* (Saleh, p.4 L: 132-134)

> *There is a team for [emergency cases] … but it is unprepared [and] the clinical nurse manager should take care of that.* (Saleh, p.5 L: 153-154)

7.3.1.6 Relationship bias

This theme includes descriptions of some CNMs caring more about the staff members they know, are related to, or who are of the same nationality. In this way, some managers favour certain nurses over others because of their personal relationships. Participants also described how the productivity of other nurses can be neglected due to this bias, either intentionally or unintentionally, and how this might prompt nursing staff to change wards.

Saleh expressed concern about managers focusing on the nurses they know personally:

> *Some clinical nurse managers are interested in staff … they know or are their relatives … no matter [whether] he works or not. … They must focus on the staff's productivity, not only on that of their relatives or friends.* (Saleh, p.2 L: 37-39)

Nawal agreed, asserting that this can lead to staff feeling that they are not a part of the ward: "*When [the] clinical nurse manager helps their friends and neglects the needs of others, the staff will feel they do not belong to this ward. … I [recall] when [a] staff member changed her ward for this reason"* (Nawal, p.4 L: 115-116).

Statements from Bandar and Nawaf supported the above:

> *Some clinical nurse managers' decisions [are influenced] by their social relations – their decisions to help and support their relatives and friends.* (Bandar, p.2 L: 49-50)

> *Some clinical nurse managers are biased towards nurses [who are their] relative or friend and/or of the same nationality. We all work for the patients, so they must be unbiased. They must [discern] the differences between personal relations and work.* (Nawaf, p.6-7 L: 206-209)

7.3.1.7 They are knowledgeable and give us confidence

Participants described that the experience of CNMs is important in fostering confidence in their staff, for example having managers with more experience makes them more assured in their work assignments. There was also a focus on experienced CNMs being able to understand the needs of the ward as well as of the staff and how the clinical experience of a manager can make them a better leader.

Every problem has a solution

This subtheme includes participants' opinions that experienced managers are capable of dealing with any challenges or obstacles that may arise to ensure the continuity of work on the ward. They also thought that experienced CNMs have a thorough understanding of the ward as well as of nursing procedures, which enables them to guide the nursing staff in the right direction.

Nasser spoke about his experience when working with an accomplished CNM: "*I remember when I was working with [an] experienced clinical nurse manager, every problem had a solution and that made us more confident on the ward"* (Nasser, p.3 L: 88-89). Saad and Tisha supported this perspective:

> *Our leader is experienced in facing challenges and obstacles and trying to solve problems very easily with less cost. I don't mean the financial cost, but I mean taking the problems and solving them very easily and very quickly and keeping the work in the ward going as she wants.* (Saad, p.6 L: 197-199)

> *She can handle everything. Also, she can solve all the problems in the ward because she [knows] everything [that] is happening. ... I'm working in [the] burn ward, so our clinical nurse manager [has] good experience. She [teaches] us how to deal with burn management, fluid management, and [everything else] in the ward because she [has] got good experience. She told us how to manage any situation or issue.* (Tisha, p.7 L: 218-223)

Experienced leaders understand the needs of the ward and the staff

In this subtheme, experienced CNMs were described as better able to understand staff's needs than their less experienced counterparts. Additionally, some participants felt that experienced CNMs are more capable of standing by their staff and of changing a ward so that it operates more efficiently.

Saad pointed out that his experienced CNM understands the needs of his staff: "*My clinical nurse manager understands our needs and stands by us and tries his best to meet the patients' needs. As long as you are in that position, you will understand the staff and the ward's needs"* (Saad, p.1 L: 12-13). Nasser added that experienced CNMs are capable of explaining unclear procedures: "*A clinical nurse manager who has experience is able to convey the idea to us clearly and simply for any procedure that needs more explanation"* (Nasser, p.1 L: 26-27). Other participants made similar statements in support of experienced CNMs about individual support for the staff and change and improvement in the wards:

> *I like to work with an experienced clinical nurse manager because [they] can observe how well my work is going in the ward.* (Saad, p.6 L: 210-211)

> *I was facing some difficulties [while] dealing with some procedures. My clinical nurse manager always tries to help me by herself because she [has been] working in the ward [for] more than 9 years, I guess.* (Ebtisam, p.6 L: 180-181)

> *[An experienced] clinical nurse manager can improve the ward. I [recall] when one ward in our hospital was struggling and had more complaints from patients. ... The nursing director assigned [an] experienced clinical nurse manager to that ward. In [a] few months, the ward became one of the best [in the hospital].* (Nawal, p.4 L: 103-105)

> *I prefer to work [with an] experienced clinical nurse manager [wherever they come] from ... because they know everything in the ward and give us [confidence] to improve our ward.* (Suliman, p.7 L: 211-212)

More specifically, Suliman provided the following explanation:

> *There were a lot of absentees among the staff in the ward. ... Our experienced clinical nurse manager discussed the issue with the staff ... [and] asked each nurse the reason [for their absence]. Some of them [preferred a] particular shift [and so] he assigned [it to] them. ... That was good because the [absenteeism] was not [the] same as before.* (Suliman, p.8 L: 273-276)

In summary, Bandar said:

> *[Our experienced] clinical nurse manager … rewards us with an extra day off when we do excellent work in the ward, and this has a positive [effect on] us because he is confident that the success of the staff is his success.* (Bandar, p.6 L: 180-182)

Experience can make you a better leader

Some participants felt that greater experience enables CNMs to lead their teams more effectively and that leadership capabilities can be developed through working for an extended time as a CNM. Some said that it is clear from the behaviour of experienced CNMs that they have confidence in their own leadership skills.

Fares believes a good leader can emerge from working on the ward for a number of years, saying: "*You can become a leader [through] practice when you have spent years on the ward. I can say that leadership qualities come from experience. [My] clinical nurse manager is very friendly, and she makes me confident about my work"* (Fares, p.2 L: 64-66). Majeed felt similarly: "*Most of [the] experienced clinical nurse managers are more confident on the ward because they [are] able to avoid [mistakes] before they happen or because they can easily solve [them]"* (Majeed, p.2 L: 75-77). Saad spoke about a specific experience with a CNM:

> *The first time our clinical nurse manager prepared our vacation schedule, it was very difficult for him because some staff wanted their vacation in the same month. He struggled very much to solve that problem. But after that, he had more experience and then he was more confident and more aware about the challenges. If some staff wanted their vacation in the same month, he would try his best to talk with each one to solve the problem, so that one of them could choose another month. I think experience is very important to make you a better leader.* (Saad, p.2 L: 64-68)

Tisha said:

> *My clinical nurse manager has good clinical experience, so I can approach her. If I have any doubt, I can approach her easily … I found that if you have any*

> *[question for] the clinical nurse manager, it's [sometimes] very difficult for them to [answer].* (Tisha, p.2 L: 58-61)

Tisha continued, emphasising the importance of a CNM having extensive clinical experience:

> *For a clinical nurse manager, I think a minimum of 10 or seven years of [clinical] experience … is needed … so he or she can answer any doubts raised by their staff [and] clear any particular issue regarding any procedure or anything. If any staff [asks] questions and she [doesn't] know due to the lack of experience, that would not be ideal. In such a case, [it would be] very difficult for her to be [the] clinical nurse manager.* (Tisha, p.2 L: 35-41)

Bandar described the relationship between experience and confidence: "*The clinical nurse manager who has experience is confident, knows everything in the ward, and thus is cooperative, unlike the one who has less experience [and tries] to prove that his opinion is always correct. [This] affects the staff"* (Bandar, p.5 L: 150-152).

7.3.1.8 Saudis are better able to lead in their own country

This theme highlights participants' view that Saudi clinical nurse managers are better able to lead their staff, revealing that Saudi managers are able to build visibility and that it is easier for members of staff to reach out to Saudi clinical nurse managers to discuss their needs. In addition, these statements demonstrate participants' belief that Saudi managers can motivate, inspire and support their staff in the wards. Another highlighted point is that Saudi clinical nurse managers can establish effective communication with their staff in addition to their superiors.

They are building the national vision

In this subtheme, participants described how Saudi clinical nurse managers are able to prioritise the country's future vision. They thought that Saudi managers are particularly eager to educate their staff about their fields of expertise and to share their plans for improving patient care on

the wards. Fares, for example, described Saudi clinical nurse managers continually reminding staff about the country's vision, saying: "*Saudi clinical nurse managers [ensure that] we learn for the future. In fact, [they] always [remind] us that we have [a] vision [for] our country"* (Fares, p.2 L: 42–43). Saleh agreed, adding that Saudi clinical nurse managers are eager to communicate plans with staff: "*Our Saudi clinical nurse manager [shares his] vision or any plan that can improve our ward. … He always tells us [that in the] next few months, we [will] be the best ward in the hospital"* (Saleh, p.4 L: 115–117). Tisha supported the above comments, saying: "*It's their country; they can stay here for more than 10 years. … Saudi [CNMs] can share [their] vision with the staff"* (Tisha, p.4 L: 113–115).

Suliman and Saad described Saudi CMNs who worked to improve their wards:

> *I remember when the quality of our ward was not good, … the care [was] not [what] we hoped it would be. … When [the] Saudi clinical nurse manager [was] appointed to the position, he discussed with us the future of the ward – to be precise, how it will be in [the] next few months if we [collaborated] together. He was very excited and committed to the plan. Yes, I feel the ward is better now.* (Suliman, p.3 L: 86–90)

> *My clinical nurse manager built a vision for our ward, so we were not just doing the daily tasks and then leaving and doing the same thing for the next shift. You know, he is caring about creating something special, something unique to make our ward very special.* (Saad, p.6 L: 178–181)

Faisal felt much the same way and provided some specific examples:

> *The Saudi [clinical nurse manager] shares his goals with us. … For example, he shares a big goal, then divides it into small tasks in order to improve the ward and promises us for each goal a reward [will be] achieved, [such as] an extra [day] off. So, we always strive to achieve it.* (Faisal, p.8 L: 255–257)

> *For example, we had a large number of [ventilator-associated pneumonia] cases. … The Saudi clinical nurse manager spoke to us [about] what we need [to do] as staff to deal [with] and reduce [the cases]. Then, he talked to the*

> *superior to support the ward with intensive courses around [VAP case] management. [This] indeed [reduced] cases, which was manageable by the staff.* (Faisal, p.8 L: 262–265)

Nurses can approach them

In this subtheme, participants described being able to reach out to Saudi CNMs to get their support. Moreover, they felt that most Saudi and staff from other cultures prefer to work with Saudi managers because they are better able to meet their needs. Tisha felt able to approach her Saudi CNM: "*[The] Saudi clinical nurse manager is nice; she's very friendly [and] we can approach her any time"* (Tisha, p.5 L: 167–168). Nawal supported the above comment, saying: "*I was in discussion with my colleague [about] how our ward [was at] that time. [It] was better when we [had a] Saudi clinical nurse manager. ... We were strong; she [gave] us what we asked of her"* (Nawal, p.3 L: 86–85). In addition, Nawal felt that everyone preferred Saudi CNMs: "*Even non-Saudi staff prefer to work with Saudi clinical nurse managers because they support them and give them what they need"* (Nawal, p.4 L: 90–91).

Relatedly, Ebtisam said: "*If I have [an] issue with [the] nursing office, the non-Saudi clinical nurse manager can't do anything to help, unlike [the] Saudi clinical nurse manager who will stand with me"* (Ebtisam, p.4 L: 103–104). She added: "*All nurses [and] physicians respect her and [the] opinions she [expresses]. Everybody goes to her for resolutions to their problems"* (Ebtisam, p.2 L: 62–63).

They are supportive and encouraging

Participants' statements under this subtheme describe Saudi CNMs as supportive and encouraging leaders. Saudi managers seem to be excited about participating in patient care to assist their staff, and, as a result, the productivity of staff who work with Saudi managers is

perceived to be higher. Faisal, for example, felt that his Saudi CNM was supportive and flexible:

> *The Saudi clinical nurse manager is familiar with the policy but is flexible [with] what the staff need. So, I feel the productivity of the staff working with the Saudi clinical nurse managers [is] better because the staff [have their needs met].* (Faisal, p.8 L: 242–244)

Nawaf supported that perspective:

> *When I was working with a Saudi clinical nurse manager, he was very supportive and encouraged us. I remember [when] we heard he had a desire to change … to another hospital. We raised our objection as [his] staff; [because] he was supportive and encouraging, we [needed] him in the ward.* (Nawaf, p.4 L: 107–110)

Faisal described a specific time when his Saudi CNM was supportive:

> *When I [was] appointed [to] the ICU, I was afraid of doing some procedures, such as suction. ... The Saudi [clinical nurse manager] stood with me and said, "We will take a simple case and do suctioning step by step", and indeed I got it, and I don't have [that] barrier of fear now.* (Faisal, p.9 L: 291–293)

Majeed had a similar view:

> *When one of [the] staff has done a good job for patients … they can tell everyone in the hospital that [they] did a great job with [a] particular procedure. That really makes us more motivated. … But non-Saudi clinical nurse managers are not [like that] because I feel they think it is our work and we don't need encouragement.* (Majeed, p.2 L: 66–69)

Suliman supported this statement, adding that Saudi CNMs seem excited to participate in delivering care:

> *I feel the Saudi [clinical nurse managers are] better than the non-Saudi ones because they give the staff assignments, and they are very excited to participate in the care to help the staff. … I was once trying to insert a cannula, and he was involved to help me with that.* (Suliman, p.5 L: 148–150)

Nawaf described Saudi CNMs supporting staff in discussions with their superiors:

> *I feel when Saudi clinical nurse managers make a decision, [they are] not afraid. Sometimes, [they] may oppose [their] superior for the sake of the staff, so I prefer to work with them because they are not hesitant and [they seek] to serve their staff.* (Nawaf, p.5 L: 156–158)

They are enthusiastic and inspiring leaders

In this subtheme, registered nurse participants indicated that Saudi clinical nurse managers are enthusiastic and inspiring in a way that motivates their nurses. In addition, some felt that Saudi clinical nurse managers are always eager to express their appreciation of their staff, which encourages them to perform their work effectively. For example, Ebtisam described that Saudi clinical nurse managers seem eager to inspire their staff: "*The Saudi clinical nurse manager is always very excited [while] sharing the [ward's] vision; this motivates us to achieve and complete certain goals"* (Ebtisam, p.6 L: 172–173). Nawal supported that view: "*Some of the staff members think that the Saudi clinical nurse managers should be ward [leaders] because they motivate us to do our work"* (Nawal, p.1 L: 43-44).

Majeed spoke about his experience when working with a supportive Saudi clinical nurse manager:

> *They [are] very excited to let us learn. … I remember when I got the job … I told my clinical nurse manager that I didn't know anything. … He told me that he would let me work with him in the morning shift for three months, and if I felt like I still didn't know anything, he said, "Remember I'm with you." And for every issue, I [went] back to him, and I really feel he made my skills better than my colleagues working in other wards.* (Majeed, p.2 L: 53-57)

Tisha recounted her manager's efforts to inspire her staff: "*If we [complete] any good work or anything, [she brings] chocolate or [a] certificate. I feel most Saudi clinical nurse managers are very polite and appreciate [us]. … It is nice that we can improve our work more"* (Tisha,

p.5 L: 162–164). Faisal talked about working with his CNM when their ward was being assessed by the Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI): "*When our ward … passed [the] CBAHI accreditation, our Saudi clinical nurse manager [held] a small party in the ward and [thanked] us by giving [us an extra day off] in the new schedule"* (Faisal, p.9 L: 308-310).

Saudis communicate their needs to their superiors

This subtheme covers the participants' statements about Saudi CNMs communicating their needs to their superiors in a manner that encourages a willingness to grant their requests. Furthermore, some expressed the opinion that Saudi CNMs have better relationships with other departments, which facilitates work on the ward.

Tisha, for example, felt that Saudi CNMs can talk to their superiors with ease: "*If the Saudi clinical nurse managers have any problem in the ward, they can easily approach the higher authorities"* (Tisha, p.3 L: 70-71). Nawal felt similarly, saying: "*I prefer to work with Saudi clinical nurse managers because the hospital director supports them and [is] more active with them, which is evident in the director's willingness to approve their requests, I feel"* (Nawal, p.3 L: 65-66). Nawal explained further that, in her experience, Saudi CNMs achieve what they ask for: "*Saudi clinical nurse managers will get exactly what they ask from the hospital. They don't have to take it by force, but they do need to discuss [it several] times"* (Nawal, p.3 L: 60–61). On this same theme, Nasser said: "*Saudi clinical nurse managers have better relations with the administration departments, and this always helps and facilitates our work in the ward"* (Nasser, p.2 L: 84-85).

They can communicate effectively

This subtheme is focused on the participants' experiences of Saudi CNMs' capacity to communicate effectively in their wards. Some noted, for example, that Saudi managers are fluent in both Arabic and English, which makes communication easier when they have staff of different nationalities. In addition, they are capable of handling issues that may arise with the patients and their relatives. Tisha described an occasion when a Saudi CNM was able to resolve a conflict on the ward:

> *In our ward, we have a patient. His mother was [always] complaining to us. But for us, it was difficult to answer her. Then, she was fighting with us. The next day, when our Saudi clinical nurse manager came, we told her the problem. She talked to her nicely, [and] all problems were solved. So, they can communicate easily with everyone. They know more than non-Saudi [CNMs]. Well, if any patient is complaining or there is any problem, they can solve [it with] good communication.* (Tisha, p.5 L: 141-147)

Suliman supported this view, saying: "*[Saudi CNMs] can manage the ward well. ... I mean, they can communicate in Arabic and English, so [it is] easy when [they] have staff with a different nationality"* (Suliman, p.2 L: 45-47). Bandar agreed and added that communicating with a Saudi CNM is better for the nurses: "*Communicating with the Saudi clinical nurse manager is more effective and easier for us. ... Explaining any procedure [seems] easier [for them] when I encounter difficulty in some points"* (Bandar, p.4 L: 131-133).

7.3.1.9 Cultural barriers for leaders from other cultures

This theme focuses on descriptions of cultural differences posing barriers to individuals' leadership abilities from other cultures. More specifically, comments under this theme suggest that a manager's cultural background affects their capacity to comprehend the needs of their staff in social, linguistic and personal terms. This theme also draws attention to managers from other cultures who are reluctant to discuss their staff's needs and those of the ward with their

superiors. Some participants felt that managers from other cultures are disengaged from patient care, do not share the ward's overall vision, and often remain in their post for a relatively short time.

They do not understand staff's personal needs

In this subtheme, some participants felt that some CNMs from other cultures are not able to understand what their staff require on a personal level or the situations faced by individuals in terms of family circumstances. Fares described this problem, saying: "*Non-Saudi [clinical nurse managers do] not understand our personal needs or problems like Saudi clinical nurse managers. Even if strict, [they] understand our needs if one of us [is facing] emergency circumstances"* (Fares, p.1 L: 27-29). Explaining this point further, Fares said: "*Non-Saudi clinical nurse managers [are] sometimes strict because they focus more on the work without being [able to] consider our family needs. [They] don't have family here"* (Fares, p.1 L: 31-32). Relatedly, Faisal explained: "*Non-Saudis are bound by the policy because of their fear. They can't achieve the interests of the staff in terms of giving extra [time] off"* (Faisal, p.7 L: 235-236).

They do not understand the local culture and language

A number of participants believed that some managers from other cultures are unable to deal with the cultural context in which they work, as explored in this subtheme. Participants also mentioned that most CNMs from other cultures face language barriers because they do not understand or speak Arabic. Faisal described his experience of requesting a day off: "*I remember when I applied for some time off for a special day. It was my engagement, and my non-Saudi clinical nurse manager complained about staff shortages"* (Fares, p.1 L: 35-36). Nasser's comments support this perspective:

> *Non-Saudi clinical nurse managers sometimes do not understand our culture well. It is hard for us to work with them. ... If you have a special circumstance with your family, non-Saudi clinical nurse managers will not allow you to leave work.* (Nasser, p.1 L: 53-55)

Nawal expressed concern about CMNs from other cultures difficulty communicating in Arabic: "*If non-Saudi clinical nurse managers were able to speak Arabic and English, [it would] help them to lead easily. Most of them do not understand or speak the Arabic language"* (Nawal, p.1 L: 39-40). Saleh supported this, saying: "*Non-Saudi clinical nurse managers face difficulties sharing their opinions or the ward vision [with] the staff because they don't speak Arabic. ... Maybe their thoughts are good, but [they are] not able to address all staff"* (Saleh, p.3 L: 91-93).

They hesitate to consult their superiors

Participants felt that some clinical nurse managers from other cultures hesitate to ask the higher authorities for help. They also talked about managers needing to be clear about what they expect of their superiors. For example, Nawal had observed a manager who was unwilling to consult their superiors:

> *If we have a problem or a shortage in the ward, or if we need something, our non-Saudi clinical nurse manager feels too shy to ask or is hesitant because she thinks it's not her right to ask for what our ward needs.* (Nawal, p.2 L: 53-54)

Nawal continued on this subtheme, adding that managers from other cultures should be more assertive when asking for something for their staff:

> *[Non-Saudi CNMs] need to be clear what they want from their managers, and if they ask, they should be stronger. [Sometimes, they] will ask only once without repeating. Sometimes, [they] need to be firmer with [the] manager, for [the sake of] our ward. I feel they think that the managers may get angry, but actually, she [is] not asking for herself. [It is] for the staff she manages.* (Nawal, p.3 L: 69-71)

Tisha, on the other hand, thought the reason managers from other cultures cannot consult their superiors was communication: "*I feel it is difficult because [they] lack communication skills. Some are facing difficulties in speaking in Arabic, so … we feel they can't approach the higher authorities"* (Tisha, p.3 L: 71-73).

Non-Saudis are disengaged and do not stay in their post

In this subtheme, participants stated that clinical nurse managers from other cultures did not usually stay for long periods of time. Participants emphasised that managers from other cultures did not share the vision of the staff. Faisal commented: "*When I was working with a non-Saudi clinical nurse manager, I was shocked when she told me, 'This is your patient. Nothing to do with me; you should do your work.' She did not stand [by] me for anything"* (Faisal, p.9 L: 300-302). Bandar had a similar experience:

> *I had difficulty learning when I was with a non-Saudi clinical nurse manager. She was always busy. I remember a day I needed to ask her about a specific thing so she could teach me. She gave me very short answers, really not enough, so I tried to learn them myself.* (Bandar, p.4 L: 111-114)

Suliman described CMNs from other cultures who were disengaged: "*[Non-Saudi CNMs] give staff assignments without participating in the care"* (Suliman, p.5 L: 147-148). Nasser talked about a lack of longer-term commitment: "*Non-Saudi clinical nurse managers may not share the department's vision for [the future] because they do not stay a long time with us"* (Nasser, p.2 L: 76-77). Nawal felt the same: "*Non-Saudi clinical nurse managers will not stay for long, so we need a Saudi clinical nurse manager who can dedicate themselves to the position for a long time"* (Nawal, p.1 L: 46-47).

7.3.1.10 Good leadership from Filipino leaders

Some participants described experiences of good leadership from CNMs from the Philippines, particularly highlighting the friendliness, emphasis on teamwork, and professional manner of these individuals. The following statements from Fares, Nawaf and Saad concern the leadership of their CNMs from the Philippines.

Fares, for example, described the friendliness of Filipino clinical nurse managers: "*I like to work with clinical nurse managers from the Philippines because they are more friendly when they lead the staff"* (Fares, p.2 L: 45-46). Explaining this point further, Fares said:

> *I was stressed because I was unsure about my future when I started my duty, but I was with [a] clinical nurse manager from the Philippines. She made me feel happy because she explained everything very clearly and in a detailed manner for me.* (Fares, p.3 L: 52-53)

Saad supported this perspective: "*Clinical nurse managers from East Asia, for example from the Philippines, are more active, and they are more careful about details on the ward. They strive for high quality, and they want everything super professional"* (Saad, p.4 L: 103-105). Nawaf added: "*Our Filipino clinical nurse manager knows when to be strict and when to be lenient while dealing with the staff, and this is appropriate because he treats every nurse according to what they deserve"* (Nawaf, p.6 L: 188-190).

7.3.1.11 Preparing the staff for future leadership

This theme is focused on the importance of preparing staff to become leaders through relevant development training. Moreover, some participants talked about having to prepare themselves for the sudden departure of CNMs from other cultures.

We should prepare ourselves

Registered nurse participants felt they should prepare themselves for becoming CNMs particularly because managers from other cultures often leave suddenly. Some participants felt that, when such a transition occurs, it is important to have the necessary experience, leadership training and understanding of what is expected. Nawal described the sudden departure of CNMs from other cultures: "*It [is] our country; we must be able to handle the position because one day, the non-Saudi clinical nurse managers will leave suddenly. ... What will we do? We must deal with this situation and prepare ourselves"* (Nawal, p.2 L: 49-50). Similarly, Ebtisam felt that a nurse must have the necessary experience and education before becoming a leader, saying: "*If I [become] clinical nurse manager at a particular ward, I need more experience in that ward to sharpen my knowledge [and] skills and get a clear picture of my responsibilities"* (Ebtisam, p.7 L: 202-203).

The need to train the staff

Fares extended the above opinions, suggesting that in order to prepare themselves for leadership, nurses need leadership training: "*As a staff nurse, I need workshops to cover leadership training because, today, I'm just a staff member, but tomorrow, I may be promoted to clinical nurse manager"* (Fares, p.3 L: 69-70). Bandar agreed, saying: "*It is important to provide leadership training for nurses because, one day, one of the staff will be the clinical nurse manager of the ward, so everyone who is concerned with leadership needs training"* (Bandar, p.7 L: 218-220).

7.4 Commonality themes

Though the themes and subthemes from the clinical nurse managers and registered nurses were presented above as discrete elements, they were interrelated (Figure 7.3). Both groups expressed positive and negative perspectives about clinical nurse managers' leadership in the

Saudi healthcare context, with the negative observations including clinical nurse managers having insufficient experience and the cultural barriers faced by managers from other cultures, as well as the prevalence of poor leadership and obstacles to improving it. The positive perspectives included that Saudis are better leaders in this context and the importance of working as a team and solid clinical expertise. Moreover, both groups stressed the value of developing leadership skills for the future.

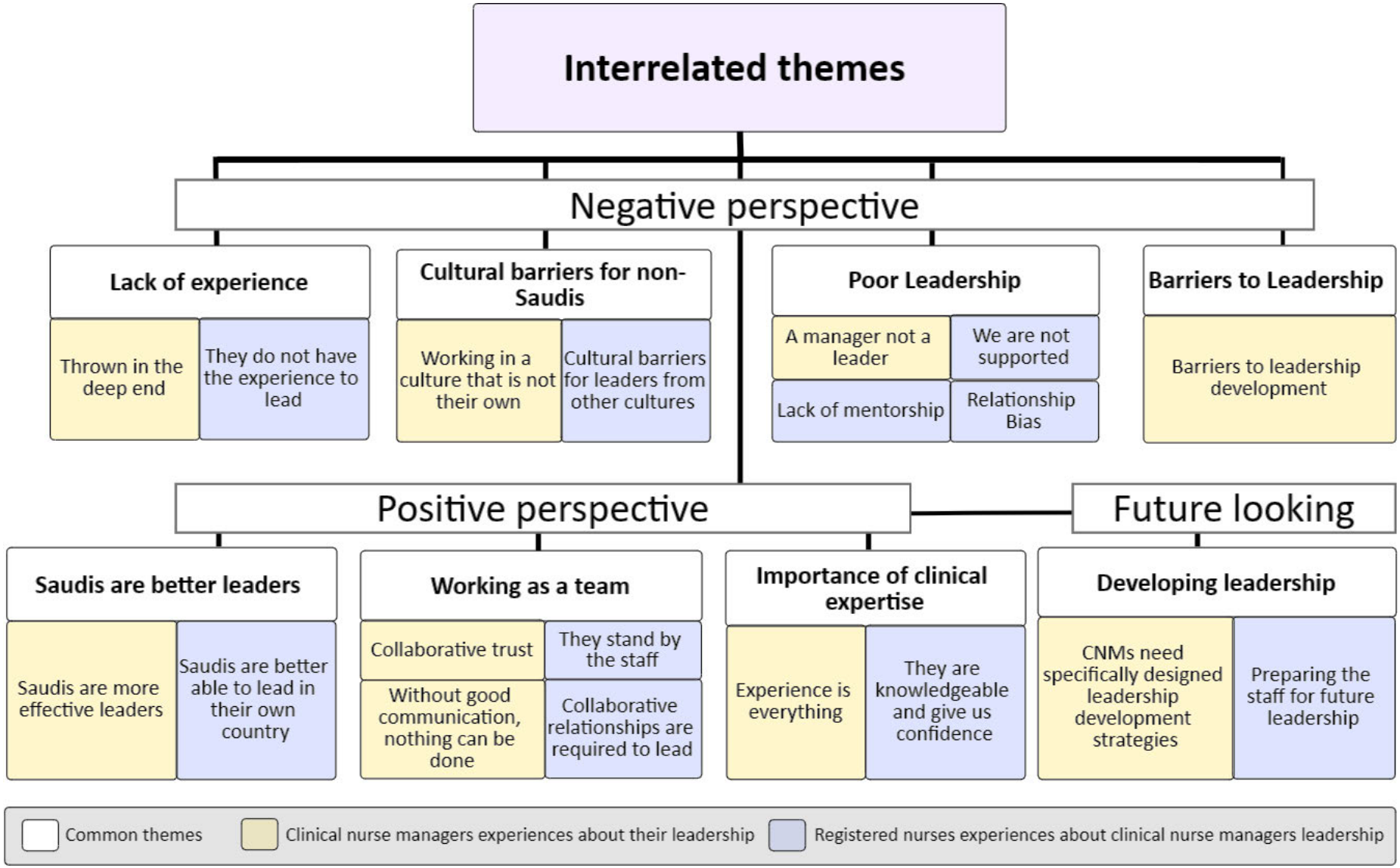

Figure 7.3: Interpretation of experiences recounted by the clinical nurse managers and registered nurses

7.4.1 Lack of experience

An important finding of this study is that the clinical nurse managers themselves and the registered nurses recognise that experience is critical to clinical nurse manager leadership. Both groups felt that clinical nurse managers face difficulties in and uncertainty about their leadership abilities due to a lack of experience when they are appointed to the role, and this translated to a feeling that clinical nurse managers want to lead but some do not act like leaders in their day-to-day work. This poses challenges for inexperienced managers and their staff, not only because they do not know how to lead but also because the nurses do not have an experienced or well-prepared clinical nurse manager to lead and guide them effectively. This is often due to the study hospitals appointing nurses without sufficient experience and preparation to clinical nurse manager positions.

7.4.2 Cultural barriers for non-Saudis

Both groups identified some cultural issues that can hinder the leadership of clinical nurse managers from other cultures, for example that there are certain nuances a manager from overseas might not be familiar with, making it feel as though they are working with one hand tied behind their back. They can feel restricted by working in a culture that is not their own and facing many problems with their superiors, nursing staff, patients and relatives. The clinical nurse managers and registered nurses in this study thought that managers from other cultures find it difficult to convey their ideas on account of not being Saudi and not always being able to communicate in Arabic and that they are less able to comprehend their staff's cultural, linguistic and personal needs. In addition, the superiors who are supposed to support those in the clinical nurse manager role and facilitate their work sometimes prevent them from making decisions independently.

7.4.3 Poor leadership

This study found that both clinical nurse managers and registered nurses recognise poor leadership behaviours from some of the clinical nurse managers in their hospitals. According to participants in each group, some clinical nurse managers merely perform managerial tasks and leave their staff without assistance. That is, they agreed that clinical nurse managers are often disengaged from patient care and do not take responsibility for it and that some feel they are better than other staff and that everyone should listen to them. Many were of the opinion that their clinical nurse manager does not support or allow them to make their own decisions. Moreover, the registered nurses in this study agreed that there is a lack of mentorship from their clinical nurse managers and that they are not sufficiently taught or directed by their ward leaders, which has affected their ability to advance their knowledge and practical skills. In addition, some nurses felt concern about clinical nurse managers who appear to neglect team productivity because of existing relationships with some individuals, caring more for staff they are familiar with, are related to, or who have the same nationality as them. This had prompted some of the nurses to change their wards because they did not feel they were being treated fairly.

7.4.4 Barriers to leadership

The clinical nurse managers revealed that they face multiple barriers to developing their leadership capabilities and advancing their careers, and these obstacles are often related to inadequate training opportunities provided by their hospitals. More specifically, a lack of lectures, courses and workshops designed for clinical nurse managers is a significant barrier, the timing of the training that is offered is often inappropriate for clinical nurse managers' schedules and external costs make it impossible to attend some courses. Some participants agreed that their hospitals do not take the clinical nurse managers' timetable' into account when

organising in-house training, leading some to look for options outside of their hospitals, which are often too costly to attend. This made the participants feel that there is no true support to help them develop their leadership abilities. Similarly, some felt that other clinical nurse managers are treated preferentially by superiors and that this nepotism in their hospitals affects both their effort and their success in leadership.

7.4.5 Saudis are better leaders

The clinical nurse managers and registered nurses interviewed for this study felt that Saudi managers are tremendously influential on the wards because of specific ways in which they behave. Both participant groups mentioned a number of factors that contribute to the effective leadership of Saudi clinical nurse managers. These factors including support from their superiors, cultural and linguistic similarities with the majority of staff and patients and the need of those groups for a Saudi manager, the ease with which Saudis make decisions autonomously, and their capacity to guide staff towards a vision of the future. The participating clinical nurse managers and registered nurses noted that culture and language are two important factors in making Saudi managers more influential and more effective in their leadership, suggesting that Saudi clinical nurse managers are able to take advantage of their cultural background to lead their staff and manage their wards. They can share cultural understandings and are able to communicate effectively with new staff or administrative staff who do not speak English well.

Most participants perceived Saudi clinical nurse managers to be more effective in their actions and leadership because their superiors support them, and both groups of participants felt that Saudi managers maintain close relationships with their supervisors and with administrative departments, which leads to their having greater authority. In addition, interviewees in both groups felt that Saudi clinical nurse managers are more aware of and had acquired more knowledge about the future of nursing in the country, with the belief that managers from Saudi

Arabia are sufficiently aware of Saudi Vision 2030. Consequently, they are able to lead the nursing staff and manage the wards more effectively because all parties share that vision of advancing the nursing profession and expectations of the future. There was also a strong perception among the participants that registered nurses value the encouragement they receive from Saudi managers more than that from clinical nurse managers from other cultures and that patients and their families have fewer problems when a Saudi clinical nurse manager is on duty as they can communicate more easily with them.

7.4.6 Working as a team

Both groups identified the importance of certain leadership traits for clinical nurse managers to build collaborative trust with their team in clinical areas, including working with and caring for them, enabling individuals to develop their expertise and make their own decisions, and showing their motivation to their staff. When a leader demonstrates these characteristics, the knowledge and skills of the nursing staff can be enhanced which ultimately leads to better patient care. Participants also agreed that the clinical nurse manager must strengthen relationships with and listen to the nurses, for example by holding regular meetings to discuss any difficulties they encounter. That is, they will have a strong relationship with their staff which will support the nurses in advancing their abilities by helping them overcome any issues and obstacles. The participants agreed that another important team skill for clinical nurse manager leadership is the capacity to act as a conduit for organisational communication. Because of their position, a clinical nurse manager is able to facilitate communication between nurses and management or other health professionals. In addition, the participants stated that working in a multicultural context itself requires clinical nurse managers who are capable of effective communication and who demonstrate the confidence to lead staff and manage wards in order to provide quality nursing care to the patients.

7.4.7 Importance of clinical expertise

The current study shows that clinical nurse managers and registered nurses recognise clinical expertise as a highly important aspect of leadership, with both groups indicating that clinical experience is crucial to a leader's credibility in the ward. Some participants agreed that the managers with the most experience have better skills and more insight, they are able to understand what the staff are experiencing and they are capable of coping with difficult situations on the ward. The participants also agreed that experience enables clinical nurse managers to work more cooperatively with all staff because they are often capable of understanding people from a variety of cultural backgrounds. Experience is also one of the factors that makes a manager competent in appointing tasks to their nursing staff. They seem more capable of allocating duties based on clinical skill, which in turn leads to enhanced patient care. In addition, the registered nurses in this study recognised that experienced clinical nurse managers are confident and know what they are doing on the ward which means they are able to foster a sense of trust in the abilities and performance of their staff.

7.4.8 Developing leadership

Participants in both groups had a strong positive intention to undertake leadership development, agreeing that appropriate training is necessary for clinical nurse managers to build practices that will enable them to lead effectively. Leadership development is needed at three key stages. First, there is a need to train nursing staff in leadership skills to prepare them for becoming clinical nurse managers, that is, some participants felt nurses should be ready for a sudden appointment to the position. In the second stage, existing clinical nurse managers need to be trained in leadership skills through practical and workshop activities, to improve their communication skills and to build a positive work culture for managing their wards. Finally, the participants agreed that it is necessary for clinical nurse managers to receive ongoing

counselling and psychological support from their hospitals in order to foster positive thinking and self-confidence and subsequently develop and promote their leadership abilities.

7.5 Summary

This chapter has presented the themes and subthemes that emerged from interviews with clinical nurse managers and registered nurses, with ten themes being identified from clinical nurse managers and eleven from registered nurses. Despite being presented as discrete elements, the themes and subthemes from both sets of participants are interrelated, with eight thematic commonalities emerging from the combination of the two datasets. In the next chapter, these qualitative findings will be integrated with the quantitative results, discussed and compared with the existing relevant literature.

Chapter 8: Integration

The Kingdom of Saudi Arabia's Vision 2030 demonstrates a path to the future for the country. In 2016, the government announced a transformative and considerably ambitious plan aimed at unleashing the kingdom's vast potential by building a resilient, innovative and globally competitive nation for future generations through the National Transformation Program. Since the launch of Vision 2030, Saudi Arabia has witnessed both unprecedented change and remarkable growth (Kingdom of Saudi Arabia 2016b). These developments have included modifications to the country's economic and health systems, which were intended to accommodate the country's growing population. Saudi Arabia also recently announced the Health Sector Transformation Program, which was launched in 2022 (Kingdom of Saudi Arabia 2021). This program is directed at transforming the health sector into an efficient, integrated and comprehensive health system that focuses on the health of individuals and society (including citizens, residents and visitors). This initiative encompasses the reshaping of the kingdom's social and cultural landscape to create an era of inclusivity and dialogue (Kingdom of Saudi Arabia 2021). Saudi Arabia aspires to empower its citizens as active contributors to the nation, while establishing a shared sense of responsibility, with an emphasis on the empowerment of women and youth, enhanced access to education, employment avenues and unprecedented cultural opportunities. Clearly, this may have a significant influence on hospitals seeking to appoint Saudis to manage staff and wards in these institutions. Rapid change, however, is always likely to have unintended consequences. Given that sustainability is at the centre of the country's vision, achieving the desired sustainable change necessitates understanding the current challenges that confront clinical nurse managers and their critical needs.

This chapter discusses the findings that emerged from the quantitative and qualitative analyses. It is aimed at integrating the quantitative and qualitative data with the results derived by other studies to gain insights into the experiences of clinical nurse managers and registered nurses. This discussion is intended to provide a cohesive and clear picture of leadership among clinical nurse managers in Saudi hospitals. As outlined in Section 1.7, there were three main research questions and related sub-questions that guided the study.

8.1 Synopsis of the results of the study

The results of the quantitative and qualitative phases of the study will be summarised here. A significant difference was found between the perceptions of the two groups of participants – that is, the self-reports by the clinical nurse managers regarding their leadership practices contrasted with the perceptions of the registered nurses working in their wards. This result indicates that the clinical nurse managers exercise transformational leadership less effectively than they should, as perceived by the registered nurses. Generally, most of the clinical nurse managers had less than five years of experience in their position and in overseeing their current wards and registered nurses. A positive correlation was found between the *enable others to act* leadership practice of the clinical nurse managers and their overall experience and their experience managing the wards in particular. This finding suggests that experienced clinical nurse managers tend to be collaborative leaders who involve registered nurses in new opportunities in their wards. A positive association was also found between the clinical nurse managers' experience and the *encourage the heart* practice, indicating that experienced clinical nurse managers appreciate individual contributions to management success in their wards. The clinical nurse managers from other cultures self-rated their *model the way* practice significantly higher than their Saudi counterparts, reflecting that the former may have a clearer understanding of and are more confident that they are adhering to the guiding principles and their roles within their wards. From the registered nurses' perspectives, there were differences

between the Saudi and clinical nurse managers from other cultures in the *inspire a shared vision, challenge the process and encourage the heart* transformational leadership practices. This finding implies that Saudi clinical nurse managers engage in these practices more often than their counterparts from other cultures. It also denotes that the Saudis are more likely to share their vision with the registered nurses working in their wards, take risks regarding innovative ways to change the status quo and concentrate intently on recognising the contributions of individual registered nurses. In addition, the questionnaires revealed that 61% of the clinical nurse managers had not received training on the development of their leadership skills, even though these managers exhibited positive attitudes towards such development. This suggests that the hospitals in the study did not offer leadership training opportunities to their clinical nurse managers.

This aspect was further examined during the qualitative phase of the study with the clinical nurse managers and registered nurses. The clinical nurse managers were asked about their experience of their leadership within their wards. Then the registered nurses were asked about their experiences of the leadership of the clinical nurse managers. Particular attention was paid to expanding and comprehensively exploring the results of the quantitative study. The findings revealed both positive and negative perceptions of clinical nurse managers' leadership in the Saudi healthcare context. Both groups of participants confirmed that the clinical nurse managers face difficulties with and uncertainty about their leadership abilities because of their lack of experience. The groups also identified certain cultural issues that can hinder the leadership of clinical nurse managers from other cultures. They recognised poor leadership behaviours from some of the clinical nurse managers in their hospitals. For their part, the clinical nurse managers acknowledged the existence of multiple barriers to the development of their leadership capabilities and the advancement of their careers. Moreover, the participating groups mentioned a number of factors that contribute to effective leadership by Saudi clinical

nurse managers. They pinpointed the importance of certain leadership traits and clinical expertise in the efforts of clinical nurse managers to build collaborative trust with their teams in clinical areas. Both groups likewise exhibited a strong intention to participate in leadership development, agreeing that appropriate and specific training is necessary for nurses and current clinical nurse managers to cultivate practices that will enable them to lead effectively. These results of the quantitative and qualitative phases of the study have been integrated in Figure 8.1.

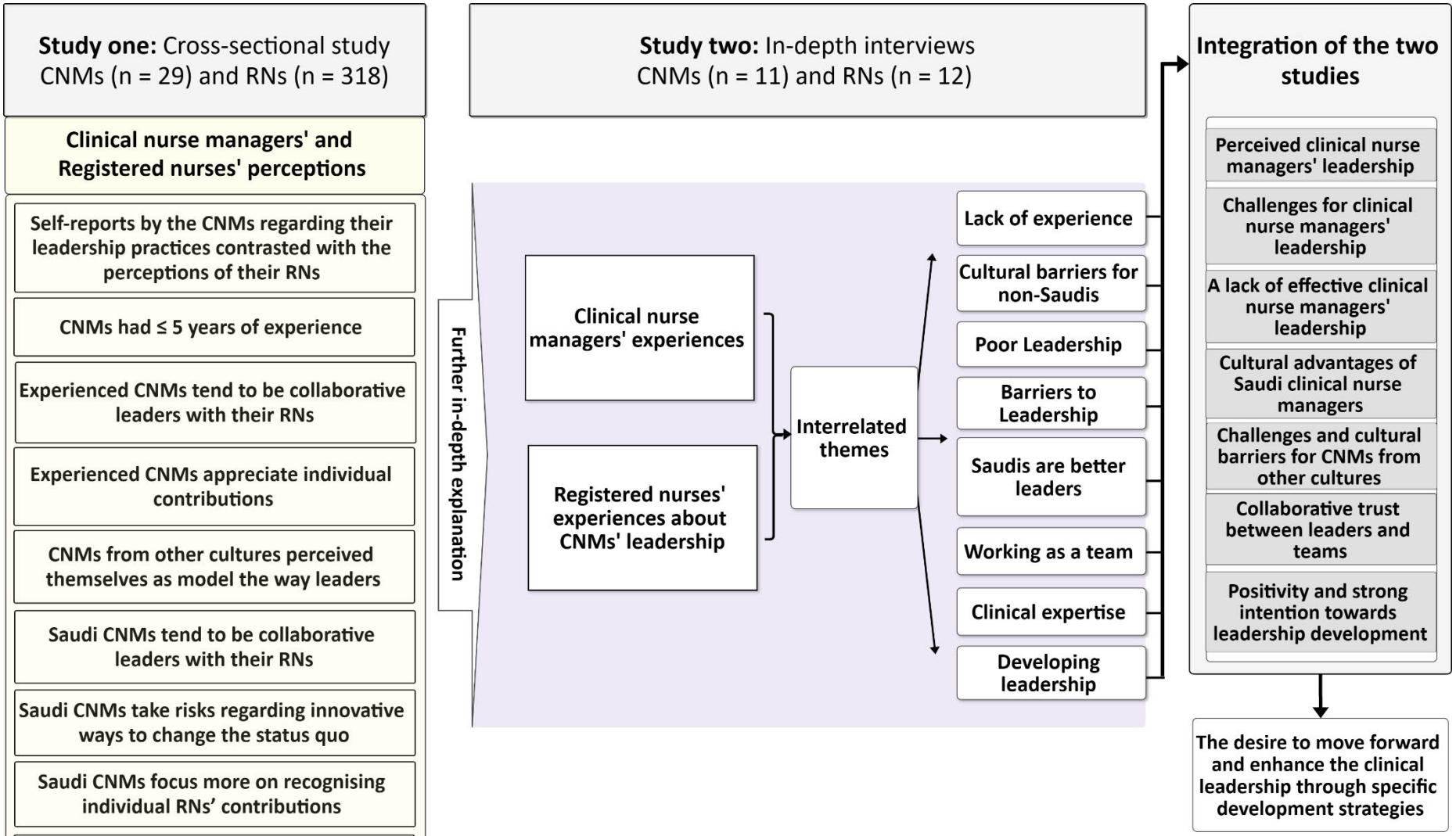

Figure 8.1: Visual model of the integration of the two components

8.2 Perceived transformational leadership of clinical nurse managers

8.2.1 Self–observer agreement on clinical nurse managers' leadership

The quantitative phase showed that the clinical nurse managers consistently assessed their transformational leadership practices (using the Leadership Practice Inventory) significantly differently from the assessment of the registered nurses. This result is in agreement with the study by Heuston, Leaver and Harne-Britner (2021); in other studies, similarly, self-report scores were also higher than those in observer reports completed using other leadership instruments (Alsadaan 2018; McGuire & Kennerly 2006; Goh et al. 2018). Meanwhile, the study conducted by Al-Yami et al. (2018) found that nurse managers perceived themselves as transformational leaders. A growing body of research identifies transformational leadership as a significant success factor in propelling change in any organisation (Richter et al. 2016; Agha et al. 2019; Gemeda & Lee 2020; Singh 2020). The findings from this study suggest that registered nurses are less confident about the transformational leadership practices of clinical nurse managers than the managers themselves, in all practices (*model the way, inspire a shared vision, challenge the process, enable others to act* and *encourage the heart*). Such a lack of agreement between self- and observer ratings was discussed in previous studies, where leaders tended to rate themselves higher than observers – a phenomenon that may lead to the overestimation of leadership skills (de Vries 2012; Fleenor et al. 2010). The results also indicate that clinical nurse managers practise transformational leadership in their wards less effectively than they should, as perceived by registered nurses. This finding is consistent with a recent study conducted with nurses in the USA who rated the leadership practices of their clinical nurse managers lower than their managers did (Heuston et al. 2021). This may affect clinical nurse managers' ability to foster relationships, collaborate with and empower others to take initiative and recognise individual contributions to create a shared sense of accomplishment within a team. They may exhibit diminished willingness to seek innovative

ways to change the status quo, to focus on envisioning the future and to create an ideal, unique image of what an organisation can become.

The qualitative phase of the study showed that the clinical nurse managers believed that the registered nurses had a poor understanding of the managers' responsibilities and roles. The low rating that the registered nurses gave to the clinical nurse managers was possibly due to work stress and difficulties that they face. This issue was discussed in previous studies (de Vries 2012; Fleenor et al. 2010). The current study suggests that this absence of agreement may be due to the insufficient knowledge of registered nurses regarding the duties and responsibilities of clinical nurse managers. These findings have not been confirmed or negated in any other nursing research for the purpose of illuminating the absence of agreement between the perspectives of the two groups. Consequently, this study contributes to our understanding of the circumstances surrounding clinical nurse managers and registered nurses who work in the same wards.

8.2.2 Leadership practices related to demographics and professional factors

The results from the quantitative phase of the study show that most clinical nurse managers have less than five years of experience in general and in their current role, indicating that clinical nurse managers in Saudi Arabia tend to leave their role quickly than those who work in developed countries (Caramanica & Spiva 2018; Clavelle et al. 2012; Echevarria et al. 2017; Moon et al. 2019; Spano-Szekely et al. 2016). This may suggest that the hospitals where the research was conducted have high attrition rates, leading to the employment of less experienced clinical nurse managers. The current quantitative study found that the mean ages of clinical nurse managers and registered nurses were 34.8 and 30.3 years, respectively, which corroborated Saudi studies reporting that the nursing workforce is largely composed of young, inexperienced professionals (Alboliteeh et al., 2017; Alghamdi et al., 2018). The mean age of

Australian and American nurses is 44 years (Australian Health Practitioner Regulation Agency, 2020), and 48.8 years (Halpern, 2016), respectively. The findings from the qualitative interviews corroborated and extended the quantitative results. The findings revealed that Saudi hospitals typically appoint inexperienced nurses to clinical nurse manager positions. Consequently, clinical nurse managers encounter difficulties and uncertainties with respect to their leadership abilities. Most of the participants spoke about feeling confused when suddenly being assigned the role for the first time without enough clinical experience to effectively lead the staff. One participant claimed that the consequences of difficulties and uncertainties about their leadership abilities may lead to the clinical nurse manager failing to manage the staff and not continuing in their positions. This lack of experience may affect clinical nurse managers' decisions to remain in their roles, and also affect how they lead their staff, which may then have an indirect effect on patient care.

The quantitative study demonstrated a positive correlation between the *enable others to act* and *encourage the heart* practices and clinical nurse managers' experience in general and in their current wards, suggesting that experienced clinical nurse managers tend to be collaborative leaders who give registered nurses new opportunities in their wards (Kouzes & Posner 2017). These results are corroborated by studies conducted in the United States by Clavelle et al. (2012) and Herman et al. (2017). The findings from the qualitative interviews supported the results of the quantitative study and provided a deeper understanding. The findings revealed that clinical nurse managers and registered nurses recognise clinical expertise as a highly important aspect of leadership, with both groups indicating that experience is crucial to a leader's management style. This finding is consistent with a previous study by Patrick et al. (2011), which found that clinical expertise is one of the most important attributes for clinical leadership. Some participants in the current study agreed that the managers with the most experience have better skills and more insight, and that they are able to understand what the

staff are experiencing and are capable of coping with difficult situations in the ward. The participants also agreed that experience enables clinical nurse managers to work more cooperatively with all staff because they are often capable of understanding people from a variety of cultural backgrounds. Experience is also one of the factors that makes a manager competent in allocating work to the nursing staff appropriately. They seem more capable of allocating duties based on clinical skills, which in turn leads to enhanced patient care. In addition, the registered nurses in this study recognised that experienced clinical nurse managers are confident in their role, which means that they are able to foster a sense of trust in their abilities and promote the optimal performance of their staff. They also confirmed that experienced clinical nurse managers reward staff when they excel in their work in the ward, and this has a positive effect.

The quantitative study results reveal no correlation between other clinical nurse manager characteristics, such as age, educational level and transformational leadership practices. The quantitative and qualitative findings from the current study support each other regarding the lack of a relationship between age and educational level and transformational leadership practices. These results align with those of some previous studies (Spano-Szekely et al. 2016; Shaughnessy et al. 2018). In contrast, other studies found a positive correlation between age and the *inspire a shared vision* and *challenge the process* transformational leadership practices (Clavelle et al. 2012), as registered nurses whose mean age was between 40 and 49 years rated the *inspire a shared vision* leadership practice more highly (Herman et al. 2017).

8.3 Challenges for clinical nurse managers' leadership

8.3.1 Lack of preparation for the leadership roles

One of the most significant challenges facing clinical nurse managers is a lack of preparation prior to their assignment to leadership roles. The quantitative results show that most of the

clinical nurse managers in this study had less than five years' experience, and 62.1% had not held a management position elsewhere prior to taking on the role. This issue was further explored in the qualitative phase, with both the clinical nurse manager and registered nurse groups feeling that managers face difficulties in and uncertainty about their leadership abilities due to their lack of experience when appointed, which translates to the sense that, although clinical nurse managers want to lead, they do not act like leaders in their day-to-day work. This poses challenges for the inexperienced managers and their staff, not only because they do not know how to lead but also because the nurses do not have an experienced or well-prepared manager to guide them effectively in their clinical practice. This can be traced back to the study hospitals appointing unqualified, inexperienced and untrained managers to the role.

These findings align with those of previous studies conducted in both developed and developing countries, which confirm that a lack of preparation and the inexperience of clinical nurse managers in leadership positions can result in ambiguous expectations and can negatively affect their performance (McCallin & Frankson 2010; Pilat & Merriam 2019; Alsadaan 2018; Saaweh 2018; Manion et al. 2021; Kauffman 2020; Moore, Sublett & Leahy 2016; Keys 2014; Saifman 2017). The current study indicates that clinical nurse managers are not adequately prepared for assuming a leadership role, despite the fact that policymakers and hospitals provide financial and other incentives for nurses holding this position. The financial rewards are certainly a key incentive for those who occupy this role but preparing for it should be even more important to avoid possible negative consequences, such as ineffective leadership and clinical nurse manager attrition.

8.3.2 Lack of continuing professional development focused on leadership

The results from the questionnaire indicate that some limited professional development courses were available; however, 61% of the clinical nurse managers had not received training to

develop their skills, particularly leadership training, short leadership courses or leadership workshops. The qualitative study found that hospitals rarely provided training and educational opportunities to enhance and advance the leadership capabilities of clinical nurse managers. In addition, the qualitative study's findings showed that, if hospitals offered educational opportunities, they often neglected to ensure that clinical nurse managers were able to attend. Most of these opportunities are available only during the morning, which is the busiest time for clinical nurse managers in supervising their respective wards, and they are not able to attend. This can be attributed to the lack of a well-structured, sustainable plan that focuses on training and providing regular leadership development for clinical nurse managers. It was found that the findings of both the current quantitative and qualitative studies are aligned with each other with regard to clinical nurse managers not receiving training to develop their leadership skills. Furthermore, the qualitative study helped to shed light on the obstacles that prevent clinical nurse managers from developing their leadership skills and advancing their careers. The results of the current study are consistent with previous studies that have identified limited opportunities for nurse managers to develop their leadership skills (Keys 2014; Gaskin et al. 2012; Stanley et al. 2017). Inadequate professional development or overlooking leadership development for clinical nurse managers can negatively affect hospitals and clinical nurse managers themselves (Flatekval & Corbo 2019).

8.4 A lack of effective clinical nurse manager leadership

A surprising finding from the qualitative phase is that both clinical nurse managers and registered nurses recognise poor leadership behaviours from some of the clinical nurse managers in their hospitals. Several studies have linked ineffective leadership with difficult relationships between nurse managers and nursing staff, decreased productivity, lower morale, higher frequency of adverse events, poorer quality care and greater intention to leave the

profession (Estes 2013; Labrague & de Los Santos 2021; Morsiani, Bagnasco & Sasso 2017; Lu, Zhao & While 201; Lavoie-Tremblay et al. 2016; Labrague et al. 2020; Roche et al. 2010).

One of the duties of a nurse manager is to provide support for their staff (Nurmeksela et al. 2021; Kodama & Fukahori 2017; Adams, Chamberlain & Giles 2019), and nurses managers' involvement in clinical care activities is vital to the future of nursing leadership (Duffield et al. 2019). However, participants from both groups in this study stated that some clinical nurse managers only perform managerial tasks and leave their staff without assistance. Some also felt that clinical nurse managers are often disengaged from patient care and do not take responsibility for it, with some managers feeling they are better than other staff and that everyone should listen to them. A lack of clarity about nurse managers' roles, such as administrative duties within clinical management roles, is causing nurse managers stress, thus limiting their ability to lead frontline nurses effectively (Duffield et al. 2019), and also leads to lack of knowledge translation (King et al. 2021).

Several studies have emphasised the importance of supporting and enabling nurses to make their own decisions (Price et al. 2017; Nibbelink & Brewer 2018; Oshodi et al. 2019). The current study revealed that many registered nurses feel their clinical nurse managers do not allow them to make decisions, for example, in relation to daily assignments or shift duties which are instead randomly assigned. Fostering a supportive environment for nurses and considering their input could enhance interprofessional collaboration (Dorgham & Al-Mahmoud 2013; Cosentino et al. 2021). Moreover, some of the registered nurses in this study described a lack of mentorship from their managers and that they are not sufficiently taught or directed by their ward leaders, which affects their ability to advance their knowledge and practical skills. Mentoring has a role in the promotion of high-quality patient-centred care and the development of positive relationships in the workplace (Coventry & Hays 2021; Jakubik et al. 2017), and is a career-enhancing practices (Coventry & Hays 2021). Thus, the lack of

mentorship from some nurses' managers may affect nurses' ability to provide high-quality care and negatively affect their working relationships.

In addition, some registered nurses were concerned about clinical nurse managers who appear to neglect team productivity because of existing relationships with particular individuals, caring more for those they are already familiar with, related to or who have the same nationality. Favouritism is defined as the act of treating one individual more favourably than another (Hornby 2018), and managers often fail to earn the respect of their staff due to favouritism (Nesengani et al. 2019). When nurses feel that their peers are enjoying perks while their own efforts go unrecognised, they can become demoralised and are more likely to leave (Saleh et al. 2018; De Los Santos et al. 2020; Nesengani et al. 2019). In addition, this kind of implicit bias in the workplace may hinder diversity and inclusion, resulting in health disparities and poor patient outcomes (Stamps 2021). In the current study, favouritism by a nurse manager prompted some of the nurses to change wards because they did not feel they were being treated fairly.

8.5 The influence of culture on the leadership of Saudi and clinical nurse managers from other cultures

8.5.1 Cultural advantages of Saudi clinical nurse managers

The registered nurses' questionnaire responses show that there are significant differences in the leadership practices of Saudi and clinical nurse managers from other cultures in terms of the *inspire a shared vision, challenge the process* and *encourage the heart* leadership practices. The results indicate that Saudi managers are more actively engaged in these transformational practices than their counterparts from other cultures. A number of studies have shown that nurse managers working in the context of Saudi Arabia's healthcare system apply transformational leadership (AbuAlRub & Alghamdi 2012; Al-Yami et al. 2018; Alghamdi et

al. 2018), although none has examined the differences between Saudi and clinical nurse managers from other cultures. The quantitative study's results contribute to this existing knowledge by demonstrating that Saudi managers are more actively engaged in transformational leadership practices than their equivalents from other cultures, particularly in the *inspire a shared vision, challenge the process* and *encourage the heart* practices. This indicates that Saudi clinical nurse managers are more likely to share their vision with their registered nurses and take risks regarding innovative ways to change the status quo, and that they focus more on recognising individual registered nurses' contributions.

The qualitative findings from the two groups of participants provide additional support for and further explanation of the results of the quantitative study. The study found that participants felt strongly that Saudi clinical nurse managers are extremely influential in wards because of the specific ways in which they behave. A recent Irish study found that local cultures influence nurse leaders in clinical settings (Hughes, Priode & Wenzel 2020). Both participant groups in the current study also revealed a number of factors that contribute to the effective leadership of Saudi clinical nurse managers. These factors include support from their superiors, cultural and linguistic similarities with the majority of staff and patients, the need of those groups for a Saudi manager, the ease with which Saudis make decisions autonomously and their capacity to guide staff towards a vision of the future. Most participants perceived Saudi clinical nurse managers to be more effective in their actions and leadership because their superiors supported them, and both groups of participants felt that Saudi clinical nurse managers maintained close relationships with their supervisors and administrative departments, which led to them having greater authority.

The participating clinical nurse managers and registered nurses noted that culture and language are two important factors in making Saudi managers more influential and effective in their leadership, suggesting that Saudi clinical nurse managers are able to take advantage of their

cultural background to lead their staff and manage their wards. They have cultural understanding and are able to communicate effectively with new staff or administrative staff who do not speak English well. There was also a strong perception among the participants that registered nurses value the encouragement they receive from Saudi managers more than that from clinical nurse managers from other cultures and that patients and their families have fewer problems when a Saudi clinical nurse manager is on duty, as they can communicate more easily with them. Some participants perceived that Saudi clinical nurse managers are able to make their own decisions, and they agreed that Saudi clinical nurse managers are in a position to make certain decisions that managers from other cultures might not be able to. For example, Saudi nurse managers might be able to decide on the ward's needs and discuss with their superiors the benefits of changing decisions regarding the wards, rather than simply following and obeying orders that are not in the best interests of the wards. In addition, interviewees in both groups felt that Saudi clinical nurse managers are more aware of and have acquired more knowledge about the future of nursing in the country, with the belief that managers from Saudi Arabia are sufficiently aware of Saudi Vision 2030. Consequently, they are able to lead the nursing staff and manage the wards more effectively because all parties share that vision of advancing the nursing profession and have similar expectations of the future.

8.5.2 Challenges and cultural barriers for clinical nurse managers from other cultures

The results from the questionnaire showed that registered nurses believed there are significant differences in leadership practices between Saudi and clinical nurse managers from other cultures, as mentioned in the previous section, indicating that clinical nurse managers from other cultures were less engaged in effective leadership practices than their Saudi counterparts. The findings from both groups in the qualitative study provide additional support for and an explanation for the quantitative study's findings. There are certain nuances a manager from other culture might not be familiar with, which can make them feel unsure when working in a

culture that is not their own and can increase the problems they experience with their superiors, nursing staff, patients and relatives. The clinical nurse managers and registered nurses in this study thought that managers from other cultures find it difficult to convey their ideas on account of not being Saudi, not always being able to communicate in Arabic and being less able to comprehend their staff's cultural, linguistic and personal needs. These results are consistent with the majority of nursing studies in the Saudi context, indicating that non-Saudis face cultural and language issues in this setting (Van Rooyen, Telford-Smith & Strümpher 2010; Almutairi 2015; Al-Khathami et al. 2010; Al-Harasis 2013; Albalawi, Kidd & Cowey 2020; Felemban, O'Connor & McKenna 2014; Alosaimi & Ahmad 2016; Albougami & Alotaibi 2020; Bit-Lian et al. 2020; Alboliteeh, Magarey & Wiechula 2017; Salvador et al. 2021), the culture has also influenced the role of clinical preceptors from other cultures in the context (Al Harbi et al. 2021). Previous studies have reported solely on registered nurses who experience cultural and linguistic barriers. However, none of these studies have examined clinical nurse managers as a group; therefore, the findings of this study provide new insights in this area, namely the issue of cultural and language difficulties that still hinder CNMs from other cultures after they take on roles as leaders. Previous research has found that language barriers can lead to increased levels of anxiety for nurses, which could negatively impact the quality of care (Almualem, Darwish & AlFaraj 2021). Consequently, it is highly probable that this also impacts their leadership effectiveness within their wards. In addition, the current findings indicate that the superiors who are supposed to support those in clinical nurse manager roles and facilitate their work sometimes prevent them from making autonomous decisions. Consequently, in the absence of the authority to make decisions, as well as lacking support from their superiors, it is much more difficult for clinical nurse managers to lead their staff and manage their wards (Baddar et al. 2016). It has also been reported that a lack of support from superiors leads to feelings of uncertainty in nurse managers (Rudolfsson & Flensner 2012),

negatively affecting them and resulting in intentions to leave their position (Arakelian & Rudolfsson 2021) as well as a feeling of abandonment in the leadership position (Solbakken, Bondas & Kasén 2021). In contrast, the support of superiors plays a pivotal role in nurse managers' self-confidence and independence in their leadership (Solbakken, Bondas & Kasén 2021).

In contrast, some registered nurse participants thought that Filipino clinical nurse managers are good leaders despite their cultural differences. The current study's findings revealed that Filipino clinical nurse managers treat their staff with friendliness, emphasise teamwork, and act professionally towards their staff. Filipinos are collectivists in their cultural orientation, much like most Asians (Church 1987; Church et al. 2012; Hofstede 1984). Members of collectivist cultures place higher value on teamwork and community than on themselves as individuals (Triandis 1995). Also, according to Winston and Ryan (2008), a humane orientation is closely related to servant leadership, as both emphasise caring, concern and benevolence toward others. The servant leader "always accepts and empathizes, never rejects" (Greenleaf 1970, p. 12), and others prefer servant leaders as "those who lead them empathize" (p. 14). Friendly, teamwork-oriented and professional Filipino clinical nurse managers can enable their staff in clinical settings to provide good patient care.

8.6 Collaborative trust between leaders and teams

The World Health Organization (2010) has emphasised the importance of improving staff morale through interprofessional collaboration in an effort to strengthen health systems' performance and achieve better health outcomes. In addition, the WHO reported that working in a multicultural context itself requires clinical nurse managers who are capable of effective communication and who demonstrate the confidence to lead staff and manage wards in order to provide quality nursing care to patients. Both groups in the current qualitative study

identified the importance of certain leadership attributes for clinical nurse managers to build collaboration and trust with their team in clinical areas, including working with and caring for them, and enabling individuals to develop their expertise, making their own decisions and motivating their staff. These attributes of clinical nurse managers to build collaboration and trust were ascribed to four transformational leadership practices: *inspire a shared vision, challenge the process, enable others to act* and *encourage the heart* (Posner & Kouzes 1988; Kouzes & Posner 2013, 2017). Similarly, they may be ascribed to three other transformational leadership behaviours: *idealised influence, inspirational motivation* and *individualised consideration* (Bass & Avolio 1994; Avolio, Bass & Jung 1999). The participants stated that, when a leader demonstrates these attributes, the knowledge and skills of the nursing staff can be enhanced, which ultimately leads to better patient care – that is, it strengthens collaboration. This study confirms the findings of a previous study showing that when nurse managers care for nurses it means they are caring for patients (Solbakken, Bondas & Kasén 2021).

The participants agreed that another important team skill for clinical nurse manager leadership is the capacity to act as a conduit for organisational communication. Because of their position, clinical nurse managers are able to facilitate communication between nurses and management or other health professionals. Several previous studies have discussed the importance of effective communication in the nursing environment (Ennis et al. 2013; Wittenberg et al. 2015; Bit-Lian et al. 2020; Goldsby et al. 2020; Dewald & Reddy 2020). The quality of clinical nurse managers' communication skills has a strong direct effect on nurses' job satisfaction and patient care (Jankelová & Joniaková 2021; Fowler, Robbins & Lucero 2021). However, the current study indicated that both groups of participants were aware of the importance of effective communication for clinical nurse managers. Therefore, some registered nurses who participated hoped that clinical nurse managers would strengthen their relationships with the nurses and listen to them, for example, by holding regular meetings to discuss any difficulties

they encountered. That is, this study confirms that it is important for nurse managers to have a strong relationship with their staff that will support the nurses to advance their abilities by helping them overcome any issues and obstacles. If nurse managers are open with staff and schedule regular meetings, this will allow them to identify and resolve problems to improve employee engagement in their work (Mousa, EldinFekry & Elewa 2019), and could increase job satisfaction (Cosentino et al. 2021).

8.7 Positivity towards and strong intention to undertake leadership development

The results of the quantitative study demonstrate that the participants had positive attitudes towards leadership development. The qualitative findings reveal that members of both groups had a strong positive intention to undertake leadership development, agreeing that appropriate training is necessary for clinical nurse managers to build practices that will enable them to lead effectively. The importance and benefits of clinical nurse managers' leadership development have been discussed in the literature (Cable & Graham 2018; MacPhee et al. 2012; Bressler 2012; Zwink et al. 2013; Whitney-Dumais & Hyrkäs 2019; Seidman, Pascal & McDonough 2020; Sherman & Pross 2010). The qualitative findings and the participants' suggestions indicate that appropriate tailored development strategies can be applied at three key stages. They need to be both personally and professionally meaningful to clinical nurse managers' leadership and based on their needs and preferences. First, there is a need to train nursing staff in leadership skills. Second, there is a need for existing clinical nurse managers to be trained in leadership skills. Third, clinical nurse managers need to receive ongoing counselling and psychological support. These three development suggestions are based on nurse managers' needs and preferences and are discussed in detail below.

8.7.1 Training nursing staff in leadership skills

Gaining leadership skills is an important step in preparing nursing staff for managerial roles in the future. Nurses are expected to perform as leaders at every level in healthcare organisations regardless of their title or clinical experience (Major 2019; Al-Dossary, Kitsantas & Maddox 2016; Hallock 2019; Xu 2017). Organisational support is necessary in order to prepare nurses for leadership roles in the transformation of healthcare delivery systems in the future (Beal & Riley 2019). Previous research recognised that nurses need better leadership preparation by 2020 to cope with increasing pressures (IOM 2011; Al-Dossary 2017) and to take on leadership positions when the opportunity presents itself (Doria 2015). Providing leadership development for registered nurses will ensure that the profession is well prepared for future challenges (Cummings et al. 2021). This study found that some participants feel nurses should be ready for a sudden appointment to managerial positions through training. A number of registered nurses also felt it is important a nurse has the necessary experience, leadership training and understanding of what is expected when an appointment occurs so that they can avoid the issues their clinical nurse managers encountered during their own transitions. Nurses must be aware of and capable of undertaking the leadership training that will qualify them for a management role, meaning that there is a critical need to train nursing staff in leadership to prepare them for becoming clinical nurse managers in the near future. Currently, there is no program designed specifically for staff nurses to develop their leadership skills at the participating hospitals (nursing directors, personal communication, 6 April 2022). However, recently in July 2021 one of the study hospitals introduced a first-line leadership program to orient new clinical nurse managers to the role (nursing director, personal communication, 6 April 2022).

8.7.2 Practical and interactive workshops for clinical nurse managers

Providing development activities to enhance leadership skills is vital (Heinen et al. 2019; Ficara, Veronneau & Davis 2021; Titzer, Shirey & Hauck 2014; Deyo, Swartwout & Drenkard 2016; Bressler 2012; Zwink et al. 2013). Such initiatives could assist clinical nurse managers to be more successful in their role (Doria 2015) and prevent the adoption of ineffective leadership practices in clinical settings (Simard & Parent-Lamarche 2022). One of the participants suggested that hospitals should offer practical and interactive group workshops for clinical nurse managers, and several previous studies have discussed the importance of peer-based interactive learning and of sharing peer experiences (Flatekval & Corbo 2019; Göktepe et al. 2018; Jeon et al. 2018; Luk 2018; Mackoff, Meadows & Nash 2017; McGarity et al. 2020). In the current study, some clinical nurse manager participants stated that their hospitals should consider providing practical training activities to explore, for example, case study scenarios and how they might react in particular situations as well as to share their experiences with each other. A number of the clinical nurse managers felt that these kinds of development activities would enhance their leadership skills and abilities. At present, there are no leadership programs specifically designed to develop current clinical nurse managers' skills and abilities at the participating hospitals (nursing directors, personal communication, 6 April 2022).

8.7.3 Counselling and psychological support

Psychological support for frontline nursing staff and their managers is now seen as even more important due to the impact of the COVID-19 pandemic on wellbeing and teamwork in the form of increased workloads, challenges and stress (Gab Allah 2021; Freysteinson et al. 2021; Chen et al. 2021; Specht et al. 2021; Labrague & de Los Santos 2021; Labrague et al. 2018; Middleton et al. 2021; Halcomb et al. 2022; Jeong & Kim 2022; Moore 2020; Kılınç & Sis Çelik 2021; Jäppinen et al. 2021). Providing psychological support after the pandemic is also

necessary due to burnout and moral injury (Herron et al. 2022; Sawyer et al. 2022). Moral injury refers to the profound psychological distress caused by actions or inactions that violate one's moral code (Litz et al. 2009). A morally injurious act can involve the commission of an act, the omission of an act by leaders or someone actions you trust, or the actions of others (Williamson, Murphy & Greenberg 2020), which could lead to a "sense of losing hope, trust, integrity" (Čartolovni et al. 2021 p. 597). In the nursing context, it can occur when nurses and nurse managers are faced with suffering patients, and they feel they cannot provide the care the patient requires due to a shortage of resources and the overwhelming number of patients who need care quickly (Čartolovni et al. 2021; Hossain & Clatty 2021). It can also occur in situations where staff feel that an institution has failed to provide the necessary support for their psychological wellbeing during the pandemic (Hossain & Clatty 2021; Irandoost et al. 2022). Thus, resulting in unprecedented levels of exhaustion, stress and frustration leading to failure on a personal and professional level. In the current study, one clinical nurse manager participant stated that clinical nurse managers in particular need counselling and psychological support from their organisations in order to enhance teamwork and maintain a positive attitude that could allow them to lead more effectively to maintain their staff's morale. Currently, there is no such counselling, social or psychological support available for clinical nurse managers in the participating hospitals (nursing directors, personal communication, 6 April 2022).

8.8 Summary

This chapter interpreted the study's results and integrated the findings from the quantitative and qualitative phases as well as insights offered by the relevant literature. Perceptions of the transformational leadership of clinical nurse managers in Saudi hospitals were discussed, and some of the many challenges that lead to a lack of effective leadership were identified. The influence of similarities and differences in culture and language on the leadership practices of clinical nurse managers of different nationalities and the importance of collaboration and trust

between leaders and teams in multicultural workplaces were also presented. The participants were generally enthusiastic about taking part in leadership training to improve their skills. Participants in the current study emphasised the need for practical training activities and education, especially related to leadership development. They also emphasised the need for counselling and psychological support that could enhance wellbeing and teamwork and help them maintain a positive attitude, which could allow them to lead more effectively.

Chapter 9: Implications and conclusion

In the preceding chapter, the results of the two components of the study were integrated and summarised. This study investigated the leadership practices of clinical nurse managers in Saudi Arabia from two perspectives by examining how Saudi and clinical nurse manager from other cultures leadership is perceived by registered nurses and the clinical nurse managers themselves. A comprehensive study of the lived experiences of clinical nurse managers and the registered nurses working in the wards they managed was conducted and this revealed the complexities of the clinical nurse manager role as well as the additional challenges faced by healthcare leaders from other cultures in the Saudi context. This study found that both clinical nurse manager and registered nurse participants were aware of the importance of effective clinical nurse manager leadership. Many felt that clinical nurse managers had insufficient experience and were promoted too quickly into their management positions. They also reported that clinical nurse managers received inadequate support from their leadership group and are not sufficiently prepared to take on leadership roles within their organisations. Registered nurses' perceptions of poor leadership from their clinical nurse managers confirmed the lack of support for clinical nurse manager leadership. A failure to address the complexities of the clinical nurse manager role and the presence of poor leadership may result in a failure to enhance the effectiveness of clinical nurse managers' leadership within wards.

9.1 Study implications and recommendations

The implications outlined in this section are derived from the study's findings and participants' own suggestions, viewed in light of the relevant literature. The implications and recommendations are demonstrated as a visual model below (Figure 9.1). The implications of this study are outlined in three main sections (practice, education and further research) with related recommendations.

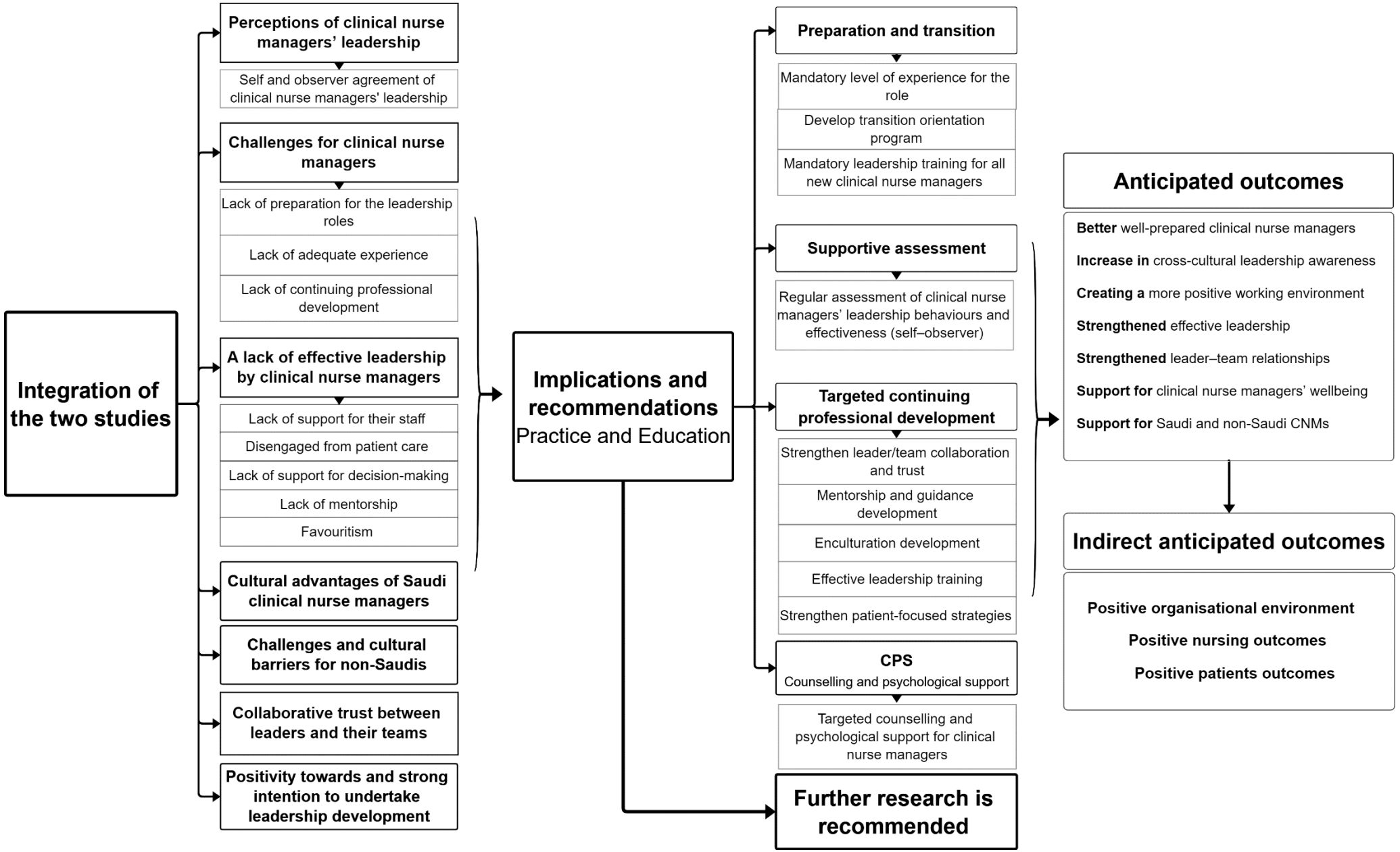

Figure 9.1: A visual model of the implications and recommendations of the study

9.1.1 Implications for practice

There is a need to establish a roadmap for well-structured, innovative and sustainable leadership development strategies for clinical nurse managers, as well as counselling and psychological policies to support them in improving their leadership practices.

The present study shows that some hospital clinical nurse managers display poor leadership behaviours. These practices, which include leaving staff without assistance, disengaging from patient care, not allowing staff to make decisions and failing to provide mentorship, can lead to decreased staff productivity, lower morale, higher frequency of adverse events and poorer quality of care (Estes 2013; Labrague & de Los Santos 2021; Morsiani et al. 2017; Lu et al. 2019; Lavoie-Tremblay et al. 2016; Labrague et al. 2020; Roche et al. 2010). If leaders do not understand the scope of their leadership, it is likely "they will be set up to fail" (Maxwell 2020, p 176). It is therefore essential that clinical nurse managers receive effective leadership training, and it may also be necessary to strengthen patient-focused strategies to ensure that managers and nurses collaborate effectively to provide quality care.

Furthermore, providing clinical nurse managers with mentoring opportunities is key to promoting personal, professional and organisational growth in the work environment. Mentorship can benefit mentors, mentees and healthcare organisations, promoting ward efficiency, improving teamwork, increasing nurse confidence, strengthening organisational performance and supporting professional success as well as reducing staff turnover rates through enhanced satisfaction (Sheppard-Law et al. 2018; Gruber-Page 2016; LaFleur & White 2010; Vergara 2017; Goodyear & Goodyear 2018; Roth & Whitehead 2019; Gayrama-Borines & Coffman 2021). It is anticipated that providing a mentorship program for clinical nurse managers in all Saudi hospitals would provide a large return on investment. This mentorship would enable clinical nurse managers to execute optimal leadership, create a positive work

environment and achieve excellent ward outcomes. This may support one of the main goals of Saudi Arabia's National Transformation Program, namely to create motivating work environments (Kingdom of Saudi Arabia 2016a).

Most clinical nurse managers from other cultures face particular challenges in the context of Saudi health care, for example not sharing the language or culture in which they are working, and not having the same vision. In addition, their contracts are shorter, which heightens their feelings of insecurity, and there is little support for the decisions they make. Consequently, it is also important to develop an enculturation strategy to ensure all clinical nurse managers share the same understanding of and vision for optimal leadership on the ward. Cultural awareness is essential in providing effective staff support in multinational nursing contexts (Strouse 2012; Rittle 2015; Dauvrin & Lorant 2015; Kaifi, Mujtaba & Mujtaba 2022), and the greater the integration, the more effective the relationships between healthcare professionals (Kaifi, Mujtaba & Mujtaba 2022). There is ongoing assistance for Saudi clinical nurse managers through the Saudisation program, but leaders from other cultures will be required for some time and support for them must continue, as there is a need to increase the number of attracting nursing specialists from other cultures by 5.7% annually over the coming years, while maintaining the current number of nurses from other cultures (SCFHS 2017). Thus, clinical nurse managers from other cultures also require additional support because they lack the language skills and do not have good connections with the hospital administration. Enabling and supporting clinical nurse managers from other cultures to make autonomous decisions would benefit staff and improve ward outcomes. Strategies such as training sessions, familiarisation meetings, workbooks, shadowing experiences to integrate managers from other cultures into the hospital culture, and addressing norms, values and linguistic skills would familiarise them with the local environment and prepare them to engage with it more

effectively. These strategies would also enhance the cross-cultural awareness of both Saudi and nurses from other cultures working in healthcare organisations.

Most of the clinical nurse managers in the hospitals studied have insufficient experience, having been promoted too quickly. Individuals need more experience before they are promoted to management positions to avoid having a negative effect on ward culture and, consequently, on patient care. Some participants acknowledged that experienced clinical nurse managers can be collaborative and effective leaders because of their greater knowledge, and this gives staff more confidence. There should perhaps be a mandatory level of experience before a nurse is promoted to a clinical nurse manager role.

The findings show that most clinical nurse managers are not prepared to lead and that they receive only limited professional development and no leadership development before or after assuming the role. It is crucial to immediately evaluate a clinical nurse manager's leadership skills and identify their needs and preferences so that development programs can be tailored to their requirements, as some of the participants in this study suggested. Some participants who experienced challenges during their own transition from registered nurse to clinical nurse manager felt that training should have specifically prepared them to assume managerial positions. There is therefore a need to establish transition programs for any nurse who might be assigned the role of clinical nurse manager. An orientation program to the ward during transition is crucial as it fosters acceptance and learning of new clinical nurse managers (Hussein et al. 2017). In addition, all new clinical nurse managers should receive structured mandatory leadership training to ensure they are appropriately skilled in planning, preparation and continuous evaluation. Such initiatives to support the successful transition into management could increase the success of new clinical nurse managers (Doria 2015; Flatekval & Corbo 2019) and prevent their adoption of ineffective leadership practices in clinical settings (Simard & Parent-Lamarche 2022). It has been found that effective leadership promotes work–

life balance and reduces role ambiguity even during the COVID-19 pandemic (Charoensukmongkol & Puyod 2021).

Some of the clinical nurse manager participants felt that their hospitals should consider providing practical training activities to explore, for example, case study scenarios and how they might react in particular situations as well as to share their experiences with each other. Several previous studies found that nursing leadership programs can improve competency, ethical leadership and sustainability on wards and enhance workplace wellness (Flatekval & Corbo 2019; Göktepe et al. 2018; Jeon et al. 2018; Luk 2018; Mackoff et al. 2017; McGarity et al. 2020). McGarity et al. (2020) evaluated a program designed to help frontline nurse leaders advance their experience, and levels of their knowledge, confidence and education, as well as advancing their ability to contribute to high-quality and evidence-based practice to improve the effectiveness of their leadership. Their results indicated that the program provided for frontline nurse leaders was effective, as each individual improved in their overall competency and nursing leadership competencies. The clinical nurse managers in the current study also suggested that those in management positions require counselling and psychological support to cope with their workload. Therefore, a new service or unit should be created within each hospital to provide this support in order to enhance teamwork and maintain the positive attitude that will allow nurse managers to lead effectively to maintain their staff's morale. Recently, this kind of support initiative has been widely recommended for frontline nursing staff and their managers as a result of the COVID-19 pandemic's impact on wellbeing and teamwork in terms of increased workloads, challenges and stress (Freysteinson et al. 2021; Chen et al. 2021; Specht et al. 2021; Labrague & de Los Santos 2021; Middleton et al. 2021; Halcomb et al. 2022; Jeong & Kim 2022; Moore 2020; Kılınç & Sis Çelik 2020; Hosseini Moghaddam et al. 2022). The evidence shows that frontline nursing staff become more motivated and confident after receiving targeted psychological support (Chen et al. 2021). It is important to consider the

wellbeing of nurse managers through counselling and psychological support, since work wellbeing is positively correlated with nurse manager ability, leadership and the support they provide to their nurses (Jarden et al. 2022). Thus, this could mitigate challenges and stress that they facing, and to cope properly with their workload, which would ultimately strengthen the leadership skills of the clinical nurse manager workforce.

The results of this study should encourage clinical nurse managers to collect regular feedback from the registered nurses working in their wards, using 360-degree evaluations to enable them to make timely changes to their leadership practices as needed. Strategies are also needed to increase collaboration and trust between managers and nurses. Policymakers and other stakeholders can help clinical nurse managers by supporting their use of regular assessments, such as the Leadership Practices Inventory (Kouzes & Posner 2017), and helping them to interpret the results. Such evaluations can help managers identify and appraise their own leadership practices and strengthen collaboration with the registered nurses on their team.

In the current study some participants were concerned about bias during CNM selection, and or favouritism by a nurse manager towards some nurses. The government is working to strengthen its anti-corruption efforts in every sector, through the Oversight and Anti-Corruption Authority. Hospitals should consider their internal structure for good governance to manage structurally the problem of nepotism. According to the WHO Global Strategy on Human Resources for Health, recruitment process and practices should be fair, transparent, and sustainable (WHO 2021). There should be codes of conduct and conflict of interest declarations for all interview panel members for CNM selection. A code of conduct should be implemented that combats nepotism and favouritism in the workplace.

9.1.2 Implications for education

A well-educated nursing workforce in Saudi Arabia is vital to meeting the needs of a growing population and achieving the transformations proposed in Vision 2030. It is essential that healthcare organisations, nursing colleges and universities collaborate effectively to develop the profession, particularly in terms of leadership. Although most participants in the present study hold bachelor's degrees in nursing and would have taken units in leadership and management during the final year of their programs, the results indicate that clinical nurse managers in Saudi hospitals have poor leadership skills.

These findings suggest the need to evaluate and strengthen the leadership and management curriculum of nursing programs in general and in Saudi Arabia in particular, and it would be helpful to include transformational leadership theories and applications in these curricula. Furthermore, encouraging and motivating students to learn more about transformative leadership may assist them in their later careers. The importance of developing effective leadership skills must be emphasised to students since they will also be expected to demonstrate them as registered nurses (Ailey et al. 2015; Barry et al. 2016; Clancy et al. 2017; Kara 2019; Linares et al. 2020; Stubin 2021).

The results also support the recommendation that students should be offered interactive management workshops that allow them to assess their strengths and weaknesses as leaders. For example, undergraduate participation in student-led nursing conferences can result in an improvement in students' perceptions of their own leadership abilities (De Juan Pardo et al. 2021). Furthermore, nursing colleges and healthcare organisations should collaborate to provide students with opportunities to work in nursing offices and with clinical nurse managers during the leadership and management units of their final year of study, and nursing interns should be given similar opportunities during the fifth/internship year. The results of this study support previous suggestions (Curtis et al. 2011; Galuska 2015; Johansson, Fogelberg-Dahm

& Wadensten 2010; Miles & Scott 2019) that emphasise the importance of developing and fostering leadership skills throughout nursing education at the undergraduate level.

9.1.3 Implications for future research

The findings of the present study suggest several directions for further research into the leadership skills of clinical nurse managers. Nursing leadership, and particularly the effectiveness of clinical nurse managers, has not received the attention it requires in Middle Eastern countries, and neglecting this important area will continue to increase the burden on healthcare providers and, subsequently, damage the organisational environment and lower the satisfaction of both staff and patients.

Future research could explore the influence of different hospital cultures in the main Saudi cities, such as Riyadh, Jeddah, Makkah and Medina, as well as private, military and university facilities, on the availability of leadership training and support for clinical nurse managers. Perhaps most importantly, future research should evaluate the effectiveness of specific leadership development interventions. Previous evidence has shown that leadership development interventions have a positive effect on leadership behaviours (Le Comte & McClelland 2017; Law & Aquilina 2013; Eide, Dulmen & Eide 2015; Moustafa Saleh et al. 2021). Such interventions lead to enhanced communication, a more supportive culture and leadership teamwork (Le Comte & McClelland 2017), and improvement in clinical nurse managers' self-awareness, feelings of support, and achievement of personal and professional goals (Law & Aquilina 2013).

In the present study, the findings provided valuable information about the current status of clinical nurse managers in the studied hospitals. It is highly recommended not only that the recommendations from this study are implemented, but also that the outcomes of the implementation are evaluated. Therefore, strategies should include program evaluations after

implementation, as well as pre- and post-evaluations of leadership practices, or a qualitative study of participants' experiences after participation in an implemented program.

Further research is needed to investigate nurses' perceptions of nepotism in hospitals, as there is data indicating that this is occurring. Investigating this issue in-depth may lead to the establishment of an appropriate code of conduct in the workplace to prevent nepotism and or favouritism. Further research is needed also to examine why more Saudis are not entering the nursing profession, despite the government's efforts to recruit more health professionals in order to increase the nurse-to-population ratio. It is also important to consider research that explores the factors that influence Saudis to leave the profession. Investigating these issues in-depth may lead to a better understanding of how to overcome obstacles that may hinder the development of profession in the country.

9.2 Significance of the research

This study has made several contributions to the nursing leadership and management field, for example by adding a new understanding that there is a difference in the leadership practices of Saudi and clinical nurse managers from other cultures. It also explicated the complexities of the clinical nurse manager role as well as the additional challenges faced by leaders from other cultures in the Saudi Arabian healthcare context. Moreover, the results indicated clinical nurse managers lack experience, lack adequate education and training, and are not prepared for leadership roles, resulting in poor leadership on the wards, which may have a negative impact on patient care. In addition, some clinical nurse managers tend to neglect team productivity because of existing relationships with particular individuals, resulting in forms of favouritism.

The opinions of the research participants are a crucial component of the study of clinical nurse managers' leadership, and they can contribute to enhancing and developing leadership behaviours in the hospitals. The findings of this study are important because they can assist

policymakers at the Hail Health Cluster, the General Directorate of Hail Health Affairs, and the Saudi Ministry of Health in planning interventional and transformational change. They also indicate that collaboration between hospital administrations, human resources departments and nursing units is crucial to the enhancement of clinical nurse managers' leadership and the nursing profession across the country.

9.3 Strengths and limitations

The present study has several strengths and limitations. One strength is that all of the clinical nurse manager participants had the same responsibilities and the same role in managing the wards. This is in contrast to previous Saudi nursing leadership studies, which recruited clinical nurse managers, charge nurses, supervisors and nursing directors in the same study. It is likely that these studies did not fully explore the effectiveness of clinical nurse managers' leadership in the wards. The different roles and perspectives of these individuals may not reflect the leadership practices of clinical nurse managers. In addition, in this study the participating registered nurses were paired with the clinical nurse manager of their ward, which can also be considered a strength; perspectives on the leadership practices of each clinical nurse manager were collected from that manager and the nurses they actually supervise.

This is the first study to use the Leadership Practices Inventory to examine transformational leadership behaviours among clinical nurse managers in Saudi hospitals. This instrument is well-established and robust (Posner 2016; Huber et al. 2000), being the only one of the 17 leadership scales that were reviewed to receive a high rating for its psychometric properties (Huber et al. 2000). In addition, the present study used an explanatory-sequential mixed-methods design, enabling the in-depth examination and evaluation of clinical nurse managers' leadership from the dual perspective of the clinical nurse managers and the registered nurses they supervise, and it is the first to do so in the context of Saudi nursing leadership.

There are, however, some limitations of the study, including the relatively small clinical nurse manager sample and the use of convenience, rather than random, sampling. Since the study was conducted in one region, the results cannot be generalised to other Saudi hospitals. Similarly, all of the participants work at governmental hospitals, with no other type of healthcare facility included, so the findings cannot be generalised to private, military or university hospitals, which may have different planning and management structures. In the present study, quantitative data were collected via self-administered questionnaires, which is a limitation in that it is difficult to avoid response bias, meaning participants may answer in accordance with what they perceive to be socially desirable practices. Also, Bonferroni correction was used but only non-adjusted p values reported as the research is exploratory and adjustments are usually conservative.

9.4 Research reflection

At the outset, I had to acknowledge that research is value-laden and that biases may be present. I began asking essential questions to become more aware of my own values, attitudes and biases, such as what data should be collected, what methods should be used to explain or shape this understanding, and what methods would be most practical and useful for those who will benefit from this research. It was a new experience for me, as a novice researcher, to conduct primary research within a mixed-methods research paradigm, because I was accustomed solely to systematic appraisal research. Shifting from secondary research to complex primary research using mixed methods and learning their requirements for the first time was challenging. Also, the fact that the second phase of the study cannot be fully developed until the first phase is complete, the study needs to be approved by an ethics committee of the University of Adelaide and institutional review board – Hail, Saudi Arabia for another round application for the qualitative phase. Nevertheless, the overall experience was truly enriching, from the initial stages of the research to the publication process, to the final stages of writing this thesis. This

method provided some surprising results, which could facilitate collaboration between hospital administrations, human resource divisions and nursing administrations to improve clinical nurse managers' leadership capacities.

From the beginning of my academic career, I have experienced many different aspects of the world of research. Through extensive reading, I have learned how a complex project is planned, conducted and completed and how much detail goes into each phase in order to contribute to discovering new knowledge in the field. While conducting this study, I learned about the different designs of mixed-methods research and their uses, and I was able to determine which methodology was best suited to answer the research question at hand. I worked with my supervisory team, learning from their wealth of experience and relevant knowledge. They have been incredibly supportive, ensuring that I gained the knowledge and skills I needed to conduct mixed-methods research and analyse the results. This support has helped me feel confident in my abilities, and it will help me continue on this path towards serving the nursing profession and contributing to nursing research.

9.5 Conclusion

In general, this research offers a comprehensive and in-depth understanding of clinical nurse managers' leadership and its effectiveness in the context of Saudi Arabian hospitals. A significant difference was found between the perceptions of the two groups of participants – namely, the self-reports of the clinical nurse managers compared with those of the registered nurses working in their wards. The majority of clinical nurse managers had less than five years' experience overseeing their current wards and registered nurses. A positive correlation was found between the *enable others to act* leadership practice of the clinical nurse managers and their overall experience and their experience managing the wards in particular. Also, a positive association was found between the clinical nurse managers' experience and the *encourage the*

heart practice. In addition, there were differences between the Saudi and clinical nurse managers from other cultures in the *inspire a shared vision*, *challenge the process* and *encourage the heart* transformational leadership practices as reported by their registered nurses. This research also revealed clinical nurse managers' and their registered nurses' poor perceptions of clinical nurse managers' leadership. The clinical nurse managers had insufficient experience and were promoted too quickly into their positions. In addition, the study revealed the challenges faced by leaders from other cultures in the Saudi healthcare context. Challenges include managers from other cultures not understanding the language and culture they are working in, feeling insecure due to shorter contracts, and experiencing a lack of support for their decisions. Also, the clinical nurse managers had insufficient support to develop their leadership skills. Education and a minimum level of experience should be required before a nurse is assigned to a clinical nurse manager role. An enculturation strategy is essential to enhance leaders' cross-cultural awareness to ensure effective leadership in the wards. Leaders from other cultures require support because of the lack of language, and of good connections with the hospital administration. Structured counselling and psychological services could effectively support clinical nurse managers and promote good leadership behaviour. It can be concluded that the generated findings of this thesis have contributed to narrowing the evidence gap about clinical nurse managers' leadership skills and provided recommendations for future changes. These changes require a collaboration between policymakers at the Hail Health Cluster, the General Directorate of Hail Health Affairs, and the Saudi Ministry of Health to plan interventional and transformational changes that contribute to enhancing clinical nurse managers' leadership, which will impact positively on the profession in general.

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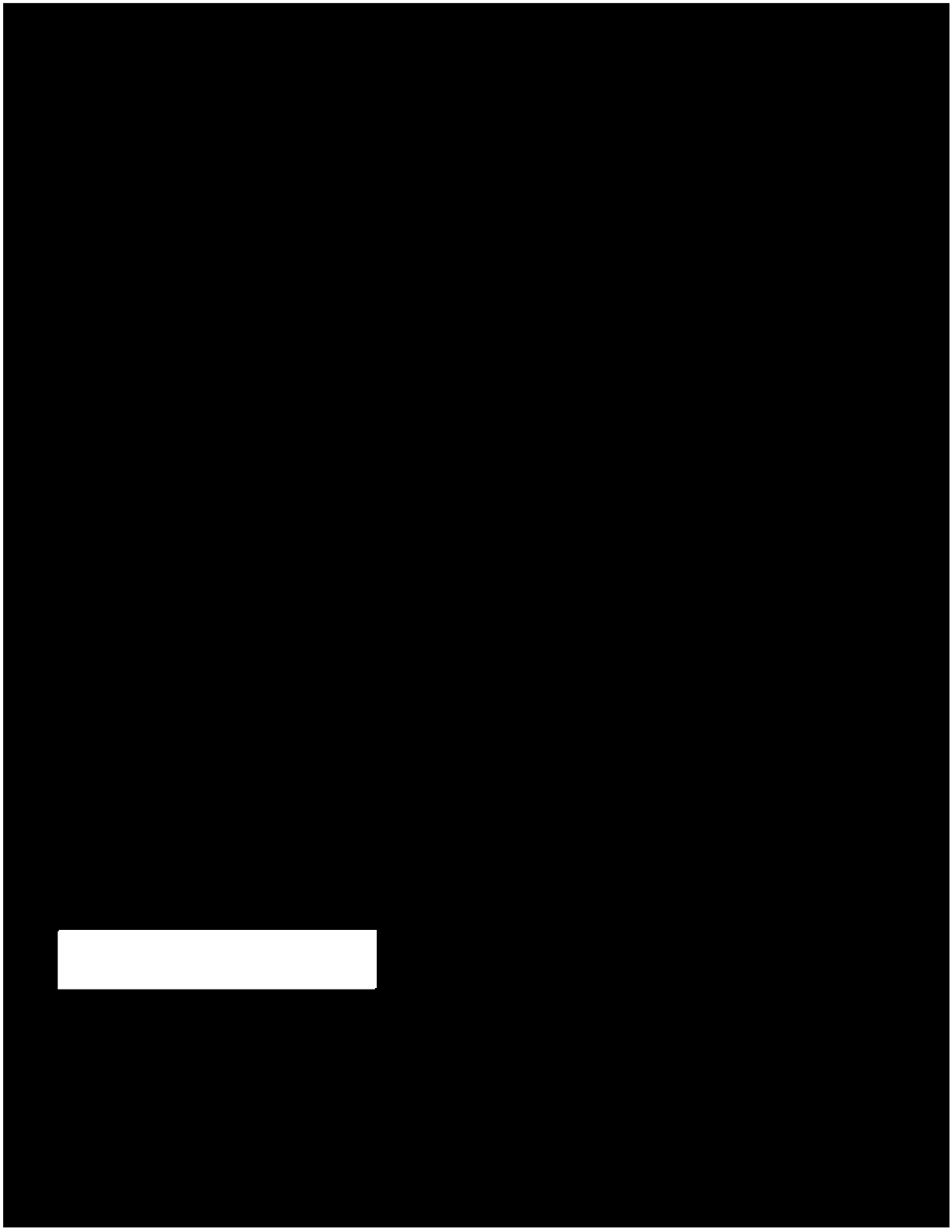
Appendices

Appendix A: **Permission** to use Leadership Practices Inventory



Appendix B: Clinical nurse manager questionnaire

Study Title: Leadership styles of clinical managers in Saudi Arabian Hospitals

The purpose of the study is to explore the clinical nurse managers leadership styles in Saudi Arabian hospitals, the participation in this study is strictly voluntary.

You qualify for participation in this study if:

- You are a clinical nurse manager in this ward.
- You have been employed at the hospital for a minimum of six months in your current clinical ward.

Requirements:

- If you are interested in participating in this study, please complete a questionnaire which is available at the reception desk in your ward.
- Completing the questionnaire will take about 10-15 minutes.
- The completed questionnaire can be placed in secure box which is available at the Nursing Administration Office in your hospital.

Formal Invitation Letter, Participant Information Sheet and Questionnaire will be provided to you by the Nursing Administration Office

Thank you for your assistance, I look forward to your participation in this study.

If you need more information, contact the researcher:
Abdulhafith Alharbi, PhD Student at University of Adelaide, South Australia
Email : abdulhafith.alharbi@adelaide.edu.au, Phone : 00966599935997

Note: Complete anonymity cannot be guaranteed. However, the utmost care will be taken to ensure that no personal identifying details are revealed. The confidentiality and privacy of all participants will be upheld, and your views and opinions will not be publicly accessible in a personally identifiable manner.

THE UNIVERSITY of ADELAIDE

Letter Inviting Participation

Dear Clinical Nurse Manager,

If you are a clinical nurse manager with at least six months experience in your current ward, I would like to invite you to participate in a study. The study is designed to explore the leadership styles practiced by clinical nurse managers in your hospital. Your participation is highly appreciated. **What is involved?** Please fill out the enclosed questionnaire regarding your leadership style and return it to the secured collection box at the Nursing Administration Office in your hospital. The questionnaire should take about 10-15 minutes to complete.

Risks; Participation in this study should involve no physical or mental discomfort, However, as the study is voluntary, you are free to omit any questions or not complete the questionnaire. **Confidentiality and security of data;** complete anonymity cannot be guaranteed. However, the utmost care will be taken to ensure that no personal identifying details are revealed. The confidentiality and privacy of all participants will be upheld and their views and opinions will not be publicly accessible in a personally identifiable manner.

Ethics Approval and Contacts; this study complies with the ethical conduct of research in both Saudi Arabia and Australia. It has been approved by the Directorate of Research Ethics at the MOH, the Human Research Ethics Committee at the University of Adelaide and this hospital. For more information, please see the Participant Information Sheet which is attached to this letter, and you are, of course, free to discuss your participation with the researcher on email: abdulhafith.alharbi@adelaide.edu.au and if there are questions not answered by the researcher you could contact the researcher's principal supervisor, Associate Professor Philippa Rasmussen on: **Email:** philippa.rasmussen@adelaide.edu.au.

Thank you for your participation in this study.

Sincerely,

Abdulhafith Alharbi
PhD Student at University of Adelaide, South Australia
Adelaide Nursing School | Faculty of Health and Medical Sciences
Email : abdulhafith.alharbi@adelaide.edu.au
Phone : (+966) 599935997

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Leadership Styles of Clinical Managers in Saudi Arabian Hospitals: A Mixed Methods Study
HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: H-2018-***
PRINCIPAL INVESTIGATOR: Associate Professor Philippa Rasmussen
STUDENT RESEARCHER: Abdulhafith Alharbi
STUDENT'S DEGREE: PhD Student

Dear Clinical Nurse Manager,

You are invited to participate in the research project described below.

What is the project about? This research project will explore the leadership styles of clinical nurse managers' in Saudi Arabian hospitals. A possible outcome is it may assist in improving the leadership of Clinical Nurse Managers in Saudi Arabia and inform future research. This study may also be helpful to hospitals administrators and government policy makers in developing strategies to improve the ability and skills of clinical nurse managers. **Who is undertaking the project?** This project is being conducted by Abdulhafith Alharbi. This research will form the basis for the degree of the Doctor of Philosophy at the University of Adelaide, South Australia under the supervision of Associate Professor Philippa Rasmussen and Associate Professor Judy Magarey.

Why am I being invited to participate? You are being invited as you are a clinical nurse manager with at least 6 months working in the current ward. **What am I being invited to do?** You are being invited to fill out the questionnaire included which is involves two main parts (the first part is about demographic questions in terms of your current ward, ethnicity, gender, age, the length of time as a nurse, the length of time as a clinical manager and your qualification. Secondly part is a 30-items assessment regarding your leadership styles you most engage) and return the completed questionnaire to the secured collection box at the Nursing Administration Office in your hospital. It has been asked you about the (demographic questions and Leadership style questions) to link managers with the staff that they are managing, to understand the frequency of manager's styles, and to consider the relationship of management styles with demographics. The data identifying the location where the participants work will not be reported, and age, length of time as a nurse/clinical nurse manager will combined the data to avoid any identify an individual. **How much time will my involvement in the project take?** The questionnaire should take about 10-15 minutes to complete.

Are there any risks associated with participating in this project? Participation in this study should involve no physical or mental discomfort, however, as the study is voluntary you are free to omit any questions or not complete the questionnaire. **What are the potential benefits of the research project?** There are no immediate benefits to the participant, but the research may result in a possible outcome is it may assist in improving the leadership styles of Clinical Nurse Managers in Saudi Arabia and inform future research. This study may also be helpful to hospitals administrators and government policy makers in developing strategies to improve the ability and skills of clinical nurse managers.
Can I withdraw from the project? Participation in this project is completely voluntary. Participation only be withdrawn prior to the submission of response. Submission of the completed questionnaire will be considered to be implied consent to participate. **What will happen to my information?** Complete anonymity cannot be guaranteed. However, the utmost care will be taken to ensure that no personal

identifying details are revealed. The confidentiality and privacy of all participants will be upheld, and the views and opinions will not be publicly accessible in a personally identifiable manner. The researcher and his supervisors will have access to the data of the participants. The hard copies of the questionnaire containing the data will be locked in a personal secured cupboard in the principal investigators' home during the data collection. After data are entered to computer the hard copy will be transported by secure post to University of Adelaide, stored by the Adelaide Nursing School for a period of five years (as University of Adelaide Regulation) and will be destroyed confidentially. Data will be entered and stored on the personal computer of the researcher, and only the researcher and his supervisors will have the ability to log and access into data. Results of the research will be published as a PhD thesis. You will not be identified in any report or publication; the data will be combined to avoid any identify an individual.

Who do I contact if I have questions about the project?
You are, of course, free to discuss your participation and for more information contact with the researcher on email: abdulhafith.alharbi@adelaide.edu.au, phone: 00966599935997) and if there are questions not answered by the researcher you could contact the researcher's principal supervisor, Associate Professor Philippa Rasmussen on email: philippa.rasmussen@adelaide.edu.au.

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2018-xxx). This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research 2007 (Updated 2018). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant, please contact the Human Research Ethics Committee's Secretariat on:
Phone: +61 8 8313 6028
Email: hrec@adelaide.edu.au
Post: Level 4, Rundle Mall Plaza, 50 Rundle Mall, ADELAIDE SA 5000
Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If I want to participate, what do I do?
Please fill out the questionnaire included and put your completed questionnaire in a secure box available at Nursing Administration Office in your hospital which will be locked with a key held only by the researcher.

Yours sincerely,

Abdulhafith Alharbi
PhD Student at University of Adelaide, South Australia
Adelaide Nursing School | Faculty of Health and Medical Sciences

CLINICAL NURSE MANAGER QUESTIONNAIRE

Participation in this project is completely voluntary. Completion of the questionnaire will be considered to be consent.

(This information will only be used to link data and will not be reported or published)

Demographics

1. **In which ward do you currently work?**

☐ Intensive Care Unit (ICU)
☐ Coronary Care Unit (CCU)
☐ Emergency Room (ER)
☐ Medical – Male
☐ Medical – Female
☐ Surgical – Male
☐ Surgical – Female
☐ Trauma
☐ Obstetrics and gynecology
☐ Out Patient Department (OPD)
☐ Others: please specify: ……

2. What is your gender?

☐ Male ☐ Female

3. What is your age in years?

……..

4. What is your nationality?

☐ Saudi ☐ Non-Saudi

If Non-Saudi, please specify……

5. How long you have been a nurse?

……Months …… Years

6. How long you have been a Clinical Nurse Manager?

……Months …… Years

7. **Have you been a clinical nurse manager elsewhere?**

☐ Yes ☐ No

If YES, for how long? ……Months …… Years

8. **How long have you been a Clinical Nurse Manager in <u>your current ward</u>?**

……Months …… Years

9. **What is your highest nursing qualification?**

☐ Diploma in Nursing
☐ Bachelor of Nursing
☐ Master's Degree in Nursing
☐ PhD in Nursing
☐ Others: please specify……

10. **In your opinion, what do you think are the essential leadership skills of a Clinical Nurse Manager?**

……

……

……

……

……

11. **Have you undertaken any leadership training courses or workshops? If yes, please list in the table below.**

Name of Training	Description	Valuable	Not Valuable	Comments

12. **How would you describe <u>your</u> role as a Clinical Nurse Manager?**

.....

.....

.....

.....

.....

.....

13. **What are the critical elements of the Clinical Nurse Manager role? (List up to 5)**

.....

.....

.....

.....

.....

14. **What continuing professional development is offered in your institution to support the development of Clinical Nurse Managers as nursing leaders?** (Such as; programs, courses and education session)

.....

.....

.....

.....

Thank you for taking the time for provide this important information. Please turn over the page and complete the attached questionnaire. Your participation in this research project is very much appreciated.

Leadership Practices Inventory (LPI)

(Kouzes, J.M & Posner, B.Z (2008)

Below are thirty statements describing various leadership behaviors. Please read each carefully. Then look at the rating scale and decide how frequently you engage in the behaviors described.

All Questions on the LPI questionnaire must be answered to obtain a complete score.

Here is the rating scale that you will be using

Instructions:

- Please answer in terms of how you would typically behave on most days, on most projects and with most people
- Be thoughtful of your responses.
- If you feel that a statement does not apply to you, it's probably because you don't frequently engage in the behavior. *In that case, assign a rating of 3 or lower.*
-

Ratings:

1 = Almost Never	6 = Sometimes
2 = Rarely I am not skilled in this area	7 = Fairly Often
3 = Seldom	8 = Usually
4 = Once in a while	9 = Very Frequently
5 = Occasionally	10 = Almost Always

To what extent do you typically engage in the following behaviours? Choose the response number that best applies to each statement and record it in the box to the right of that Statement. ***Leadership Behaviours***	Rating 1= Almost Never 2= Rarely 3= Seldom 4= Once in a while 5= Occasionally 6= Sometimes 7= Fairly Often 8= Usually 9= Very Frequently 10= Almost Always
1. I set a personal example of what I expect of others.	
2. I talk about future trends that will influence how our work gets done.	
3. I seek out challenging opportunities that test my own skills and abilities.	
4. I develop cooperative relationships among the people I work with.	
5. I praise people for a job well done.	
6. I spend time and energy making certain that the people I work with adhere to the principles and standards we have agreed on.	
7. I describe a compelling image of what our future could be like.	
8. I challenge people to try out new and innovative ways to do their work.	
9. I actively listen to diverse points	
10. I make it a point to let people know about my confidence in their abilities.	
11. I follow through on the promises and commitments that I make	
12. I appeal to others to share an exciting dream of the future.	
13. I search outside the formal boundaries of my organisation for innovative ways to improve what we do.	
14. I treat others with dignity and respect	
15. I make sure that the people are creatively rewarded for their contributions to the success of our projects.	

Continue	Rating									
	1= Almost Never	2= Rarely	3= Seldom	4= Once in a while	5= Occasionally	6= Sometimes	7= Fairly Often	8= Usually	9= Very Frequently	10= Almost Always
16. I ask for feedback on how my actions affect other people's performance.										
17. I show others how their long-term interest can be realized by enlisting in common vision.										
18. I ask, "What can we learn?" when things don't go as expected.										
19. I support the decision that people make on their own.										
20. I publicly recognize people who exemplify commitment to shared values.										
21. I build consensus around a common set of values for running our department.										
22. I paint a big picture of what we aspire to accomplish.										
23. I make certain that we set achievable goals, make concrete plans, and establish measurable milestones for the projects and programs that we work on.										
24. I give people a great deal of freedom and choice in deciding how to do their work.										
25. I find ways to celebrate accomplishments.										
26. I am clear about my philosophy of leadership.										
27. I speak with genuine conviction about the higher meaning and purpose of our work.										
28. I experiment and take risks, even when there is a chance of failure										
29. I ensure people grow in their jobs by learning new skills and developing themselves.										
30. I give members of the team lots of appreciation and support for their contributions.										

THE END

Thank you for participating in this study about leadership styles of clinical nurse managers.

Your contribution to this important research is invaluable for helping in the understanding of and in improving leadership styles of clinical nurse managers in the future.

Appendix C: Registered nurse questionnaire

THE UNIVERSITY of ADELAIDE

Letter Inviting Participation

Dear Nurse,

If you are a nurse with at least six months in your current clinical ward, I would like to invite you to participate in the study. The study is designed to explore the leadership styles practiced by clinical nurse managers in your hospital. Your participation is highly appreciated. **What is involved?** Please fill out the enclosed questionnaire included in regards leadership styles of your clinical manager and return it to the secured collection box on your ward. The questionnaire should take about 10-15 minutes to complete.

Risks; Participation in this study should involve no physical or mental discomfort, However, as the study is voluntary you are free to omit any questions or not complete the questionnaire. **Confidentiality and security of data;** complete anonymity cannot be guaranteed. However, the utmost care will be taken to ensure that no personal identifying details are revealed. The confidentiality and privacy of all participants will be upheld and the views and opinions will not be publicly accessible in a personally identifiable manner.

Ethics Approval and Contacts; this study complies with the ethical conduct of research in both Saudi Arabia and Australia. It has been approved by the Directorate of Research Ethics at the MOH, the Human Research Ethics Committee at the University of Adelaide and this hospital. For more information about the study, please see the Participant Information Sheet which is attached to this letter, and you are, of course, free to discuss your participation with the researcher on email: abdulhafith.alharbi@adelaide.edu.au and if there are questions not answered by the researcher you could contact the researcher's principal supervisor, Associate Professor Philippa Rasmussen on: **Email:** philippa.rasmussen@adelaide.edu.au.

Thank you for your participation in this study.

Sincerely,

Abdulhafith Alharbi
PhD Student at University of Adelaide, South Australia
Adelaide Nursing School | Faculty of Health and Medical Sciences
Email: abdulhafith.alharbi@adelaide.edu.au
Phone: (+966) 599935997

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Leadership Styles of Clinical Managers in Saudi Arabian Hospitals: A Mixed Methods Study
HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: H-2018-***
PRINCIPAL INVESTIGATOR: Associate Professor Philippa Rasmussen
STUDENT RESEARCHER: Abdulhafith Alharbi
STUDENT'S DEGREE: PhD Student

Dear Nurse,

You are invited to participate in the research project described below.

What is the project about? This research project will explore the leadership styles of clinical nurse managers' in Saudi Arabian hospitals. A possible outcome is it may assist in improving the leadership of Clinical Nurse Managers in Saudi Arabia and inform future research. This study may also be helpful to hospitals administrators and government policy makers in developing strategies to improve the ability and skills of clinical nurse managers. **Who is undertaking the project?** This project is being conducted by Abdulhafith Alharbi. This research will form the basis for the degree of the Doctor of Philosophy at the University of Adelaide, South Australia under the supervision of Associate Professor Philippa Rasmussen and Associate Professor Judy Magarey.

Why am I being invited to participate? You are being invited as you are a nurse with at least 6 months working with your clinical nurse manager in the current ward. **What am I being invited to do?** You are being invited to fill out the questionnaire included which is involves two main part (the first part is about demographic questions in terms of your current ward, gender, age, the length of time as a nurse and the qualification. Secondly part is a 30-items assessment in regard to leadership styles of your clinical manager) and return the completed questionnaire to the secured collection box on the ward. It has been asked you about the (demographic questions and Leadership style questions) to link managers with the staff that they are managing, to understand the frequency of managers styles It has been asked you about the (demographic questions and Leadership style questions) to link managers with the staff that they are managing, to understand the frequency of manager's styles, and to consider the relationship of management styles with demographics. The data identifying the location where the participants work will not be reported, and age, length of time as nurse will combined the data to avoid any identify an individual. **How much time will my involvement in the project take?** The questionnaire should take about 10-15 minutes to complete.

Are there any risks associated with participating in this project? Participation in this study should involve no physical or mental discomfort, if, however, as the study is voluntary you are free to omit any questions or not complete the questionnaire. **What are the potential benefits of the research project?** There are no immediate benefits to the participant, but the research may result in a possible outcome is it may assist in improving the leadership styles of Clinical Nurse Managers in Saudi Arabia and inform future research. This study may also be helpful to hospitals administrators and government policy makers in developing strategies to improve the ability and skills of clinical nurse managers.
Can I withdraw from the project? Participation in this project is completely voluntary. Participation only be withdrawn prior to the submission of response. Submission of the completed questionnaire will be considered to be implied consent to participate. **What will happen to my information?** Complete

anonymity cannot be guaranteed. However, the utmost care will be taken to ensure that no personal identifying details are revealed. The confidentiality and privacy of all participants will be upheld, and the views and opinions will not be publicly accessible in a personally identifiable manner.

The researcher and his supervisors will have access to the data of the participants. The hard copies of the questionnaire containing the data will be locked in a personal secured cupboard in the principal investigators' home during the data collection. After data are entered to computer the hard copy will be transported by secure post to University of Adelaide, stored by the Adelaide Nursing School for a period of five years (as University of Adelaide Regulation) and will be destroyed confidentially. Data will be entered and stored on the personal computer of the researcher, and only the researcher and his supervisors will have the ability to log and access into data. Results of the research will be published as a PhD thesis. You will not be identified in any report or publication; the data will be combined to avoid any identify an individual.

Who do I contact if I have questions about the project?
You are, of course, free to discuss your participation and for more information contact with the researcher on email: abdulhafith.alharbi@adelaide.edu.au, phone: 00966599935997) and if there are questions not answered by the researcher you could contact the researcher's principal supervisor, Associate Professor Philippa Rasmussen on email: philippa.rasmussen@adelaide.edu.au.

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2018-xxx). This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research 2007 (Updated 2018). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant, please contact the Human Research Ethics Committee's Secretariat on:
Phone: +61 8 8313 6028
Email: hrec@adelaide.edu.au
Post: Level 4, Rundle Mall Plaza, 50 Rundle Mall, ADELAIDE SA 5000
Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If I want to participate, what do I do?
Please fill out the questionnaire included and put your completed questionnaire in a secure box available on the ward which will be locked with a key held only by the researcher.

Yours sincerely,

Abdulhafith Alharbi
PhD Student at University of Adelaide, South Australia
Adelaide Nursing School | Faculty of Health and Medical Sciences

Participate TODAY
to shape future nurse leaders

Study Title: Leadership styles of clinical managers in Saudi Arabian Hospitals

The purpose of the study is to explore the clinical nurse managers leadership styles in Saudi Arabian hospitals, the participation in this study is strictly voluntary.

You qualify for participation in this study if:

- You are a nurse in this clinical ward.
- You have been employed at the hospital for a minimum of six months in your current clinical ward.

Requirements:

- If you are interested in participating in this study, please complete a questionnaire which is available at the reception desk in your ward.
- Completing the questionnaire will take about 10-15 minutes.
- The completed questionnaire can be placed in secure box which is available in your ward.

Formal Invitation Letter, Participant Information Sheet and Questionnaire are available at your ward reception desk

Thank you for your assistance, I look forward to your participation in this study.

If you need more information, contact the researcher:
Abdulhafith Alharbi, PhD Student at University of Adelaide, South Australia
Email: abdulhafith.alharbi@adelaide.edu.au, Phone: 00966599935997

Note: Complete anonymity cannot be guaranteed. However, the utmost care will be taken to ensure that no personal identifying details are revealed. The confidentiality and privacy of all participants will be upheld, and your views and opinions will not be publicly accessible in a personally identifiable manner.

REGISTERED NURSE QUESTIONNAIRE

Participation in this project is completely voluntary. Completion of the questionnaire will be considered to be consent.

Have you been working under the direction of your current clinical nurse manager for 6 months or more?

☐ Yes
☐ No
If **Yes,** please complete the questionnaire.
If **No,** please don't complete the questionnaire, thank you for your time.

(This information will only be used to link data and will not be reported or published)

Demographics

1. In which ward do you currently work?

☐ Intensive Care Unit (ICU)
☐ Coronary Care Unit (CCU)
☐ Emergency Room (ER)
☐ Medical – Male
☐ Medical – Female
☐ Surgical – Male
☐ Surgical – Female
☐ Trauma
☐ Obstetrics and gynecology
☐ Out Patient Department (OPD)
☐ Others please specify: ……

2. What is your gender?

☐ Female ☐ Male

3. What is your age in years?

……

4. How long have been a nurse?

…….. Months …… Years

5. How long have you been a working as a Registered Nurse in your current ward?

…….. Months …… Years

6. What is your highest nursing qualification?

☐ Diploma in Nursing
☐ Bachelor of Nursing
☐ Master's Degree in Nursing
☐ PhD in Nursing
☐ Others please specify……

Thank you for taking the time for provide this important data. **Please turn over the page and complete the attach questionnaire**. Your participation in this study is very much appreciated.

Leadership Practices Inventory (LPI)

(Kouzes, J.M & Posner, B.Z (2008)

Below are thirty statements describing various leadership behaviors. Please read each carefully. Then look at the rating scale and assess your current Clinical Nurse Manager's leadership behaviors.

All Questions on the LPI questionnaire must be answered to obtain a complete score.

Here is the rating scale that you will be using

Instructions:

- Be realistic about the extent to which your CNM actually engages in the behavior.
- Do answer in terms of how your CNM typically behaves on most days, on most projects and with most people.
- Be as honest and accurate as you can be.

If you feel that a statement does not apply, it's probably because you don't see or experience the behavior. That means this CNM does not frequently engage in the behavior, at least around you. *In that case, assign a rating of 3 or lower.*

Ratings:

1 = Almost Never	6 = Sometimes
2 = Rarely I am not skilled in this area	7 = Fairly Often
3 = Seldom	8 = Usually
4 = Once in a while	9 = Very Frequently
5 = Occasionally	10 = Almost Always

To what extent does your CNM typically engage in the following behaviors? Choose the response number that best applies to each statement and record it in the box to the right of that statement. *He or She* ***Leadership Behaviours***	**Rating** 1= Almost Never 2= Rarely 3= Seldom 4= Once in a while 5= Occasionally 6= Sometimes 7= Fairly Often 8= Usually 9= Very Frequently 10= Almost Always
1. Sets a personal example of what is expected	
2. Talks about future trends that will influencing our work	
3. Seeks out challenging opportunities that test skills	
4. Develops cooperative relationships	
5. Praises people for a job well done.	
6. Makes certain that people adhere to the principles and standards that have been agreed upon	
7. Describes a compelling image of the future	
8. Challenges people to try new approach	
9. Actively listens to diverse points of view	
10. Expresses confidence in people's abilities	
11. Follows through on promises and commitments	
12. Appeals to others to share dream of the future	
13. Actively searches for innovative ways to improve what we do	
14. Treats others with dignity and respect	

Continue	Rating									
	1= Almost Never	2= Rarely	3= Seldom	4= Once in a while	5= Occasionally	6= Sometimes	7= Fairly Often	8= Usually	9= Very Frequently	10= Almost Always
15. Makes sure that people are creatively recognized for their contributions to the success of our projects										
16. Asks for feedback on how his/her actions affect people's performance										
17. Shows others how their interests can be realized										
18. Asks "What can we learn?"										
19. Involves people in the decisions that directly impact their job performance										
20. Recognizes people for commitment to shared values										
21. Builds consensus around organization's values										
22. Paints "big picture" of group aspirations										
23. Identifies measurable milestones that keep projects moving forward										
24. Gives people choice about how to do their work										
25. Tells stories of encouragement about the good work of others										
26. Is clear about his/her philosophy of leadership.										
27. Speaks with conviction about meaning of work										
28. Takes initiative in anticipating and responding to change										
29. Ensures that people grow in their jobs										
30. Gets personally involved in recognizing people and celebrating accomplishments										

THE END

Thank you for participating in this study about leadership styles of clinical nurse managers.

Your contribution to this important research is invaluable for helping in the understanding of and in improving leadership styles of clinical nurse managers in the future.

Appendix D: Ethics approval (quantitative component)

Our reference 33457

RESEARCH SERVICES
OFFICE OF RESEARCH ETHICS, COMPLIANCE AND INTEGRITY
THE UNIVERSITY OF ADELAIDE

LEVEL 4, RUNDLE MALL PLAZA
50 RUNDLE MALL
ADELAIDE SA 5000 AUSTRALIA

TELEPHONE +61 8 8313 5137
FACSIMILE +61 8 8313 3700
EMAIL hrec@adelaide.edu.au

CRICOS Provider Number 00123M

09 April 2019

Associate Professor Philippa Rasmussen
Nursing

Dear Associate Professor Rasmussen

ETHICS APPROVAL No: H-2019-049
PROJECT TITLE: Leadership styles of clinical managers in Saudi Arabian Hospitals: A mixed methods study

The ethics application for the above project has been reviewed by the Low Risk Human Research Ethics Review Group (Faculty of Health and Medical Sciences) and is deemed to meet the requirements of the *National Statement on Ethical Conduct in Human Research 2007 (Updated 2018)* involving no more than low risk for research participants.

You are authorised to commence your research on: 09/04/2019
The ethics expiry date for this project is: 30/04/2022

NAMED INVESTIGATORS:

Chief Investigator:	Associate Professor Philippa Rasmussen
Student - Postgraduate Doctorate by Research (PhD):	Mr Abdulhafith Yahya Alharbi
Associate Investigator:	Associate Professor Judith Magarey

CONDITIONS OF APPROVAL: Thank you for your responses to the matters raised. The revised application provided on 08/04/19 has been approved.

Ethics approval is granted for three years and is subject to satisfactory annual reporting. The form titled Annual Report on Project Status is to be used when reporting annual progress and project completion and can be downloaded at http://www.adelaide.edu.au/research-services/oreci/human/reporting/. Prior to expiry, ethics approval may be extended for a further period.

Participants in the study are to be given a copy of the information sheet and the signed consent form to retain. It is also a condition of approval that you immediately report anything which might warrant review of ethical approval including:

- serious or unexpected adverse effects on participants,
- previously unforeseen events which might affect continued ethical acceptability of the project,
- proposed changes to the protocol or project investigators; and
- the project is discontinued before the expected date of completion.

Yours sincerely,

Ms Alison Harwood

Secretary

The University of Adelaide

وزارة الصحة
Ministry of Health

Institutional Review Board (IRB), Hail

IRB Registration Number with KACST, KSA: H-08-L-074

April 16, 2019

IRB Log Number: 2019-8

Category of Approval: EXMPTED

Dear Abdulhafith Alharbi,

I am pleased to inform you that your submission completed at April 14, 2019 for the study tilted: "*LEADERSHIP STYLES OF CLINICAL MANGERS IN SAUDI ARABIAN HOSPITALS" was* reviewed and approved. Please note that this approval is from the research ethics perspective only. You will still need to get permission from the concerned institution to commence data collection.

We wish you well as you proceed with the study and request you to keep the IRB informed of the progress on regular bases, using the IRB log number shown above.

If you have, any further questions feel free to contact me.

Sincerely yours,

[redacted]

Dr. Talal Majed AlZabni
Chairman, Institutiona[redacted]n, KSA
General Directorate of
Tel. + 966 16 5324270
E-mail: IRB-Hail@moh

وزارة الصحة
General Directorate of Health Affairs
Hail Region
Institutional Review Board (IRB)
Approved
Date: 16/4/2019

التاريخ : / / ١٤٤٠هـ الرقم :.....

وزارة الصحة
Ministry of Health

الموضوع: خطاب تسهيل مهمة

سعادة مدراء المستشفيات مدينة حائل وفقكم الله

السلام عليكم ورحمة الله وبركاته

نفيدكم بأن الباحث/ عبد الحافظ الحربي حصل على موافقة لجنة أخلاقيات البحوث الحيوية بحائل بالقرار رقم ٢٠١٩/٨ وتاريخ ٢٠١٩/٤/١٦م (مرفقه) لإجراء دراسة بعنوان (أنماط القيادة لدى رؤساء التمريض في المستشفيات السعودية).

نأمل منكم التوجيه بتسهيل مهمة الباحث لجمع البيانات اللازمة لمهمته البحثية بما يضمن عدم تأثر الخدمة الصحية المقدمة للمراجعين، شاكرين لكم حسن تعاونكم.

والسلام عليكم ورحمة الله وبركاته

مساعد المد والتطوير

د. طلا

الرقم: .....

التاريخ: / / ١٤هـ

Appendix E: Ethics approval (qualitative component)

RESEARCH SERVICES
OFFICE OF RESEARCH ETHICS, COMPLIANCE AND INTEGRITY
THE UNIVERSITY OF ADELAIDE

LEVEL 4, RUNDLE MALL PLAZA
50 RUNDLE MALL
ADELAIDE SA 5000 AUSTRALIA

TELEPHONE +61 8 8313 5137
FACSIMILE +61 8 8313 3700
EMAIL hrec@adelaide.edu.au

CRICOS Provider Number 00123M

Our reference 34644

07 August 2020

Associate Professor Philippa Rasmussen
Nursing

Dear Associate Professor Rasmussen

ETHICS APPROVAL No: H-2020-151
PROJECT TITLE: Leadership styles of clinical managers in Saudi Arabian hospitals: A mixed methods study (Phase 2)

The ethics application for the above project has been reviewed by the Low Risk Human Research Ethics Review Group (Faculty of Health and Medical Sciences) and is deemed to meet the requirements of the *National Statement on Ethical Conduct in Human Research 2007 (Updated 2018)* involving no more than low risk for research participants.

You are authorised to commence your research on: 07/08/2020
The ethics expiry date for this project is: 31/08/2023

NAMED INVESTIGATORS:

Chief Investigator:	Associate Professor Philippa Rasmussen
Student - Postgraduate Doctorate by Research (PhD):	Mr Abdulhafith Yahya Alharbi
Associate Investigator:	Associate Professor Judith Magarey

CONDITIONS OF APPROVAL: Thank you for addressing the feedback. The revised ethics application provided on the 5th of August 2020 has been approved.

Ethics approval is granted for three years and is subject to satisfactory annual reporting. The form titled Annual Report on Project Status is to be used when reporting annual progress and project completion and can be downloaded at http://www.adelaide.edu.au/research-services/oreci/human/reporting/. Prior to expiry, ethics approval may be extended for a further period.

Participants in the study are to be given a copy of the information sheet and the signed consent form to retain. It is also a condition of approval that you immediately report anything which might warrant review of ethical approval including:

- serious or unexpected adverse effects on participants,
- previously unforeseen events which might affect continued ethical acceptability of the project,
- proposed changes to the protocol or project investigators; and
- the project is discontinued before the expected date of completion.

وزارة الصحة
Ministry of Health

IRB Registration Number with KACS, KSA: H-08-L-074

August 16, 2020

IRB Log Number: 2020-30

Category of Approval: EXPEDITED

Dear Mr. Abdulhafith Alharbi,

I am pleased to inform you that your submission completed on **12 August 2020** for the study entitled "**Leadership styles of clinical managers in Saudi Arabian hospitals: A mixed methods study**" was approved. Please note that this approval is from the research ethics perspective only. You still need to get permission from the concerned institution to commence data collection.

We wish you well as you proceed with this study and request you to keep the IRB informed of the progress on regular bases (every three months), using the IRB log number shown above.

If you have any further questions feel free to contact me.

وزارة الصحة
General Directorate of Health Affairs
Hail Region
Institutional Review Board (IRB)
Approved
Date: 16/08/2020

Sincerely yours,

Dr. Talal Majed Alzabni

Chairman, Institutional R

General Directorate of Health Affairs, Hail Region, KSA

Tel: + 966165324270

Email: IRB-HAIL@MOH.GOV.SA

التاريخ: ٦/ ١٢/ ١٤٤٢هـ

الرقم: ٣٠٨٠٠٠٠٠٠

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وزارة الصحة
Ministry of Health

الموضوع: تسهيل مهمة باحث

سعادة مدراء مستشفيات المنطقة وفقكم الله

السلام عليكم ورحمة الله وبركاته

نفيد بأن الباحث / عبد الحافظ بن يحيى علي الحربي قد حصل على موافقة لجنة أخلاقيات البحوث الحيوية بحائل بالقرار رقم ٢٠٢٠/٣٠ وتاريخ ٢٠٢٠/٨/١٦م لإجراء دراسة بعنوان **"أنماط القيادة لدى رؤساء اقسام التمريض في المستشفيات السعودية: طرق مختلطة"**.

نأمل تسهيل مهمة الباحث من جمع البيانات اللازمة لإجراء البحث بما يضمن عدم تأثر الخدمة الصحية المقدمة للمراجعين. شاكرين ومقدرين لكم حُسن تعاونكم.

والسلام عليكم ورحمة الله وبركاته

ر العام للتخطيط والتطوير

ي بن ماجد الزبني

الرقم: ٣٠/٢٠٢٠ التاريخ: ٢٦ / ١٢ / ١٤٤١هـ

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Appendix F: Invitation poster and an invitation letter for each group

HREC approval number: H-2020-151

THE UNIVERSITY of ADELAIDE

Participate TODAY
to shape future nurse leaders

Study Title: Leadership styles of clinical managers in Saudi Arabian Hospitals: A mixed methods study

The purpose of the study is to explore the clinical nurse managers leadership practices in Saudi Arabian hospitals, the participation in this study is voluntary.

You qualify for participation in this study if:

- You are a clinical nurse manager in this ward.
- You have been employed at the hospital for a minimum of six months in your current clinical ward.

Requirements:

- Participation in interview.
- The interview will take approximately 30-60 minutes.
- If you are interested in participating in this study, please contact the principal researcher Abdulhafith Alharbi (contact details below).

Formal Invitation Letter, Participant Information Sheet are available at your ward reception desk

Thank you for your assistance, I look forward to your participation in this study. If you need more information, contact the researchers:

Abdulhafith Alharbi, PhD Candidate at University of Adelaide Email:abdulhafith.alharbi@adelaide.edu.au, Phone: +966599935997, +61410494363
Researcher's principal supervisor, Associate Professor Philippa Rasmussen, Email: philippa.rasmussen@adelaide.edu.au

Letter Inviting Participation

Dear Clinical Nurse Manager,

If you are a clinical nurse manager with at least six months experience in your current ward, I would like to invite you to participate in a study. The study is designed to explore the experiences of clinical nurse managers as leaders in your hospital. Your participation is highly appreciated. **What is involved?** You are invited to participate in individual Zoom interview about your experiences as leader. The researcher Abdulhafith Alharbi will assist and guide the Zoom interview. The interview will include questions that target your experience as leader. The interview will be audio-recorded. The interview will be conducted through the online Zoom platform.

Risks; The anticipated burden on you by participating in this study is the time you will spend in the interview. To reduce this burden, the schedule of the interview will be flexible based on the time that suits you. The researcher will discuss the appropriate time for interview with you to avoid interfering with any work, family or social commitments. You will be given an opportunity to schedule the time of your interview. **Confidentiality and security of data;** Please be assured that your identity will remain confidential and will not be able to be identified throughout the study. Your real name will not be used, and you will be given a code, for example, participant A or participant B.

Ethics Approval and Contacts; this study complies with the ethical conduct of research in both Saudi Arabia and Australia. It has been approved by the Institutional Review board, Hail (IRB), and the Human Research Ethics Committee at the University of Adelaide and this hospital. For more information, please see the Participant Information Sheet which is attached to this letter, and you are, of course, free to discuss your participation with the researcher on email: abdulhafith.alharbi@adelaide.edu.au and if there are questions not answered by the researcher you could contact the researcher's principal supervisor, Associate Professor Philippa Rasmussen on: **Email:** philippa.rasmussen@adelaide.edu.au.

Thank you for your participation in this study.

Sincerely,

Abdulhafith Alharbi
PhD Candidate at University of Adelaide, South Australia
Adelaide Nursing School | Faculty of Health and Medical Sciences
Email: abdulhafith.alharbi@adelaide.edu.au
Phone: (+966) 599935997
(+61) 410494363

HREC approval number: H-2020-151

THE UNIVERSITY of ADELAIDE

Participate TODAY
to shape future nurse leaders

Study Title: Leadership styles of clinical managers in Saudi Arabian Hospitals: A mixed methods study

The purpose of the study is to explore the clinical nurse managers leadership practices in Saudi Arabian hospitals, the participation in this study is voluntary.

You qualify for participation in this study if:

- You are a nurse in this clinical ward.
- You have been employed at the hospital for a minimum of six months in your current clinical ward.

Requirements:

- Participation in interview.
- The interview will take approximately 30-60 minutes.
- If you are interested in participating in this study, please contact the principal researcher Abdulhafith Alharbi (contact details below).

Formal Invitation Letter, Participant Information Sheet are available at your ward reception desk

Thank you for your assistance, I look forward to your participation in this study. If you need more information, contact the researchers:

Abdulhafith Alharbi, PhD Candidate at University of Adelaide Email:abdulhafith.alharbi@adelaide.edu.au, Phone: +966599935997, +61410494363
Researcher's principal supervisor, Associate Professor Philippa Rasmussen, Email: philippa.rasmussen@adelaide.edu.au

Letter Inviting Participation

Dear Nurse,

If you are a nurse with at least six months experience in your current ward, I would like to invite you to participate in a study. The study is designed to explore the experiences of nurses regarding the clinical nurse managers leadership practices in your hospital. Your participation is highly appreciated. **What is involved?** You are invited to participate in individual Zoom interview about your experiences regarding clinical nurse manager leadership practices. The researcher Abdulhafith Alharbi will assist and guide the interview. The interview will include questions that target your experience. The interview will be audio-recorded. The interview will be conducted in a special meeting room in the hospital.

Risks; The anticipated burden on you by participating in this study is the time you will spend in the interview. To reduce this burden, the schedule of the interview will be flexible based on the time that suits you. The researcher will discuss the appropriate time for interview with you to avoid interfering with any work, family or social commitments. You will be given an opportunity to schedule the time of your interview. **Confidentiality and security of data;** Please be assured that your identity will remain confidential and will not be able to be identified throughout the study. Your real name will not be used, and you will be given a code, for example, participant A or participant B.

Ethics Approval and Contacts; this study complies with the ethical conduct of research in both Saudi Arabia and Australia. It has been approved by the Institutional Review board, Hail (IRB), and the Human Research Ethics Committee at the University of Adelaide and this hospital. For more information, please see the Participant Information Sheet which is attached to this letter, and you are, of course, free to discuss your participation with the researcher on email: abdulhafith.alharbi@adelaide.edu.au and if there are questions not answered by the researcher you could contact the researcher's principal supervisor, Associate Professor Philippa Rasmussen on: **Email:** philippa.rasmussen@adelaide.edu.au.

Thank you for your participation in this study.

Sincerely,

Abdulhafith Alharbi
PhD Candidate at University of Adelaide, South Australia
Adelaide Nursing School | Faculty of Health and Medical Sciences
Email: abdulhafith.alharbi@adelaide.edu.au
Phone: (+966) 599935997
(+61) 410494363

Appendix G: Participant information sheet for each group

THE UNIVERSITY of ADELAIDE

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Leadership styles of clinical managers in Saudi Arabian Hospitals: A mixed methods study

HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: H-2020-151
PRINCIPAL INVESTIGATOR: A/Prof Philippa Rasmussen
STUDENT RESEARCHER: Abdulhafith Alharbi
STUDENT'S DEGREE: PhD Candidate

Dear Clinical Nurse Manager,

You are invited to participate in the research project described below.

What is the project about?
This research project will explore the leadership practices of clinical nurse managers' in Saudi Arabian hospitals. A possible outcome is it may assist in improving the leadership of Clinical Nurse Managers in Saudi Arabia and inform future research. This study may also be helpful to hospitals administrators and government policy makers in developing strategies to improve the ability and skills of clinical nurse managers.

Who is undertaking the project?
This project is being conducted by Abdulhafith Alharbi. This research will form the basis for the degree of the Doctor of Philosophy at the University of Adelaide, South Australia under the supervision of Associate Professor Philippa Rasmussen and Associate Professor Judy Magarey.

Why am I being invited to participate?
You are being invited as you are a clinical nurse manager with at least 6 months working in the current ward.

What am I being invited to do? You are invited to participate in individual Zoom interview about your experiences as leader. The researcher Abdulhafith Alharbi will assist and guide the Zoom interview. The interview will include questions that target your experience as leader. The interview will be audio-recorded. The interview will be conducted through the online Zoom platform (Note that Zoom records video and audio). After the interview, you will be given the option of looking at a written transcript of what was said to allow you to check that it has been accurately recorded. The researcher will email you an invitation letter to look at the verbatim transcript of your interview for accuracy purpose (once all the data for the entire research project had been gathered). Then you will have to return any comments or feedback on your transcript within two weeks.

How much time will my involvement in the project take?
The interview will take approximately 30-60 minutes.

Are there any risks associated with participating in this project?
The anticipated burden on you by participating in this study is the time you will spend in the interview. To reduce this burden, the schedule of the interview will be flexible based on the time that suits you. The researcher will discuss the appropriate time for interview with you to avoid interfering with any work,

family or social commitments. You will be given an opportunity to schedule the time of your individual interview.

What are the potential benefits of the research project?
There are no immediate benefits to the participant, but the research may result in a possible outcome is it may assist in improving the leadership practices of Clinical Nurse Managers in Saudi Arabia and inform future research. This study may also be helpful to hospitals administrators and government policy makers in developing strategies to improve the ability and skills of clinical nurse managers.

Can I withdraw from the project?
Participation in this project is completely voluntary. There will be no impact on your career now or in the future should you choose not to participate. If during the interview you decide not to continue you are free to withdraw from the study.

What will happen to my information?
Please be assured that your identity will remain confidential and will not be able to be identified throughout the study. Your real name will not be used, and you will be given a code, for example, participant A or participant B. Your information will be accessed by the research team members only. The results of the study will be used for a PhD thesis, and journal paper/s may be published. After the interview, you will be given the option of looking at a written transcript of what was said to allow you to check that it has been accurately recorded. Your information will only be used as described in this participant information sheet and it will only be disclosed according to the consent provided, except as required by law.

Who do I contact if I have questions about the project?
The best contact for any questions about the project is Mr Abdulhafith Alharbi, who will be responsible to conduct the study. Email: abdulhafith.alharbi@adelaide.edu.au, Phone: 00966599935997.

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2020-151). This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research 2007 (Updated 2018). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant, please contact the Human Research Ethics Committee's Secretariat on:
Phone: +61 8 8313 6028
Email: hrec@adelaide.edu.au
Post: Level 4, Rundle Mall Plaza, 50 Rundle Mall, ADELAIDE SA 5000
Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If I want to participate, what do I do?
If you agree on participation, contact the researcher on e-email: abdulhafith.alharbi@adelaide.edu.au to discuss the suitable time you are prefer. In addition, prior starting the interview you will sign the consent form and your identity will remain confidential and you will not be identified in the reporting of the results.

Yours sincerely,

A/Prof Philippa Rasmussen Principal supervisor
A/Prof Judy Magarey Co-supervisor
Mr Abdulhafith Alharbi PhD candidate
University of Adelaide, South Australia
Adelaide Nursing School | Faculty of Health and Medical Sciences

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Leadership styles of clinical managers in Saudi Arabian Hospitals: A mixed methods study

HUMAN RESEARCH ETHICS COMMITTEE APPROVAL NUMBER: H-2020-151
PRINCIPAL INVESTIGATOR: A/Prof Philippa Rasmussen
STUDENT RESEARCHER: Abdulhafith Alharbi
STUDENT'S DEGREE: PhD Candidate

Dear Nurse,

You are invited to participate in the research project described below.

What is the project about?
This research project will explore the leadership practices of clinical nurse managers' in Saudi Arabian hospitals. A possible outcome is it may assist in improving the leadership of Clinical Nurse Managers in Saudi Arabia and inform future research. This study may also be helpful to hospitals administrators and government policy makers in developing strategies to improve the ability and skills of clinical nurse managers.

Who is undertaking the project?
This project is being conducted by Abdulhafith Alharbi. This research will form the basis for the degree of the Doctor of Philosophy at the University of Adelaide, South Australia under the supervision of Associate Professor Philippa Rasmussen and Associate Professor Judy Magarey.

Why am I being invited to participate?
You are being invited as you are a nurse with at least 6 months working in the current ward with your current clinical manager.

What am I being invited to do?
You are invited to participate in interview to share your experiences regarding the clinical nurse manager leadership practices. The researcher Abdulhafith Alharbi will assist and guide the interview. The interview will include questions that target your experience and finding from the quantitative study. The interview will be audio-recorded. The interview will be conducted through the online Zoom platform (Note that Zoom records video and audio). After the interview, you will be given the option of looking at a written transcript of what was said to allow you to check that it has been accurately recorded. The researcher will email you an invitation letter to look at the verbatim transcript of your interview for accuracy purpose (once all the data for the entire research project had been gathered). Then you will have to return any comments or feedback on your transcript within two weeks.

How much time will my involvement in the project take?
The interview will take approximately 30-60 minutes.

Are there any risks associated with participating in this project?
The anticipated burden on you by participating in this study is the time you will spend in the interview. To reduce this burden, the schedule of the interview will be flexible based on the time that suits you. The

researcher will discuss the appropriate time for interview with you to avoid interfering with any work, family or social commitments. You will be given an opportunity to schedule the time of your individual interview.

What are the potential benefits of the research project?
There are no immediate benefits to the participant, but the research may result in a possible outcome is it may assist in improving the leadership practices of Clinical Nurse Managers in Saudi Arabia and inform future research. This study may also be helpful to hospitals administrators and government policy makers in developing strategies to improve the ability and skills of clinical nurse managers.

Can I withdraw from the project?
Participation in this project is completely voluntary. There will be no impact on your career now or in the future should you choose not to participate. If during the interview you decide not to continue you are free to withdraw from the study.

What will happen to my information?
Please be assured that your identity will remain confidential and will not be able to be identified throughout the study. Your real name will not be used, and you will be given a code, for example, participant A or participant B. Your information will be accessed by the research team members only. The results of the study will be used for a PhD thesis, and journal paper/s may be published. Your information will only be used as described in this participant information sheet and it will only be disclosed according to the consent provided, except as required by law.

Who do I contact if I have questions about the project?
The best contact for any questions about the project is Mr Abdulhafith Alharbi, who will be responsible to conduct the study. Email: abdulhafith.alharbi@adelaide.edu.au, Phone: 00966599935997.

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number H-2020-151). This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research 2007 (Updated 2018). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the Principal Investigator. If you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant, please contact the Human Research Ethics Committee's Secretariat on:
Phone: +61 8 8313 6028
Email: hrec@adelaide.edu.au
Post: Level 4, Rundle Mall Plaza, 50 Rundle Mall, ADELAIDE SA 5000
Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

If I want to participate, what do I do?
If you agree on participation, contact the researcher on e-email: abdulhafith.alharbi@adelaide.edu.au to discuss the suitable time you are prefer. In addition, prior starting the interview you will sign the consent form and your identity will remain confidential and you will not be identified in the reporting of the results.

Yours sincerely,

A/Prof Philippa Rasmussen Principal supervisor
A/Prof Judy Magarey Co-supervisor
Mr Abdulhafith Alharbi PhD candidate
University of Adelaide, South Australia
Adelaide Nursing School | Faculty of Health and Medical Sciences

Appendix H: Demographic survey for each group

CNM Interview - Demographics survey

(This information will only be used to link data and will not be reported or published)

1. Did you participate in the first phase of this study?

☐ Yes
☐ No

2. What is your gender?

☐ Male
☐ Female
☐ Prefer not to answer

3. What is your age in years?

……..... Years

4. What is your nationality?

☐ Saudi
☐ Non-Saudi
If Non-Saudi, please specify……

5. How long you have been a nurse?

…… Years

6. How long you have been a Clinical Nurse Manager?

…… Years

7. How long have you been a Clinical Nurse Manager in your current ward?

…… Years

8. Have you been a clinical nurse manager overseas?

☐ Yes
☐ No
If YES, where else? .....

9. What is your highest nursing qualification?

☐ Diploma
☐ Bachelor
☐ Master's Degree
☐ Doctorate
☐ Others: please specify……

RN Interview - Demographics survey

(This information will only be used to link data and will not be reported or published)

1. Have you participated in the first phase of this study?

☐ Yes
☐ No

2. What is your gender?

☐ Male
☐ Female

3. What is your age in years?

……..

4. What is your nationality?

☐ Saudi
☐ Non-Saudi
If Non-Saudi, please specify……

5. How long you have been a nurse?

…… Years

6. How long have you been a working as a Registered Nurse in your current ward?

…… Years

7. What is your highest nursing qualification?

☐ Diploma in Nursing
☐ Bachelor of Nursing
☐ Master's Degree in Nursing
☐ PhD in Nursing
☐ Others: please specify……

Appendix I: Consent form

Human Research Ethics Committee (HREC)

CONSENT FORM

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	**Leadership styles of clinical managers in Saudi Arabian Hospitals: A mixed methods study**
Ethics Approval Number:	**H-2020-151**

2. I have had the project, so far as it affects me, and the potential risks and burdens fully explained to my satisfaction by the research worker. I have had the opportunity to ask any questions I may have about the project and my participation. My consent is given freely.

3. Although I understand the purpose of the research project, it has also been explained that my involvement may not be of any benefit to me.

4. I agree to participate in the activities as outlined in the participant information sheet.

5. I agree to the Zoom interview being audio recorded.

6. I understand that I am free to withdraw from the project at any time.

7. I have been informed that the information gained in the project may be published in journal article, thesis and conference presentations.

8. I have been informed that in the published materials I will not be identified, and my personal results will not be divulged.

9. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

Participant to complete:

Name: _____Signature: _____ Date:_____

Researcher/Witness to complete:

I have described the nature of the research to _____
(print name of participant)

and in my opinion she/he understood the explanation.

Signature: _____Position: _____ Date:_____

Appendix J: Interview protocol

Interview Protocol

Interview Protocol Checklist

Research interview data collection protocol checklist- complete for each interview

Date of the Interview	Time	Location	Interview number

☐ Obtain written consent and demographic survey data.

☐ Providing a unique link and password for Zoom interview.

☐ Welcoming the participant and verbally confirm consent. (informal verbal confirmation)

☐ Ensure that the participant is ready for the interview to begin.

☐ The Zoom record will be turned on to record the discussion between the interviewee and the interviewer.

☐ The interviewer will read the interview overview which includes explaining the study, interview purposes and reading of definitions/leadership terms.

☐ Interviewer will conduct the interview by asking the interview questions clearly and slowly.

☐ Reading interview questions and using follow-up questions and affirm participants responses (one by one).

☐ Complete the interview and then ask the participant's if they have any additional questions or if they would like to add any additional information.

☐ Thank participant for their participating in the study.

☐ End the recording.

Researcher name: Abdulhafith Alharbi

Date and time:

Signature:

Appendix K: Developed interview questions guide for each group

Questions for clinical nurse manager participants

To explore and understand the experiences of clinical nurse managers and their current leadership practices, the following developed questions guide was used with each clinical nurse manager participant:

1. Do you think you have a good understanding of your own leadership practices?
   To enrich the discussion around this question the participants were asked about (CNMs consistently self-reported their leadership practices higher than their RNs observed, what do you think about that?)
2. Do you think your colleagues "other CNMs" have a good understanding of their own leadership practices?
3. Do you think there's a difference in leadership practices between Saudi CNMs and non-Saudi CNMs?
4. Do you think there's a difference in your leadership practices when leading RNs from different cultures?
5. In your opinion, why are communication skills important to the leadership of clinical nurse managers?
6. Why are managing the ward, influencing, motivating, and supervision important to the clinical nurse managers role?
7. There are a range of courses available in most of the hospitals to CNMs, but it appears most CNMs have not undertaken these? Why do you think this is so?
8. What would you like to add that you feel we have not covered?

Questions for registered nurse participants

To explore and understand registered nurses' experiences regarding their clinical nurse managers' leadership practices in clinical settings, the following developed questions guide was used with each registered nurse participant:

1. Could you describe the leadership practices of your clinical nurse manager?
   To enrich the discussion around this question the participants were asked about (RNs consistently reported their nurse managers' leadership practices lower than the CNMs self-reported, what do you think about that?)
2. Do you think there's a difference in leadership practices between Saudi CNMs and non-Saudi CNMs?
3. Do you think there's a difference in the leadership practices of CNMs from different cultures?
4. Do you think experience in the ward or experience as a manager influences leadership practice of your CNM?
5. What would you like to add that you feel we have not covered?

Also, follow-up questions were used for each question to enrich the discussion of the current research

Appendix L: Published journal article

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ORIGINAL ARTICLE

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Clinical nurse managers' leadership practices in Saudi Arabian hospitals: A descriptive cross-sectional study

Abdulhafith Alharbi BSN, MSc, PhD Candidate, Lecturer[1,2] |
Philippa Rasmussen BN, MN, PhD, Associate Professor[1] |
Judy Magarey BN, MN (Research), DNurs, Associate Professor[1]

[1]Adelaide Nursing School, The University of Adelaide, Adelaide, South Australia, AU

[2]College of Nursing, University of Ha'il, Hail, Saudi Arabia

Correspondence
Abdulhafith Alharbi, PhD Candidate at Adelaide Nursing School, The University of Adelaide, Level 4, Adelaide Health and Medical Sciences Building, Corner of North Terrace and George Street, Adelaide, SA, AU.
Email: abdulhafith.alharbi@adelaide.edu.au

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Abstract

Aim: To understand the situational profiles of clinical nurse managers' transformational leadership practices in Saudi hospitals.

Background: Clinical nurse managers' effective leadership may enable registered nurses to provide safe patient care.

Methods: This included 29 clinical nurse managers and 318 registered nurses from three Saudi hospitals. Data were collected using the leadership practice inventory-self and the leadership practice inventory-observer.

Results: A significant difference between self- and observer-assessed transformational leadership practices of clinical nurse managers was found. There was also a significant difference in transformational leadership practice between Saudi and non-Saudi clinical nurse managers. Ward experience of clinical nurse managers was statistically positively associated with higher ratings of "enabling others to act". Length of clinical nurse managers' experience was associated with "enabling others to act" and "encouraging the heart" practices.

Conclusion: Clinical nurse managers rated their transformational leadership performance higher than that reported by registered nurses. Further, non-Saudi clinical nurse managers working in Saudi hospitals overestimated the extent of their transformational leadership practices.

Implications for Nursing Management: Clinical nurse managers should gather feedback about their leadership performance regularly and implement required changes. Hospital administrations should provide additional support to clinical nurse managers through effective leadership programmes, enculturation and team-building strategies, to create a shared vision regarding the execution of optimal leadership.

KEYWORDS
clinical nurse manager, transformational leadership, demographic differences, professional differences, registered nurse

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