THE LEADERSHIP PRACTICES OF NURSES IN THE NEW ZEALAND HOSPITAL WARD: A FOCUSED ETHNOGRAPHY

By

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ABSTRACT

At a time when healthcare is experiencing a global shortage of nurses, and safety culture permeates hospitals compounding the challenges in caring for patients, nurses are responding using nursing leadership practices to influence and lead each other, to protect nurses and nursing identity and respond to safety culture expectations.

Leadership is a social practice of influence. Nursing leadership has long been associated with the formal nursing roles within the profession. Through survey, interviews and case studies, leader-centric research has focused on nursing leaders, their styles, qualities, traits, and functions and has been associated with positive patient outcomes, reduced errors and nursing satisfaction and retention. Little is known about how nursing leadership practices occur in the hospital ward nursing team and the situations and context in which this happens.

The purpose of this research was to describe and explore how nursing leadership practices were occurring in contemporary hospital wards in Aotearoa New Zealand. Through the lens of leadership-as-practice, this focused ethnography utilised 18 months of episodic fieldwork observations in four wards of a hospital, individual discussions with nurses, and a collection of artefacts. Qualitative analysis revealed the setting that was simultaneously complex and mundane and that nurses engaged in leadership practices in various moments. What nurses said about leadership varied from the activity and performance of leadership practices. Crucially leadership was not the sole practice of those named in formal roles. Informal leaders or those nurses without formal leadership titles led others.

This thesis describes distinct new understanding about collective nursing leadership practices at all levels of the nursing team. Being present, being alongside, being apart, and role-modelling and enabling followership were patterns of leading that emerged within the data. Safeguarding practices of leadership occurred in response to the safety conscious context which exposed nurses to vulnerabilities and perpetuated the leadership practices. These safeguarding practices anticipated, shielded, and protected patients and nurses. In turn, nurses adapted and developed resilient leadership practices to maintain wellbeing, and the identity of nurses and the nursing team so that both nurses and patients would be safe.

Nursing leadership practices are visible at all levels of the nursing team in response to the hospital ward. These collective practices have implications for healthcare practice, for nursing education and the profession of nursing.

Keywords

leadership-as-practice, safeguarding practices, shielding, informal leadership, teamwork, alongsider

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I wanted to do this research as there is talk in the healthcare sector about the invisibility of leadership in nursing. It seemed to me that we might be looking at nursing leadership from the wrong angle and not in the right places. This research has enabled me to take a deep dive into the social phenomenon of nursing leadership as it happens in the hospital ward, to challenge this notion of invisibility.

I would like to dedicate this work to the wonderful nurses who let me into their world. It is not easy letting someone watch you intently as you work, or have conversations with you about your interactions, actions, and behaviour. Your commitment to the patients, to each other and to nursing, shone through.

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ABBREVIATIONS

ACNM	Associate Charge Nurse Manager
CNM	Charge Nurse Manager
DHB	District Health Board
EN	Enrolled Nurse
HCA	Health Care Assistant
MDT	Multi-Disciplinary Team
MOH	Ministry of Health
NCNZ	Nursing Council of New Zealand
NZNO	New Zealand Nurses Organisation
PDRP	Professional Development and Recognition Programme
RN	Registered Nurse
SN	Senior Nurse

CHAPTER 1: INTRODUCTION

Ward nurses are the cornerstone of the 24-hour care delivered to hospitalised acutely unwell and vulnerable New Zealanders. Nursing leadership is pivotal to safe nursing care in the hospital ward and beyond (Solbakken et al., 2018). In Aotearoa New Zealand's health system, significant transformation is on the horizon, with structural changes signalled to influence the delivery of health services and meet future health challenges (Department of the Prime Minister and Cabinet, 2021). In response to the Health and Disability system review (Simpson, 2020), government determined "more active leadership at all levels" is called for, noting "leadership is as much about the culture of the sector as it is about the structure" (p. 5). For nursing within the hospital setting, this means understanding the culture of nursing leadership within the nursing teams in the wards. This thesis presents the findings of a study designed to understand leadership practices in hospital wards in one District Health Board (DHB) of New Zealand.

"Nursing leadership is about influencing others to accomplish common goals" (New Zealand Nurses Organisation [NZNO], 2018, p. 49). Studies of nursing leadership have involved the examination of perceived and desired behaviours, styles and characteristics, anticipated outcomes including effectiveness, work productivity, staff job satisfaction and retention, and patient safety. Most studies have focused on formal nurse leaders with little attention paid to all nurses within the ward setting, and much less on the organisational culture in which nurses work. The intersection between nurses, their leadership practices and the context and work environments, is relatively unknown.

This chapter provides the background for my research. Beginning by introducing my interest in nursing leadership, the discussion then outlines key influences that have created challenges for hospital nursing leadership. These include gendered expectations, societal and political influences, health reforms and the commodification of nursing care. Collectively these influences have led to a reduction in nursing leadership positions, and in the invisibility of nursing leadership. The nursing profession's expectation for nursing leadership is then explored along with the career structures that support this expectation in New Zealand. This is followed by other influences on nursing leadership including politics and safety culture before narrowing the discussion to the New Zealand hospital setting. The chapter concludes with an overview of the thesis.

1.1 My Research Interest

My interest in nursing leadership stemmed from being told when I was young that I had leadership potential. I remember wondering what I had done that suggested that leadership was in my future and what was expected by well-meaning others? As I grew, I heard this statement repeatedly and my own expectations for my future developed. As a nurse, I was exposed to the influences of diverse and changing teams, professional hierarchies and the pressures and structures that exist within hospitals and particularly, the wards. Opportunities for leadership arose everyday across the nursing teams I worked in. There were ways to influence and lead without a formal role and I found others followed on and did as I directed or advised. As a registered nurse (RN), I developed the ability to influence and convince other nurses and the healthcare team generally, to make decisions that positively influenced patient outcomes and the nursing team.

As a senior nurse for 12 years, I was given authority with which to fulfil a leadership role. During this time, I experienced leadership from many different leaders who approached leadership in varying ways. Some were in formal roles and others were acknowledged for their leadership but were without formal authority or role. I observed that when leadership went well, it appeared effortless, almost invisible. In contrast, poor, or destructive leadership had catastrophic effects on patients, individuals, and the nursing team.

Having been away from the hospital ward setting for five years when I started this research, I continued to be interested in how nursing leadership occurred, given the many influences that individual nurses, nursing teams and hospitals were juggling. Knowing that expectations and the reality of a phenomenon can be different, an opportunity to capture nursing leadership in everyday practice, became the focus.

1.2 Forces that Shaped Nursing and Nursing Leadership in New Zealand 1990 - Present

Nursing and nursing leadership in New Zealand has been subject to societal, political, and economic pressures, interprofessional forces, and technological and scientific advances. As a predominantly female profession (Donovan et al., 2012), nursing leadership has been shaped by women's position in New Zealand society and by professional, industrial, and public expectations of nursing and nurses. Since the 1990s, health system reforms (Upton, 1991) informed by neoliberalism and new public management created radical structural changes focused on competition, performativity, and

efficiencies (Hornblow & Barnett, 2000). This has seen the ongoing decimation of nursing leadership positions within the public hospitals (NZNO, 2018). This section of the introductory chapter summarises key features influencing nursing leadership in New Zealand up until this study took place. It begins with a brief focus on women in New Zealand society and their participation in the workforce.

1.2.1 Women in the New Zealand Workforce

In 1893 women in New Zealand were granted the right to vote in parliamentary elections (Ministry for Culture and Heritage, 2018); New Zealand was the first self-governing country globally to grant this right. New Zealand was also the first country to establish a national system for training and registering nurses. This system was established after two years of campaigning when the Nurses' Registration Act 1901 was passed (Wood, 2022). Since this time, the role of women in New Zealand's patriarchal society (Nolan, 2000a) has contributed to how nursing and nursing leadership have developed. Doctors, who were historically male, have been credited by some with providing oversight of the access to and the training of nurses, and for the early setting and marking of the first nursing examinations (Gage & Hornblower 2007; Sargison, 1997). In contrast, exploring early nurses training, registrations and education, nurse historian Pamela Wood (2022) argues the prevailing social and political influence of male-dominated medicine was not as influential within nursing as was reported at the time. Wood credits nursing leaders such as the hospital chief nurses and matrons including Grace Neill and Hester McLean for the development of the nursing syllabus and teaching, the accreditation of hospitals as nursing-training hospitals, and working with regulatory authorities to develop and monitor the examination processes.

Societal expectation during the first half of the 20th century, saw New Zealand women largely as wives, mothers, and homemakers (Nolan, 2000b). To be considered and trained as a New Zealand registered nurse (RN), women were expected to be single and unmarried (Wood, 2022). On marrying, nurses and nurse trainees were expected to leave the profession to manage the home and have children. This was the case until the late 1960s (Wood, 2022) when married nurses were allowed to continue to practice.

Men were able to train and become RNs when the Nurses and Midwives Act 1925 was amended in 1945 (Wood, 2022). The nursing training for men was different to that for women as men were excluded from lectures about female anatomy and conditions and they were not allowed to nurse women (Sargison, 1997). Therefore, few hospitals offered the two-year training programme for men, and those that did, had very high attrition rates – approximately two-thirds (Sargison, 1997). Men were directed to train to be psychiatric nurses and were paid more than their female counterparts.

When gendered training specifications were removed, the pay rates were not aligned leading to male nurses continuing to be paid more. Like many other female dominated professions, nursing has continued to struggle to achieve pay equity with male dominated service professions (Harré, 2007).

Female participation rates in the New Zealand workforce have influenced nursing numbers. The participation rates show three distinct participation patterns. Firstly, and like other developed countries, female participation in employment generally increased significantly following World War II due to the need for economic growth and demand for labour (Jacobsen, 1999: Johnston, 2005; Nolan, 2000b). This increase was influenced by women attaining higher educational qualifications, having lower fertility, flexible working arrangements, growth in service-industry employment, increasing debt-servicing costs for homeowners and more recently, improved parental leave support and childcare availability (Hyslop et al., 2019). Secondly, participation rates increased during the mid-1980s in response to economic reforms which emphasised education and training to expand human capital development, and minimum wage rates were introduced which resulted in significant increases in youth employment during the 2000s (Hyslop & Stillman, 2011).

At the other end of the lifespan, older worker participation increased sharply in New Zealand from 1991 to 2001 due to "policy changes that increase the age of eligibility for NZ Superannuation from 60 – 65 years" (Hyslop et al., 2019, p. 5). Around the same time, changes in human rights legislation, the Human Rights Act 1993, meant that age could not be a reason to dismiss or retire workers. In further legislation in 1999, the ability to require retirement once a worker is beyond the age of NZ superannuation eligibility, was made unlawful (Hurnard, 2005). Combined, these changes contributed to the third distinctive trend in New Zealand workforce participation with older workers including women, continuing to increase steadily since 2001 (Hyslop et al., 2019; Maré, 2018). Nursing benefitted from all these changes.

1.2.2 Nursing in New Zealand

For nursing, the changing patterns of workforce participation has led to more people training as nurses. In 2019, New Zealand had 365 nurse practitioners (NPs), 51,700 registered nurses (RNs) and 2,391 enrolled nurses (ENs) with 91% of the nursing workforce being female (Nursing Council of New Zealand [NCNZ], 2019). Additionally, nurses were remaining in practice for longer, leading to an ageing workforce "with 43% aged 50 years or over and 19% aged 60 or over" (NCNZ, 2019, p. 5). Additional nurses were needed to address New Zealand's demographic changes, increased numbers of immigrants, and people living longer.

Historically, RNs trained for three years in hospitals to gain a hospital training certificate. There were three types of registration: general and obstetric, psychiatric (formally known as mental health), and psychopaedic nursing (Carpenter, 1971). Later, training occurred in dedicated schools of nursing within or alongside hospitals before nursing training moved to the polytechnics or technical institutes in the 1980s where nurses were comprehensively trained and awarded diplomas (Wood & Knight, 2010), and to universities in the 1990s when undergraduate degrees became the foundational level of academic achievement for New Zealand RNs.

During the 1960s, community nurses were trained to give basic care, either in hospital or in the community under the supervision of a RN or doctor. Usually having completed two to three years of secondary school education, these nurses undertook a basic nursing programme for 12–18 months and studied nursing of medical and surgical patients, the care of mothers and children, and district or home-based nursing (Carpenter, 1971; McCool, 2020). The programme consisted of six weeks of theoretical content and extensive 'hands-on' experience (Carpenter, 1971). On completion, these nurses were added to the Nurses Roll. Enrolled nurse training continued until 1992 when it ceased (Capital & Coast DHB, 2020). Between 2000 and 2004, a new training programme was introduced for the second level nurses. Initially gazetted in 2004 under the Health Practitioner's scope of practice as nurse assistants, the role was re-titled enrolled nurse (EN) in 2008 by the then Minister of Health David Cunliffe (New Zealand Government, 2008). Subsequently, to become an EN, candidates must complete and pass an 18-month programme that is assessed against Nursing Council of New Zealand (NCNZ) competencies for enrolled nurses. Enrolled nurses work under the direction and delegation and leadership of RNs and NPs (NCNZ, 2012b).

The newest and most advanced of New Zealand's clinical nurses is the nurse practitioner (NP) role. This role, introduced in 2001, was and continues to be controversial for perceived blurring of the boundaries between nursing and medicine, and for challenging medicine's domain (Carryer & Yarwood, 2015). This regulated advanced nursing role with prescribing rights, has a NCNZ scope of practice which recognises academically and clinically prepared expert nurses who have achieved mentored clinical hours and practice autonomously and collaboratively (NCNZ, 2017). Deborah Harris was the first NP in December 2001 with the number growing slowly to 365 in 2019 (NCNZ, 2019). Nurse practitioners contribute across the health system, their presence partly addresses the shortage of nurses and doctors (Radio New Zealand, 2022), particularly in primary health and rural settings. Just under a third of NPs (n = 116) worked in acute care settings within DHBs (NCNZ, 2019).

Along with the regulated roles described above, are unregulated members of the nursing team known as health care assistants (HCAs) (previously nurse aides). These HCAs contribute to care provision

under the direction and delegation of RNs and NPs. Health care assistants numbered 33,513 in the 2018 Census (Statistics New Zealand, 2019) and were at the base of the nursing hierarchy. Above HCAs, are the ENs and then the RNs (previously known as staff nurses). A few specialty areas in the hospital have NPs as the most expert clinical nurse within the team. The senior nurse of the hospital ward nursing team is the charge nurse formally the ward sister (who was also an RN). Previously all ward sisters reported to the hospital Matron. Today charge nurse managers professionally report to the Director of Nursing or Chief Nursing Officer of the hospital and have line-reporting to a senior hospital manager.

Nurses in New Zealand recognised early, that those amongst its ranks needed to reflect the ethnic diversity of society to improve the care of patients (Wood, 2022). Yet New Zealand has struggled to train nurses in numbers representative of the indigenous Māori population. In 2018 16.5% of the population identified as Māori whereas only 8% of the nurses were Māori (Statistics New Zealand, 2018). In the same year, 59% of nurses identified as New Zealand European/Pākeha and 4% of nurses were of Pacific ethnic origins (NCNZ, 2019).

Early Māori nurses grappled with the challenge of navigating western medicine and traditional Māori views of healing, to support Māori settlements and Māori health and wellbeing, alongside their pākehā nursing colleagues (Wood, 2022). In 1900, formal nursing training was in an apprenticeship model within hospitals, and both Pākeha and Māori women aged over 21 years old were on the waiting list to become nurses, with three Māori nurses known to have registered by 1908 (Wood, 2022). These early Māori nurses led the way, though it would be nearly 100 years until a National Council of Māori Nurses was established in 1983 (Ministry of Health [MOH], 2017b). This was a specialty interest group of the New Zealand Nurses' Association (NZNA) with an interest in cultural safety. Nearly 40 years on, in 2019, former executive member of the National Council of Māori Nurses, Margareth Broodkoorn, who is of Ngāpuhi and Dutch descent, and a former Director of Nursing and Midwifery, was appointed as the first Māori Chief Nursing Officer to advise the Minister of Health. Highly qualified for the role, this appointment was amongst many over preceding years, attempting to address inequities within the health sector and leadership roles.

Societal perceptions of nursing are reflective of contemporary issues of different time periods. Nursing has been viewed as a vocation or a calling, based on its origins in religious order of the Sisters of Mercy (Meehan, 2012), thus nurses were seen as angels of mercy (1854-1919) (ten Hoeve et al., 2013). Nursing has also been viewed as subservient to medicine with nurses the handmaidens to doctors with an image of 'Girl Friday' (1920-1929) (ten Hoeve et al., 2013). Following these depictions of nursing, others have arisen including: "Heroine (1930-1945); Mother (1946-1965); Sex Object

(1960-1982); and Careerist (1983-Present)" (ten Hoeve et al., 2013, p. 298). New Zealand nurses have juggled these images (Wood, 2022) but more recently have focused on professional and industrial tensions. The next section begins in the 1990s when significant changes in health system structures and in nursing influenced the landscape in which hospital nursing and nursing leadership occurred.

1.2.3 New Zealand Health Reforms and Nursing

The 1990s saw two significant changes in the structure and delivery of healthcare in New Zealand. The centre right government of the time, the National Party, implemented radical free-market reforms. Economic neo-liberalism influenced business models of efficiency and profitability (known as New Public Management) focused on the commodification or the business of caring in the health sector (White, 2004). Firstly between 1993 and 1997, the 14 Area Health Boards which had been established in 1983 and funded by a population-based formula (New Zealand Parliament, 2009) became four Regional Health Authorities (RHAs) to fund and purchase healthcare provisions from 23 Crown Health Enterprises (CHEs) which were publicly owned and autonomous business units subject to company law. Each CHE was a single hospital or geographically located hospitals and health services, which set and monitored its own financial performance (Gauld, 2001; Tenbensel et al., 2008).

The second health system reform of the 1990s was introduced by the first coalition government in New Zealand between 1998 and 2001. With a focus on centralising health funding and emphasising collaboration, the four RHAs became the single national purchaser, the Health Funding Authority. The 23 CHEs became 24 Hospital and Health Services (Hornblow & Barnett, 2000). Despite a focus away from the for-profit and commercialisation of healthcare delivery toward being business-like, the downsizing and reconfiguring of the hospital sector and reduction of hospital beds continued in response to what was seen politically as poor hospital performance (Gauld 2001; New Zealand Parliament, 2009). This included reducing what was considered non-core services such as "midwifery services, sexual health services and mental health staff training…" (Gauld, 2001, p. 160).

The significant structural changes within the health system during the 1990s which saw a centralisation and competitiveness amongst CHEs, resulted in nursing leadership roles within hospitals being disestablished. The responsibilities of budgets for nursing personnel, training and decision-making moved from frontline nursing professionals to managers (many of whom had non-nursing backgrounds). The managers were subject to the neoliberal influences of the day (McKelvie, 2019). Reduced nursing leadership roles within the wards impacted the ability to influence direct patient care and nursing development and teamwork, negatively impacting patients and compounding the

shortage of nurses at the bedside. With roles being disestablish, the visibility of nursing leadership was waning.

Tensions amongst New Zealand nurses contributed to significant development during the 1990s. The passing of the Employment Contracts Act 1991 made it difficult for the New Zealand Nurses Organisation (NZNO), the industrial union for the largest group of nurses in New Zealand, to maintain their collectivism as workers. At the time, the union had industrially focused leadership (Sargison, 2018) and was considered by some, to be neglecting the professional issues of nursing (Carryer, n.d). This caused concern for those mainly academic nurses from critical feminist social theory background, who had begun the academic nursing journal Praxis. These nurses felt that the public was beginning to view nursing as a trade union, with self-interested views that were not serving the public (Carryer, n.d.).

Amidst the political tensions, two groups of nurses were evident: the industrial and the professional academics. In 1991 a decision by some nurses was made that an additional organisation was needed for nurses who viewed nursing as a profession with ongoing advanced education. The organisation would need to support the integration of theory and practice, opportunities for networking, an aim of improving the health of New Zealanders, and be prepared to negotiate with tangata whenua. In 1992, the College of Nurses was established with a goal of maintaining the professional and bicultural perspectives of nurses in contemporary New Zealand health contexts. The College had a flattened hierarchy and encouraged nurses to speak up and comment on professional and academic nursing and health matters freely (Carryer, n.d). In contrast NZNO members were required to speak as one.

The health reforms of the 1990s also led to workload pressures primarily related to the level of inexperience of much of the hospital nursing workforce; up to 80% of nursing staff had a maximum of 18 months of experience and attrition rates of RNs was high due to difficult and unsupportive clinical environments (Sargison, 2018). On the back of this, a Ministerial Taskforce on Nursing (1998) got underway. The then Minister of Health sought to understand the obstacles for the nursing profession to work effectively and increase access to healthcare services. The Taskforce sought representation and opinions from a variety of nurses, nurse leaders and nursing groups to identify barriers that prevent nurses realising their full potential for health service delivery. This included the College of Nurses, the Māori Nurses Association (a subgroup of the NZNO representing Māori health professionals) and NZNO, the nurses' union. However, a unified view of the obstacles and strategies was not achieved. The NZNO, the largest nursing organisation in New Zealand, withdrew from the consultation amidst outstanding tensions about the forward direction of the profession and its role (Ministerial Taskforce on Nursing, 1998; Wilkinson, 2008). This demonstration of a lack of unity in

nursing leadership across the two key nursing organisations (Wilkinson, 2008) created a barrier to nursing's reputation and effectiveness (Ministerial Taskforce on Nursing, 1998; Wilkinson, 2008).

The key recommendations from the Ministerial Taskforce (1998) included reviewing access to funding and education at undergraduate and postgraduate levels for nurses, the establishment of a competency framework for nurses, the employment of graduate nurses across the sectors including community practice settings and increasing implementation of nursing research to improve nursing practice. For nursing leadership and management, recommendations included "involvement in policy and health-care strategy, in nursing leadership and leadership development" (p. 66). The Taskforce had noted the now limited influence of nurses within management and on the direction of healthcare services, despite being the largest health-professional workforce and having "a unique overview of clients and communities" (p. 66). This had resulted in nurses not being involved in the organisation of nursing services or holding budgets to influence the correct mix of nursing roles, responsibilities, and resources to optimise healthcare delivery.

Further restructuring of the health system continued. Overly competitive and deemed to have created a lack accountability and efficiency, the 1999 Labour-Alliance Coalition government continued to centralise health funding by moving it inside the Ministry of Health (MOH) (New Zealand Parliament, 2009). As the Health Funding Authority was slowly disestablished, the MOH became purchaser and monitor of health provider performance, as well as the agency developing national health policies. Health service delivery was purchased and provided by 21 DHBs which were established in 2001 following the New Zealand Public Health and Disability Act 2000. Providing planning, funding, and care provision to geographically defined populations, the DHBs were governed by locally elected and Minister-appointed board members. The focus for hospitals was on patients not on commercial gains with an emphasis on preventative health services. As such, national health goals and targets foreshadowed care delivery within budgets and reducing inequity and increasing access, and each DHB became responsible and accountable for monitoring its own performance. Population based funding was reintroduced on 1 July 2003 (MOH, 2008).

With the focus on performance and efficiencies (Newman & Lawler, 2009), emphasis was put into measuring nursing work and outcomes. Patient acuity tools such as TrendCare began to be tested to capture this data (Wilson & Nelson, 2001). Hospital management also began to use this data to inform nursing staff-to-patient ratios and re-allocate nursing resources across hospitals as safety concerns and unmanageable workloads had gained the attention of the government (McKelvie, 2019).

Fair pay and national employment agreements had been eroded by constant changes to the system and funding streams, creating disparities in nursing across New Zealand (Sargison, 2018). Safe staffing

and working conditions were at the centre of industrial bargaining. A partnership was reached between NZNO and DHB providers and The Nurse Safe Staffing Project was established which included implementation of the Care Capacity Demand Management (CCDM) programme informed by data entered in TrendCare by nurses at least twice a shift (McKelvie, 2019). However, after over a decade of slow implementation, not all DHBs had the CCDM programme in place and the resurgence of disestablishing and curtailing of nursing leadership positions continued. Twenty per cent of New Zealand's DHBs nursing leadership roles between 2015-2018 were disestablished (NZNO, 2018). Again, nursing leadership had been structurally eroded yet the profession maintained its leadership expectations within practice. This is elaborated on in the next section to position the focus of this study within current professional nurse contexts.

1.3 The Professional Expectation for Nursing Leadership

The three nursing bodies in New Zealand had different foci. The NZNO is the industrial body which represents nurses as workers, and the College of Nurses focused on academic and the professional issues. Most countries have a professional regulatory nursing body charged with ensuring nurses are up to the task of providing nursing care for the public, and that patients will be safe. For New Zealand, this is the Nursing Council of New Zealand (NCNZ). Educational preparation and training, standards of conduct and performance, guidelines and expectations for practice including competencies for nurses are developed and maintained by these regulatory bodies, providing the rules and boundaries for nursing ensuring nurses are fit to provide high quality care.

Leadership is an expectation within the nursing profession. In 1987, the International Council of Nurses (ICN) recognised the importance of leadership within the nurse's role, noting that basic nursing education prepares the nurse for a leadership role. Pre-registration nursing education and nursing competencies worldwide recognise leadership as part of the professional role of a nurse and describe this either explicitly or implicitly. As New Zealand nurses commonly seek registration in Australia, Britain, Canada, and the United States of America (USA), only these countries' professional leadership expectations of nurses are presented here followed by New Zealand's expectations.

The national *Standards of Practice for Australian Registered Nurses* outlines seven interconnected standards for practice (Nursing and Midwifery Board of Australia, 2016). Leadership is not explicitly identified in these standards. However, in the *Code of Conduct for Nurses* (Nursing and Midwifery Board of Australia, 2018) 'Domain 2: Practise safely, effectively and collaboratively' points to nurses providing "leadership to ensure the delivery of safe and quality care and understand their professional responsibility to protect people…" (p. 7).

In Britain, nurses register and work in four distinct fields or scopes of nursing: adult nursing, children's nursing, mental health nursing, and learning disability nursing. They are expected to meet the standards for proficiency for RNs including accountable professionalism, "promoting health and preventing ill health, assessing needs and planning care, providing and evaluating care, leading and managing nursing care and working in teams, improving safety and quality of care and co-ordinating care" (Nursing and Midwifery Council, 2018, p. 6). Leadership is an expectation in all fields where nurses manage care, co-ordinate inter-professional care in responding to individual needs, and delegating and supervising care.

In Canada, the nursing regulatory body - the Canadian Council of Registered Nurse Regulators - ensures public safety by regulating the practice of RNs. This is achieved through both educational and competency programmes designed so that entry-level RNs and practicing RNs provide competent, compassionate, ethical, and safe nursing care (Canadian Council of Registered Nurse Regulators, 2016). Leadership appears to be implicit in the foundational education preparation and competencies of Canadian RNs, which focuses on professional responsibility and accountability, knowledge-based practice, ethical practice, service to the public and self-regulation. However, the Canadian Nurses Association have an eight-page position statement about nursing leadership indicating the characteristics, practice of and political and technological contexts in which the act of nursing leadership is undertaken. At its foundation is the expectation "that nurses can be and must be leaders" (p. 1) and begins with student nurses through to those nurses working within a global context.

In the USA, nursing students prepare for the reality of the complex healthcare settings, inter-professional teams, safe patient centred care, and professional practice across an ever-changing lifespan, by studying at baccalaureate or master's level for professional nursing practice (American Association of Colleges of Nurses [AACN], 2008). The courses they undertake are structured on nine essential curriculum components that inform the expected outcomes for graduates. The second of these is 'Basic Organisational and Systems Leadership for Quality Care and Patient Safety' (AACN, 2008). The AACN (2008) argue that to be effective in promoting high quality safe patient care, nurses need to have leadership skills that focus on the patient and their care needs. The Association emphasises professional teamwork whilst being aware of processes and influences of quality, political and regulatory guidelines on the local, micro-, and macro-systems of health. Simultaneously there is an expectation that nurses will apply evidence-based knowledge and deliver contemporary nursing models within the bounds of cultural, economic, organisational, and political perspectives. To achieve this, baccalaureate nursing students in the USA develop skills and knowledge in the aforementioned areas, in addition to leadership "theory, behaviours, characteristics, contemporary approaches, leadership development and styles of leadership" (AACN, 2008, p. 14).

Once qualified, the leadership expectations for American RNs are set out in the *Nursing: Scope and Standards* (3rd Ed.) (American Nurses Association, 2015). These requires each nurse to demonstrate leadership in their professional practice setting and, in the profession (American Nurses Association Leadership Institute [ANA LI], 2013). Further to this, those in nursing leadership roles in USA are expected to meet other expectations. The AACN (2013) outlines the "Competencies and Curricular Expectations for Clinical Nurse Leader Education and Practice" and the American Nurses Association Leadership Institute (ANA LI) (2013) has developed a competency model for nurse leaders which focuses on three distinct domains: Leading yourself; Leading others; and Leading the organisation.

The professional nursing leadership expectations are explicitly described internationally, however, the concept of leadership is more difficult to find in the guiding documents of New Zealand's nursing profession. New Zealand training programmes for RNs must meet the NCNZ (2015) *Educational Programme: Standards for Registered Nurse Scope of Practice*. Included within the curriculum is 'leadership' as is 'teamwork', though further detail is not specified about what and how these are to be taught or assessed. At the completion of the three-year baccalaureate degree or two years master's nursing programmes (for students with a prior degree), students are expected to meet the NCNZ's (2007) competencies for registered nurses and pass a national examination.

Two pertinent guiding frameworks influence clinical nursing practice in New Zealand. The first is the *Registered Nurse Competencies* (NCNZ, 2007). Every nurse in New Zealand is required to declare annually whether they are competent to practice and are expected to maintain a portfolio of professional development to reflect this. The competencies for RNs focus on four domains: professional responsibility, the management of nursing care, interpersonal relationships, and interprofessional healthcare and quality improvement. An examination of the detail within each domain, indicates leadership qualities, behaviours and activity underpin the expectations for practice and yet 'leadership' is not specifically identified within the competencies. Role descriptions for RN positions across the wider health sector are often more explicit about the expectations for leadership. Nurse employees are expected to demonstrate characteristics and qualities of leadership whilst enacting leadership within their work teams.

The second framework is the professional career plan programme known as the *Professional Development and Recognition Programme (PDRP)* to develop and "recognise the expertise of nurses in clinical practice" (NCNZ, 2013, p. 1). The PDRP reflects Benner's (1984) *From Novice to Expert* work applying the Dreyfus model of skill acquisition to nursing. It describes the expected practice skills, qualities, knowledge, and experiences that RNs and ENs must develop and demonstrate as they move along the expertise continuum. Whilst participation in this is not compulsory (depending on

employment agreements), the PDRP programme assists with identifying a hierarchy of clinical expertise amongst nurses. The apprenticeship model of preceptorship recognises this expertise and experience, with more experienced nurse(s) teaching and guiding the development of nurse colleagues (NZNO, 2022). Both the PDRP and preceptorship are endorsed by the NCNZ.

Collectively these two documents guide how nurses in New Zealand should develop their role and expertise, whilst maintaining patient safety and professional expectations. Yet despite these significant influences underpinning New Zealand clinical nursing practice, nurse leader and leadership development in clinical nursing are not explicitly recognised within them.

There is no one route by which a nurse develops leadership skills and/or becomes an appointed nurse leader in clinical practice in New Zealand. There is evidence that nurses are taught about leadership roles in their undergraduate programmes. During their education they learn that they should be leaders of care and leaders of care teams. Yet no detail about these leadership roles is evident in the RN competencies or the PDRP. For those formal and senior nurse leaders such as Charge Nurse Managers (CNMs), Clinical Nurse Specialists (CNSs) and Clinical Nurse Educators (CNEs), their healthcare employers may offer specific leadership training. Additionally, many of these formalised nursing leadership roles are expected to undertake post-graduate education to support their chosen role and area of expertise.

Across the countries examined above, there are differing professional expectations for nursing leadership. Whether nurses are informal leaders within teams, or formal clinical or professional leaders within the hierarchy of a healthcare organisation, the leadership practices of nurses are not consistently recognised. The inconsistency of expectations contributes to the perceived invisibility of leadership in everyday nursing practice.

1.4 Nursing Leadership and Safety Culture in Hospitals

Investigations into recent tragedies in hospitals have identified that invisible and inadequate nursing leadership practices contributed to substandard hospital nursing care and patient deaths (Francis, 2013a, 2013b). Often these investigations are not limited to a particular hospital but are undertaken by national agencies. In England, the Mid-Staffordshire NHS Trust put the achievement of Trust targets ahead of delivering safe standards of care for years. Following two inquiries into the system and organisational culture that had contributed to hundreds of patient deaths, nursing leadership and a dysfunctional culture in nursing were found to be complicit in the systems breakdowns that failed

the public (Francis, 2013a). These findings put the spotlight on nursing leadership practices and how these are subject to financial, social, and structural influences.

New Zealand has had similar failings within the public hospital setting. An investigation into allegations concerning the treatment of cervical cancer at National Women's Hospital in Auckland, New Zealand, is one inquiry in which nursing leadership was questioned. In 1987, Sandra Coney and Phillida Bunkle authored an article in a national magazine titled the *Unfortunate Experiment at National Women's Hospital* which outlined the 'conservative' cervical screening and treatment of women during the 1960s and 1970s. A committee of inquiry into the allegations made in the article, was undertaken. Headed by Judge Silvia Cartwright several failings were found in relation to care and treatment of women and babies at National Women's Hospital including that the women were unaware they and their babies were participants in research projects and that their treatment was not necessarily in line with recommended practices of the time (Cartwright, 1988). The culture of nursing and nursing leadership were found to be complicit (Manning, 2009).

Law changes in New Zealand, and the establishment of the Health and Disability Commission (HDC) in 1994 saw the creation of a patient Code of Rights known as the *Code of Health and Disability Services Consumers' Rights* (Health & Disability Commissioner, 2022). The rights of the patient to information, knowledge and to consent to health diagnostics, interventions, and treatment (including participating in research) were established as fundamental for healthcare provision (Manning, 2009).

The HDC acts as a watchdog receiving complaints and investigating where poor-quality care has caused harm. In their 2020 Annual report, they recorded having received 2393 complaints about code breaches in 2019/20 (Health and Disability Commissioner, 2020). The HDC commissioner reflected that "culture, leadership, and a system under pressure" were contributors. The complaints had increased 22% over the previous five years. Their observations were "systems that do not support staff to work well together…", the negative impacts of hierarchy and "instances where a culture of tolerance emerges and the sub-optimal becomes normal" (p. 5) contribute to code breaches.

The Health Quality and Safety Commission (HQSC) was established in 2010 to monitor and report on quality and safety within health and disability support services in New Zealand. Tasked with building capability and quality within the sector, the HQSC works to improve equity and experiences for health consumers and whānau (family) so that "fewer people [are] harmed, more lives saved, and financial savings are made" (HQSC, 2022, February 22).

Collectively, these agencies recognised that there were problems with the provision of safe healthcare and have regularly monitored and reported on these problems. In 2020, a review of the Health and

Disability System resulted in a comprehensive report of the state of the New Zealand health system. Known locally as the Simpson report after the chairperson Heather Simpson, this report recognised that the strength in the health system was people. Therefore, recommendations sought to address system level changes to allow staff to be more effective. Of the four key themes for change that were signalled, one specifically identified the need for "culture change and more focused leadership" (New Zealand Health and Disability System Review, 2020, p. 3).

A new structure for the health system was proposed in April 2021 with a new governance agency and clear accountabilities and responsibilities for clinical and financial leadership (Little & Henare, 2021). Effective leadership was identified to be about creating a collective culture across all parts of this health system including strengthening partnership with Māori at governance and local levels and setting out how a legislated charter for "common values and workforce behaviours expected of those throughout the system" (New Zealand Health and Disability System Review, 2020, p. 5). My research started before the intended health reforms were known; the findings are important given the calls for leadership in the reforms.

In summary, government watchdogs, investigations and reviews have led to impending changes being signalled for the New Zealand health system including attention being paid to leadership. Whilst macro changes are afoot, at the micro level, nursing leadership in the New Zealand hospital ward is not well documented. Following years of restructuring within the health sector and the reduction in nursing leadership roles and responsibilities over the past two decades, some believe nursing leadership to be invisible or absent in the daily practice of nurses (Walker & Clendon, 2013). Given the correlation between leadership and safe patient care, as well as the profession's expectation for nursing leadership, this research was designed to answer the question: How does nursing leadership occur in the hospital ward?

As nursing is a practice, a research design which captures a practice perspective to better understand the phenomenon of nursing leadership, was warranted. Additionally, research which enables naturally occurring nursing leadership to be observed, would draw attention to what is happening. Focused ethnography as a method and methodology draws the spotlight to nursing leadership practices and activities, and nurses' experiences and perceptions of nursing leadership practices in the hospital ward. Leadership-as-practice captures leadership practices occurring every day between people in context (Karp, 2022). This practice-based philosophical approach is examined in Chapter 2, as a lens to inform how nursing leadership practices might be better observed, understood, and made visible.

1.5 Thesis Overview

This thesis is presented in seven chapters. This first chapter has introduced my interest in nursing leadership and my reasons for doing this study. First drawing attention to some of the influences shaping the contemporary contexts of nursing and nursing leadership in New Zealand, the discussion included women's role in the workforce, nursing in New Zealand and the 1990s New Zealand health reforms. The professional expectations for nursing leadership were outlined including some of the international differences. Following both international and national incidence of poor patient care and an evolving focus on safety culture in the New Zealand health system, the significance for research into the everyday leadership practices of hospital ward nurses is outlined.

In Chapter 2, the literature review begins with some definitions of leadership before looking to the two dominant perspectives of leadership (leader-centric and pluralistic approaches) that inform how nursing leadership are considered. This includes exploring the commonly adopted leadership theories that nursing uses. Leadership practices are examined from formal, informal and team perspectives finding that hospital ward nursing leadership practices are not well understood beyond leader-centric perspectives. The pluralistic leadership-as-practice perspective which was used in my research is then critiqued as a lens to analyse and interpret fieldwork observations and data. This lens considers the daily practices of nursing leadership as processes and social interactions. For my study this required examining the context of the ward and the hospital and wider society, the practitioners which in this case is those in the ward nursing teams and their leadership activity in the context of the hospital ward, so that nursing leadership can be visible.

To describe how nursing leadership practices naturally occurred in the hospital ward, the methodology of focused ethnography is presented in Chapter 3. This methodology is influenced by social constructionism and situated me, the researcher, as a participant observer within the hospital ward to undertake fieldwork. As a focused ethnography, three ethnographic data collection methods (observations made of participants in 'the field' or as they undertook their duties in the hospital ward, individual discussions with consenting participants and the collection of artefacts) were used (Cruz & Higginbottom, 2013). The research design then provides detail of the steps taken for data collection and analysis including the measures taken to ensure the rigour and quality of the study.

Two findings chapters then follow. Chapter 4 presents the context in which this study is set. The monotony and complexity of the hospital wards provide the backdrop and foreground influencing the nursing culture and nursing leadership practices. Chapter 5 describes what nursing leadership is and

reveals how the nursing leadership practices occurred. This includes patterns of leading and safeguarding leadership practices.

The significance of the findings is examined in Chapter 6 where connections are made so that the meaning and impact of what was occurring becomes clear. The key findings of nurses at all levels of the nursing team engage in collective leadership practices; how the hospital ward context shapes nursing leadership practices; and safeguarding practices of leadership that nurses used, are discussed. My reflexive journey as a researcher is also presented.

Finally, Chapter 7 draws conclusions for the reader identifying the explicit contributions this thesis makes to nursing knowledge, and leadership scholarship, and to methodology. Implications for nursing practice, education and policy are made as are recommendations for future research of nursing leadership practices.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Having provided a background to the context for this study in the previous chapter, this chapter provides an overview of what is known in the literature about nursing leadership within the hospital ward. The chapter is in eight sections. Section 1 describes the search strategies used to locate and analyse the literature. In Section 2 definitions of leadership are then presented followed by Section 3 which explores the two ways of conceptualising leadership: leader-centric and pluralistic perspectives. Research on nursing leadership is in the next section revealing that there is little literature about the collective enactment of doing leadership. This informs the research question: How does nursing leadership occur in the hospital ward? In Section 5, nursing research using three of the commonly adopted leadership theories, is explored. As leadership practices are activities occurring in specific contexts and social interactions, Section 6 presents nursing leadership literature from the perspective of hospitals, formal nursing leadership roles, and ward nurses. From here, the aim and purpose of the study are identified in the next section. Finally, leadership-as-practice is examined as the lens that would enable me to capture the intersection between nurses, the context of the hospital ward, and everyday leadership practices, to make visible what was occurring.

2.2 Search Strategies

For the novice researcher, the volume of literature about aspects, contexts and perspectives of leadership created a quagmire to navigate. At the beginning of my doctorate, I read widely to come to know the topic and the exclusion and inclusion criteria that needed to be applied. I began with the literature search, configurations of the terms 'nurs*', 'lead*', 'practices' and 'team*' were entered into the databases CINAHL, Emerald, and ProQuest. These searches returned significant numbers of articles, so limitations such as 'hospital', 'ward' and limiting to peer reviewed research were added. Exclusion criteria were articles not in English and initially, not published before 2000. The search was updated further once the specific research questions were identified. The inclusion criteria were narrowed to 'nursing leadership practices' as it became clear that this was an area of nursing leadership that had been understudied. The snowballing technique was also used from this point identifying and gathering additional research and literature on specific aspects of nursing leadership practices. The snowballing technique utilised is similar to that described by Wohlin (2014) who undertook a systematic review, where literature is identified in both backward and forward

snowballing. Backward snowballing involved looking at titles in the reference list and abstracts of the referenced paper and the full references of that paper. This technique was undertaken more frequently than forward snowballing which involves identifying articles from the reference list of papers found. The snowballing technique revealed some pre 2000 references that were important to include in the review. Research was critiqued and selected based on key findings and implications. Additionally, the methodologies and methods or research designs within the publications were examined alongside the findings that were offered. This addition was to evaluate the rigour of the published findings and to guide planning my research. The next section begins the literature review examining what is understood as 'leadership'.

2.3 Defining Leadership

"Leadership is one of the most observed and least understood phenomena on earth" (Burns, 1978, p. 2). Since this statement by political scientist and leadership scholar James McGregor Burns, much attention has been spent defining and describing the phenomena of leadership. Researchers from many fields have contributed to this exploration of 'leadership' including psychology, sociology, organisational development, management, human resources, and professions. The volume of research has resulted in leadership and the development of leaders and structures to support leadership being increasingly understood, though consensus about this phenomenon is lacking. Some of the lack of consensus comes from the different approaches from which leadership is considered and the different context and workplaces in which leadership is examined.

Leadership as a term may be considered straightforward, but it is a complex and complicated concept. There are two common elements to most conceptualisations of leadership. One element is that leadership is a social phenomenon of interactions which usually occur face-to-face. The second is that leadership structures activities and relationships, enabling sensemaking processes (Hosking, 1988). Whilst for some people, leadership is a property and action of leaders (Hosking, 1988), for others leadership involves a complex equation between a leader, a follower or followers and environmental factors (Day et al., 2014; Padilla et al., 2007). The evolution of leadership thinking provided over 200 definitions across the 20th century (Rost, 1991). The definitions differ as settings, relations, situations, and cultural contexts influence how leadership is understood (Alvesson, 2013; Ciulla, 2005; Heinen et al., 2019).

Leadership scholar Peter Northouse (2019) summarises the evolution of the traditional leader-centric view of leadership where the leader influences the followers in a top-down fashion. Between 1900-1929 leadership was about domination, of power and control. In the 1930s the focus moved to that

of influence and the personality traits of leaders and the reciprocal influence of groups on leaders and leaders to groups. The emphasis in the 1940s was on leader behaviour within groups and on persuasion rather than coercion. Group dynamics continued to be a focus in the 1950s and attention centred on what leaders do in groups, on shared goals and on effectiveness. For example, having reviewed studies undertaken between 1900 and 1957, to examine "the relationship between personality and performance in small groups" (p. 241), Mann (1959) concluded that "Leadership is an emergent phenomenon, created through the interaction of individuals (leaders and followers), and that the selection and stability of any leadership pattern is a function of the task, composition, and culture of the group" (pp. 246-7).

By the 1970s, the influence of organisational behaviour on leadership had become a focus, as had group or organisational goals (Northouse, 2019). An explosion of scholarly ideas pertaining to leadership occurred in the 1980s. This included influence as non-coercive leadership, doing what leaders wanted, and revisiting the traits of leadership (Rost, 1991). A significant advance during the 1980s stemmed from Burn's (1978, p. 425) argument that

> leadership is the reciprocal process of mobilizing by persons with certain motives and values, various economic, political, and other resources, in a context of competition and conflict, in order to realize goals independently or mutually held by both leaders and followers.

Transformational leadership developed from this definition during the 1980s and gained momentum, where "one or more persons engage with others in such a way that leaders and followers raise one another higher levels of motivation and morality" (Burns, 1978, p. 83). Since the 1990s, further leader-centric approaches of leadership have emerged. These have included authentic leadership, adaptive leadership, discursive leadership, followership, servant leadership and spiritual leadership (Northouse, 2019).

An alternate view from leader-centric leadership looks at the collective nature of leadership. Collective or pluralistic leadership can include shared responsibility for leadership and "involves the relational *process* [sic] of an entire team, group or organisation…embedded in the dynamics of the social system" (Hiller et al., 2006, p. 388). Collective leadership can be viewed as role-based or as a collective process of shared responsibility and actions (Hiller et al., 2006). Karp and Helgø (2008) contend that leadership is a shared social influence process of relating to others. Similarly, Denis et al. (2012) argue that leadership is a collective process that unfolds through social interactions and is not a sole individual's role. There is a growing body of research into plural forms of leadership which is examining how leadership is distributed, shared, and conveyed amongst people (Denis et al., 2012).

The numerous definitions and perspectives of leadership creates challenges for studying leadership, primarily as the term may not adequately encompass its meaning. As leadership can be a unitary or a plural phenomenon, there can be difficulty in neatly categorising leadership. This is particularly given its social constructs and that leadership is shaped and perhaps best understood by those involved in the phenomena (Alvesson, 2013). This is a challenge for the researcher looking to define the focus of study. The leadership literature is examined further in the next section to untangle this challenge.

2.4 Leadership Perspectives

Two leadership perspectives were evident in the research located. The first is the traditional unitary leader-centric leadership, which was dominant within literature and afforded hero-status to some leaders. The second is the less well-known but growing perspective of pluralistic or collective leadership, which considers leadership beyond individuals, and to the leadership activity distributed or shared in different ways. These two leadership perspectives are explained in more detail before the literature review draws specifically on research as it relates to nursing leadership. Three commonly used leadership theories (transformational leadership, situational leadership and caritative leadership), which inform how nursing leadership is conceptualised, are explained. Then the discussion narrows further, to the leadership practices in the hospital, of formal nurse leaders, informal nurse leaders and amongst the nursing team. This narrowing contributes to determine a gap in the literature and the research aim and question for this thesis.

One pluralistic leadership perspective is 'Leadership-as-practice'. This perspective captures leadership practices occurring between people in context. This practice-based philosophical approach is examined considering nursing literature, as a lens to inform how nursing leadership practices might be better understood before Chapter 3 looks to a methodology and research design to address the research aims.

2.4.1 Unitary Leader-Centric Leadership

Leader-centric leadership has been defined based on a person's knowledge, skills, and attributes (Kouzes & Posner, 2013), as a role, and in relation to managing a team or organisation (Gosling & Mintzberg, 2003), where the person doing the leading is known as a leader. Leadership has also been explained as occurring between leader and follower (Alimo-Metcalfe & Alban-Metcalfe, 2005; Bolden, 2004; Mann, 1959) and through transformational processes of a person leading and inspiring a group to achieve a common goal (Northouse, 2004). The act of leadership can influence "task objectives and

strategies, influencing commitment and compliance in task behaviour to achieve these objectives, influencing group maintenance and identification and influencing the culture of an organisation" (Yukl, 1989, p. 253). Alvesson (2013) concurs with Yukl (1989) that leadership involves an influencing process in which a leader has influence over a follower but considers that a positional power imbalance in favour of the leader may exist. Rost's (1991) position on leadership is similarly defined as an influencing relationship among leaders and followers but varies by proposing that both are intent on real changes that reflect their mutual purposes.

Leadership is also recognised by some as the process, relationship and influence an individual person has on others (Cuilla, 2005). The success of an individual's leadership relies on whether leadership behaviours and outcomes are supported or inhibited by followers (Oc & Bashshur, 2013; Tee et al., 2013). Followers were thought by early writers on leadership to passively engage with leaders however, this has been reconsidered. Some scholars argue that following another requires active commitment, critical thinking, and personal responsibility to contribute to a collaborative environment (Kelley, 1988; Whitlock, 2013). Recognising the role that followers play, Kelley (1988) described how corporate success was due to adopting good followership rather than good leadership. The reciprocal influence of followers on leaders within social processes and interactions, has also been recognised (Dierckx de Casterlé et al., 2008; Oc & Bashshur, 2013; Tee et al., 2013).

Three waves of leader-centric theory and research were identified by Lord et al. (2017) who reviewed a century of *Journal of Applied Psychology* publications for content regarding leadership theories, methodologies, and practice. Increased attention on leadership research in this journal, began following World War II. At this time, the first wave (1948-1961) focused on the behavioural style approaches of leaders with attention moving from leadership personalities to behaviours in actions. Research in this wave began by identifying leadership traits and then trying to understand and measure leader behaviours. Bass' (1949) research on leaderless group discussions and Fleishman's (1953) analysis of leader behaviour questionnaire contributed to this wave of development. Research identifying how "to assess leadership potential and ability" followed (Lord et al., 2017, p. 438).

The second wave of leader-centric research included behavioural and social cognitive approaches. Four categories of publication occurred between 1969-1989. Beginning with Megargee (1969) and Schein's (1973) research on gender and leadership, social cognitive theories followed. Further developments emerged with the addition of contingency and situational approaches to leadership which acknowledged the variations occurring in the interactions between individuals and the environments or situations (Fiedler, 1967; Hamric et al., 2014). These various contingent situations including tasks affected outcomes and meant that leadership could be viewed from multiple lenses.

Additionally, in this wave Hater and Bass's (1988) early research on transformational leadership is noted.

Leadership findings were revisited in the third wave, from 1999, due to the development and acceptance of meta-analysis and meta-synthesis in the social sciences (Lord et al., 2017). Meta-analysis was able to accurately quantify effect sizes across studies and meant that earlier leader-centric work could be quantitively reviewed to find or correct relationships between leaders and outcomes. For example, leaders' intelligence and their leadership were revisited across numerous studies finding a lower correlation between intelligence and leadership than had previously been described (Lord et al., 2017). In this third wave, transformational and transactional leadership, charismatic, inspiring, and empowering leadership emerged. Other forms and aspects of leadership began evolving including leader-member exchange theory, the dyad of leader and follower, team leadership and how it functions, trust in leadership, the change effects and the qualities of transformational leadership and charismatic leadership, along with the effects on followers' perceptions and attitudes.

Over the last 20 years, trends in leadership studies have shifted to the practices and interactions in which leadership is expressed and effected (Wood, 2005). Many leadership studies progressed into a post-heroic phase moving beyond leadership being exercised by an individual where cultural context is detached, to looking at leadership activities collectively (Crevani et al., 2007, 2010). Numerous leadership scholars such as Stogdill (1950), had referred to shared leadership (Lord et al., 2017) with more focus now placed on exploring this field of leadership. Post-heroic leadership includes shared and distributed leadership, collective leadership, and collaborative leadership. These forms of pluralistic post-heroic leadership are examined more closely in the next subsection.

2.4.2 Pluralistic Post-Heroic Leadership

An alternative to the traditional leader-centric view of leadership as the act or property of an individual leader (Crevani et al., 2007; Denis et al., 2012) is leadership as a collective construction. This form of leadership is known as pluralistic leadership or post-heroic leadership. Pluralistic leadership has evolved from research such as Stogdill and Shartle's (1948) study which instead of focussing on leadership problems or leader personalities, focused on processes "of interaction between persons who are participating in *goal oriented* group activities" (p. 287), with most research in this field to have emerged since the 1990s. It has three distinguishing characteristics. First, post-heroic leadership is "a collective phenomenon that is distributed or shared among different people" (Denis et al., 2012, p. 212). Second, leadership is potentially fluid and constructed in interaction (Bohl, 2019; Crevani et al.,

2007), and finally, pluralistic leadership creates learning and growth for those people involved and their organisation (Denis et al., 2012; Fletcher, 2004).

Forms of plural leadership include "'shared', 'distributed', 'collective', 'collaborative', integrative', 'relational' and 'post-heroic'" leadership (Denis et al., 2012, p. 213). I concur with Denis et al.'s (2012, p. 213) finding that inconsistency of term use comes from some scholars applying labels "loosely and interchangeably and others adhering to narrower definitions". To address this variability in label application, Denis et al. used the dominant theoretical and methodological approaches of research on leadership in the plural, to categorise the streams of scholarship. Four streams of leadership in the plural were reported. These include a focus "on sharing leadership in teams, on pooling leadership at the top of organisations, on spreading leadership across boundaries over time and on producing leadership through interaction" (p. 211). These streams were refined by Sergi et al. (2016) for application in healthcare settings. Structure or emergence and mutual or coalitional representations create the variances in the streams (Denis et al., 2012).

Sharing leadership focuses on mutual leadership in organisations and groups with members leading each other towards common goals (Denis et al., 2012; Pearce & Conger, 2003). Featuring predominantly in the organisational behaviour and social psychology disciplines, research on this form of leadership indicates it works well in complex and knowledge-based workplaces where shared leadership behaviours and team effectiveness are contingent on the other (Denis et al., 2012). In the post-heroic period, both self-leadership and vertical leaders are found to contribute to shared leadership development. Achieving this development involves task interdependence, complexity, and commitment. In contrast, pooling leadership, gathers several leaders at the top of organisations to lead others. Qualitative case studies have largely been used to understand this form of structurally embedded plural leadership (Sergi et al., 2016). This pooling is found to often occur in knowledge-based organisations to provide legitimacy and bridge expertise and when two or more people occupy a single leadership space. The number of people involved informs the leadership relationships as dyads, triads, or constellations where these may be specialised, differentiated and complementary collaborations (Hodgson et al., 1965). Pooled leadership is fragile as it is dependent on the shifting evaluations of leaders' actions (Denis et al., 2012). The nature of this form of collective leadership attracts those with sociological or management interests (Denis et al., 2012; Gronn, 2002).

Spreading leadership is the third stream or form of plural leadership. It is mostly associated with distributed leadership. This leadership is distributed between people to achieve outcomes and has been successful in inter-organisational collaborations and change processes, in public services and in education (Sergi et al., 2016). Cross-boundary projects are examples of where this form of leadership

occurs over time. Structures, routines, and artefacts contribute to this. However, factors inhibiting distributed leadership include tensions between accountability and need for participation and boundaries (Denis et al., 2012).

The fourth stream of plural leadership, producing leadership, is mainly associated with relational leadership. This leadership is produced through interactions in place and context. The focus within this stream is that leadership is an emergent property of relations and is informed by practice theories of leadership (Hosking, 1988). De-centring individuals from leadership, this form of plural leadership locates leadership in practices and is created in communication. It is emergent and collectively enacted in situations. Producing leadership is the consequence of actor relations, actions, and interactions and fundamentally, is the performance of leadership through social processes. Further research is required to understand how this form of leadership is created and maintained (Sergi et al., 2016).

There is a growing body of organisational research into plural forms of leadership (Denis et al., 2012). This research includes a focus on the daily social interactions of leadership rather than on individual leaders, emphasizing the processes, practices, and interactions in leadership activities (Crevani et al., 2010). In the context of organisations, plural leadership is structurally and culturally enabled where individual and collective elements of leadership simultaneously reside (Denis et al., 2010; Denis et al., 2012, Sergi et al., 2016). This means individual agency is paradoxically important "in enabling the construction of effective forms of plurality" (Sergi et al., 2016, p. 1).

Following gaining an understanding of the perspectives of unitary leader-centric and pluralistic post-heroic leadership, three leadership theories that are dominant within nursing were examined to determine what is known about nursing leadership practices and to identify where further contributions to the scholarship of nursing leadership could be made.

2.5 Research and Nursing Leadership

Nursing has largely adopted leadership theories and models from other disciplines and contexts to explain nursing leadership. Reflecting the trends in leader-centric leadership literature, the focus in nursing leadership studies has been on who is leading and describing the characteristics and styles of the individual. This focus has included the influences on and of nursing leadership and exploring the effects of team leadership in nursing and of the organisational effects on context and nursing leadership. This section covers three of the dominant leadership theories that nursing has adopted. These are transformational leadership, situational leadership and caritative leadership.

2.5.1 Transformational Leadership

Since the late 1980s, nursing has embraced transformational leadership as the preferred style for nursing leadership due to the ever-changing landscape of healthcare (Aspinall et al., 2021; Hutchinson & Jackson, 2013; Jackson et al., 2021). Originating with a study of political leaders' charismatic behaviours and influencing characteristics, Burns' (1978) identified concepts of transactions or rewards for compliance by followers, and of transformations, motivating others towards a higher goal (Hutchinson & Jackson, 2013). In the early 1980s, Bass and colleagues popularised the theory of transformational leadership as one of three styles of leadership. The other two styles were transactional leadership which involves the promotion of follower compliance "through contingent rewards or negative feedback" and laissez-faire leadership which is passive and without direction (Hutchinson & Jackson, 2013, p. 12). Transformational leadership is relationally focused (Bass & Avolio, 1993) where motivation and inspiration from leaders is credited with generating superior results and fulfilment of potential of followers (Bass, 1985; Burns, 1978). Studies have examined transformational leadership from the individualised needs of the follower (Avolio et al., 1999) and by examining the emotional intelligence of leaders (Boyatzis & McKee, 2005) even in adversity (Goleman et al., 2002).

Survey tools such as the multi-factor leadership questionnaire (MLQ) to identify the three styles of leader behaviour in the work setting were developed. The MLQ is a psychological inventory tool that captures the characteristics of these three styles, their effectiveness, and outcomes (Avolio & Bass, 1988). In nursing, the MLQ has been widely adopted as an authoritative tool to confirm leadership styles (Hutchinson & Jackson, 2013). I concur with Hutchison and Jackson's (2013, p. 11) statement that the "adoption of transformational leadership by nursing has been [and still is] largely uncritical and evidence into its efficacy in terms of clinical outcomes and workplace quality remains unconvincing".

McCay et al.'s (2018) systematic review of nurse leadership style, nurse satisfaction and patient satisfaction found that of the 14 studies set in acute hospital settings published between January 2009 and September 2016, transformational and transactional leadership models were described most (n=8 times) with authentic leadership, emotional intelligence, and situational leadership each being described three times. The 14 studies all used quantitative measures and gathered data via survey or questionnaire. Five studies took place in North America (4 in USA and 1 in Canada) and others in hospitals in Australia (n=2), and one in China, Ethiopia, Greece, Lithuania, Portugal, Saudi Arabia, and Taiwan. Respondents were hospital staff nurses (8 studies), nurse managers only (1 study) and both staff nurses and nurse managers (3 studies) with two studies including only head nurses, though this

role is not further defined. Sample sizes ranged from 16 to 2488 respondents. Those in "mental health, paediatric and outpatient settings were excluded for the purpose of generalizability" (McCay et al., p. 363). The review which addressed risks of bias within and across the studies concluded that greater nurse satisfaction and intent to stay were influenced by relational leadership traits and that task-oriented styles did not have similar positive effects.

Similar findings were made by Specchia et al. (2021) who also undertook a systematic review of leadership styles and nurses' job satisfaction. However, the search criteria for this latter review used PubMed, CINAHL and Embase databases. McCay et al.'s (2018) review used PubMed, CINAHL and the Cochrane library. The detail provided by Specchia et al. of the process for article selection and appraisal was rigorously presented and a PRISMA flowchart illustrated the process. Differing from McCay et al.'s focus, this review included studies with qualitative synthesis, however, two studies feature in both McCay et al.'s review and Specchia et al.'s review. These were Abualrub et al.'s (2012) cross-sectional study in Saudi Arabia using the MLQ and Wang et al.'s (2012) cross-sectional study in China which used the Leadership Practice Inventory (LPI). The LPI survey tool is discussed in the next paragraph. Specchia et al. (2021) identified 12 studies published between 1995 and 2017, all the studies were cross-sectional. Six studies were undertaken in North America with the remaining occurring in China, Ethiopia, Italy, Jordan and two in Saudi Arabia. Participant numbers ranged from 83 - 1216. The tools used to assess leadership styles and job satisfaction were the MLQ (n= 8 studies), the Job Satisfaction Survey or a combination of the two. Seven leadership styles were identified in the review. These were "authentic, laissez-faire, passive-avoidant, resonant, servant, transactional and transformational" (p. 9). Transformational leadership styles were found to be presented in three quarters of the studies and transactional leadership style in two thirds of the studies. Transformational leadership and resonant leadership each require high levels of emotional intelligence and empathy. These styles empower others and facilitate nurses and others subject to such leadership to achieve goals with guidance and support. They have positive impacts on job satisfaction. The autocratic leadership style of transactional leadership was found to have a negative impact on staff reducing motivation and contributing to isolation. Passive-avoidant and laissez-faire leadership each appeared three times in these studies with each also having negative impacts on staff.

Another leadership tool frequently used to assess leadership behaviours of individual leaders as either transformational or transactional was developed by Posner and Kouzes (1988) who explored how people became leaders. Associated with developing further understanding about transformational leadership and influenced by the work of Avolio and Bass in the 1980s, Kouzes and Posner had developed the Leadership Practices Inventory (LPI) for exemplary leadership. Assuming that leadership can be developed and measured, the LPI tool assesses the transformational and

transactional leadership behaviours of individuals and organisations through self and observational reporting, thus providing a 360° view of leadership. With 30 statements about actions that leaders do, the survey describes behaviours and activities of leadership. Kouzes and Posner then went on to describe five practices and 10 commitments of exemplary leadership which are internationally recognised as contributing to leadership development and success. The leadership practices described are model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart. The practices centre on the actions and behaviours of individuals within teams or organisations. These five leadership practices resonate with values underpinning nursing however there are limitations as exemplary leadership was not designed and developed with nursing in mind.

The general nature of the MLQ and the LPI leadership assessment tools, which use quantitative measures to identify qualities and styles of leadership and the practices of leadership, has given rise to their popular use in workplaces (Hutchinson & Jackson, 2012). Nursing has used these to explore the transformational and transactional leadership styles of those in formally designated leadership roles, with little attention being paid to others in the organisations or teams who are providing leadership.

Critiques of these leadership tools are that they were initially tested on male executives and then later extended to male military officers (Hater & Bass, 1988; Hutchinson & Jackson, 2012) with the resultant characteristics and behaviours being gender influenced. In many of the countries where the research has been conducted, nursing is a female dominated profession. Therefore, assessing nursing leaders and nursing leadership styles and behaviours with these tools has limited relevance. Further limitations are these tools do not measure leader integrity, avoidant or 'dark' behaviours of leaders, do not include cultural considerations and the subscales are ambiguous which may impact their validity (Hutchinson & Jackson, 2012). The self-reporting aspect of these tools has also attracted critique due to the known halo-effects of self-reporting (Wetzel et al., 1981). Self-reporting has been argued to have no bearing on what is observed as actual leadership behaviours in practice and therefore, beyond self-reflection, can skew the results of leadership impacts. Additionally, many of the studies assessing the correlation between transformational leadership and effect, such as work outcomes, gather data simultaneously from the same respondents, creating a methodological bias which can threaten the validity of the findings (Hutchison & Jackson, 2013). An additional critique concerns the distance between formal leadership positions and followers in organisations. This distance is noted for affecting the perceptions of those using the MLQ and LPI survey tools. Hutchison and Jackson (2013) draw on the work of Alimo-Metcalfe and Alban-Metcalfe (2005), Avolio et al. (2004) and Sosika et al. (2011) who concur that the greater the distance there is between leaders and followers, the higher the perceptions of exemplary leadership.

Internationally, Magnet hospitals have been credentialed as meeting the standards for empowering nurses to lead patient care and drive change and innovation within the healthcare organisation. Being recognised as models of excellence for exemplary professional practice, new knowledge, innovations and improvements, and empirical outcomes, Magnet hospitals use transformational leadership and structural empowerment to develop and benchmark quality care (American Nurses Credentialing Centre [ANCC], 2021). Nurse leaders enacting transformational leadership consider and attempt to understand individuals and their context. This is done whilst encouraging innovative exchanges of ideas to solve problems considered opportunities (Upenieks, 2003). In research comparing leadership in Magnet and non-Magnet hospitals, Upenieks (2003) interviewed four nurse executives and 12 nurse directors or managers about what were valuable leadership qualities and traits in the healthcare context at that time. Honesty, credibility, supportiveness, and visibility were found to be pertinent to nurse leaders in the Magnet hospital whereas being direct, business oriented, flexible, and confident (having strength) were identified by non-magnet employees. It was apparent in Upenieks' study, organisational culture of the healthcare facility (including vision, structure, staffing and business orientation) had a significant impact on leadership practices of leaders and the success of the organisation. Not evident from the study is how leadership practices were enacted or performed in everyday nursing work, thereby offering a potential gap in the literature.

Nursing has used the MLQ and LPI to assist with leadership development despite the tools being generalist (Hutchinson & Jackson, 2013). These tools do not capture nursing contexts, situations, the complexity of dynamics and politics of teams and healthcare organisations nor do they address the clinical leadership aspects of nursing. Yet these tools are popular in both nursing practice and research into nursing leadership. By using these tools, nursing may be missing other aspects and practices of nursing leadership that are context bound which are not captured or addressed by the tools, meaning that what is known about nursing leadership is incomplete.

2.5.2 Situational Leadership and Teamwork

Situational leadership is a form of transformational leadership and is leader centric (Lynch et al., 2011; O'Donovan et al., 2021). Developed from the work of Hersey and Blanchard (1969) and their life cycle theory of leadership, situational leadership concerns the leadership style of a leader in relation to the behaviour of the task and the readiness or maturity of the person or group being led, in addition to the environment or situation. Situational leadership and the term contingent leadership are used interchangeably by some scholars, yet they are different. In situational leadership, the leadership style of a person is viewed as fixed or inflexible meaning that different people may be needed to lead in different situations. In contrast, contingency theory argues that there is no one way to lead or make

decisions, and therefore contingent leaders are socially intelligent, flexible, and adaptive to the situations faced (Fiedler, 1967; O'Donovan et al., 2021).

Context is integral to understanding the practices of situational leadership (O'Donovan et al., 2021) as leadership occurs in situations within a context. Therefore, teamwork and hospital culture need to be considered as the context in which nursing leadership practices occur. In hospitals, nursing care is provided by teams of nurses. There is an interdependency between the nursing team and their collective purpose or goal which is to provide the everyday care needed by patients admitted to the hospital wards. To achieve the common goal, team members interact, make decisions and co-ordinate tasks (Kalisch et al., 2009). High performing nursing teamwork is associated with improved quality of care (decreased errors), improved patient safety, and patient satisfaction (Kalisch et al., 2007; Kalisch et al., 2009; Leach et al., 2009; Temkin-Greener et al., 2004). Leadership practices are key to these benefits. Team leadership is one of the five core components of effective teamwork performance (Salas et al., 2005) and has been positively and significantly associated with individual nursing work satisfaction, turnover and performance (Cummings et al., 2009).

Teams have been studied for the past 50 years. The research has examined group development (Tuckman, 1965), co-ordination of activity patterns (Gersick, 1989, 1991), social interaction (Carboni & Ehrlich, 2013), and system-oriented approaches (Mickan & Rodger, 2000; Temkin-Greener et al., 2004). Where teams are bounded by organisation's multiple levels, functioning or performance occurs in both a top down and bottom-up fashion (Kozlowski & Ilgen, 2006). Underlying these topics but not explicitly stated, is leadership. Factors which influence the performance of teams include the environmental context, that being both the organisational workplace, as well as the social and political context; leadership (Salas et al., 2005); internal team culture including diversity (Daspit et al., 2013); interactive and networked dynamics including relational characteristics and team maturity (Carboni & Ehrlich, 2013); commitment of resources (including timeframe); and the goal (Salas et al., 2005).

There are three key overarching functions of leaders of effective teams (Salas et al., 2005). The first of these is a role in creating and maintaining a shared mental model or vision for the team. Daspit et al. (2013) argue this relates to the internal team environment, which develops over time and is influenced by "shared purpose, social support and voice" (p. 36). In studying whether business teams with members from various functional areas within an organisation can effectively work together for a specific goal, Daspit et al.'s research found that the internal team environment indirectly influenced team effectiveness. In healthcare, where the specific goal of patient care is commonly shared, evidence of nursing team functioning, and shared leadership should be observable. In a hospital ward, members of the multi-disciplinary team work together to enhance the health of the patient. However,

the hierarchical structure within and amongst the disciplines influences perspectives of shared leadership, as does the regularly changing membership of individuals (not roles) thereby affecting the internal team environment. Therefore, the internal dynamics of such a team influences the 'doing' of leadership. Consideration needs to be given to the specific situations and cultural context in which nursing leadership relationships and interactions take place.

Secondly, the team leader facilitates team characteristics and adaptability by them being aware of and responding to the internal and the external environment of the team (Salas et al., 2005). This is achieved by using information to coordinate team behaviours, interactions, and skill development activities (van Knippenberg, 2007). Lastly, the team leader needs to set behavioural and performance expectations within the team. The abilities, skill and knowledge deficiencies of each team member should be monitored, addressing what needs to change to re-establish norms. This will result in a team climate where mutual performance monitoring, back-up behaviour and adaptability become the norm (Salas et al., 2005). The teamwork that results creates social identity and relationships which are managed across social systems and organisations (Mathieu et al., 2008).

2.5.3 Caritative Leadership

Due to the increased attention arising from recent failures within different health systems resulting in patient harm and deaths (Francis, 2013a; Panagioti et al., 2019), the spotlight on safety and the role of nursing leadership has increased as has the publics and profession's expectation for care and compassion (International Council of Nurses, 2022). Bondas (2003) theorised that caritative leadership alleviates patient suffering and leads and motivates staff to create a caring healthcare culture, and in response, energy and economic value would develop. Caritative leadership is caring leadership and sees the nurse leader as a key role in establishing a caring environment to ensure patient care and safety. A caritative leader combines knowledge of nursing leadership and administration, where administration is viewed from the caring approach of ministering to, serving, and helping. For example, when a nurse is not meeting role development expectations, a caritative leader's approach to meeting with the nurse might include naming the issues, seeking improvements using competency expectations, organisational educational resources and funding, orchestrating collegial and senior support, and providing feedback mechanisms to achieve motivation and change. Rather than an aggressive approach, showing care and support for the nurse to develop further contributes to an environment which keeps nurses and patients safe.

Bondas' (2003, p. 250) values-based theory combines Eriksson's theory of caritative caring (or "love of humanity and mercy") with Schein's theory of organisational culture constructing five theses. These

are the patient is a human being; the caritas motive or visible caring; recognising the individual dignity of each employee to care for patients; that all aspects of healthcare cannot be measured, and meaning can be found where measures cannot be; and relationships exist in the caring culture between practitioners, patients, and stakeholders. Leadership is one part of healthcare culture and nurse leaders need to manage this. Caritative leaders have a responsibility to serve the patients by "developing, guiding, planning, organizing, reporting, directing, staffing, budgeting, coordinating, and evaluating…[showing] softness as well as strength" (Bondas, 2003, p. 251). Bondas described further characteristics and qualities of caring leaders such as "availability, openness, and hospitality" (p.251). The caritative leader role models ethical practice through qualities of straightness, justice, and honesty, shows understanding, tolerance and respect and focussed on the goal of patient care. Whilst caritative leadership contributes to a caring culture, the complexity of dynamics and relations, systems and structures in which nursing leadership takes place, was not addressed creating a gap in understanding how this theory might be enacted in context and requires further exploration.

This section described and critiqued the theories of leadership commonly adopted by nursing. It is evident that no one theory captures the phenomenon that is 'nursing leadership'. Transformational leadership theory supports change. For nursing which occurs in a dynamic system exposed to changing influences, transformational leadership works well when change is required but it is not clear how this works in the everyday routines of nursing leadership. Situational leadership in teamwork considers that different leaders are needed to lead in different situations and yet in nursing teams, those with leadership responsibility have fixed roles. Caritative leadership is based on caring and describes the qualities and characteristics of a caritative leader. Yet it does not take into consideration how such a leader navigates the context of nursing environments and situations. Something is missing in each of these theories to best explain what and how nursing leadership occurs. Recent attention in the literature is moving away from leader-centric to collective, distributive, and social or relational leadership (Jackson et al., 2020). The next section focuses specifically on leadership practices.

2.6 Leadership Practices

Nursing is a practice-based profession; where 'practice' links what people do with generation and application of knowledge (Gherardi, 2009). Focusing on the practice perspective, leadership practices are the 'doing' of leadership and its performance, which differs from the perceptions of leadership and its affects according to leaders and followers (Alvesson & Sveningsson, 2003; Carroll et al., 2008; Denis et al., 2010; Endrissat &Von Arx, 2013; Raelin, 2011). Practices need to be considered in the context in which they occur and by and for whom they are occurring, so that leadership can be found

(Raelin, 2011). According to Gherardi (2009) this resonates with the thinking of sociologists such as Schutz, Dewey, Mead, Garfinkel and Giddens who saw practice from an enacted, performed or produced perspective whereas Weber and Parsons differentiated practice from action privileged intention within theories of action. "Theories of practice view actions as 'taking-place' or 'happening', as being performed through a network of connections-in-action" (Gherardi, 2009, p. 115). Through reciprocal and cyclical patterns, practices create and recreate social meaning and structures (Bourdieu, 1977; Jarzabkowski et al., 2012).

Given the importance of context and situation, different perspectives have been used to study leadership practices which are context-bound and evident in practice (Denis et al., 2010). These include dynamic, collective, situated, and dialectical perspectives. In the next subsection leadership practices occurring in hospital contexts are outlined.

2.6.1 Leadership Practices in Hospitals

Hospitals are complex organisations where socio-political tensions exist between clinical, administrative and management discourses (Day et al., 2014). The complexity is compounded by the competing voices of multiple disciplines and the unpredictability of patient conditions. Drawing on several studies of leadership since 2017, the discussion below highlights that leadership practices in hospitals have been examined from both leader-centric and pluralistic perspectives and in relation to safety culture within the New Zealand hospital contexts.

Leach et al. (2021) explored how distributive leadership or leadership that is shared amongst multiple individuals, may occur vertically between hospital hierarchal layers. Hospital executives, managers, and clinical staff from two hospitals in Australia and America were interviewed, finding that the social identities of leadership groups influenced communication and performance. In one American hospital, structurally organised leadership dyad partnerships between executives and clinical management were found to improve intergroup communication and troubleshooting in comparison to other hospitals where tension between dyad groups existed (Leach et al., 2021). The practice implication being that along with competencies to promote social and relational leadership practices, dyadic structures may improve hospital leadership and identity.

A qualitative study of dual leadership in a Danish hospital setting found that pairs of leaders (one doctor and one nurse, each with different levels of leadership experience) operated in different ways resulting in different leadership outcomes (Thude et al., 2017). Two of the three pairings shared an office whilst the third pairing had separate offices 20 metres apart. The same two pairings divided up the work and communicated as needed across the day. Whereas the third pairing frequently had their

weekly meeting to discuss and share out the tasks, cancelled. Communication for the third pairing most often occurred via email instead. Semi-structured interviews with a doctor and nurse in each pairing, identified that power balances between leaders, personal relations including respect and decision processes, created effective dual leadership.

Using a realist evaluation together with appreciative inquiry, Jackson et al.'s (2021) study of nursing, midwifery, and allied health leadership examined the systems approaches to leadership. Three phases of research were used. The study included reviewing the literature, use of social media tweeting with leaders in practice, education, research and strategy contexts across the four countries of the United Kingdom (England and Northern Ireland, Scotland, Wales, and Eire), and workshops in each country to develop narratives. Five rules or principles to enable and enhance leadership were identified as 'guiding lights' based on individual's qualities and practices in various contexts which were found to effect individuals, teams, people, organisations, systems and society. These guiding lights or principles were "The Light Between Us as interactions in our relationships", "Seeing People's Inner Light", "Kindling the Spark of light and keeping it glowing", "Lighting up the known and the yet to be known" and "Constellations of connected stars" (p. 392). Expanding on these principles, strengthening leadership came from building authentic caring relationship through interactions, recognising each person's contribution, and making it safe to be authentic, generating shared understanding and commitment. By sharing information and being comfortable with uncertainty, and creating and maintaining networks and connectivity, stability was shown to be created. This systems approach to research about leadership came down to individuals and their leadership.

Safety culture permeates healthcare disciplines in hospitals including nursing. Safety culture "is concerned with minimising exposure of employees, managers, customers, suppliers and members of the general public to conditions considered to be dangerous and injurious" (Turner, 2000, p. 241). In Aotearoa New Zealand, safety was captured in healthcare policy as part of the *National Strategy for Quality Improvement* (Minister of Health, 2003a, 2003b). This inclusion was in part due to the fiscal cost saving opportunities identified and the human cost of patient harm where adverse events were causing disability or death (Beaver, 2017). This new focus was brought sharply into view when the Mid Staffordshire Inquiry in England, found that the quest for Trust status was put ahead of patients and care. Cost cutting had led to a resource poor system and deficiencies in communication and teamwork resulted in multiple failures compromising patient safety and leading to unnecessary deaths. Leadership and nursing leadership within the NHS Trust were found to be wanting (Francis, 2013a).

More recently, harm reduction has become a foci in New Zealand and global healthcare, reinforced by a myriad of safety improvements, performance targets, incident reporting and quality improvement (Beaver, 2019). Managers and named leaders have needed to change their leadership practices in response to these influences and embed new processes and structures to address the challenges that have arisen. For instance, to embed new safety improvements into daily routines, the tensions between engagement and organisation capacity have counteracted improvement processes (Beaver, 2019). Beaver's study of the challenges of safety improvement for hospital staff found that there was no slack in the system to enable staff to step back and consider service improvements which, in addition to siloed and bounded departments contributed to safety improvements being compromised. Though not named as organisational leadership practices, Beaver identifies practices of leadership which were structural in nature. These included leadership practices to create time and availability of staff to develop safety improvements and implement them. Having identified that staff empowerment and motivation are key to the success of safety improvement, Beaver argued organisational leadership practices and processes would need to drive new messaging and the ownership of the safety improvements and embed these within routines thereby altering understanding and notions of safety.

Looking for change in healthcare professional's perspectives on quality and safety in New Zealand hospitals between 2012 and 2017, Gauld and Horsburgh's (2020) study investigated the safety culture in New Zealand public hospitals at two time points. In 2012, participants were health professional staff from 19 DHBs (Canterbury DHB did not participate in 2012 due to Christchurch earthquake) and in 2017 from 20 DHBs. "Completed surveys were received from 10,303 respondents (25% of total workforce approached) in 2012 and 8,541 respondents (20% of total workforce approached in 2017" (Gauld & Horsburgh, 2020, p. 779). Situational and individual factors were identified that influence safety and quality environments. Though not statistically significant, the survey findings showed a drop in the proportion of staff who would speak up despite an increased emphasis in the professions about voicing concerns if patients were at risk. The researchers concluded there was an urgent need for stronger clinical leadership and support from policymakers and management to support the development and maintenance of a safety culture. Capturing how nursing leadership occurs in the context of a safety culture within New Zealand hospital wards, is needed given the historical and global incidences resulting from limited speaking up and perceived unsafe practices. In the next subsection, research about the leadership practices of the members of the hospital nursing team are presented.

2.6.2 The Leadership Practices of Formal Nurse Leaders

Formal nursing leadership roles are visible within the hierarchy of a hospital. The focus of many nursing leadership studies has been on those appointed to formal positions in the nursing hierarchy, where a process granting the formal nurse leader authority in the role has occurred. Different healthcare organisations and different countries have various names for roles in the nursing hierarchy. Previously known as the Matron-in-chief (Wood, 2022), in contemporary times, the head nurse of a hospital may be referred to as a Director of Nursing, Executive Director, Chief Nursing Officer or Chief Nurse Executive (MOH, 2023). This role involves nursing leadership and management including business administration, professional leadership, and supervisory perspectives at an organisational level. It is common for these roles to have deputies to span the larger hospitals.

In the hospital those nurses appointed to manage wards are referred to in the literature by terms including charge nurse (Connelly et al., 2003; Hewison, 2013; NZNA, 1988), clinical nurse manager (McCallin & Frankson, 2010), ward sister (Bradshaw, 2010; Hewison, 2013), or ward team leader or ward manager (Pegram et al., 2013). In the setting where this research was undertaken, the term is charge nurse manager (CNM) and is used in the thesis to refer to this role. Key responsibilities of those with this senior nurse title include being the line manager of a team of nurses and being the primary professional leader responsible for ensuring the delivery of quality nursing care is achieved, and managing resources (Boyal & Hewison, 2016). Patients and the public may have day-to-day interactions with the charge nurse as the frontline manager of a hospital ward, whereas the Directors of Nursing are removed from the clinical environment and represent nursing at the executive level and interface with other disciplinary leads, health organisations, education providers and professional bodies (NZNA, 1988).

Other formal leadership roles within a hospital ward nursing team include the senior roles of nurse practitioners (NPs), clinical nurse specialists (CNSs), and clinical nurse educators (CNEs). To understand what these nursing team members do in their formal roles, literature describing the leadership of the hospital ward formal nurse leaders is presented by role title, as is the tradition in nursing literature. The terms used to describe the roles are those commonly adopted in New Zealand. This section also reports on what is known about the impact of their formal leadership practices.

2.6.2.1 Charge Nurses

As the nurse leader of a ward or unit in a hospital, the charge nurse role (formally known as the ward sister) balances the clinical needs of patients with nursing staff skills, experience and competence with

managing resources and facilitating patient flow and discharge whilst attending to the agenda of the organisation in which they work. The leadership style and effectiveness of the CNM role has been linked to influencing the satisfaction (Feather & Ebright, 2013; Rad & Yarmohammadian, 2006) and retention of nursing staff (Larabee et al., 2003; Roche et al., 2015); improving nursing productivity and performance (Germain & Cummings, 2010; North & Hughes, 2012); improving patient outcomes (Murphy et al., 2009); and quality improvement (Scott-Cawiezwell et al., 2004). Hewison's (2013) critical review using discursive narrative analysis and integrative review techniques concurs that the charge nurse role is "at the heart of the hospital system" (p. 268) to ensure quality care is provided.

The personal competencies, attributes and traits of charge nurses have been reported in several studies. An example is Connelly et al.'s (2003) exploratory qualitative study. Researchers interviewed 42 nurses across the levels of military nursing to determine the perceived competencies of charge nurses. Interpretive analysis resulted in 54 competencies being identified and grouped in four categories: clinical and technical, critical thinking, organizational and human relation skills. The study found 15 characteristics that an effective charge nurse should possess including: "accountability; assertiveness; positive attitude; authority; confidence; need to control; fairness; flexibility; humour; image; Initiative; maturity; ability to learn from mistakes; command respect; and responsibility" (p. 303). Of significance to my research, is that the term leadership is not listed. These researchers concluded that the combination of identified characteristics and competencies, support charge nurses in their roles. However, how a charge nurse interacts within the clinical settings, hospital organisations and the military hierarchy are not clear from this study.

To understand the experience of nursing leadership by those being lead, Rosengren et al. (2007) took a phenomenographic approach to investigate ICU staff views of reality and how they experience and conceive their work life environment. Seven nurses, two doctors and a secretary were interviewed from one ICU in a Swedish hospital. Rosengren et al. identified the concepts of presence and availability as key to nursing leadership shown by the ward manager. In addition to supporting everyday practice and facilitating professional acknowledgement, Rosengren et al. found that nursing leadership protected quality care. This was shown through clinical and operational knowledge about front line care emphasising in their interviews the importance of timing, sensitivity, and the ability to keep pace with unfolding situations.

In Scotland, the views and experience of 50 (out of 93) senior charge nurses were explored via an electronic survey in relation to their clinical leadership roles. Following the implementation of a national clinical leadership policy (Leading Better Care, 2008), clarification of roles occurred in that "Senior charge nurses concentrate on clinical care delivery and managers concentrate on service

delivery, usually for a collective of specialty-related clinical areas" (Stoddart et al., 2014, p. 50). Both groups manage and lead within their spheres of situated influence and specified responsibilities. A sub-sample of nine nurses were interviewed using a semi-structured tool based on the dimensions and capability of the policy. Findings from the mixed method study supported the connection between clinical leadership and improvement in the quality of care. Role clarity and expectations provided confidence and enhanced visibility of the senior charge nurse role although the study identified that the associated workload and time pressures impacted on the senior charge nurses' experience. Stoddart et al. identified limited political and strategic engagement by this group and that they were still finding their voice in political and strategic arenas. This is an important point to be revisited considering the findings of this research.

Exploring hospital nurse leader's experiences and perceptions of caring in nursing, Solbakken et al.'s (2018) meta-ethnography examined nine Nordic studies about caring in nursing leadership. Analysis of the findings of the nine studies identified activities of nursing leadership. Themes (n=5) and subthemes (n=15) emerged from the data with the five themes being portrayed by five metaphorical mental and physical rooms in which nurse leadership occurs. The themes describe the activities of nursing leadership in relation to each room. These are "trusting and respecting each other and facilitating dialogue" in the staff room, "avoiding suffering by clinical presence" in the patient's room, "having the strength to hang on and persist" in the leader's secret and lonely room, "balancing and prioritising limited resources" in the organisational room, and in the superior's room having relationships "and competence encouraged or neglected" (Solbakken et al., E17). The ethnography identified that caring in nursing leadership involves moving between the "rooms of the nurse leader's house of leadership to safeguard best nursing care" (Solbakken et al., E1). According to these researchers, the nurse leader role is pivotal to safeguarding patient care. Actions and practices which are patient focussed are key.

The transformational leadership performance of clinical nurse managers was assessed to understand their situational profiles (Alharbi et al., 2021). Self-assessments by 29 clinical nurse managers and the perspectives of 318 registered nurses were gathered from three Saudi hospitals. Using Kouzes and Posner's (2013) quantitative Leadership Practices Inventory (LPI), the performances of clinical nurse managers were assessed with the five elements of transformational leadership: encouraging the heart; modelling the way; inspiring a shared vision; challenging the process; and enabling others to act. Both Saudi and non-Saudi clinical nurse managers rated their own leadership practice performance higher than was observed by the registered nurses, with non-Saudi clinical nurse managers inflating the effect of their practices beyond their colleagues (Alharbi et al., 2021). The self-

reports by the combined clinical nurse manager group rated themselves most commonly 'enabling others to act', then 'encouraging the heart'. Registered nurses commonly noted that clinical nurse managers 'enabled others to act' with the practice of 'modelling the way' as the next most common practice. This demonstrates that perceptions of leadership activity and performance differed depending on the perspective taken.

O'Donovan et al.'s (2021) systematic review explored "the impact of focal leader behaviours on healthcare team performance" (p. 1420) where 'focal leader' captured the formal appointed leader role within a healthcare team. Identifying 50 papers published between 2000 and 2020, this review grouped leadership styles into four overarching categories and respective key leader behaviours. Findings included that there had been a shift from the leader-centric perspectives of directive leadership and task-focused leadership that were favoured in the 20th century, toward leadership styles that were relational and empowering. These person-centred leadership styles were underpinned by the redistribution of power acknowledged in contemporary leadership theories. The review found that influence increasingly played a more significant role in health leadership than authority, with individuals and the collective largely responding positively and effectively. Whilst O'Donovan et al. identified the shifting trend of leadership behaviours relating to the leadership style and approach, they also acknowledge that there are limited longitudinal studies available and a focus on context which would clarify the results. The findings also point to the 'what' or purpose of leadership, with some behaviours indicating how individuals interact to influence. This includes the levels of engagement, communication strategies and non-verbal cues, and role-modelling to motivate, and providing autonomy and transparency. These findings are not too dissimilar to caritative leadership presented earlier in this chapter as the focus is person centred, with the influence of contexts including social, political, and financial climates, not addressed.

In New Zealand, as was evident in the previous chapter, nursing leadership has been in a state of paradox with different health reforms requiring different responses and posing different challenges. Kan and Parry's (2004) mixed method study looked at nurses' responses to organisational change in New Zealand following a decade of national structural, policy and funding changes for hospital providers. Data were collected over two years, including non-participant observation of three wards, semi-structured interviews with team leaders, nurses, doctors, nurse co-ordinators and senior nurse managers (n=22) as well as 25 informal and unstructured interviews with team leaders, nurses and MDT staff and 196 responses to a modified Multi-factor Leadership Questionnaire about nurse managers behaviours. The results for transformational leadership were reported to be a good reflection of New Zealand national norms and pointed to a lack of nursing influence. Role changes, historical memory of the nursing practice and systems, and systemic organisational constraints

alongside time constraints, high workload, and high staff turnover were contributing factors. Kan and Parry (2004) conclude that political leadership is needed to re-establish the organisational power base of nursing and thus reconcile the paradox of effective leadership.

Six years later, a descriptive exploratory study investigated the leadership experiences of 12 New Zealand hospital charge nurse managers. McCallin and Frankson's (2010) structured interviews and thematic analysis revealed that CNMs were appointed for their clinical expertise, and they lacked management skills. They found role ambiguity, deficits in management and role overload were experienced by the nurse leaders. Better role preparation and ongoing training were identified as ways to address these issues.

2.6.2.2 Senior Nurses

Senior nurses are registered nurses with advanced nursing roles who provide care and leadership in hospitals wards. Each of the various senior nurses has a leadership role within the hospital ward. The research below has identified role responsibilities, competencies and expected capabilities of each of these senior nurses. In some international literature, senior nurses are referred to as advanced nursing roles or advanced practice nurses (NPs, CNSs, and clinical nurse leaders) and they demonstrate leadership practices through the competencies required by their roles. Heinen et al.'s (2019) integrative review of 15 studies and seven frameworks, identified leadership competencies and attributes of advanced nurses. Using Hamric et al.'s (2014) four domains of Advanced Practice Nurse competence, Heinen et al. synthesised 150 identified competencies into 30, and then classified these competencies into the domains of clinical leadership, professional leadership, health systems leadership and health policy leadership competencies. The competencies describe what is expected, not what happens.

The perceptions of leadership capability of Canadian Advanced Practice Nurses were assessed in a qualitative descriptive study (Lamb et al., 2016). Using the LEADs in a Caring Environment Leadership Capabilities Framework, 14 participants were purposefully recruited from two tertiary acute care facilities and interviewed twice. At the second interview initial findings were shared and validated by the participants. Two overarching themes (patient-focused leadership and organisation and system-focused leadership) were identified to describe the leadership of advanced practice nurses. Each theme identified leadership capability domains. The domains of the patient-focused leadership theme were managing patient-centred care; coaching and educating; advocating and initiating meaningful communication. Seven domains were identified for the organisation and system-focused leadership theme. These were: improving the quality of care provided, enhancing professional nursing practice,

being an expert clinician, communicating effectively, mentoring and coaching, providing leadership on internal and external committees and facilitating collaboration. Lamb et al. drew comparisons between their findings and Kouzes and Posner's (2007) five practices of exemplary leaders finding synergy between all but the practice of encouraging the heart. Whilst the activities are identified and Lamb et al. look to other studies and frameworks to draw comparison and difference, it remains unclear how advanced nurses achieve the activities beyond what is described as perceptions of what they do.

Another focus in the literature has been to look independently at the senior nursing roles and their leadership and expected effects of their leadership and outcomes. The next subsection captures key literature on the leadership of NPs, CNSs and CNEs.

Nurse Practitioners

As advanced nurse experts, NPs are the most senior nursing clinicians in a healthcare team. These nurses have had specialist training in practice and educational preparation at master's level, to meet expert competencies to achieve a scope of practice which is advanced beyond that of a registered nurse (NCNZ, 2017). In Canada, Van Soeren et al. (2011) used a mixed methods approach to track, observe, and interview in focus groups, 46 NPs from nine hospital sites. Tracking the NPs activities, Van Soeren et al. identified responsibilities in clinical, research, leadership, and consultation and collaboration. Whilst the focus of the study was interprofessional practice, it was clear from descriptions of the NP responsibilities that the time spent undertaking leadership responsibilities was 6-10% of a given day. The activities included advocating for patients and family, mentoring, evaluating programmes, representing NP at external committees and institutions, organising educational rounds, and preparing the teams for accreditation. How NPs approached and undertook these activities was not captured.

Exploring how advanced nurse practitioners impacted patient care and nursing practice, Williamson et al.'s (2012) ethnographic study set in an English hospital, identified that advanced nurse practitioners were pivotal within the wards. Five ward based advanced practitioners were observed and interviewed, in addition to interviews with "14 ward-based nurses and five patients" (p. 1581). Finding that the practitioners were the lynchpin between people, processes, and patient care, four subthemes captured the skills and roles observed. These were that the advanced nurse practitioners were a resource, facilitated every aspect of patient care, were role models and ensured continuity of care. Whilst leadership is not identified, leadership is implied as the role is a senior nursing role.

In New Zealand, NP roles span primary, secondary, and tertiary level specialists. Safety issues have been a focus of research on NPs. Nurse Practitioners can prescribe medications and are expected to provide "dynamic practice, professional efficacy and clinical leadership" (Carryer et al., 2007, p. 1818). These included key clinical leadership functions such as influencing care by engaging in policy development at local or government level or in professional organisations. Whilst these are role functions, the leadership practices have only been minimally described. Nelson et al.'s, (2009) research on nursing innovations revealed the significant leadership contribution that the first NP in youth health brought to practice and service development. In comparison to Carryer's research, Woo et al.'s (2019) nationwide survey of 87 advanced practice nurses (APN), identified practice patterns of the role. However, role ambiguity was identified due to various role titles and perceptions of competencies and practice. With role expansion on the horizon for Singapore, Woo et al. point to joint development of the APN role between relevant stakeholders including the APNs.

Clinical Nurse Specialists

The CNS is a RN who has had specialist preparation beyond general training (Holloway, 2012) including a master's qualification or higher and provides direct specialist care and expertise to a specific population. In addition, the CNS supports other staff to manage this client group. In a thematic analysis of 15 CNS role descriptions from DHBs, the CNS role was found to cover four functions: clinical expert, co-ordinator, educator, and leader (Roberts et al., 2011).

Though often associated together in the literature, CNS leadership is different from NPs. Cooper et al.'s (2019) systematic review of the differences and similarities of CNS and NP confirms that both roles have leadership expectations. Similarities included autonomy, acting as a resource, and facilitating multidisciplinary teams. NPs were likely to network and serve on high-level committees providing expert clinical and professional leadership along with providing leadership through research outputs. CNSs had leadership roles locally within the multidisciplinary teams and were likely to be involved in audit activity. Cooper et al. (2019) noted that globally, the role definition of the NP appears to be more consistent whereas there is ambiguity in the role of CNSs. This was similarly recognised in a systematic review and meta-synthesis involving acute hospital settings (Jones, 2005) and a scoping review in Canada by Donald et al. (2010).

Using qualitative descriptive methods, Fulton et al. (2019) aimed to identify the work processes of CNSs. Seventeen CNSs participated in focus group discussions about completing system-level projects. Common work processes were found irrespective of clinical practice setting. Identified as articulation work, CNSs co-ordinated and carried out work through interactions involving people, technology, and

the organisations. This research identified interactional processes such as persuading, valuing, negotiating, and modifying communication, where CNSs used feedback, listening, prioritising and "smoothing things out" (p. 520) in their work. The researchers note these to be invisible work as they were situated in interactions and not the completion of tasks. Influence, empowerment, autonomy, and trust were noted to play significant roles in these interactions (Fulton et al., 2019).

Clinical Nurse Educators

Clinical Nurse Educators (CNEs) are the third senior nursing role in hospital wards. These nurses are educated at master's level, have significant clinical experience and expert clinical competency. CNEs are responsible for the professional development and teaching of evidence-based care and skill acquisition at the different levels of the nursing team (Brennan & Olson, 2018).

The leadership of CNEs is "visible, approachable and relational" (Coventry & Russell, 2021, p. 8). Using a mixed method convergent design, 122 graduate nurses working in three acute care hospitals completed an online questionnaire. Interviews were conducted with 10 graduate nurses, 11 clinical nurse educators and 9 CNMs, to explore the extent to which Clinical Nurse Educators are perceived as clinical leaders in acute hospitals. The findings presented in the form of a figure show that most of the time the CNEs are 'guided by concern and compassion', 'share their values, beliefs and principles' and 'encourage positive cultural change' (Figure 2., p. 12). The CNE leadership practices promoted themselves as leaders, as influences in the ward and in the hospital, showing they were congruent leaders.

A phenomenological study of 11 hospital-based Nurse Educators in Australia identified that these nurses perceived their role to be about "becoming an educator, capability building, tension and Panacea" (Thornton, 2018, p. 276). The nurse educator role was understood to simultaneously add value and be undervalued requiring "resilience, being educationally literate, investing (in the workforce) and having a presence" (p. 279). This meant that through education and leadership, CNEs promote quality patient care and are integral in the development of the nursing team. However, identifying the practices of CNEs was similarly challenging as the previous senior roles. Perceptions of characteristics, qualities and actions are captured. It is in the way that they are described that they are seen as occurring in interactions and are therefore relational. The study of leadership practices of hospital nurse educators is not well understood.

In this section, evidence of the changing understanding of nursing leadership is found in the variety of studies undertaken and the multiple types of nurses involved. While this often draws on leadership-

centric research foci, the very presence of this literature indicates a changing understanding about leadership

2.6.3 Informal Leadership Practices of Ward Nurses

The study of leadership of informal nurse leaders has gained momentum over the past decade with recognition that nurses working in hospital wards play a significant role in leading and influencing clinical care, teamwork, organisational culture, and professional standards. Informal leaders are those who lead without a formal appointment to a leadership role (Larsson & Sahlsten, 2016). Others including colleagues and formal leaders look to these informal nurse leaders for guidance, support, current expertise and knowledge, clinical decisions, and calmness.

In nursing research, nurses are accountable for the provision of safe patient care and lead that care (Aspinall et al., 2020; Daly et al., 2014). As such, nurses have an informal leadership role that is negotiated amongst the team and is influenced by expectations from others (Larsson & Sahlsten, 2016). Informal nurse leaders are recognised by their peers for sharing their expertise and knowledge and being credible high performers who enhance the whole team (Downey et al., 2011). These informal nurse leaders were found to have a strong work ethic and integrity, are committed to patients, and see the team and unit as one. For these reasons, they are sought out by colleagues and by formal leaders for their contribution to influencing nursing team, climate, and work, and for their relationship building knowledge and expertise (Smart, 2010; Tee et al., 2013). Such informal nurse leaders can mobilise people around them, influence team norms and values and co-ordinate group efforts. Their power and influence stems from being effective communicators, developing and maintaining robust relationships and defined boundaries (Edmonstone, Hamer & Smith, 2003) as well as being savvy in reading situations and the organisation in which they work (Downey et al., 2011; Karp, 2013). These leaders have also been named and referred to as 'emergent' leaders (Karp, 2013).

Emergent leadership often occurs in periods of uncertainty or instability when self-identified leaders step up and lead. This happens because the informal leader acts beyond motivation to lead, and because colleagues and team-members consent to being led by this informal leader (Karp, 2013; Karp & Johannessen, 2010). Informal leaders or emergent leaders are individuals within a team who impact and influence how team members work together and perform. They wield considerable influence (either positive or negative) and can shape a team or organisation (Downey et al., 2011; Neubert & Taggar, 2004). As individual nurses are expected to be leaders, each could be considered an informal leader (Downey et al., 2011; Karp, 2013).

Challenges are known to exist for informal nurse leaders who act as leaders of care teams. Dependence on team composition and challenges in the direction and delegation of colleagues can affect leadership practices. Team dynamics, resourcing and regularly changing skill-mix also add to the complexity of informally leading from within the team (Kalisch et al., 2009). Boamah's (2019) cross-sectional study found direct and positive links between registered "nurses' leadership behaviours, patient care quality and job satisfaction" (p. 1005). Using structural equation modelling, a random sample of 378 Canadian RNs responded to a survey questionnaire. Role-modelling of effective communication, professional standards, and clinical behaviours, and empowering and advocating for others were identified as contributing to effective clinical leadership to maintain quality care and job satisfaction.

Swedish nurses' perceptions of the informal leadership role at the bedside were explored using phenomenographic interviews with 15 purposefully selected ward nurses. The analysis revealed five descriptive categories and 12 concepts elaborating on the actions of the informal leaders (Larsson & Sahlsten, 2016). To be a leader at the bedside included demonstrating clinical knowledge, establishing a good atmosphere of collaboration, consciously structuring the work to ensure patients' best possible nursing care; customising presence in the practical work with patients according to predetermined prerequisites; and monitoring co-workers' professional practice (p. 3). These informal nurse leaders deliberately applied their core values to both patients and colleagues in social processes and gained and maintained "trust, leader status and authority" (p. 5), from networks of colleagues (Larsson & Sahlsten, 2016; Lawson & Fleshman, 2020). Drawing on Foss et al.'s (2014) study into responsible leadership, Larsson and Sahlsten point to "nearness, distance, sensitivity, understanding and reflection" as being involved in the social processes of leadership (p. 5) though these were not further explored.

The term Clinical leadership is often used to describe the type of leadership that is provided by nurses within the clinical setting. As with other forms of leadership, clinical leadership is not well defined. Patrick et al. (2011, p. 451) state that it includes "clinical expertise, effective communication, collaboration, co-ordination and interpersonal understanding". Developed from Kouzes and Posner's model of Transformational leadership (2007), Patrick et al. (2011) created and tested a survey to measure staff nurse clinical leadership. Testing this psychometric instrument on 480 Canadian RNs who provided patient care, the key finding was that structural empowerment was needed for clinical leadership to occur. Relying on role-modelling of clinical competence and knowledge (Stanley, 2008) and encouragement from nurse leaders, structural processes to support staff nurse autonomy and control of practices were also identified as significant (Patrick et al., 2011). However, it is not clear from the survey how clinical leadership occurs across the nursing team, in what contexts or situations.

A further limitation of the survey tool was that respondents were not afforded the opportunity to answer beyond the options offered, thus limiting the potential for other responses about clinical leadership.

Frontline clinicians, specifically staff nurses, influence and lead patient care (Chávez & Yoder, 2015). Reviewing the literature, a conceptual model of staff nurse clinical leadership was developed for the hospital unit environment. This had three components: antecedents, attributes, and consequences. The conditions or experiences that are antecedent for clinical leadership include an "integrative collaborative healthcare team, professional nursing competence and structural empowerment (p. 94). The model identifies attributes of the staff nurse clinical leader. These are "leader status attainment" through clinical ability, effective communication, and relational co-ordination and "leader status maintenance" through the ability to produce innovation and change. The proposed consequences of staff nurse clinical leadership include "facilitation of individual and team level achievement of shared clinical objective, maintenance of team processes, efficiency of the healthcare team and higher quality of work life" (p. 93). Case examples are provided to show how the conceptual model can be considered. I argue that further work is needed on the conceptual model drawing attention to the antecedents of staff nurse clinical leadership as leadership may occur in absence of healthcare team collaboration and structural empowerment. Further examples are needed to test the ideas about the antecedent influences of leadership. This was considered when shaping this research.

In New Zealand, nursing leadership was recently explored in relation to the intersection between empowerment and culture of acute care hospitals. Aspinall et al.'s (2021) case study of the perceptions of nurses and managers in acute care hospitals found that leadership was associated with a title or role and leadership practices are not seen as part of day-to-day nursing. In the qualitative aspect of their study, the embedded case study design, included semi-structured interviews with 31 participants who were nurses, nurse managers, or managers. The quantitative survey results were not reported in this work. Four levels of data analysis were applied to the interview data. The study revealed that ward nurses who informally lead "do not identify themselves as leaders without an associated title" (p. 1927). This was due to organisational structures and the invisibility of nurses' leadership practices in everyday practice despite nurses being clinical leaders of the care of their patients. In contrast, nurses in specific leadership roles were recognised as leaders and contributed to leadership being unseen beyond these formal roles.

As with other forms of leadership, the definition of clinical leadership is elusive (Boamah, 2019). Yet clinical leadership is what makes nursing leadership different from leadership in other fields and disciplines. It requires clinical nursing knowledge and skills to anticipate and safeguard patient care

and resources whilst maintaining the relational aspects of teamwork and ensuring the best care is provided in a timely way. Drawing on 27 studies of clinical nursing leadership between 1974 and 2016, Stanley and Stanley 's (2017) literature search noted that both RNs leading the care of their patients, and those with formal nursing leadership roles, provide clinical leadership.

Organisational leadership practices shape and support the effective functioning of healthcare teams and teamwork by valuing teamwork and ensuring that teams compositions meet the requirements to effectively function (Taplin et al., 2013). The examples above provide insights into both formal nurse leaders' and informal nurse leaders' leadership qualities, and behaviours, on what is expected and what is perceived to be done as leadership practices. Nursing teamwork has been studied but little is known about how leadership practices occur within and across the nursing team beyond the leader-centric perspectives that are dominant in nursing.

The studies outlined in this section have used methods including reviewing the literature, interviewing, and surveying nurses about informal leadership. Perceptions about nursing experiences and survey with predetermined answers within the tool, have been used to contribute to what is known about ward nurses and informal leadership. Ward nurses do not see themselves as leaders but lead through role-modelling, caring and compassion. Their leadership is said to be contingent on support and structural empowerment. The clinical leadership of ward nurses does occur but how this happens is not clear. Further research is needed to know how ward nurses lead and if this occurs in everyday practice.

2.7 Study Aim and Purpose

The literature reported in this chapter demonstrates that nursing leadership has been explored by focusing on appointed roles and to a lesser extent, on informal nurse leaders largely examining clinical leadership. Knowing little of the collective leadership experience of the whole nursing team (their shared practices, interactions, and behaviours), this research addresses this gap by exploring how leadership practices occur amongst nurses in the hospital ward in New Zealand. To achieve this a research design was needed to capture the everyday micro-practices of leadership including those that are subtle and mundane, thereby revealing the 'doing' of leadership within a nursing team in a hospital ward.

The research was guided by addressing four questions:

1. What leadership practices, behaviours and actions occur within hospital ward nursing teams?

2. What influences the leadership practices of hospital ward nurses?
3. What are the effective leadership practices in the hospital wards?
4. What are the effects of the leadership practices in the hospital wards?

As the research questions focus on the practices or doing of leadership, a leader-centric perspective would not adequately address the research aim. Factors contributing to the experience of leadership, such as relational and contextual aspects are not captured nor explained in leader-centric perspectives of leadership. In leader-centric perspectives of leadership, demographics including age, gender, ethnic background, experience, and education of those in the context are not considered as contributors to the dynamics and relationships that exist within leadership and therefore reduce what is understood about leadership practices and outcomes. Followers feature in some theories, as passive subjects in asymmetrical or unequal power relations or influences and are thereby recipients of leader actions and decisions (Takoeva, 2017). Contextual influences such as social dynamics, political influences and resources and the complexity and pressures of work do not play a role in leader-centric perspectives and therefore, the picture of leadership is incomplete. Therefore, a pluralistic or collective leadership perspective emerged as the best way to address the research aim. To examine the collectively enacted and potentially emergent leadership practices in the hospital wards, the consequence of actor relations, actions, and interactions in context, would provide a focus on the performance of leadership through social processes (Karp, 2022; Sergi et al., 2016). This focus rules out 'sharing leadership', 'pooling leadership' and 'spreading leadership' but retains the pluralistic perspective of 'producing leadership' where the focus is on everyday relationships and actions in the context of the hospital ward. To address the four research questions, I returned to the leadership perspectives that were examined to better understand what is known about leadership-as-practice.

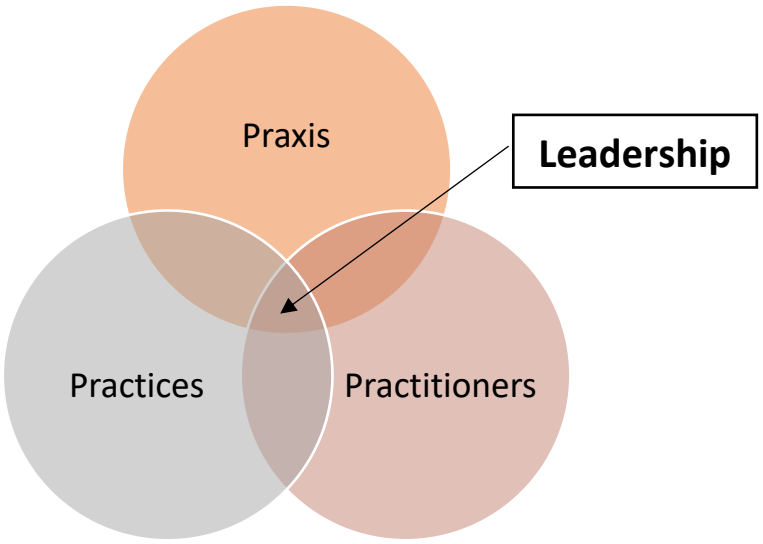
2.8 Leadership-as-practice

Offering an alternative to the mainstream leadership literature which posits what leadership ought to do to be successful, the leadership-as-practice (LAP) approach is a practice-based approach of the pluralistic producing leadership perspective. Central to this is the premise that leadership is an activity and occurs in the space amongst people and in relation to everyday contexts and situations in which people find themselves. It is how people, or practitioners in the case of hospital wards, get on with the doing of leadership in everyday work and in response emergent and dynamic processes (Chia & Holt, 2006; Crevani & Endrissat, 2016; Dovey et al., 2016; Filstad & Karp, 2021; Whittington, 2006).

Described as the fourth and last stream of pluralistic post-heroic leadership, leadership-as practice differs from other collective leadership approaches (Denis et al., 2012); it explores leadership through the creation and maintenance of relationships between practitioners, practices, and praxis (Raelin, 2016). Informed by recent developments in the strategy-as-practice field, leadership-as-practice turns the focus away from an individual (Karp, 2022; Raelin, 2016) to a focus on "practice as it unfolds, so the verb leading, rather than the noun leader comes to the forefront of our understanding" (Youngs, 2017, p. 141).

In LAP, practices are routine and patterned behaviours, interactions, and actions. "Practice refers both to the situated doings of the individual human beings (micro) and to the different socially defined practices (macro) that the individuals are drawing upon in these doings" (Jarzabkowski et al., 2007, p. 7). This includes collective language and non-verbal communication (Filstad & Karp, 2021). Practices are relational, collective, situated and culturally defined resulting in social and cultural constructions of leadership practices where leadership is both the activity and outcome (Carroll et al., 2008; Karp, 2022; Raelin, 2016; Youngs, 2017). Practitioners are the actors (Carroll et al., 2008). Praxis refers to the context and situations in which activity and work are both shaped and enacted (Carroll et al., 2008; Jarzabkowski et al., 2007). In this study, praxis refers to the dynamic yet situated culture of the hospital wards, and how individuals and groups within the hospital wards are shaped by social, political, and economic influences. The intersection of these three is where leadership occurs and can be seen (Figure 1).

Figure 1. ***Leadership-as-practice Conceptualised****



Note: Leadership occurs where Practice, Praxis and Practitioners intersect.

*Adapted from Jarzabkowski et al. (2007). A conceptual framework for analysing strategy-as-practice in strategizing: The challenges of a practice perspective. *Human Relations, 60*(1), 5-27. https://doi.org/10.1177/0018726707075703

Leadership-as-practice has its critics, for example Collinson's (2018) examination of LAP research stated no findings have been generated that were not already known via post-heroic leadership studies. Contesting this view is work of LAP researchers such as Endrissat and von Arx (2013) who identified the role of context in producing and on influencing leadership. Their work found that leaders' actions influenced context and that leadership was contextually influenced. Another researcher, Takoeva (2017) found how leadership practices were enacted within a Russian organisation and how everyday interactions and activities affected the context in which these were occurring. Yet another research project using LAP found that leadership practices included various types of conversations and talk at different times to influence leadership (Simpson et al., 2017) and that individuals exercise power contingent on the agency granted to them and that this is not equal or consistently applied (Case & Śliwa, 2020). Power beyond roles requires the legitimacy of others. Those without appointed leader roles may be granted legitimacy as influencers and leaders due to the authority and trust they have earned amongst their colleagues (Karp, 2022). This contributes to leadership practices being emergent, contingent, and situated and therefore dynamic. From the discussion here it can be seen that though LAP research is in its infancy, the notion that LAP research does not contribute to the leadership landscape is inaccurate.

Research using LAP enables examination of what is happening, how things are done, who is doing it and the context (Karp, 2022; Takoeva, 2017). Everyday leadership can occur in "mundane and subtle acts" and is dependent on the individuals and their skills and knowledge in and of the context, their everyday activities be they operational, tactical, and strategic and the activity that is achieved (Karp, 2022, p. 4). Leadership-as-practice has been used to frame research which explores the everyday leadership of service professions. The complexity of the police service is described using leadership-as-practice where observation and interviews provide data about the dynamics between the officers and hierarchy, the structures and policies resulting in leadership practices (Filstad & Karp, 2021). These practices are reciprocally influenced capturing the "complexity between police actions and police culture" (p. 770). Studies in higher education have also used the alternative ontology of leadership-as-practice. Youngs' (2017) critical exploration of collaborative and distributive leadership in higher education identified 29 studies based in Australia, New Zealand, United Kingdom, the United States and Europe.

Hospital nursing occurs in a multifaceted health system where complex unwellness is the norm. Leadership-as-practice offers an alternate lens to consider leadership that is not solely reliant on individual leaders. To examine the leadership of nurses working in the hospital ward, a practice-based approach that considers the interplay between practices, the nurses (practitioners), and the context (praxis) is justified. Leadership-as-practice would enable capture of the influences and intersection

between the people (actors or practitioners) undertaking and being influenced by leadership, the collaborative practices that they use including relational practices and processes, and the context (praxis) in which this occurs (Raelin, 2011). In-depth, longitudinal studies are needed (Karp, 2022) so that the social world of nursing leadership can be revealed.

2.9 Chapter Summary

This chapter examined the literature in relation to unitary leader-centric and pluralistic post-heroic leadership perspectives as there is a lack of consensus about the definition of leadership and of nursing leadership. As there is no widely adopted nursing leadership theory, the commonly used leadership theories were critiqued in relation to their application to nursing. These theories have informed research on individual leaders in times of change and in different situations including within teams. However, aspects of nursing leadership remain unknown as these theories are not specific to nursing. Caritative leadership is caring leadership which resonates with nursing values, yet this theory is not cognisant of situations and contexts.

The context of the hospital was explored in relation to literature about hospital leadership and safety culture. In respect to hospital safety culture and leadership, unanswered questions arose in relation to factors affecting nursing leadership and nurses' ability to speak up about risk. The literature provided insights of the influence of individual nursing roles (either formal or informal) and by teams but in isolation of context, other practitioners, and the practices of leading. The critique showed that whilst the effects and expectations of and for leadership are captured and reside in formal leaders, there is limited understanding of how ward nurses lead in the hospital. What ought to be done or what is perceived to be achieved can be very different from what occurs.

The initial literature review revealed that little is known about how leadership practices of nurses occur in the hospital ward. This gap in knowledge informed the focus and aim of this study. Leadership-as-practice was identified to provide a lens to understand how the doing of leadership occurs across the nursing team within the hospital ward. A LAP lens captures the intersection between people, activity and practices and the context in which leadership is occurring. As a form of pluralistic leadership, LAP has been used to explore and describe leadership practices in other service professions such as the police, and education. Nursing is performed using nursing models of care, where people, dynamics, processes, and structures influence how activity is performed and nursing leadership has not been researched from this perspective. The next chapter outlines the considerations in choosing a focused ethnography methodology to address the research questions. Following this, the research design is explained in detail.

CHAPTER 3: METHODOLOGY and RESEARCH DESIGN

3.1 Introduction

The methodological approach for a study is informed by the research question, data considerations and ethics. In the previous chapter, literature was provided that showed that individual nursing leaders' qualities and characteristics affect nursing retention, care outcomes, and patient and staff satisfaction. Whilst leadership practices were described as what ought to be done, what is less well known is how the practices of leading occur. The relationships between hospital ward contexts and situations, nurses, and leadership practices are not explained. The purpose of this research was to describe how nursing leadership occurs in the hospital wards. To reveal the leadership practices required detailed description of the leadership behaviours and social interactions of nurses within the contexts and situations happening in the hospital ward. Therefore, a qualitative approach that supported observation of leadership practices *in situ*, was adopted.

Ethnography is a methodology which reveals the culture and cultural practices of a specific group of participants (Creswell, 1998; Wall, 2015). Ethnographic approaches vary depending on the perspectives applied, and the nature of the participants being examined. There are several forms of ethnography which seek to explore and describe social groups. Focused ethnography, which I utilised is typically concerned with a research question or focus rather than observing a whole community or group (Cruz & Higginbottom, 2013). This chapter is in two sections. Section 1 presents the philosophical underpinnings that led to choosing focused ethnography as the methodology. Other forms of ethnography that were examined and rejected, are described. Next, the methodological positioning of the study is presented. In section 2, a detailed description of the study design and processes are presented including the setting, data sources, and ethics and rigour strategies.

3.3 Overview of Ethnography

Ethnography describes and interprets a social group, system, or culture (Creswell, 1998; Wall, 2015). Derived from Greek, 'ethnos' refers to people or nation and '-graphy'- refers to writing. Ethnography is "the art and science of describing a group or culture" (Fetterman, 1998, p. 1). Since the 19th century ethnography has evolved from anthropological and more recently sociological backgrounds (Atkinson, 2017; Creswell, 1998; Hammersley, 1992; Wall, 2015). An ethnographical approach involves researchers examining the meaning of daily occurrences according to the participants, to represent their social reality (Cruz & Higginbottom, 2013; Van Maanen, 1988). This is done by observing and

describing through thick description, the complexities of language, shared rules and beliefs, negotiated action and behaviour occurring in interactions and encounters in the social world (Atkinson, 2017; Creswell, 1998; Kalou & Sadler-Smith, 2015). The outcome of which influences how an individual perceives themselves (social constructivism) and how a group identifies together (social construction). Sommers-Flanagan (2015) describes these differences philosophically: "Constructivists focus on what's happening within the minds or brains of individuals; social constructionists focus on what's happening between people as they join together to create realities" (para. 3). To explore how nursing leadership practices occur in the hospital wards, social construction is needed.

Social worlds are founded on layered and complex encounters and interactions where people as actors or participants observe rules and conventions within the time and space in which they live (Atkinson, 2017). Ethnographies uncover social identity, work, threats, social controls, and social orderliness and thereby patterns of behaviour, customs and culture (Atkinson, 2017; Creswell, 1998; Kalou & Sadler-Smith, 2015). Such activities typically occur when a group is involved. Researchers have used ethnography in a variety of contexts to observe and explore the experiences of different groups including professions such as teachers (Wolcott, 2003), police (Filstad & Karp, 2021) and nurses (Adams, 2017; Coombs, 2004; Hales, 2015; Thurma-McDermond, 2011). Ethnographic research approaches have developed in relation to the philosophical assumptions of the researcher(s), and applications to the context and the phenomena studied (Van Maanen, 1988; Wall, 2015).

Historically, anthropological ethnographies have involved the researcher entering a 'foreign' culture or setting and immersing themselves in that setting for extended timeframes to study 'the other', observing and listening directly to systematically collect data (Kalou & Sadler-Smith, 2015; Knoblauch, 2005) to create valid, accurate descriptions of the social world (Van Maanen, 1988) from the perspective of those being studied. These were long-term field studies and are understood to be the epitome of ethnography. Sociological ethnographers have challenged this anthropological approach contesting the need for the researcher to be unknown or foreign to the culture or group being studied. Debate also exists about the duration of researcher exposure within the research setting including several months, or days and even episodic field visits. Questions about the 'natural occurring' aspect of settings, about which data sources can be relied upon and whether 'what actually goes on' can be documented, are also debated (Knoblauch, 2005). Some ethnographers challenge whether another can fully understand the meaning others make of and on their world (Skeggs, 2013); whether it be from a holistic perspective or a narrowed focus.

Contemporary discussions have called into question the definition of ethnography and its underlying processes and philosophical positioning, which is evident in the lack of unity amongst ethnographers

and questions about the contribution such research studies offer (Hammersley, 2018). Yet loosely, there is agreement that ethnography has a data collection process of some length of time, occurring in natural settings and including observation where the researcher documents in detail what is occurring to develop a richer understanding of the dynamic complexities of the social world social life and the workings of the group or society being studied.

Sociological ethnographies differ from anthropological ethnographies in that a core data collection method, participant observation, is sociological in tradition. Rather than disguising one's own culture as if it were foreign (Miner, 1956), sociological ethnographers are often members of the societies which they study with implicit and explicit knowledge enabling the area of study interest to be identified (Knoblauch, 2005). As a nurse wanting to explore and describe a phenomenon in nursing, this is an attractive quality of this methodology. Ethnography has also evolved as it has been applied to different disciplines and to study specific activities, social issues, and discreet populations. New ethnographic styles have emerged as ways of researching specific groups to understand the problem or society. These styles include critical ethnography, institutional ethnography, and focused ethnography.

Critical ethnography has a political purpose as it looks to address injustice and social or material inequality. Ethnographers in critical ethnography set out to challenge the status quo by examining the taken-for-granted assumptions or behaviours and power relations of a population or group. Critical ethnographers work in the "divide between the powerful and the powerless" (Foley & Valenzuela, 2005, p. 217). This approach is used to emancipate cultural members by exposing hidden agendas and challenging oppressive notions to create change and political consequence (Manias & Street, 2001). Critical ethnography has an emancipatory critical approach seeking transformation (Thomas, 1993), or to focus on technical efficiency and performance where function and causal explanations are dominant. This was rejected as incongruent with the aim of this research.

Institutional ethnographers explore the organisational structural and social systems that shape an individual's ordinary day-to-day life experience (Smith, 2006). This form of ethnography examines the ruling relations and institutional arrangements that creates social control (Devault, 2006) to expose how people's micro-practices in daily work life are influenced by macro-level politics and organisational knowledge (Rankin, 2017). The focus in this research was to describe how nurses perform leadership rather than on how institutions or organisations arrange structures and co-ordinate work activities. Therefore, institutional ethnography was also dismissed in favour of an approach that involved description and interpretation (Habermas, 1972).

3.3.1 Focused Ethnography

Focused ethnography differs from traditional ethnography in several ways. Unlike traditional ethnographies which observe a whole community or group, focused ethnography explores discrete elements of a specific context or a smaller group of people within a larger society (Cruz & Higginbottom, 2013). The actions, interactions and social situations are the prime concern in focused ethnography. This focus differs from classical ethnography which involves the study of social groups, social institutions, and events (Knoblauch, 2005). Drawing on Roper and Shapira's (2000) work, Cruz and Higginbottom (2013) outline three main purposes of focused ethnographies. These are to "discover how people from various cultures integrate health beliefs and practices into their lives; to understand meaning that members of a subculture or group assign to their experiences; [and] to study the practice of nursing as cultural phenomenon" (p. 38).

There are several other distinguishing features of focused ethnography which are significant for this study. Firstly, focused ethnography enables the researcher to have insider or background knowledge of the cultural group (Wall, 2015) which likely contributes to the identification of the issue for research (Higginbottom et al., 2013). The methodological stance of the researcher being familiar with the culture or society, stems from sociological ethnographies and is known as 'alterity'; whereas anthropological ethnographers are inclined to situate their study in groups or cultures of the unfamiliar and thereby are a stranger or 'other' to the culture, focused ethnographies can only occur where alterity is a pre-requisite (Knoblauch, 2005). As a nurse for over 20 years, I had previous experience of nursing leadership. As a nurse researcher with professional distance from the clinical setting, I was able to use my experience when searching the literature to identify the gaps and limitations in what is known about nursing leadership in hospital wards. This personal experience led to identifying the research questions (Cruz & Higginbottom, 2013).

Another feature of focused ethnography is that instead of immersion of the researcher for extended periods of time as in traditional ethnographies, episodic field visits can be undertaken where the researcher takes on a field-observer role during bounded periods of time (Cruz & Higginbottom, 2013; Wall, 2015). The episodic field visits glean intense data collection and analysis (Cruz & Higginbottom, 2013; Knoblauch, 2005), which provides a counterargument to the argument that focused ethnographies are superficial in nature (Wall, 2015). Focused ethnography offered a congruent way to address the aims of this study and was therefore the methodology of choice. From a pragmatic perspective, this enabled maintenance of employment alongside fieldwork across the nursing shifts.

Nursing focused ethnographies have included exploring exemplary emergency nursing practice in the United States of America (USA) (Walsh, 2009), nursing students' perceptions of cultural competence and social justice between the US and Africa (Thurma-McDermond, 2011), and the transitioning experiences of internationally educated nurses into a Canadian healthcare system (Higginbottom, 2011). In Australia, a recent focused ethnography looked at the assessment and management of pain in older people by nurses in acute care (Harmon 2015) and in New Zealand, the attitudes and care practices of intensive care staff towards critically ill fat patients (Hales, 2015). These focused ethnographies describe specific aspects of nursing care, nursing personnel and nursing skills and knowledge.

To demonstrate how focused ethnography was used as the methodology, the philosophical underpinnings are presented next. These underpinnings highlight the different aspects on which the study was conceived.

3.3.2 Philosophical Underpinnings: Leadership-as-practice

Fundamental to this study is the adoption of the leadership-as-practice (LAP) lens. I did not go into the field with any one theory in mind and did not know about LAP as a theory when data collection began. Rather LAP emerged through initial data analysis following fieldwork. As a nurse, I knew that nursing and nursing leadership could not be viewed in one dimension and as I was interested in how leadership practices were occurring, my observations were drawn to the activity of nurses, their interactions, the contexts, and the situations that were evolving. I captured these details in fieldnotes and interviews. Through initial analysis to understand the factors contributing to leadership practices, I began drawing circles to capture the relationships and overlapping them, to pictorially make sense of what was occurring. As I sought clarity about what was being observed, I continued to read about leadership, practices and activity, and the leadership-as-practice literature was located.

Leadership-as-practice offered a lens with which to consider leadership as it is not solely reliant on individual leaders. To examine the leadership of nurses working in the hospital ward, it was necessary to consider the interplay between the nurses (practitioners), their practices, and the context (praxis). Informed by recent developments in the strategy-as-practice field, LAP is "where 'practice' refers both to the situated doings of the individual human beings (micro) and to the different socially defined practices (macro) that the individuals are drawing upon in these doings" (Jarzabkowski et al., 2007, p. 7). Leadership-as-practice captures the influences and intersection between the people (actors or practitioners) undertaking and being influenced by leadership, the practices that they use and the context (praxis) in which leadership takes place (Raelin, 2011). Leadership should be found in

everyday nursing practice (Raelin, 2016). Of significance for this research, a "practice is a coordinative effort among participants…and tends to encompass routines as well as problem-solving or coping skills, often tacit, that are shared by a community (Raelin, 2016, p. i). In some circumstances, "leadership does not exist prior to the interaction but emerges (or not)" from it (Carroll, 2016, p. 103).

3.3.2.1 Constructionist Ontological Assumptions

Social constructionism is a theoretical position that considers knowledge of social realities or cultures as constructed by collective individuals rather than created (Andrews, 2012). To study the practices of leadership it was necessary for me as researcher to make a significant shift from the assumptions that are regularly adopted within conventional leadership studies. This involved departing from assumptions of individualism where the focus is on the individual leader, their qualities, and characteristics (Wood, 2005). Instead, I adopted a theoretical position where leadership is studied considering the processes and practices situated within interaction, and the social world of nursing; and not solely on formal leaders' actions and thoughts (Crevani et al., 2010; Raelin, 2011). Central to this theoretical positioning of leadership is a focus on practice as it evolves and unfolds, or rather as the verb 'leading' and not on the noun 'leader' (Youngs, 2017) resulting in leadership being repositioned as a process and an outcome.

One of the ontological challenges in adopting a leadership-as-practice position, was moving away from the concrete definitions and static accounts of leadership. This meant examining the social processes of relating and interacting, looking for internal dynamics, some of which were likely fixed, and the social webs within interactions. These processes are not reversible nor controllable and are constantly under construction or reconstruction (Chia, 1995). This study required focus on the practices and interactions not forgetting the practitioners or actors. Looking at practice brought focus on how leadership was conducted and performed rather than on actions intentionality (which is leader-centric); it offered the social dimension of leadership (Gherardi, 2009). By looking at the micro-level within interactions and behaviour, involving more than an individual and including non-human artefacts or materials (Gherardi, 2009), and being cognisant of the socially defined practices, the researcher can reveal everyday leadership practices (Crevani et al., 2010).

3.3.2.2 Constructionist Epistemology

The next challenge in applying a LAP lens was considering what can be known and what nurses want to know about leadership. With a focus on practices, interactions, and processes at the micro level of the hospital ward nursing team, this research aimed to create a detailed description of leadership-as-

practice and to relate what happens at the ward level to discourses on leadership (Crevani et al., 2010). To do this, as the researcher I needed to look beyond the point of view of the practitioner to the activity being performed. In data gathering, priority was given to observing local practices and processes, and being open to multiple voices, and various forms of interaction, even those that were elusive or contradictory to what may already be known as leadership in the mainstream (Gherardi, 2009). Describing what was occurring and obtaining multiple versions or perspectives (multi-vocality) (de Munck & Sobo, 1998) would shape what we know about how leadership occurs.

Leadership-as-practice has been criticised for not taking account of engagement with asymmetrical power relations and control practices (Collinson, 2017). This point is significant particularly in relation to nursing and hospital structures where hierarchy has historically existed. Therefore, observed or expressed examples of such factors were collected to inform how nursing leadership practices and processes were occurring. To capture such data, it made sense that a fieldwork methodology should be the vehicle to study leadership practices of hospital nurses (Crevani et al., 2010). Aimed at capturing and revealing what goes on (Hammersley, 2018), ethnography offered the opportunity to observe, talk with and describe in detail, how leadership was occurring for this social group of nurses (Wall, 2015). Focused ethnography was chosen as this enabled examination of nursing leadership in practice in the everyday occurrences within the ward and the wider context of the hospital and health sector (Cruz & Higginbottom, 2013).

3.3.3 The Researcher's Approach to Observation

In focused ethnography, the researcher is immersed within the field of research, observing the community of interest in their natural setting (Hammersley, 2018) and capturing descriptive written accounts of what is occurring. It is a way of researchers' being-in-the-world rather than a technique. There are four typologies for social research. Researchers may be 'complete participants' interacting as naturally as possible in the field of research and whose identity and purpose are unknown to those being observed. Secondly, as a participant-as-observer, the researcher is within the field and therefore is a participant and those being observed know the researcher is there to observe. The researcher is unlikely to be doing what the participants are doing, just observing as they do it (Delamont, 2011). The third is the observer-as-participant researcher who has brief and perhaps superficial contact with those being studied such as in an interview. The observation is formal and can result in misperceptions and limited understanding. In the final typology the complete observer removes all social interaction from the fieldwork and observes and listens and is not able to get meaningful clarity from those being observed (Byerly, 1969; Gold, 1958).

For this focused ethnography, where ethical consent to observe and record individual discussions was approved, and the intentions of the study were made clear to the nurses, I adopted a participant-as-observer approach to describe and explore the practices of leadership within the social world of the hospital ward. As a participant observer my interactions with the participants and others in the field were limited as I wanted to reduce my influence within the study. The next section presents how I adapted this approach.

As leadership is observable (Posner & Kouzes, 1996), expressed behaviours, actions, and attitudes, as well as context, interactions and relationships were recorded in fieldnotes. Central to these observations was remaining mindful of how nurses influence others and how they are influenced in their practice; what goes on between the nurses, the context (praxis) and how social practices (interactions and behaviours) occur. This included capturing descriptions of artefacts and their significance to practices, of places and routines as well as those unexpected events that occurred.

Observations do not have to be continuous, rather observations can be targeted and episodic (Higginbottom et al., 2013; Wall, 2015). Wards were visited on weekday and weekend morning and afternoon shifts, with observation periods shadowing different members of the nursing teams. These were targeted to capture the whole. Enough observations had been captured when the same patterns were reoccurring in the data analysis and no new findings were emerging and thus was saturated (Creswell, 1998).

3.3.4 Insider and Outsider Perspectives

The research questions required an ontological approach that frames the reality of how things are and how they work (Denzin & Lincoln, 1998). An emic perspective of a particular culture comes from inside the group and is created through social and contextual understanding. In contrast, an etic perspective observes cultural practices from a universal or outsider view without the perspective of those in the cultural group (Hoare et al., 2013). This study aimed to describe the observed practices of leadership (the etic perspective) and talk with nurses about how these practices occur and what influences this (the emic perspective).

Observing the nurses and talking with them enables the nurses' collective reality to be recorded. The data produced through documenting observations of what is occurring; "what people do, how they do it, and/or why" (Hammersley, 2018, p. 8) provided the etic view. Fieldnotes and subsequent analysis are detailed and often reflect what participants themselves may be unaware of in their behaviour, actions, interactions, and environment.

As a nurse it was important to be cognisant of my knowledge, understanding and assumptions about the hospital ward. I was clear that I was a professional nurse and bound by the nurses' Code of Conduct (NCNZ, 2012a) however, I was a researcher in this setting. Whilst I had inside or emic knowledge of the nursing profession, language and how hospitals worked, my role as researcher was as an outsider looking in on unfamiliar nursing teams and wards.

I entered the field with no known connection to the wards, or nursing teams beyond the charge nurse manager. I introduced myself as a nurse and researcher, using 'nurse' to look for common ground on which to gain some trust and perhaps the nurses would let me into their world more easily. As I began to meet some of those working in the four wards, I became aware of five nurses who I had some professional nursing history with, though this had not been for at least 10-15 years. Recognising their faces, I wondered if they would remember me in my earlier role as a ward nurse and what this would mean for the study and the perspective I intended to bring to the study. Would these nurses view me as an insider or an outsider as I did not have a clinical role in these wards? As I met these and other nurses, would being a nurse mean that these nurses would assume I understood all the nuances about the context? These were some of the reflections and questions I asked myself in my reflexive journal as this phase of the research got underway.

Ethnographers gain the insider view by gaining the trust of participants. It was imperative that I was authentic, honest, and non-judgemental so participants did not feel threatened or judged. The participant insider lens came through nurses talking informally and formally about their world within the wards and nursing leadership. Observations gained an etic view of trying to understand the insider perspective.

With an etic or outsider's view, I was able to maintain distance from participants. Not wanting to influence the setting or participants, I initially thought I could separate or bracket my emic nursing self and remain a silent observer and wait for the answers or links to some of my questions, to surface or materialise. However, there was several times when I felt professionally and morally obligated to respond following observing specific interactions. This included when one participant was managing a scenario in which the male nurses were being excluded from caring for gynaecology patients. In this instance, I responded to questions asked directly of me as a nurse. I answered with further questions that lead this participant to discovering services and resources that might provide her some direction. By responding in this manner, I was attempting to balance my insider 'caring' nursing self with my etic researcher role. It was an uncomfortable compromise, but I felt it enabled both emic and etic perspectives to be maintained in this moment.

As I spent more time in the wards, my role as researcher was increasingly accepted. My regular appearance in the wards created a sense of familiarity. Being a familiar outsider resulted in some of the nurses telling me their personal thoughts and information. It was as if the distance of being an outsider made it safe to share but at the same time, it felt like the distance between us was being reduced through the sharing of thoughts and burdens. Some of the disclosures meant that I knew insider information which I kept in confidence. Grappling with being drawn in when needing to maintain the researcher role, I felt inwardly conflicted at times as my perspectives felt blurred. Hoare et al. (2013) recognised the emic and etic viewpoints on a continuum with these at opposite ends rather than occurring as an either-or view. In experiencing situations as described above, I realised that both options were possible simultaneously creating another viewpoint. In these moments I was beside nurses, seeing both insider and outsider perspectives. This viewpoint moved with activity and covers the distance between insider and outsider so would be better understood as an alongsider perspective.

Being an alongsider is not a new perspective. Wickins and Crossley (2016) found that positioning the researcher as either an insider or as an outsider did not capture the emerging relationship between participants and the researcher. Alongsider is "an alternative fluid, active and proximal research position" (p. 226) on the insider-outsider continuum. Alongsider also captures the experience of the researcher as they are exposed to the field and witness experiences in doing the research which informs their perspective (Wickins & Crossley). Corbin Dwyer and Buckle (2009) identify this as the space between insider and outsider membership noting that the researcher can occupy both spaces and no spaces. As my research journey continued within these wards, I became an alongsider in some moments. This will be explored further in the later parts of the next section.

3.3.5 Written Representation

Writing is central to ethnography as it is through the written description that interactions, relationships, and culture are presented (Clifford & Marcus, 1986; Wolcott, 2004). This includes writing about what is seen and heard, and through this writing, culture is made visible (Van Maanen, 1988). Using words to paint a detailed picture of what was happening, writing is subject to interpretation of the researcher who observes and frames the representation of the field and those within it. The researcher selectively chooses to write fieldnotes about what seems relevant or significant, ignoring or leaving out other details (Atkinson, 2017; Emerson et al., 2013).

To capture fieldnotes, is not without challenge. Speed and urgency are noted to be the enemies of ethnography as in haste one can overlook details (Van Loon, 2013). Therefore, notes are made in the

moment or as soon after a period of observation with fuller details being added as soon as possible after witnessing the situation (Denzin & Lincoln, 2005). Capturing observations and accounts in fieldnotes results in a large body of fieldnotes being produced. This develops from one field visit to the next, creating a collection of observations which can appear without logic or coherence (Emerson, et al., 2013). Using date sequences for the fieldnote entries is one way to create systematic order. However, the data within the fieldnotes still requires analysis to demonstrate logically and meaningfully what is occurring. The data analysis processes for this research are explained in section 2 of this chapter.

Balancing the fieldnote observations with individual discussions and the meaning and influence of artefacts is another challenge for the researcher. Data from all collection methods combine to provide the detail that contributes to writing ethnographically. This is done through the cyclic nature of revisiting the research question(s) whilst simultaneously examining and analysing the data for patterns and commonalities.

When writing ethnographically, there is an art in balancing the vignettes of what was occurring with explanations of what occurred (Emerson et al., 2013). For this study, the challenge was looking at leadership actions, behaviours, and interactions. As explained in the literature review the many definitions of leadership meant that this would be a challenge. This was addressed by capturing all actions, behaviours, and interactions over a concentrated period. Leadership practices were not assumed to be known but were assumed to occur. By writing fieldnotes of what was occurring as it happened, this created opportunity for time to lapse, and multiple activities and interactions to occur. Sometimes leadership took place over time with reactions occurring in interactions hours or days after an initial interaction, action, or behaviour. It was in writing and capturing the detail that leadership could be seen. Additionally, when reviewing fieldnotes and adding detail missed at the time, leadership practices were also noticed.

After analysis has occurred, writing presents the representation of the findings. Often in the process of writing the findings, analysis continues, extending the analysis through the writing process. This is a complex writing challenge. In creating the written representation of the whole, observations, individual discussions and artefacts need to be incorporated. As this research was practice focused, weight was given to what was observed in the practices of participants which was triangulated or tested against other participant practices to notice patterns and conferred with what was described by participants and the role of artefacts within the setting.

Identifying representational vignettes of leadership practice and then providing explanations in the writing of this, contributed to painting the picture of what was occurring. Balancing the complexity of

what needs to be in the foreground and in the background of the vignettes to provide an accurate representation of what occurred is also a challenge for the ethnographer. Creating this picture also requires that the context is accurately detailed and represented as the context is as significant as the practices and participants. This includes recording the physical, social, and political environments and situations, as they arise.

Managing the written representation of a social group requires both artistic and technical. Writing is subject to interpretation of the ethnographic researcher who is observing and capturing what is occurring. Due to the nature of interpretation, written representations can be challenged however measures are taken to dispel such challenges and increase the rigour of this work. These are addressed in the 'Rigour and trustworthiness' section where measures to reduce researcher bias within the data are outlined, as are the reflexive journaling during the whole research experience and memoing.

3.4 Study Design

"Ethnography is both a process and a product of research" (Coombs, 2004, p. 40). The use of focused ethnography informed the design including what data were collected, the analysis and the written representation of this study (Clifford & Marcus, 1986; van Maanen, 1988; Wolcott, 2003, 2004). The design provides the steps taken to gain entry and access to the hospital wards and participants; to gather data including participant data, observations, individual discussions, and artefacts; to analyse and write the findings; and to ensure that the study was conducted ethically and rigorously. Details about how the study was undertaken are presented in the following subsections to provide transparency and rigour to the process, findings, and written representation of this research.

3.4.1 Study Setting – The Hospital Wards

The setting for this research needed to be a hospital ward. Several key factors influenced the choice of which ward. Firstly, the ward(s) had to be geographically accessible. Secondly, to protect the confidentiality and identifiability of the research participants, I felt it appropriate to find a clinical area where a single charge nurse manager (CNM) was responsible for the day-to-day operations of more than one ward; this was becoming the trend in public hospitals when nursing leadership positions were disestablished as referred to in Chapter 1. Such a research site would offer the opportunity to recruit nurses of different levels and skills from several teams, including multiple nurses in formal nursing leadership positions. This would also offer the opportunity to see if this structure had any influence on nursing leadership across the wards. In addition, this type of setting with several nursing

teams would offer numerous occasions to observe leadership practices of nurses in the context in which they occurred.

3.4.2 Accessing the Hospital Wards

An organisation was identified that was geographically accessible and where there were several CNMs who oversaw several wards. An approach was made to one CNM who had a reputation for supporting nursing initiatives. Interest in the study was shown by this CNM and the relationship to gain access began. This occurred in 2017 when foundational work for the thesis (including the ethics applications) was underway. It was not until later that year that access to the site was formally negotiated with the CNM and the service manager (Appendix 4).

Whilst access to the ward was being negotiated, I sought support for the study from the hospital Research Advisory Group - Māori who were the Māori cultural advisory partners for research in the hospital, the Nursing Leadership group of the hospital, and the hospital management. The Research Advisory Group - Māori endorsement process involved an application to their committee outlining the study and the cultural considerations when undertaking research where Māori may be participants and where the results may have significance for Māori. Following a meeting with a committee representative to discuss the application, an endorsement letter was received indicating no changes were needed (Appendix 1). This was added to a briefing report which was provided to the hospital Nursing Leadership group, outlining the study. A meeting with the Director of Nursing's delegate, an Associate Director of Nursing, took place to allay concerns which particularly related to nurses being observed in practice. Following an explanation of the participant consent processes and how observations would take place, the hospital research committee processes were completed and a locality agreement for the study was signed in February 2018 with a DHB in the North Island of New Zealand.

3.4.3 Participant Selection and Recruitment Strategy

Through a pluralistic lens, leadership occurs beyond roles and people. All members of the nursing teams could demonstrate leadership practices, or had experience of and had been influenced by, nursing leadership. Therefore, all nursing team members of the four hospital wards, were invited to be part of this study.

Recruitment strategies to gain participants included attending two regular unit meetings where nurses from all four wards met to discuss and address shared issues. At these meetings I presented the research project and answered questions. I also went to each ward on four occasions to create

opportunistic moments to explain the research to potential participants. The study's participant information sheet (Appendix 5), and consent forms for observation (Appendix 6) and for individual discussion (Appendix 7) were left in the nursing stations and staff rooms of each of the four wards. Word of mouth and later, observation of the research in action, were successful in gaining further participants beyond initial recruitment.

3.4.4 Ethical Approval

With the study being deemed out of scope for the Health and Disability Ethics Committee (Appendix 2), ethical approval was sought from Victoria University of Wellington Human Ethics Committee approved the study Ref:25476 – 22.12.2017 (Appendix 3). Key ethical issued raised in the ethics application were the need to manage observations around patients; confidentiality of participants, and what to do if professionally witnessing an issue when observing. I intentionally chose not to observe patients or nurses in patient bed spaces nor nurse-patient interactions. The confidentiality of participants was maintained with the use of codes in the fieldwork journal and a pseudonym was used when a scenario involved a specific nurse. Participants were made aware in the consenting process that serious breaches of the code of conduct may result in me informing management as required by my own nursing code of conduct (NCNZ, 2012a).

My purpose in being in the wards was to gather data and not to nurse. Therefore, I negotiated with the hospital wards that my level of clinical engagement would meet my role as researcher but also that of maintaining my nursing registration and the nursing Code of Ethics (NZNO, 2019). This is in relation to beneficence (doing good) and maleficence (doing no harm).

3.4.4.1 Ethics

Nurses could contribute to the study by consenting to being observed in practice and or choosing to participate in an individual discussion. Initially, senior nurses self-selected and consented and soon after, other nurses did the same. Over time I became a regular sight on the wards, and I was able to recruit more participants. As nurses work in teams, generalised responses of those who chose not to be involved in the study were captured in fieldnotes, when these responses were related to the practices of consenting participants. These were not attributed to a particular nurse.

At the time of the study there were 111 staff across the four nursing teams. This included 11 Senior nurses (SNs) appointed to formal leadership roles in the wards, 73 RNs, seven ENs and 20 HCAs. All 111 staff were invited to participate. The decision to include the unregulated HCAs in the study was made as these roles support the nursing team caring for patients and follow the leadership of nurses.

HCA experiences, behaviours and actions and interactions regarding nursing leadership would add to the understanding of leadership within the hospital nursing team because like others in the team, HCAs are exposed to leadership practices and conversely, they may lead others. However, only one of the 20 HCAs consented to being observed. Additionally, specialty clinical nurses (senior nurses) who visited the wards as part of their practice, were invited to participate. Table 1 shows the number of nurses who consented to each data collection method with a total of 27 participating in the study.

Table 1. ***Nursing Team Members Consenting to Being Involved***

Nursing Participants	Consented to being Observed	Consented to Individual Discussion	Total number
Senior Nurses (SN)	8	10	10
Registered Nurses (RN)	11	10	14
Enrolled Nurses (EN)	2	2	2
Health Care Assistant (HCA)	1	-	1

Of the 27 nurses, 25 were from the rostered nursing staff, and two from patient services external to the wards. In addition to the CNM, Ward W and Ward Y had five nurses participate, Ward X had six nurses and Ward Z had eight nursing staff participate. Table 2 provides a summary of the demographic characteristics of the participants, including their pseudonym.

3.4.6 Data Collection

The three methods of data collection were observations, discussions and ward and hospital artefacts. Ethnographic data analysis is cyclical in nature with the researcher going back and forth collecting data and analysing (Gillis & Jackson, 2002) resulting in an interplay between the researcher and data (Strauss & Corbin, 1998). As fieldwork and data collection began, so too did the analysis process. Following each field site visit, fieldwork journal entries were transcribed capturing fuller details of what had occurred. Questions were asked of the data to inform the next site visit and where questions remained, noted in the individual discussion schedule for a particular nurse.

Table 2. ***Summary of Participants' Demographics***

Pseudonym	Role	Years of Nursing experience	Years In current role (years)	PDRP level
Nicole	CNM/SN	15-19	5-9	Senior
Elle	ACNM/SN	25-29	Up to 4	Senior
Jane	ACNM/SN	25-29	5 -9	Senior
Lavender	ACNM/SN	5-9	Up to 4	Senior
Patricia	ACNM/SN	30-34	5-9	Senior
Anne	SCN/SN	20-24	up to 4	Senior
Margaret	SCN/SN	5-9	up to 4	Senior
Sally	CNS/SN	40-44	up to 4	Senior
Alice	CNE/SN	5-9	up to 4	Senior
Juan	CNE/SN	10-14	up to 4	Senior
Candice	RN	10-14	up to 4	RN Expert
Erica	RN	35-39	10-14	RN Expert
Sera	RN	15-19	10-14	RN Expert
Charissa	RN	5-9	5-9	RN Proficient
Diana	RN	20-24	Up to 4	RN Proficient
Grace	RN	15-19	10-14	RN Proficient
Joy	RN	10-14	up to 4	RN Proficient
Leilani	RN	10-14	10-14	RN Proficient
Monica	RN	10-14	5-9	RN Proficient
Talia	RN	15 -19	10-14	RN Proficient
Beth	RN	up to 4	up to 4	RN Competent
Daniel	RN	up to 4	up to 4	RN Competent
Kelly	RN	up to 4	up to 4	RN Competent
Victoria	RN	up to 4	up to 4	RN Competent
Emma	EN	up to 4	up to 4	EN Accomplished
Jeanne	EN	up to 4	up to 4	EN Accomplished
May	HCA	40-44	25-29	HCA

3.4.6.1 Fieldwork Observations

Experiencing the social context and cultural settings first-hand (Borbasi et al., 2005), the focus for data collection was on the nurses emic (insider) perspective and I captured my own feelings and views as an outsider to inform the existence of multiple realities (Higginbottom et al., 2013). This enabled the construction of plausible and credible ethnographic accounts.

The cultural immersion of the researcher in the field of interest results in relationships developing between the researched and the researcher (McGarry, 2007; Pitts & Miller-Day, 2007). When the hospital wards self-selected, I had no knowledge of the nurses in the teams beyond the CNM. Finding that some of the nurses were familiar to me from my previous roles, I sought to re-establish connections and establish myself as a nurse researcher. I was an outsider.

I drew on my insider experience as a nurse to develop a rapport with potential participants. Engendering "trust, empathy, understanding and mutual respect" was central to this (McGarry, 2007, p. 11). As someone new in these wards, watching practice can create suspicion (Agar, 1999). To avoid negative images that can reduce creating trust, I attended meetings and greeted staff to establish rapport with the ward staff and nursing teams in each area so that I was alongside the teams. Wanting to be unobtrusive and to blend in, I consciously decided to wear smart casual clothes similar to those nurses wearing day clothes. Soft soled shoes were a must, and I wore a researcher name badge to be clearly recognised as a researcher and not management or a nurse on the team. This was important to provide clear identification and limit deception (Coombs, 2004). I aimed to be approachable, open and transparent about the research, to contribute to an atmosphere where participants would feel comfortable in my presence whilst I balanced closeness and distance with participants (Pitts & Miller-Day, 2007). This included managing confidences and remaining non-judgemental.

Though I was unknown to most (effectively an outsider), nurses were keen for the study to take place and for their perspective and experiences to be the focus. Initially I tried not to effect or influence the teams with my presence by trying to minimise interactions. This was naive, as my presence was an influence and as such my relationship with them evolved (Pitts & Miller-Day, 2007). However, as time passed my presence became familiar to the nursing teams. With this, the nuances of the emic (insider) experience began to reveal themselves regarding dynamics, tensions, interactions, and contexts. As I clarified actions and thinking to understand practices, my relationship changed to be more alongside the nurses as they took in me into their confidence and shared thoughts and expectations. It was at this point that I recognised that trust and rapport had developed in a positive way across time (Pitts & Miller-Day, 2007).

Having gained consent and negotiated times to shadow participants, I began fieldwork by observing all senior nurses on a team-building day. Two of the senior nurses had recently joined this team and this day was about establishing the team. This day provided the opportunity to observe interactions and dynamics amongst these nurses and to hear the vision and goals that the group collectively set for the coming year, whilst identifying the challenges that lay ahead.

Following this day, consenting participants were shadowed and observed in the hospital wards on negotiated days. These observations were made in and from ward spaces including the corridors, the nursing stations, the medication rooms, the sluice rooms, utility rooms, staff rooms, and the offices of those nurses in formal leadership roles. Meetings were attended whilst following the everyday routines of the nurses. These occurred on-site in meeting rooms and sometimes in conjunction with the sister-hospital via computer aided technologies.

Once in the field, it felt strange and unnatural as a nurse not to engage with nurses as had been planned as a non-participant observer. Therefore, I adapted my approach strategy to engage in the day-to-day interactions that might be expected in New Zealand society. My interactions increased to greetings, enquiries about what I had observed to gain clarity and responses to direct questions. Therefore, my non-participant observer role relaxed to fit in within the wards though my research question remained the focus. To mitigate my influence on the study, I captured the role I played whilst in the wards, by including my interactions and statements on every second page of my fieldnote journal. It was these entries that I used to focus my reflexive memoing in my research journal, the details of which will be expanded on further within the reflexivity section.

Generally, observations were made in blocks of 4-5 hours. Of the nurses who were observed, nine were observed once, eight twice and five were observed three or more times. Observations were captured in fieldnote journals contemporaneously with all interactions being documented. This resulted in fieldnotes that captured descriptive accounts and notes of incidents, events, interactions, dialogue, chance meetings and other unconnected matters so that sense-making and interpretation could occur (Emerson et al., 2013). The fieldnotes became a representation of the practices, people, and hospital ward. Entries included who was present and the location, the observed behaviour and body language, interactions, and processes. This involved capturing what was said, heard or seen and at times noting if something was unsaid, and felt (Denzin, 1997). The fieldnotes included quotes of dialogue between consenting participants and when nurses offered informal commentary about situations or interactions. Reactions by others to the behaviours and interactions of participants were captured to build understanding of the relationships, history, and dynamics amongst the nursing team. Context, surroundings, and the activity of others were also described in fieldnotes to provide a picture of the leadership practices that were occurring. Communication was the key to maintaining rapport with the nursing teams and managing the leaving and re-entering of the hospital wards. Using the roster, previously consented participants were identified for shadowing or observing, and oral consent was sought prior to, or on the day of observation. When declined, another participant was identified, and the process of oral consent repeated.

Observations and documentation of nurses' leadership practices, behaviours and interactions across morning and afternoon shifts on all days of the week occurred in two time periods. The first was from March 2018 to July 2018 and then again from October 2018 to March 2019. The split timeframe was intentional. Following four months of observations, the political nursing context heated up nationwide. Planning within the hospital began in relation to proposed strikes for work conditions and nurses pay. It was at this time, that I decided that if nurses decided to strike, then I would leave

the wards until the political situation settled. Such circumstances would be neither routine nor reflective of everyday situations on the ward. I communicated this to the charge nurse manager and when the strike notice was issued, I informed the nursing teams.

Withdrawing from the hospital wards during the strike period, gave opportunity to have some distance from the participants which provided time for reflection, to analyse the data gathered and to consider the study's direction. Such an opportunity supports increased objectivity (Thurma-McDermond, 2011) and is often the practice in ethnographic studies (Fetterman, 1998; Roper & Shapira, 2000; Walsh, 2009). Clarity of ideas and concepts could be tested when re-entering the wards. During this time, I maintained communication with the CNM throughout my absence and re-negotiated my re-entry to the hospital wards in mid-October 2018, once the climate had settled. The episodic visits and participant observations recommenced. After a further six months in the field, reoccurring patterns in observation data determined that no new information was being gathered. Observations ceased at this time. Individual discussions continued onsite. Once the final individual discussions were scheduled, I let ward staff in each area know that my departure from the wards was imminent so I could complete the analysis and identify the findings.

In total, 40 site visits resulted in 22 nurse participants being directly observed in practice across 168 hours. Of these nurses, eight were SNs, 11 were RNs, two were ENs and one was an HCA.

3.4.6.2 Fieldnotes

Writing fieldnotes whilst in the wards came with the challenges. Mostly I observed at a distance from others, but to protect the identity of participants and reduce my notes being understood and subsequently affecting the research if accidentally read, I created a code that I attributed to each consenting participant. These codes were inserted into the fieldnotes and later exchanged for pseudonyms. Some nurses chose their own pseudonym while others left me to assign them one.

Documenting fast enough and in detail whilst in the field was a challenge at times (Wolcott, 2003). Being witness to multiple and simultaneous activities and interactions, required a quick hand and notes were captured as soon as possible during or after the interaction or event. Further detail and thick description were added to create a fuller picture of what was observed at the end of each observation period. My fieldnote journals would be the foundation for the written representation of how leadership occurred within the nursing team. These represented the insider or emic view whilst I also captured the outsider or etic perspective describing my impressions and feelings about what had occurred as I observed, to balance my influence on the research.

3.4.6.3 Individual Discussions

Ethnographic interviews are usually focused on the research issue or topic (Higginbottom et al., 2013). In this study, I conducted semi-structured individual discussions with participants which focused on leadership practices, influences of and on nursing leadership and on observations I made during fieldwork. Departure from a traditional interview to an individual discussion was a decision made at the conception of the study. I purposefully named the audio-recorded sessions I had with individual nurses as 'individual discussions' as these would draw on and be situated in everyday conversations of professional daily life (Kvale, 1996). By calling these 'individual discussions', I hoped this would offer familiarity and encouragement to those nurses who were considering participating. This terminology also recognised the space of the researcher between emic and etic perspectives as these face-to-face audio-recorded individual discussions began following eight months of intermittent fieldwork. Patterns were emerging in the analysis, and I was able to question these.

Drawing on my alongsider perspective, it was my intention that the already established rapport I had with the nurses, would continue through the semi-structured questioning, and that dialogue would flow, capturing what nurses thought about leadership and how this occurred in the wards. As a nurse myself, I knew that nurses talk a lot in everyday practice and tell stories. Whilst narratives construct realities and encourage the 'voice' of participants, the focus here is on the individual rather than the social context (Marshall & Rossman, 1999). Discussion enabled probing or questioning and meant that observed practices could be integrated within discussions, to question the relationship between what the participant thought, how they thought they responded to and behaved in ward contexts or situations, and therefore capture the culture of leadership practices.

The disadvantage of being part of the discussion was that my participation as the researcher could be misconstrued as influencing the direction of the discussion (Kvale, 1996). This was mediated by the development of an individual discussion schedule to reduced potential influence and provide structure (McIntosh & Morse, 2015). In the individual discussion schedule (Appendix 8), leadership practice topics were identified with open-ended questions "to elicit unstructured responses and generate discussion" (McIntosh & Morse, 2015, p. 4). These were typically asked in the same way and order however, where appropriate and in response to the participant, the order of the topics altered to maintain the flow of the discussion. The individual discussions were an opportunity to understand the thinking and hear experiences of nursing leadership, and to probe further and seek clarification of the observations made, to reveal deeper meaning than what might be interpreted at observational level.

Notes were made during and immediately following each discussion and the audio recordings were transcribed exactly word-for-word for analytical purposes. Individual discussions were undertaken

with 22 nurses with over 21 hours of audio-recordings obtained. Eleven of the discussions were transcribed by me and 11 were transcribed by paid transcribers, who signed a confidentiality agreement (Appendix 9). An overview of the lengths of the individual discussions is provided in Appendix 10.

Informal discussions also occurred in the activity of day-to-day work. These were unstructured and occurred during fieldwork through several mechanisms. Sometimes I sought clarification from participants to understand background or meaning following a situation, though waiting often resulted in answers being revealed. In other situations, participants, or others in the field, would seek me out to offer insights into the actions or practices of the participant being observed. Nurses volunteered information (data) that they thought might be useful to the study. These informal discussions were *ad hoc*, and brief. They were not audio recorded but quotes were captured, and key points were noted in the fieldnotes.

3.4.6.4 Artefacts

Cultural artefacts are objects, materials and documents that influence how participants think, act, and interact within the context. There is a tendency to think of artefacts as fixed or static or as tools that influence how work occurs. In this study which focuses on practices, artefacts were considered "as intermediaries with the ability to broker realities such as power, status, control and knowledge" (Carroll, 2016, p. 102). Artefacts contribute and influence the social fabric of a group due to the symbolism, authority or influence attributed to objects, physical spaces and how this influences work routines (Carroll, 2016).

To capture the everyday leadership practices of nurses, and the effects, and the influences of these for the nursing teams, data beyond the nursing team were also collected. This included descriptions of the research sites or hospital wards environments, and artefacts such as documents including job descriptions, policies, and wall posters (Sandelowski, 1995). These artefacts contributed to providing understanding and a picture of this phenomena for this social group.

Documents are sources of data in ethnography as they contribute to what is going on in everyday practice (Fetterman, 1998). Written documents contain decisions, rules, and statements (of fact or intention) which give insight into an organisation and present a reality that informs routine, activity, and interaction. These may include but are not limited to policies, guidelines, and memos. These written texts can be interpreted as factual in a clinical workplace (Hammersley & Atkinson, 2007) and their influences must be examined. Equally important for the ethnographer, is the response of staff to the documented facts, rules, or decisions therein.

Artefacts are also objects which exist in the setting and are central to the research issue. This includes the environment and physical space and objects which inform daily practice, routines, and activity. As such the environment can be a rich source data. Photographs were taken (with permission of the organisation) of symbols on walls and of the work environment. Objects such as uniforms, cell phones, pagers, hand-held paper diaries or notebooks, and clinical equipment like stethoscopes were also noted in the fieldwork journals including detailed descriptions, their uses or the purpose or meaning given to such objects (Hammersley & Atkinson, 2007).

Additional artefacts included rosters (structural leadership), team and organisational newsletters and intranet notices. Other artefacts such as newspaper reports, government consultation documents, and professional and union documents were collected during fieldwork. Documents such as meeting minutes, and ward communication book entries would have also been useful yet a lack of access to the first and the absence of the second in all four wards, meant these were not available. The absence of these artefacts created camouflaged communication (Berlin & Carlstrom, 2015) and the implications will be discussed further in the findings. Over 50 documents or material artefacts were gathered to inform the cultural practices occurring within the setting (Fetterman, 1998; Higginbottom, et al., 2013). A summary of the datasets is presented in Table 3.

Table 3. ***Datasets from Fieldwork***

Datasets	Details
Fieldnotes (40)	8 Senior Nurses (SNs) 11 Registered Nurses (RNs) 2 Enrolled Nurses (ENs) 1 Health Care Assistant (HCA) 1 Reflexive Journal
Recorded Individual Discussions (22)	10 Senior Nurses (SNs) 10 Registered Nurses (RNs) 2 Enrolled Nurses (ENs) 0 Health Care Assistant (HCA)
Cultural Artefacts	20 Documents • 2 Policies • 1 Guideline • 10 Role Descriptions • 3 Documents • 4 PowerPoint Presentations 24 site photos 12 rosters for the four wards

Observations and individual discussions ceased when reoccurring patterns in the data emerged indicating saturation of the data.

3.4.7 Data Management and Audit Trail

Once fieldwork began, it became necessary to log and track all the data that were being collected. A data management trail (Appendix 11) was created and used to document the process including the collection of data and artefacts. This was so that the study could be replicated, and comparable results could be attained and to increase the trustworthiness and dependability of both the recording and presentation of findings (Gillis & Jackson, 2002; Lincoln & Guba, 1985).

3.4.8 Data Analysis

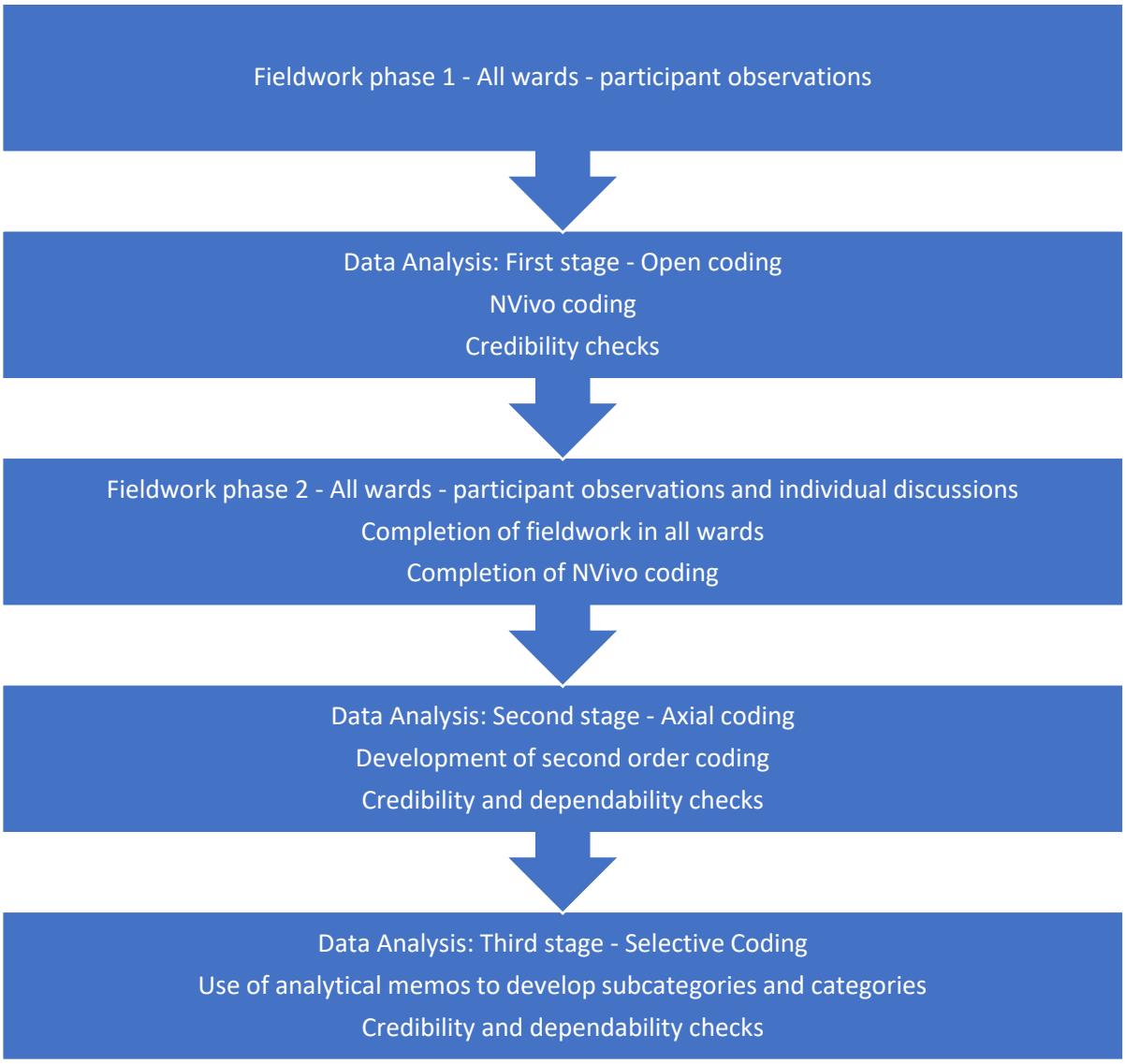
The process and structure for analysing data for this research needed to be able to construct the hospital ward nurses' social reality of leadership. Analysis began immediately following the commencement of fieldwork. Fieldnotes were reviewed following each visit and questions for the next visit captured. Coding also began at this time. Analysis involved three stages of code generation. Figure 2 details this process. The figure is a modification of the process which Coombs (2004) used to explore the power and conflict between doctors and nurses in the intensive care unit. It outlines the three-step process used in the analysis.

Stage 1 began with 'open coding' where concepts were identified, and their properties and dimensions discovered in the data by deconstructing events, actions, and behaviours (Gobo, 2008; Strauss & Corbin, 1998). Put simply, this involved each paragraph being closely examined looking for concepts and properties within. The coding was undertaken as Crevani et al. (2010) propose, without pre-defined operationalisations, enabling the data to reveal what was occurring.

This fracturing of the data allowed codes or simple phrases of up to five words, to be created to reflect the essence of the specific entry (Saldaña, 2016). These were descriptive codes to answer the question what is going on here? Memos were writing excerpts I made in my research journal when I 'dumped' down my thinking about a process, a participant, a situation, or an idea that was being considered. Going further and reflecting on the process and through analytic memo writing during data collection and analysis (Saldaña, 2016), the researcher-generated codes were initially noticed to be descriptive nouns. To answer the research question, the codes were actively altered to verbs where appropriate, to indicate the action, movement, and fluidity of leadership. Therefore, some codes became process codes (Saldaña, 2016). Whilst some of the codes were researcher generated, many codes came directly from participant quotes. Commonly known as 'In Vivo' codes, these were the direct words

taken from the voice of the participant. It was important to ensure participant views and actions were present in the coding and to provide rich "imagery, symbols and metaphors" to inform the next level of coding (Saldaña, 2016, p. 109).

Figure 2. ***Data Analysis Process****



*Adapted from *Power and Conflict between Doctors and Nurses: Breaking through the inner circle in clinical care*. M. Coombs, 2004, p.45. Routledge. *Data Analysis Model*.

Table 4 shows an example of the raw data that informed the first order or open coding.

Table 4. ***Raw Data to Open Code***

Raw data	**First order/Open coding**
• People that stepped up • Nurses that have stepped up • Use a lot of our nurses to step up • They have to step back • That person will step up when needed, you don't have to ask, they'll just step up and do the job • They're prepared to put themselves out there without getting paid extra • Encourage and then step back and let her go for gold • What they're willing to do and what they're not • She puts herself out there and she goes for whatever she wants • They're using me in that role to make decisions when the ACNM is not here • They use me, I'm quite happy to step up • Me and her have been around a long time and we stepped up and did those roles • Someone who will stood up • I will stand up for what's not ok • Step up in the role • They run the ward; they don't need to; they don't get paid to do that • The ward is just going to be chaotic again so we have got natural leaders • They step up • They are picking up other people's slack almost • I feel relieved when someone steps up • If there is something going on, someone will be influenced to lead us as a team and that isn't always our charge nurse • We lack it on our ward and someone's got to step up if those girls aren't on • I lead some people usually some non-assertive nurses we have • Sticking your neck out • As long as you can back yourself • If you stick your neck out, you get a reputation • They need someone to have the ability to speak up and stand up • They have not been taught how to speak up so others will • Not everyone will feel confident enough to stan dup and say that actually this isn't ok - I haven't • Speaking up for safety but when you do it in reality – the outcome is not what they make it out to be • They are not the type to speak up • They stand up for things for other people • You have to have courage to stand up in front of other leaders and say "well no" • Sometimes you speak up about stuff and it feels like you are sort of getting shut down • She stands up if she thinks that this is not right • I will stand up for what's not ok • Would I speak up- yes • Takes charge of some situations • They do stand out	**Stepping up**

To ensure the accuracy and rigour of the coding process, the first three fieldnotes were also independently coded by my primary supervisor and three interview transcripts independently coded

by my third supervisor. Codes were found to be similar and were verified by my supervisors. Following this initial validation of coding which was done with pen and paper, all fieldnotes and the individual discussion transcripts and artefacts such as documents like job descriptions, were uploaded into a data analysis software product called NVivo12. This was done to help organise and analyse the data. Open coding was then completed for all data sources.

Stage 2 of coding - axial coding (Gobo, 2008) began as the open codes were identified and revisited. This coding took place once all open codes were known at the completion of fieldwork. This second stage involved reassembling the data that were fractured during open coding to construct sub-categories (Strauss & Corbin, 1998). Also known as second-order coding (Van Maanen, 1979) this involved systematically comparing and re-organising the codes into categories or concepts (Saldaña, 2016; Strauss & Corbin, 1998). Data were examined and reassembled into new patterns of thought, by going backward and forward to systematically form subcategories and relationships with categories that explained the facts of the data. This was done by defining the range and distribution or the properties and dimensions of each sub-category and linking these to categories "at the level of properties and dimensions" (Strauss & Corbin, 1998, p. 123). The construction of themes resulted.

In this second phase, I used NVivo12 to examine the open codes looking for similarities which could combine to form a concept. This examination was done in conjunction with my research journal and memoing, as NVivo12 limited my ability to see beyond linear patterns. Playing with ideas from the data and using pen and paper to construct new patterns, new concepts emerged which could be tested against the data. Constant comparison and checking were done repeatedly. For example, 'being visible' and 'being aware' and 'being engaged' shared properties and were all linked by 'being present'. Table 5 demonstrates this linkage in its development. As the axial codes became clear, these were cross checked with my third supervisor to ensure data were triangulated from one source against another source to reduce the effect of researcher bias (Buchanan & Bryman, 2009; Creswell, 2014).

The third and final stage was selective coding. This stage took place once all data were collected as seen in Table 5 and involved confirming or refuting the central phenomenon through the data (Gobo, 2008; Strauss & Corbin, 1998) by grouping categories together to explain the phenomenon. In this phase, no new properties, dimensions, or relationships emerge during the analysis and those that had emerged, were confirmed.

Table 5. ***Coding and Conceptualisation of Nursing Leadership Practices***

First order/Open Coding	Second order/Axial Coding	Confirmation or selective coding
being visible/seen • wearing uniform • being heard • audible use of voice **being physically present** • being available • being approachable • presence **being actively engaged** • active listening • authentic responses • interacting with others – • explore issues and problem solve and persuade **being aware** • situational and emotional awareness • knowing team and capability • knowing	**being present**	**Patterns of leading**
physically close • inviting/approachability • reduce distance between nurses creating closeness • positioning alongside another • language – inclusive pronouns and verbs • inclusive body language **togetherness** • levelling the power differential • checking in with others • maintaining connection – eye contact, interactions	**being alongside**	
physical distance • separate or aside from the team • Role-modelling self-reliance and independent thinking **stepping up - autonomy and advocacy** • aloneness • maintaining boundaries	**being apart**	
setting standards and expectations • compliance and mimicking • enacting the standard • holding to account **permissions to follow and act** • empowerment • demonstrating knowing, showing, and guiding **professional expectation to guide and teach** • preceptoring and hierarchy	**role-modelling and enabling following**	
anticipating and acting to reduce risk • proactive thinking and actions • knowing the bottom line and holding to it • reactive thinking and actions to reduce further risk	**anticipatory leadership practices**	**Safeguarding practices**
minimise impacts to reduce or avoid harm **keeping others safe** **being safe and safety** • masks • gatekeeping access and information • role development and providing stability • reliable support and having each other's backs	**shielding and being shielding**	
protecting nursing team membership • belonging • sharing nurses • team membership and the nursing roster • the role of TrendCare **protecting nurses** • stepping up • use of voice • demonstrating courage	**protecting nursing identity**	
knowing limits of practice and capabilities, **creating and maintaining support networks**	**resilient leadership practices**	

• support • nursing teamwork and strategy • offering and receiving help **restoring leadership energy and wellbeing** • playing to strengths • sharing nurses – opportunity for growth • positive interactions • resting and wellbeing focus – breathing, mindfulness • letting go		

3.4.9 Rigour and Trustworthiness of the Research

Although a long-established methodology, ethnography has its critics in relation to rigour and trustworthiness (Hammersley, 1992). These include concerns about the researcher's influence on their interpretation, which may be shaped by values from cultural, historical, and personal contexts (Denzin, 1997) and concern exists about the influence of this on data interpretation. Therefore, the researcher's values and belief system need to be transparently acknowledged (Cruz & Higginbottom, 2013). Other measures that strengthen the trustworthiness and rigour of this study include specific strategies to address credibility, transferability, dependability, and confirmability. Research rigour is not an additional aspect added on to the planning of the study. Rather it is imbedded in the design. Credibility sometimes referred to as authenticity looks at whether there is a realistic representation of the issue or phenomenon under investigation (Gillis & Jackson, 2002). Ethnographers commonly use member checks and triangulation (Buchanan & Bryman, 2009). Member checks involve the verification process where researchers ask participants to either assess the accuracy of transcripts from the audio-recorded interviews or "the plausibility" of the ethnographer's interpretation (p. 613) following analysis. In this study, the second option was taken. Following the second stage of code analysis, axial coding, the researcher's interpretations were shared with some participants to establish that these resonated with them as a realistic representation of leadership practices in the hospital ward. At this sharing, the codes resonated with participants and were verified. Triangulation is the cross checking of data between sources and using NVivo12 enabled the data sources to contribute to codes and resultant findings. This was validated by supervisors.

Transferability refers to the degree the study's findings are applicable to other populations. Sufficient detail must be described so the reader can determine whether the findings can be transferred to their setting, that is beyond the bounds of the study setting (Gillis & Jackson, 2002). The reoccurring data patterns contribute to the transferability of this in addition to the detail provided in the descriptions. Examples of this are in the two findings chapters which outline the complexity and mundane nature of the ward contexts along with the nursing leadership practices that occurred there. Stories or vignettes of events are used to convey events in real time.

Finally, confirmability refers to the degree to which the research has been influenced by the researcher. Researcher personal bias, assumptions and values must be made explicit, and use of the audit trail assesses for neutrality (Gillis & Jackson, 2002). Organisational ethnographers are increasingly required "to be open and reflexive about their own positioning in relation to the study; their reception by participants, the process of analysis, choosing between forms of representation" (Gilmore & Kenny, 2015, p. 56). This is to address 'ethnographic authority', or problems associated with the perceived power of the researcher who solely controls themes, categories and frames, interprets and constructs meaning of the participants and the contexts being explored. This helps delineate the interactions between researcher, methodology, setting and participants (Buchanan & Bryman, 2009; Cruz & Higginbottom, 2013). The reflexive journal and memoing was used to capture decision making regarding process and content.

Memoing was the note taking I undertook to capture thoughts and ideas about aspects of the study on which I could critically reflect and consider the influence of such thinking. The notes captured decision making and rationale for the same. At each phase of the analysis, research supervisors verified the steps taken and tested the resultant codes and concepts to mitigate influence of researcher bias.

3.4.9.1 Reflexivity

Reflexive journaling is one way to capture the researchers influence within the research (Gobo, 2008) to enhance the integrity of ethnographic practice (Arber, 2006). The purpose of reflexivity is to critically reflect on the self (Lincoln & Guba, 2000) to transparently capture the researcher's subjective influences on the research process and documented writing (Allen, 2004; Cruz & Higginbottom 2013). Self-reflexivity assists in revealing biases of the researcher by questioning the data and how it has been reported (Hertz, 1997). Ethnographers have embraced reflexivity as a countermeasure to inform the power relations between researcher and the researched (Gilmore & Kenny, 2015). For this study I used reflexive journaling after each engagement with the field.

My outsider or etic viewpoint was captured through notes on every second page of my fieldwork journals and in impression statements following fieldwork site visits. This included keywords and thick description of my feelings, impressions and reactions to the experiences, situations, and interactions I was being exposed to within the research space (Gilmore & Kenny, 2015). Such reflexive practice was undertaken to counteract my effect on the research. However, as I reflected on my fieldwork journals the distance between myself and the 'researched' narrowed at times and in circumstances where nurses drew closer as I became familiar (Gubrium & Holstein, 1997).

My thinking about leadership practices changed from the beginning of the study, in response to being in the wards and with the nurses and is picked up again in Chapter 6 - the Researcher's Journey. In the literature, the term alongsider captures the space a researcher moves to, between insider and outsider. This was particularly evident when I was approached as a sounding board or confidante by nurses to reflect on their practice. I maintained distance by acting as a mirror and reflecting to the nurses what they had said and posing this as a question. Several nurses asked me specifically for feedback and evaluation on their practice. As this was not the purpose for which I was present, I maintained my response and encouraged these nurses to reflect on how they saw their own practice. This technique was captured in my reflexive journal to balance my involvement with detachment (Arber, 2006), and maintain my participant observer approach and 'flow' with the participants in their world (Charmaz, 2004).

To negate the Hawthorne effect where participants misrepresent themselves and their usual actions and behaviours because they know they are participating in a study (Seaman, 1987), those consenting were observed and notes were made, even when they were not the principal focus for the observation on any shift. This reduced the possibility of acting for the researcher. Even so, one participant drew my attention to a nurse who was acting out of character when I was observing them. In response I memoed the claim and took particular attention to also observe this nurse when my principal focus was on another. I found that indeed, when observations were planned, this nurse actively engaged with others increasing their visibility on the wards. The level of visible engagement and presence within the wards decreased when the nurse was not being directly observed. The lesson for me as a researcher from this experience was, to also observe practices of those participating in the study indirectly, to observe for the Hawthorne effect. Of significance for the findings, it was only this first nurse who clearly acted in a different way when she thought she was being observed. Through memoing about the decision to observe indirectly, which was possible within the consent process, I wondered why a colleague would inform on this nurse. Asking the colleague directly, she talked about the nurse's behaviour and actions not being a genuine reflection of her usual practice. The colleague was concerned that the nurse was not being authentic, and this may influence the research findings.

3.4.9.2 Memoing

As seen from the example above, I used memoing to record my decision-making processes. Commonly associated with grounded theory, memos enable the researcher to engage with the data, explore meanings, and maintain and sustain quality when conducting research (Birks et al., 2008). The mnemonic 'MEMO' captures the key functions of memoing in qualitative research. "Mapping research activities; Extracting meaning from the data; Maintaining momentum; Opening communication" (Birks

et al., 2008, p. 70). Mapping research activities is the recording of decision-making processes from the point of the research being conceptualised through conducting the research. These memos serve as an audit trail of the process.

Meaning is revealed in data when the researcher answers the question "what is actually happening in the data" (Glaser, 1978, p. 57). Sorting these analytic memos generates codes and categories as clustering may identify new codes and new names for codes. Sub codes reveal more specific groupings (Saldaña, 2016). I refer to my analytic memoing activity in the data analysis section above. Memos also contribute to the evolving process of the research by protecting the researcher from the fear of making errors. By capturing the researcher's thoughts and ideas without prejudice, the ideas may affect the direction of the research. Memoing reduces the researcher's insecurities about making mistakes as amendments are encouraged if needed. Having noted these down changes in operational direction, these are able to be identified and undone, maintaining momentum within the study (Charmaz, 2006; Clarke, 2005).

Observations occurred for a total of 11 months, and I concluded data collection 18 months after the first observations were documented. By this stage, nursing team members with varying roles and nursing experience from the four wards had been observed and descriptions and patterns of action, behaviour and interaction were being repeated, revealing leadership practices (Gillis & Jackson, 2002).

3.5 Chapter Summary

This chapter firstly outlined the methodology or thinking and approach that informed the study. This included the philosophical and methodological positioning for the study and my role as a non-participant observer which softened overtime due to exposure and developing rapports with nurses. In the second section of the chapter, a detailed description of the study design was presented including the processes undertaken to gather and analyse data. I also explained my fieldwork journey and the measures taken to strengthen the rigour and trustworthiness of findings. The following chapter presents the first of two findings chapters. This is the contemporary contexts in which nursing leadership practices occurred.

CHAPTER 4: FINDINGS – The Contemporary Context of Nursing Leadership in the Hospital Ward

4.1 Introduction

The findings are presented in two chapters. The first of these chapters presents the layout and features of hospital wards where the study took place. This is significant as it offers the background to how nurses navigate the many influences in the environment, the organisation, and teams. The second findings chapter (Chapter 5) presents how nurses enact leadership practices by showcasing the patterns of leadership engagement that occur in the ward nursing teams and the effect of these on nurses and the nursing team. Critical discussion combining key points from this chapter and Chapter 5 are explored in Chapter 6 to make sense of how leadership practices were occurring. Where details provided about the context are sourced from an interview, the pseudonym of the person is provided as the information source. When details are provided from fieldnotes, this is signalled with FN and the date.

A descriptive profile of each of the four inpatient wards in the study is provided, including the ward function and the physical environment. The structure and roles of the nursing teams in these wards is followed by a closer look at the hospital and nursing routines which structure everyday nursing practice. Finally, resourcing of the wards is highlighted; in particular, the limited personnel, equipment and stock and the solutions found to 'make do'. This information is important in a focused ethnography as it details the formal staffing and routines of the ward in which leadership practices are revealed.

4.2 The Setting

This study took place in a public hospital of a District Health Board (DHB) in the North Island of New Zealand. New Zealand has a publicly funded national health service committed to social service provision and reducing health inequities (Goodyear-Smith & Ashton, 2019). This publicly funded health system provides primary which are offset by co-payments from healthcare users and secondary and tertiary healthcare including disability support services which are free to residents of New Zealand. Alongside this is a pharmaceutical management agency which negotiates supply and manages subsidy of medicines, to reduce pharmaceutical costs, and a no-fault accident compensation scheme (Goodyear-Smith & Ashton, 2019). Three quarters of the government's health funding supports the day-to-day business of the health system and is administered by DHBs (MOH, 2017a).

District Health Boards were established in 2001 (MOH, 2020) “to plan, purchase and deliver health and disability services for a population within a defined geographical region” (Goodyear-Smith & Ashton, 2019, p. 434). The country is divided into 20 DHBs whose key objectives include “integration of care services, optimising arrangements for effective and efficient delivery of care and reducing health disparities by improving health outcomes for Māori and other population groups” (MOH, 2020, p.1). This study took place in a DHB which served a population of approximately 321,000 people in comparison to others in New Zealand which vary in population size from 32,550 to 628,770 people (MOH, 2016). Approximately 11.8% of this DHB’s population identify as the Indigenous Māori population compared with the national average of 16.6% and 7.1% Pasifika compared with the national average of 6.7% (MOH, 2021). The deprivation levels in this DHB show one third of the population is in the least deprived quintile, with an eighth registering as most deprived (MOH, 2021).

The hospital in this study is one of four operated by this DHB. The name of the DHB has been removed from all source documents and from here-on-in will be referenced as DHB. This hospital has four inpatient wards within a three-storey rectangular concrete building. Also located here is an outpatient area along with the hospital kitchens and a business-operations centre. This building abuts more modern buildings that have been constructed as health service provisions have evolved and house operating theatres, day and outpatient services and after-hours and emergency care. Maternity care, community services and mental health services are also onsite.

The four wards provide nursing care for a range of specialty areas. Ward W and Ward X are medical wards for the older adult. These two wards and Ward Y (a rehabilitation and stroke ward) are funded and managed by the Directorate for Medical Services. Ward Z cares for patients undergoing elective gynaecology or orthopaedic surgery and is part of the Surgical Services Directorate. The total number of patient beds resourced by nursing staff varies between the summer and winter months due to the increased complexity of illness that occurs in winter and operating theatre closures during the summer Christmas period. In the summer, resourced beds numbered between 45 and 55 and in the winter up to 80 requiring nursing staff numbers to swell and retract. This movement created leadership challenges for nursing recruitment and retention and team culture especially when nurses were scarce, and the organisation increased bed numbers. The length of patient stays varies across the specialties given that recoveries took different lengths of time. In the medical older adult wards, patients were admitted to the ward for an average of 10.1 days whereas in the surgical ward the length of stay was 4.6 days. In contrast, patients rehabilitating following medical and surgical events or following a stroke stayed in hospital longer, with an average length of stay of 21 days. Table 6 shows profiles of the wards and specialties, patient beds and average lengths of patient stays in each ward.

Along with the nursing teams (which will be profiled shortly) and ward administrators, the wards had a housekeeper, a patient activity co-ordinator and ACC (Accident Compensation Corporation) officers to claim appropriate funding from ACC to support the care needed. Other staff working within these wards included geriatric, medical and surgical doctors, physiotherapists and occupational therapists, and their assistants, and social workers. Pharmacists, dieticians, and clinical nurse specialists visited the ward to offer their expertise. The Māori health team and Pasifika health team in addition to chaplains, regularly visited patients to support their social and spiritual needs. Hospital volunteers also came to the ward to offer companionship and attend to small errands for patients.

Table 6. ***The Ward Profiles***

Directorate	Medical			Surgical
	Ward W Medical: Older Adult	Ward X Medical: Older Adult	Ward Y Rehabilitation, Stroke	Ward Z Surgical: Gynaecology, Orthopaedics
Patient beds (Summer)	18.0	18.0	16	12.0
Patient Beds (Winter*)	22.0	22.0	20	16.0
Average Length of stay (days)	10.1	10.1	21	4.6

4.3 The Ward Environment

The physical environment of the wards influenced the daily work of nurses in the study. The ward layout is presented to inform the context in which nursing, and nursing leadership occurred. The inpatient wards are on the upper two floors of a three-storey building and could be accessed via two elevators or stairwells. Each ward is laid out in a U-shape with all patient cubicles on the outside walls of the ward to maximise external light and airflow. Originally the wards were designed as a mirror image of the opposite however over time modifications for clinical needs has meant there are minor discrepancies between areas. Between the wards on each floor are the elevators and corridors to the wards; one for the public that the elevators opened onto and a corridor from the stairwells, on which staff offices and staff bathrooms are located. Whilst the public corridor is well lit at all times of the day and night, the staff corridor is dim as lights were frequently off.

Central to each ward is the nursing station, which can be accessed by both corridors. All the disciplines work from the nursing station as the computers and patient notes are located here. The space comprised of benchtops and mobile seating, and a handbasin and soap for handwashing. This space appears organised and clean largely due to the freshness of the linoleum on floor, newly painted walls, and lighting. Filing cabinets are here with forms, procedural documents and policies within it and an area designated for the mobile trolley for patient folders containing all relevant and current admission information about the patient's assessments, progress, and planning. New in each ward in February 2018, is an electronic whiteboard showing the patients and team members working with them. This could be updated from the computers. Computers are on the benchtops and collated information from several information technology platforms to provide up-to-date information about each patient including the practitioners involved in their care, estimated date of discharge and the status of referrals to services as in Figure 3. The bench that opened onto the public corridor is designated as a reception area and is where ward administration staff. An example from one ward is visible in Figure 4. Two land-line phones are on the benchtops. A ward cell phone is also present in the station and is used when personal calls for patients came in or as issues need discussing, away from the central area.

Figure 3. ***Nursing Station with Electronic Whiteboard***

Note. This shows the nurses' station and electronic whiteboard for the ward census within it. Filing systems and computers provide an administration office feel to the space.

On internal wall spaces there are standard whiteboards and pinboards so that information can be shared with colleagues including the patients for admission, the medical on-call roster and regularly used phone numbers (Figure 5). Opposite each nursing station is the swipe-card accessed medication room. Inside this is the electronic medication dispensing computer system 'Pyxis', along with other

pharmaceutical stock and a drug fridge. Each ward also has a cupboard that holds other items and equipment to support care delivery. These cupboards are not uniformly located in the ward. Visible in ward corridors are allocated places for patient assessment equipment including blood glucose monitors, dynamaps, and sphygmomanometers. A resuscitation trolley is available on each floor and the orderlies bring an electrocardiogram (ECG) machine to the wards on request.

Figure 4. ***Reception Area of Nursing Station***

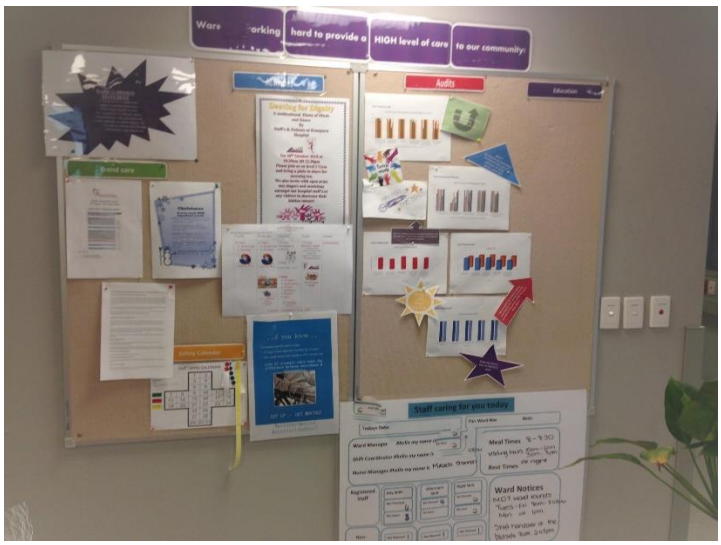
Note. Ward reception situated at one side of the ward's nursing station, around which the patient cubicles are located. This also shows how the walls are used to display notices drawing attention to important information and processes

Behind the nursing station on one side is a sluice room to dispose of human and contaminated products. On the opposite corridor, linen cupboards. Ward W and Ward Y have a staff room located beyond the sluice room near the patient lounge, whilst Ward X and Ward Z have staff rooms located between the wards, in an annexe off the public corridor. Each staff room has a fridge and a kitchenette with one or two table surfaces for dining. Seating varies from four to eight chairs depending on the size of the area. No couches are present nor televisions or radios. The walls have notice boards on them, including one designated for nursing union issues, health and safety issues and then for other social events.

Patient lounges are at the end of the ward and serve as both dining room and lounge with several tables and chairs of differing heights. Lazy-boy chairs are also along the walls, but there are no couches or televisions. At different times of the week, these spaces are utilised by staff for large meetings where members of the disciplinary groups come together to assess progress of patients and plan for discharge. On the outer walls of the wards are the patient cubicles which contain one, two, four or six patient bedspaces, each sectioned off by a curtain rail. The bedspace has an electric bed, a built-

in cupboard, and a mobile locker. Oxygen and suction ports are to the side of the bedhead and a control panel above the bed head provides switches for lighting and the nurse-call-bell. Bedspace allocation is determined by acuity, need for visibility and observation, and clinical diagnosis such as co-grouping patients with like-illnesses and isolating infectious diseases. Patient bathrooms are located on both sides of the ward at either end, with staff bathrooms located off the ward on the staff corridor of each floor.

Figure 5. ***A Typical Staff Notice Board***



Note. The organised and busy appearance of the staff notice board. Similar examples of notice boards are on the staff corridors to each ward and between the nursing station and medication room.

On three of the wards, a patient cubicle has been converted into an office for the Associate Charge Nurse Manager (ACNM) as can be seen in Figure 6. On the fourth ward, the ACNM office is centrally located within the ward behind the sluice room. The Charge Nurse Manager (CNM) has an office on the staff corridor of the top floor with nurse educators and specialists having a shared office on each floor in the staff corridor. Additionally, on the top floor is a room dedicated to education with hot-desks for staff to use. The room is also used by the multidisciplinary team (MDT) and nursing for meetings.

The décor varies between floors. In some areas the floor and wall linoleum are mustard and curtains beige brown. The carpet is worn and tired as are the wall hangings. In other areas, the wards have been refreshed with new white-toned paint to the walls, and grey-white linoleum lightening up the spaces and creating an airy feel. There is no air-conditioning. Staff, patients, and visitors are exposed to considerable heat in the summer and much cooler temperatures on winter days despite the use of boiler radiators. In response, patient cubicle windows could be opened on the middle floor and part

way opened on the third floor (to avoid issues of patient harm). However, to create airflow within the wards' central spaces, fans are available, which at times, are clinically contraindicated. As such creating a therapeutic milieu can be challenging for the nursing teams to manage.

Figure 6. ***An Associate Charge Nurse Manager Office***

Note. Located in the wards, the ACNM offices were formally patient cubicles. These offices are regularly used to store short term valuable equipment or supplies due to limited lockable storage space on the wards. This office shows the dated linoleum and curtains consistent with the décor of the rest of this ward.

4.4 The Nursing Teams

Each ward has a specific team of nurses rostered to work in one of these four wards, 24 hours a day 7 days a week. The nursing teams, their roles and the nursing hierarchy are described in this section. This includes the team structure which was supported by the nursing roster and how the nurses grouped themselves to deliver nursing care, to fulfil resource roles, and communicate to gain support and develop their practice.

Nurses are employed to a ward based on the number and occupancy of patient beds, the acuity and specialty care needs of the patients and the required skills and experience of the nurses. This means that each ward has a roster to meet the needs of their patients and the model of nursing care delivery. The full-time equivalent (FTE) model that supports the establishment of nursing numbers in these wards, responds to seasonal and social pressures across the calendar year along with the expected nursing care delivery requirements. To ensure adequate nursing numbers for each ward, the acuity assessment tool TrendCare is used to electronically calculate the nursing hours needed to provide the specialised nursing work needed for the patients' acuity. This number of hours determines the number of nurses and support staff that are needed per shift.

The nursing team for each ward (including the senior nurses and the health care assistants) numbered between 26-28 people. This equates to between 20.32 and 28.6 FTE positions per ward or 99.72 FTE across the four wards. Five of the staff are male. The ethnicities that the nursing team members identified with included: Australian, British, Cook Islander, Dutch, European, Fiji Indian, Filipino, Indian, Irish, Māori, New Zealand European, Samoan, Scottish, Sri Lankan, South African, Tokelauan, Tongan, and Welsh. Table 7 shows the FTE associated with roles within the wards. Earlier, Table 6 illustrated that the increase in inpatient beds in winter is expected to be 20-25%. Table 7 shows only 1-10% increase in nursing staff for winter occurred during the data collection period. The pressures created by the mismatch of nurses to beds and the resulting leadership practices is revisited in Chapter 5.

Table 7. ***The Ward Nursing Teams***

	Ward W Medical: Older Adult	**Ward X** Medical: Older Adult	**Ward Y** Rehabilitation	**Ward Z** Surgical: Gynaecology, Orthopaedics,
Clinical Nurse Manager (CNM)	1.0 FTE			
Associate Charge Nurse Manager (ACNM)	1.0 FTE	1.0 FTE	1.0 FTE	1.0 FTE
Clinical Nurse Specialist (CNS)	0.6 FTE		-	-
Clinical Nurse Educator (CNE)	0.5 FTE		0.6 FTE	0.5 FTE
Registered Nurse (RN)	17.5 (18.1*) FTE	16.9 (18.9*) FTE	14.8 (16.4*) FTE	15.2 (16.5*) FTE
Enrolled Nurse (EN)	1.6 (2.4 *) FTE	2.4 (2.4*) FTE	2.2 (2.2*) FTE	-
Health Care Assistant (HCA)	4.7 (3.5*) FTE	5.0 (5.8*) FTE	3.8 (4.15*) FTE	3.62 (3.22*) FTE
TOTAL	**25.60 (25.8*)**	**26.10 (28.90*)**	**22.65 (24.60*)**	**20.57 (20.91*)**

**Winter staffing numbers.*

In this study, the CNM is responsible for the nursing teams (n=110) and ward operations of the four inpatient wards (and a day ward which was not part of the study). Over time, the role of the CNM has expanded with greater focus on management tasks such as human resource management, quality and health and safety standards and meeting key performance indicators set for each area and service (DHB, 2011). This expansion has resulted in the CNM having less time and opportunity to be involved with clinical matters and patient care. It was difficult at times for the CNM to manage quality and standards with such little involvement in patient care, despite holding responsibility for these functions.

As the CNM role evolved with greater focus on more strategic management tasks, the ACNM role was introduced into each ward to take responsibility for the day-to-day functioning of the ward. The ACNM role is expected to provide clinical oversight, develop the roster, maintain ward health and safety processes, and manage patient flow and care. The ACNM role has no direct reports (DHB, 2015a) as ward nursing staff report to the CNM. The five other senior nurses are also without direct reports (DHB, 2014, 2015c, 2015d). This included the three clinical nurse educators (responsible for developing the competency and capability of the nursing team), the clinical nurse specialist (who plans and co-ordinates complex disease treatment plans) and the transitional care co-ordinator (who manages complex care needs as the patients transition to discharge). These senior nurses work part-time in a single ward or across several wards due to the specialty areas of care associated with their role. They and the ACNMs report to the CNM (DHB, 2014; 2015a) and had professional accountability to the Director of Nursing as did all nurses.

Delegated authority was held by the ACNMs to enable them to do their roles and deputise in the absence of the CNM. The creation of the roster is carried out by the ACNMs, with the CNM maintaining approval rights for changes to the roster. The nursing roster is created six weeks prior to its commencement, with nurses able to make requests for specific shifts. The four-week roster covers the 24-hour period in three eight-hour shifts across 7 days a week. Nurses have access to the electronic live version of their ward roster whilst the ACNMs can see the rosters of all four wards.

On the rosters, the nursing personnel are listed in order of nursing hierarchy. Each ward's roster begins with the ACNM followed by the nurse educator and clinical nurse specialist. As the manager of the four wards, the CNM did not appear on any of the rosters. Registered nurses (RNs) appear 3rd and are ordered according to their expertise level on the national Professional Development and Recognition Programme (PDRP) which descend from Expert, Proficient, Competent to Graduate Nurse. Enrolled Nurses (ENs) are next as their role requires them to be directed and delegated to by the RN. Those ENs who had attained Accomplished status are placed on the roster ahead of Proficient and then Competent enrolled nurses. Despite ENs not being able to direct and delegate tasks to healthcare assistants (NCNZ, 2011), their qualification and scope of practice with the Nursing Council of New Zealand, positions them ahead of the unregulated healthcare assistants (HCAs), who are last on the roster.

Along with an ACNM, morning shifts had three to five nurses rostered on with support from up to three healthcare assistants. The roster reflected that on afternoon and night shifts and the weekends less support was available as senior nurses work Monday to Friday 0730 – 1600hrs. The more experienced and skilled ward nurses (usually listed higher on the roster) would coordinate the ward

whilst maintaining a reduced patient workload with three to five nurses and an HCA working alongside them. Night shifts are usually covered with two or three nurses (one of whom may be an enrolled nurse) and a healthcare assistant.

Nursing uniforms are a visual sign of the presence and hierarchical composition of the nursing team. These uniforms denote the roles of the nurses and badges indicated the level of expertise. Black trousers are worn by all with most wearing soft soled shoes such as sneakers. The nurses wear white tunic tops with varying-coloured braids on the sleeve cuffs, collar and pocket trim with their role embroidered on the left breast. The CNM wears double navy-blue braids on the sleeve whilst the ACNM has a single bold navy-blue trim on the sleeve. The nurse educator has a pale-blue embroidery and trim whilst the CNS is signalled with burgundy trims. Registered nurses have a dark green braid and ENs have yellow braid. Healthcare Assistants wear black trousers and a dark green tunic top with 'Healthcare Assistant' embroidered in white cotton. On occasion the CNM or the senior nurse acting as CNM (in her absence), wear plain clothes.

Badges signifying the expertise of the nurses are expected to be worn in this area. In addition to an expert, proficient, or accomplished PDRP badge for those who have attained them, the nursing team including HCAs, wear name badges and have lanyards around their necks with security identification. Non-uniform jewellery is frequently added by individual nurses including various earrings, necklaces and bracelets and rings, with no consequence for this (across the time of the study) despite such jewellery not meeting the uniform policy and the known risks to health and safety for the wearer and patients.

The uniforms create visual differentiation between nursing roles, and the roster provides structured hierarchy within the nursing team. At the beginning of each shift, rostered ward nurses assemble in the nursing station or staffroom for the shift handover of patient care from the last shift to the next. At this time, along with being able to identify who is working on the next shift and therefore who is present, the nursing uniforms provide visible evidence of the roles that make up the skill mix for that next shift. Yet, depending on who is present and the purpose of interactions or work, nurses move between one another to support colleagues, deliver patient care, make decisions about day-to-day functions, and to socialise, creating changing sub-groups across the nursing teams.

To deliver nursing care, the hospital has adopted a 'team-nursing' model of care. This involves at least two nurses and an HCA identifying the nursing tasks for a group of patients and allocating tasks to each member dependent on skills, knowledge, and scope of practice. Allocating work requires close communication, support, and the sharing of expertise. Team nursing brings different nurses together although some nurses arrange the teams to suit themselves. This happens by nurses requesting the

same shifts, ensuring that collegial friends are having the same break times and teaming with colleagues whom they recognise as having similar work ethics, and complementary skills. For instance, a Proficient RN often chose to work with an Accomplished EN. Together they physically work closely, allocating and performing tasks whilst having fun, joking, and talking loudly. Laughter is often heard and others including patients smiled and laughed as well; it appears contagious.

Another group of nurses who are visible on the roster and in the wards, are the ward nurses with a resource role. These are nurses who have expertise in an area of practice or are involved in an organisational initiative. Resource roles are supported with time allocated to ensure the work could be done along with the education and skill acquisition needed to support the nursing teams. Wound care, diabetes management, frailty, TrendCare and other organisational initiatives, are supported in this way.

Experiences also brought colleagues together. New senior nurses sought each other out for support, whilst longstanding senior nurses trust each other to talk through decision making and offer different perspectives or complementary view. Similarly, nurses involved in the care of a complex patient or challenging situation in the wider team, came together as workload would allow, to explore the situation and debrief. Along the way, nurses share significant moments of their homelife with other nurses in the ward creating trust and building social relationships with colleagues.

4.4.1 Communication

The CNM considers the four inpatient wards one team and had implemented a strategy to support a 'one team' approach. This included running a monthly team meeting for the four wards. In this meeting organisational and wider team updates are provided, initiatives or change processes are discussed, and professional issues are highlighted. Attendance partly depends on which nurses are scheduled to work on the day of the meeting. On occasion a nurse comes to the meeting on a day off because they are interested in the agenda items distributed via email. Discussions at the meeting are limited mainly due to there always being a lot of information to pass on. Notably staff commented that whilst discussion is intended, information is most often offered in one direction from the CNM. No other team meetings are sanctioned to reduce division of the individual ward teams. Some members of the nursing team interpreted this as not meeting their needs especially in response to developing a specialised nursing identity. ACNMs are expected to support the communication strategy and did in the main, though this meant that issues were not always raised directly with them or in a timely manner. This resulted in perceived over-involvement of the CNM due to her leadership style and disempowerment of the ACNMs related to the reporting lines.

The CNM uses team emails to distribute information in a timely manner and where required shares information pertaining to a single ward. Individual ward communication books were removed two months prior to the study commencing, as these were determined to create friction between the wards and amongst staff. Areas of concern including equipment, processes and procedures or things to remember or pass on are no longer captured in such a 'communication' book. Removing the communication book resulted in staff not having a forum where everyday issues could be shared. Consequently, the teams became creative using emails and social media apps to share information and key concerns about practices or issues within the ward for example, linen skips being over-filled. It is evident that the lack of a communication book has driven issues underground and away from those whose membership is excluded from email and apps. This has created further divisions within the nursing teams which is the antithesis of the 'one team' approach.

To help ensure equitable sharing of every nurse and HCA, each ward previously captured such information in a ward notebook. With the 'one team' approach, the notebooks were removed as these were seen to empower the team to decide who would be 'shared' and thus reducing senior nurses' ability to influence this decision which was based on who had the skills needed in the receiving ward. Taking turns was overridden by the need to ensure a balanced skill mix across the wards, thus contributing to team frustrations.

Language is a specific focus for the concept of 'one team'. At a leadership day in March 2018, the whole senior nursing team was present. The CNM set expectations for the senior team to role-model collective pronouns in daily practice so that whole nursing team would adopt the pronouns 'we', 'us' and 'our'. This worked well as these collective pronouns are audible in everyday conversations between team members and when discussions occur at an individual level. These pronouns are increasingly used by members of the nursing team in the presence of the CNM and in public. However, in private or in especially complex, challenging or resource poor situations, there is slippage. Pronouns revert to 'them' and 'their' and 'me' and 'mine' providing insights into how the individual see their position and interactions in relation to others in the teams. This also occurs amongst the senior nurses especially when in the company of other seniors. Significantly, the CNM consistently maintains the collective pronouns of 'team'.

The desire to show a united front went beyond language. The senior nursing team are expected to;

> '*sing off the same song sheet' when it came to following DHB policy and things like that. So even if we disagree, we can have a grump in private, but we got to do it, so get on with it.* (SN Patricia, 28.2.19)

Recognised as the key to any initiative's success are the informal leaders in each of the wards. These nurses had experience and knowledge and were looked to by team members for positioning and direction. They demonstrate the courage to speak up and push back, to protect nurses and patient care. They 'stick their necks out' and are recognised by their colleagues for their decision making and advocacy skills. As informal leaders, these nurses are influencers or gatekeepers between the nursing team and the senior nursing team, or the organisation. Therefore, their influence and support are needed by the senior nurses to ensure nursing team engagement with initiatives. These informal leaders were asked to support the 'one-team' strategy and others during the time of the study.

4.4.2 Weekly Routines

Hospitals operate 7 days a week, 24 hours a day. For these wards, admissions occur via transfer following referral from another hospital or community service, or the elective operating list. As doctors need to admit the patients transferring into these wards, admissions usually occur from 1000-1700hrs Monday to Friday, after ward rounds and when ambulance transfers could also support this. Operating theatres function between 0800-1700hrs Monday to Friday and patients begin arriving to the ward following surgery from 1000hrs. Discharges could occur on any day. Once discharged from the service, patients could leave at any time before 7pm to enable family members flexibility to collect their relatives. Discharges to rest homes only occur during the weekdays when they too had medical and nursing support to admit the new resident. Acute admissions would go to another hospital in the DHB.

Other routines shaped the week in these four wards. This included meetings and delivery of pharmacy and stock supplies. A weekly ACC meeting occurred between ACNMs and the ACC officers to ensure that patients were assessed correctly for the funding needed to support their recoveries. Ward multi-disciplinary team meetings also occurred weekly with smaller progress meetings occurring daily. Senior nurses of each ward facilitated and led these weekly multi-disciplinary team meetings to discuss the patient's journey to discharge in more depth. Nurses working with each patient would contribute the nursing summary and assist to identify barriers or issues and look to support solutions. The patient is not present in these meetings but may be present at family meetings which were planned in response to progress and discharge planning. These were scheduled as needed or by request of the family.

4.4.3 Daily Routine

The daily routines in the hospital wards are organised around meals, ward rounds and meetings, nursing care tasks and shift changes and the accessibility of other services in the hospital between 0800-1700hrs. Prior to 0700hrs, the morning shift nurses begin to gather behind the "staff only" door of the staff room. They sit around a kitchen table, having made themselves a hot drink and for some, their morning breakfast. Patient lists printed from a computer programme are on the table and as the nurses sit down, each takes a list with their name on it and who is working with them in a team. Student nurses are allocated to a specific nurse and by default, a team. One of the night nurses comes in at 0700hrs and begins to handover patient care to the oncoming shift. Registered nurses, enrolled nurses and health care assistants are present. The ACNM and educator (CNE) may also be present.

During the morning verbal handover of patient status and progress, nurses write notes and query information including processes and care decisions. Once information about all patients is passed on, the nurses gather in their teams. The nursing teams may have two or three nurses, an HCA and a student nurse, where at least one nurse is a RN. Healthcare assistants whose role is to closely observe patients deemed unstable or at risk of falls or harm, go to the patient(s) they are allocated and receive a handover from the previous HCA and night nurse before the morning nurses come onto the ward.

Team membership and patient allocation is determined by the night nurses or by the ACNM from the day before. However, it was not uncommon for these decisions to be overridden by the nurses coming on to the shift (especially in the absence of a senior nurse) where patient deterioration may require different expertise, or workloads were inequitably distributed between teams or occasionally, if team membership meant that lunch pals could not have their breaks together.

Making their way to the nurses' station, one member of each team gets a 'team nursing chart' and begins filling out the care tasks which are needed by each patient, when and by whom. This is informed by the patient's documented notes which are read by the nursing team. Decisions and planning for the day are confirmed after each patient is visualised and clinically assessed. This meant that the first clinical observations were made between 0730-0800hrs. Care tasks are then confirmed and captured on the team nursing chart. The nursing team then prepares patients for breakfast or patients get up to the toilet and shower. Meanwhile, the dispensing of morning medications begins. When the ACNM and educator are not present at handover, they are usually catching up on the key changes in patient status and potential areas requiring support. Cleaners are emptying bins, starting the vacuum cleaner, and turning on lights. Meanwhile the ward radio can be heard in the background as the breakfast trolley is wheeled into the ward by the kitchen servers.

From 0800hrs members of the multi-disciplinary team begin to arrive with the majority assembling in the nursing station for 0830hrs. This results in a rise of activity and noise as interactions and movement in and out of communal areas and patient cubicles increases. Doctors have been coming in from 0730hrs checking online laboratory results requesting further radiology and laboratory investigations. The CNM makes her way between each ward area walking at pace. Her presence is noted as she greets everyone individually as she goes. The CNM gets an update on the status of a ward from each ACNM to anticipate and troubleshoot any obvious areas of tension or problems that have arisen and then leaves the ward to repeat the routine in the other three wards.

At 0830hrs a meeting chaired by the ACNM of each ward, occurs in the nursing station with the MDT including medical staff and nurses. A nurse from each nursing team leads a discussion about individual patient in the team's care, providing updates on progress. Plans towards discharge are contributed to by different members of the MDT team. The electronic whiteboard which captures the ward census information including patient details, teams and staff involved in care, referrals, planning and the estimated date of discharge is subsequently updated by the ACNM to reflect any modifications. Some of this electronic information is pulled directly into a central repository where the status of the hospital beds (supply) versus demand can be ascertained across the day.

With the medical ward rounds underway, and phlebotomists taking blood samples for testing, nursing care and tasks continue. In anticipation of a daily organisational bed meeting, the ACNMs gather information about the potential for discharges and admissions. The rosters are checked to see the nurses working across the next 24 hours as well as the skills of those nurses on each shift. However, this time is not without interruption. Emails, telephone calls and text via cell phones and landlines demand imminent attention, distracting nurses from their tasks. Senior nurses hold work cell phones and receive calls and text with one of the senior nursing team (usually a nurse educator) holding the pager to respond to medical emergencies. These communication tools provided nurses with accessibility and the ability to respond rapidly but this did result in frequent interruptions. The more devices or accesses a nurse had, the more the interruptions occurred, and for those without the phones or accesses, they were the one's disturbing colleagues to gain information or products for their patients. An example of this is the nurses wanting to fax requests forms for medications to the pharmacy or nursing referrals to community nursing or local pharmacies or rest homes. To access the fax machine, nurses required an access card which had only been assigned to senior nurses as a budget saving measure. This meant locating and interrupting the senior nurse and making the request. Afterhours this was sought from the Duty Nurse Manager (DNM) and again resulted in nurses interrupting or being interrupted, to ensure the process could be completed. This increased the

amount of time and people it took to resolve an issue or situation. Such interruptions and time were not captured in the TrendCare calculations (FN:16.4.2018).

The nurses and organisation relied on technology to communicate information, however, historically the technologies have not always been reliable. During the period of study, the electronic whiteboards were coming online across the organisation sending information centrally. To ensure that information was being passed on, additional methods of delivery were required by the organisation. For example, senior nurses would update the electronic whiteboards, the on-line roster, and TrendCare to estimate the number of nursing hours of work within the ward. This information was then emailed centrally with requests to fill gaps in the nursing resource. This information and requests were also faxed centrally. This resulted in three versions of the same information being sent to one point. Add to this the additional verbal communication via cell phone and a written email to ensure messages were received and interpreted correctly, and a significant amount of time and energy being utilised. This duplication happened regularly across the day. Staff also seek out the ACNMs for clarity of plans and decisions, to provide updates as well as clinical support for new or unusual tasks. Similar interruptions occur for all members of the nursing team. Nurses working in teams update with one another and communicate responses and outcomes to interventions, demonstrating critical thinking informing next moves resulting in regular interruptions.

At 0930hrs, the four ACNMs and the CNM leave the wards to attend a virtual organisational bed meeting. This bed meeting was held Monday to Friday at 0930hrs with all nurse managers and ACNMs, bed managers, patient flow co-ordinators and the duty operations manager. The purpose is to ensure patient flow across the four hospitals and that wards have nurses and bed spaces to facilitate patient admissions, transfers, and discharges. Each area electronically updates the computer application to give an accurate and 'live' picture of the hospital beds per ward balanced with the planned admissions and discharges. This was also balanced with what was known to be coming into the hospital electively or via the emergency department, or via the flight team, where patients were being fitted in based on clinical need and repatriation of residents to their region of origin. In addition, the nursing resource to manage patients was reviewed and areas with more need would be identified as priority to assign the casual staff from the bureau. This meeting took approximately 20-30 minutes each morning and gave those responsible for patient movement and resourcing, an organisational overview.

Decision making at these meetings was dependent on the veracity of the information provided via the technology. Assessment and allocation of casual nursing personnel was made openly to the areas of highest acuity therefore there was impetus to accurately reflect the true status of the ward or unit. This was role-modelled by the CNM. However, it was evident that some had learnt ways of working

with the technology to hide some of details when they determined patients, the ward or team were overly compromised. An example of this occurred when nurses who had resource roles such as health and safety, had been allocated time to work on their portfolio and this had not been disclosed to the wider forum either verbally or via the roster as a new electronic roster code was used. These nurses had the potential to fill absences created by sickness or recruitment issues. However, by doing so, this would reduce their ability to meet portfolio requirements and quality standards may be compromised or not attained. Therefore, requisitions for casual staff to fill the gaps were put forward (FN:24.5.18).

Centralisation provided oversight supporting transparency and an accurate snapshot of the nursing resource and acuity pressure points across the hospital. However, those with the loudest voices at the meetings or those whose medical specialty was recognised to be of higher standing could be privileged over those with significant data differentials within TrendCare (McKelvie, 2019). Centralisation and oversight also created tension for nursing leadership practices in the wards due to an innuendo of distrust which was largely ignored by senior nurses in attempts to secure nurses for their teams. For example, some senior nurses talked about this meeting reducing their authority to manage their own staff. Whilst having to report daily was useful to get a picture of the whole organisation, often acuity in these wards was perceived as lower and therefore, not attracting as much of a priority for nursing staff as other units or acute wards. The TrendCare data reinforced this, as is discussed below in the Nursing Personnel section, though it was incomplete as it did not capture all the nursing activity specifically leading, nor all aspects patient care tasks (FN:15.6.18).

Following the meeting, further communication would take place between each ACNM or their deputy and the central resource manager about patients transferring, and when and which nursing staff had been allocated for the next shift. This would occur after 1100hrs for the afternoon shift and 1700hrs for the night shift to address any further changes in acuity or patient stability, resourcing, and bed availability. As CNMs and ACNMs were not required at these meetings, new information needed to be shared with them as soon as possible and this was done via text and phone. Nurses who were sick were required to call-in sick between four and six hours prior to their start time to enable a better chance of replacement. Deterioration in patients' status leading to a need for close observation (previously known as a 'watch') also needed to be escalated to ensure help was secured.

After the bed meeting, the senior nursing team discuss any confronting issues or pressure points in their wards and re-allocate staff as needed. A coffee break is then taken before returning to the ward. Back on the ward, the nurses would start taking their negotiated morning tea breaks from 0930hrs whilst members from their team remained providing care for patients on the ward. The movement

of some patients begins around now with discharges and transfers, including admissions from theatre following surgery. Phlebotomists, clinical nurse specialists and the members of the MDT including the medical team come and go from the ward, negotiating with nursing team members to support patient care and interventions towards discharge. During these times, the activity and noise levels on the wards are matched by the number of staff which recedes during staff break times when nurses continue in their work. Orderlies deliver medications following the faxed requests. Similarly, supplies arrive and are taken by healthcare assistants and put away. Orderlies arrive with x-ray trolleys or wheelchairs and patients depart the ward for their tests. Unplanned impromptu briefings also occur in the wards. As the shifts continue, different groups of nurses congregate in an unplanned way yet with a purpose in mind. Often beginning with a conversation between two members of the nursing team, others would join in, to explore clinical concerns or trouble-shoot issues as they arose and then put plans in place to address the same.

Nurses are required to predict the nursing care requirements for patients in the next shift and for 24 hours, inputting this prediction in TrendCare so this could be seen centrally. Predictions needed to be confirmed or 'actualised' by 1100hrs. After 1100hrs, the ACNMs would receive notification from the central bureau whether their requests for additional staff to replace sick nurses or support increased acuity were available. This notification would include the nurses and their experience, skills, and knowledge. If requests were not filled, negotiating began to reallocate nurses across the wards to meet the required skill mixes by sharing nurses into another ward to cover.

Nurses taking the first of the lunch breaks start leaving the floor and heading into the staff room or off the wards to either the staff cafeteria or outside. Once done, the nurses swap with their team counterparts to maintain nursing cover for their patient-load. Senior nurses either eat together, with the nursing team in the staff rooms or in their offices while completing paper- and computer-work as they ate. Patients receive their lunches when the kitchen server brings the meal trolley to the ward and ensures delivery of the correct meal by checking with the healthcare assistants. Clinical status is re-checked, and medications are dispensed prior to the nurses readying for the second part of the shift.

At 1300hrs, the wards may have meetings. These could be a weekly MDT as described earlier, a family meeting, or a monthly senior nurses meeting where quality and organisational initiatives and planning are discussed. On the wards, ongoing patient care continues including wound care, collecting further patients from theatre and the documentation and planning for the afternoon shift. Discharge documentation including referrals are a focus now.

From 1400hrs nurses begin arriving to prepare for the afternoon shift at 1430hrs. The afternoon nurses gather in the staff room to hear handover of the whole ward and then follow the individual nurses for a bedside hand-over with the patient and morning nursing team. All the afternoon nurses and HCAs participate though sometimes this occurred closer to the corridors than with the patient when visitors were present and when the morning nurse wanted to share sensitive information. During the hand-over period between 1430-1530hrs, planned and *ad hoc* sessions would sometimes be run by educators, CNSs, professional advisers, or the CNM to support care delivery, professional development, or team functioning. Engaging the whole nursing team of the four wards occurred with a monthly meeting (as described earlier).

After the afternoon hand-over, the morning nurses complete their nursing care and documentation in the patients' notes and update computer data before leaving for the day. At 1530hrs, either the CNM or her delegated ACNM hand-over the overall management of the four wards to the DNM. The briefing would include the status of patients including any who were clinically unstable, the staffing and any other areas that would require oversight until the next morning at 0730hrs. The afterhours DNM team are responsible for bed management and patient flow after-hours including supporting clinical challenges such as medical emergencies.

Having read the patients notes, the afternoon shift begins largely mirroring the morning shift. The nurses again work in nursing teams doing regular clinical assessments and interventions and supporting patient activities of daily living. Whilst the nursing team is on the ward, the on-call doctors are in an office off the ward. By 1630hrs the allied healthcare personnel have finished their day, and the nurse educators, specialists and ACNMs have gone home. The wards quieten though nursing activity continues. The CNM comes to each ward to check on the nursing teams and then returns to her office to be available to individual members for discussions about personnel situations, rostering, and career progression.

Evening routines influence the afternoon shift. As the last of the patients return from theatre, patients' evening meal arrives. Nurses would begin to take their meal breaks at this time ensuring that the ward has nursing coverage with skills, knowledge, and expertise to manage if a patient deteriorates. Medications are usually prescribed for either 1800hrs or 2200hrs with nurses responding to pain and nausea with analgesia or anti-emetics as needed. Phone calls continue to come into the ward and nurses respond to these calls as well as to visitors who arrived on the ward to visit patients. The DNM would come around to the wards at least once in the shift, to assess the clinical status of the ward patients with the nurse co-ordinating. This co-ordinating nurse dually manages a patient load in one of the team's whilst co-ordinating the nursing work of the ward. The DNM and the

nurse in-charge of the ward look at possibilities to gain cover for any nurse that is sick and unable to work. When nurses are unavailable in the casual pool or across the other wards, the DNM passes it back to the nurse in-charge to consider other options such as asking those currently working, to stay on for either a part or full-shift.

As the evening draws on, regular nursing clinical assessments continue, final discharges and transfers occur, and patients are readied for sleep. The lights are lowered, and the ward radio quietened to signal the end of visiting. This encourages visitors to leave and indicates to patients it is time to settle for the night. Following this, documentation of patient progress is done and nursing activity which might be expected to slow, in fact continues as before, with hourly rounding or observing of each patient to ensure the patients remain stable and their needs are met. A hand-over sheet with key information about each patient is filled out by the nursing team looking after them and a nurse from each team would then hand-over this information to the night nursing team. The nurse in-charge would hand-over any other information pertaining to the afternoon, night or morning shift and any other significant messaging such as a change in policy or procedure. The afternoon nurses leave after 2300hrs.

Overnight, the nursing team consists of one or two RNs and an EN, or two RNs depending on the number and acuity of the patients. The team maintain hourly rounds of the patients attending to unwell patients and issues as they arise. Health care assistants also make up the night nursing team and support care and close observations. For those patients back from theatre, clinical assessments continue into the night. Stable patients are left to sleep with regular visual checks being made as per organisational policy. Along with intravenous fluids and antibiotics, analgesia and antiemetics, some patients require wound care for surgical sites, assistance with toileting and comfort and company overnight.

The DNM for the night shift either comes to the ward or rings the ward for updates. If a nurse calls in sick, the ward nurses would call the DNM to seek replacement. The computer rosters are updated in TrendCare. Likewise, when pharmacy stock or equipment ran out or was absent, the DNM is a resource to find replacements. However, collaboration between the wards occurs prior to seeking assistance from the DNM. The DNM is also called to cover meal breaks overnight but as there is only one DNM and up to 12 staff across the four wards on night shift, coverage for meal breaks was usually limited to those most senior on each ward and would be dependent on other hospital pressures.

As the shift advances, preparations for the morning would be made with updates to TrendCare, the patient allocation and nursing teams. Activity would increase from 0500hrs as some patients began their days and medications including intravenous antibiotics would be administered at 0600hrs.

Clinical observations were made, and final administrative preparations would be completed for the incoming shift including the allocation of student nurses to nursing teams if this had not already been planned. The nursing station light remains on all night but is dimmed. After the morning handover, the lights are turned on and the new day begins, and the routine starts again.

4.4.4 Resourcing

Following the years of contracting for services in the 1990s (see Chapter 1) and a focus on performance improvements and meeting targets beginning in the 2000s (Goodyear-Smith & Ashton, 2019), DHBs financial shortfalls created budget constraints. For the hospital wards in this study, this resulted in limited resourcing of personnel, equipment, and stock. Examples from the setting are described next.

4.4.4.1 Nursing Personnel

The wards experienced a constant pressure to ensure that there were sufficient nurses with the appropriate expertise rostered to support anticipated nursing care required by the ward patients. Tensions rose when nursing resource was insufficient. This was exacerbated during winter months with staff sickness or if infectious disease outbreaks occurred.

Centralising the electronic live roster system meant that at a moment's notice, the organisation could detect an area of high patient acuity and low nursing resource, to avert safety concerns for both patients and nurses. This was used to help distribute casual nurses to areas most in need. However, when casual nurses were scarce, it resulted in ward nurses being loaned or 'shared' to another ward to meet immediate clinical demand or anticipated demand for the coming shift. The rotating nature of rosters creates nursing teams with *ad hoc* membership. Having shared or casual nurses join the team brings opportunities to showcase the area but also the need for additional support. In either event, senior ward nurses are ideally placed to provide supervision of the 'shared' or casual nurse to support care. However, when workloads fluctuate beyond what was expected, support and supervision can be challenging to offer when time poor.

In this setting, the ACNMs together with the CNM would look ahead (for 24 hours, and across the weekend on a Friday) to identify anticipated pressure points in the roster, identifying which ward could share a nurse to another and thus, keep decision making in-house whilst appearing to 'take one for the organisation' (FN:12.4.18). For example, one area may have a full complement of rostered nurses and the patient bed numbers managed to ensure theatre cases could be done. Absences on another ward rosters due to sickness, education sessions, and resource roles, could result in wards borrowing a nurse to make up a shortfall. The CNM made these decisions and whilst the receiving

ward appreciated help, the ward now short a nurse was left to manage. This affected the nursing teams' perception of the ACNM role and its authority. ACNMs were working to create a sense of team, a positive and fun work environment. With nurses coming to work to be part of their team and finding (sometimes without notice) they were working on another ward with a different specialty focus, ill-feeling developed (FN:15.6.18).

Poor team culture and limited repercussions for calling in sick when rosters did not meet individual's expectations, were discussed by some nurses as the system and management punishing those who were committed to the strong team culture, sending them to fill the gaps left. In the background to this, existed the tension that three of the wards were managed and funded by one service, whilst the fourth was under another service. Nurses from the fourth ward talked about how their positive culture contributed to presenteeism which resulted in these nurses being shared with the other wards to support those wards' absenteeism. This was felt to compromise models of nursing care creating ill-feeling between the nursing teams. For the senior nursing team, the sharing of staff impacted the ability to embed projects or changes to practice with one ACNM saying "*I need a core group of ward nurses to maintain the momentum*" (FN:15.5.2018).

Following the first national nurses strike in 30 years (Roy, 2018), and the government signing an Accord to look at the nursing resourcing in hospitals in 2018 significant efforts began to increase the accuracy of the needed nurses in the wards. This was done in three ways. Firstly, on each shift nurses updated the data in TrendCare to predict nursing work accurately for the following shift. Secondly, nurse representatives from each ward contributed to the development of the ward- and patient-sensitive indicators to accurately capture the work that was being done and the time that this took. Finally, the transparent accurate data could then be used to advocate for the required nursing resource. At the time that the fieldwork concluded, these three activities were underway to provide the wards and the organisation a better understanding of the nursing work and the required nursing resource to meet this need.

4.4.4.2 Limited Ward Administration Support

Reduced ward administration support affected the work of ward nursing teams. Previously each ward had a ward clerk who also worked as a receptionist from Monday to Friday between 0730-1600hrs. Duties of the clerk included answering queries and phone-calls, admitting, and discharging patients, maintaining clinical records, and acting as conduit co-ordinating internal and external patient appointments with other services. Across these four wards there were two regular ward clerks. They worked part days across two wards during the weekdays, to cover the positions not replaced following

structural reviews. When these staff took annual leave or were unwell, the central bureau offered two hours a day per ward, to cover these duties.

As the administration hours were not sufficiently covered, administration tasks were largely left to the nursing team. Ward nurses admitted and discharged patients via the computer systems, copied medical notes for patient transfers, answered phone calls, left the ward to fax through referrals to other healthcare services and requests from pharmacy and supply. Senior nurses were expected to duplicate computer and phone requests by faxing through paper copies of staffing numbers and requests. All members of the team including medical staff and allied health professional were asked to ensure the ward phones were answered, but these were often left ringing due to either no one in the nursing station or an attitude that 'it is not my job'.

Some of the administrative work undertaken by nurses was not being accurately captured in the acuity tool TrendCare, as service phone calls did not always pertain to a specific patient (on which most TrendCare data was coded to). A consequence of this limitation of TrendCare is that neither nursing nor administrative management were aware of the additional work that nurses were doing reducing patient contact time.

4.4.4.3 Limited Equipment and Stock

The wards have clinical assessment equipment to assess patient stability and detect deterioration. Each ward had a blood glucose monitoring machine and three or four dynamaps to assess blood pressure and pulse, and at least one functioning oxygen saturations device (as others needed repair or charging). Tympanic thermometers and several manual sphygmomanometers were available. Stethoscopes were scarce with nurses searching the ward to find one or two when needed or borrowing this from the resuscitation trolley on each floor. Nursing time was taken identifying where the limited assessment equipment was and then negotiating and accessing the same. As the wider disciplinary team also utilised this equipment, the availability and location of the same was inconsistent taking nursing time to find what was needed.

One such example of the consequences on nurses occurred when two junior medical staff ask the temporary ward clerk where the "BP machines" are kept.

> *Indicating the cupboard nook just off the nursing station, the pair find a single pulse oximeter and a sphygmomanometer and mobile cuff* (as the sole functioning ward dynamap is already in use). *The two leave the ward taking with them the assessment equipment telling no one they have it or when it will be returned. An HCA who sees this tell the ward ACNM. Coming from her office she chases the two down the corridor.*

> *Returning she tells the nurses in the nursing station that the doctors are off to do a home visit for an hour or so, and 'the pulse oximeter is loaned to them for a short time' and that 'we can borrow from next door if we need to'. Another nurse then says, 'well it's no wonder we have no equipment for the nurses to use – and it's a medical ward.' The ACNM appears not to notice the tension and frustration in the nurse's voice stating she had reminded 'the doctors about the expectation to ask for the equipment and not to just take it'. She was pleased that she 'had enabled the home visit'.* (FN:1.11.18)

"We manage with what we have got and make do" is a phrase commonly heard whilst on the wards, but frustration and distress was evident when equipment or resources were absent but needed (FN:28.5.2018). "We are understaffed, we have no equipment, we have no products, we have no anything" (FN:15.1.19). One RN talked about not being able to give a distressed "family member a cup of tea because we had no tea, and I couldn't even give them a teaspoon to make a cup of coffee. It was so embarrassing" (FN:22.11.18). In the case of the assessment equipment, no action was taken to ensure more equipment was sourced or purchased in the longer term. No evidence was seen to demonstrate that this situation was elevated as an issue to the CNM, senior medical colleagues or management.

In contrast to the ward assessment equipment located in the ward corridors, specialised wound dressings were kept in a cupboard inside the locked educators' office. Supply was centralised across the four wards to ensure that products were not expiring beyond their best-by dates and that an inventory of these expensive items could be maintained. Additionally, if support was needed to manage a wound, then educators and specialists were often present in the office to offer their expertise. Afterhours access was via the lock combination on the office door and nurses could access this and get what they needed, noting what they had taken in a notebook.

Requests and replacement timeframes of these products via the organisation's processes did not always meet the clinical requirements to support wound healing. In response some members of the senior nursing team began to assemble their own collections of certain wound dressing items especially when they were in short supply and needed in their wards. This created tension between the senior nursing team and the wider nursing team, as the agreed process was not being followed, creating an inequity of supply by leaving the central cupboard short of products.

Financial constraints and central procurement processes also precluded the timely purchasing of other items used within the wards. This affected the care nurses were able to provide. It also influenced how they felt the organisation valued them, their nursing, and the patients. For example, items such as toiletries including shavers, toothbrushes and toothpaste had been removed from the supply list.

A consequence of this was that some men had unkept facial hair and maintaining dental hygiene was at risk. Tissues were also removed from the supply list affecting both the clinical management of some illnesses where nasal discharge, coughing and sneezing were prevalent or reducing the ability to offer tissues when emotional tears were shed during bad news and challenging moments. Donations were sought from the hospital charity to meet this demand and individual nurses sometimes plugged the deficit from their own wallets. An ACNM spoke of a time when there were no tissues around to offer a wife who had just been told that her husband was not expected to last the week. She remedied this by accessing her own supply from her handbag (FN:20.11.18). Similarly, the CNM used her own money to purchase toilet brushes for the cleaning staff (seeking reimbursement afterwards) as this was quicker and ensured that hygiene standards would be maintained without a delay. Due to the limitations of the supply list, donations of personal hygiene items were therefore much appreciated by the wards.

The impact of the limited personnel and equipment meant that time was taken addressing deficits and trying to find workable solutions. Much of this time was not accounted for. It left those involved without a sense of satisfaction, as solutions were only temporary until the next similar issue arose, and no further investment had been made for permanent changes. For nurses working in such conditions, this created complexity within the routines of the ward.

4.5 Chapter Summary

The settings of four hospital wards of a DHB in New Zealand were presented in this chapter. Along with the ward profiles and environment descriptions, the nursing teams, roles, and the hierarchical structure were described. Expectations for nurses' communication and language are also presented. Routines that provide structure within the wards were then outlined including monthly and weekly occurrences prior to focussing on the routines influencing the nursing shifts across the 24-hour period. Finally, some of the challenges of limited resourcing within the wards, were identified including the solutions nurses created to manage. This includes the 'sharing' of nursing personnel, undertaking administration support, and responding to limited equipment and stock items to enable nursing care to be provided. Technology, centralised oversight, and budget constraints contribute to the backdrop of routinisation and scrutiny for nurses in these hospital wards.

The significance of what is reported in this chapter demonstrates the constant pre-occupation with utilising the available nursing capacity amidst organisational expectations that nursing management keeps within budget. Using terms such as 'nursing resource' and the new public management ideals of meeting targets and measuring patient acuity with TrendCare to compartmentalise the minutes

and hours of nursing care each patient requires (nurse hours per patient day [NHPPD]) within the Care Capacity Demand Management programme, industrial politics create a layer of complexity for nursing care and the professional identity of nurses. This resulted in a high-tension context in which commodification of nursing is embedded in everyday practice. In such an austere yet complex environment, nurses were negotiating both professional and patient safety. In the next chapter, nursing leadership practices will be the focus. Leadership moments and patterns of leadership engagement will be presented in response to dynamics, positioning, and relationships.

CHAPTER 5: FINDINGS – Nursing Leadership Practices in the Hospital Ward

5.1 Introduction

Hospital ward nursing requires a team of nurses. By virtue of nurses being part of a team, leadership occurs both formally and informally. The nature of nursing has leadership within and across all levels of nursing. As seen in the literature review, the definition of leadership and specifically nursing leadership, varies significantly. In the literature, nursing leadership is largely understood from the perspective of those in nursing leadership and management positions such as the charge nurses (or clinical managers of the wards) and Directors of Nursing (professional nursing leaders in hospital organisations).

This findings chapter presents three distinct, yet interconnected concepts revealed during the analysis of nursing leadership practices. The first section explores what nursing leadership was to nurses at all levels of the hospital ward nursing team. This section includes examples of everyday leadership practices. In the second section, thick description is provided to demonstrate how the 'patterns of leading' occurred. These were conceptualised as 'being present', 'being alongside', 'being apart' and 'role-modelling and enabling followership'. Concepts are explained and examples paint a picture of how leadership practices were occurring in everyday situations.

Finally, safeguarding leadership practices are presented. These include the anticipatory practices that reduced potential harm to the nursing team and patients, and the shielding practices used by and for individual nurses and nursing teams, to protect professional and team boundaries and patient safety. These practices in addition to resilient leadership practices, were adopted in response to the context in which ward nursing occurred. Examples are provided which demonstrate the influence of the context and the leadership practices which supported nursing identity, nursing team membership, and patient safety.

5.2 What is Nursing Leadership?

As a starting point it was important to understand what nursing leadership was to nurses in these wards, given the extensive definitions in the literature. Whilst nursing leadership practices were being observed, understanding what nurses saw as nursing leadership and how they carried out nursing leadership practices was significant to the exploration of nursing leadership practices in this context. Therefore, the consenting nurses were asked what nursing leadership is to them and how an outsider

might know that nursing leadership is occurring and what could be seen in practice when nursing leadership occurred.

The literature review found that nursing leadership is a combination of professional nursing leadership, clinical leadership, organisational leadership, team leadership and more recently, administrative management. As I entered the wards and said I was studying nursing leadership practices, everyone appeared to understand what that was. However, given the multiple definitions in the literature, I obtained participants understanding about nursing leadership and nursing leadership practices.

To present the findings on nursing leadership and nursing leadership practices, I made the decision to present these based on the roles of those participating. This was to reflect the significance placed on roles within these nursing teams. Aligning with the ward rosters, this begins with Senior Nurses (SNs) views on nursing leadership, followed by the Registered Nurses (RNs) and then Enrolled Nurses (ENs). These views are accompanied by scenarios that demonstrate how everyday nursing leadership practices occur.

5.2.1 Senior Nurses

All 10 SNs in this study talked about leadership by identifying a person they considered displayed leadership or someone in the role of a leader. For these nurses, leadership is connected to a person and is not a standalone action or outcome. Senior nurses named the actions and functions of these leaders as including collaborating, coaching, supporting, and looking after the team, and being a role-model along with making decisions and the maintenance of standards. These actions result in facilitation of the nursing team through education, and developing and supporting colleagues, clinical care, and patients. Sally's explanation about nursing leadership beautifully articulates the conversation threads of her senior nursing colleagues.

> *Leadership means that you are the person who takes the lead in decision-making when tough decisions need to be made. Lead from the front, be clinically up to date, not necessarily doing all the work yourself but knowing what the work involves and being able to, when necessary, do some of that work. Be an educator, sharing knowledge to assist the nurses in their practice and support them. And working with your team to get the very best that you can, for your patients because that's the fundamental underlying thing for everything. Using the team and their expertise and their skills, to bring that all together. You are the person who holds that all together at the top. Consult the team*

and acknowledge them – acknowledge their strengths and help support the weaknesses. (SN Sally, 21.2.19)

Here, Sally describes nursing leadership efforts that focus on ensuring decisions are made and that nursing skills and expertise are supported, guided, and facilitated to meet patients' care. Sally's statement demonstrates that the nursing leaders need to know the team, their skillsets, and the issues on the ward. Using this knowledge and by providing encouragement and support to nursing colleagues, including helping with problem solving or upskilling colleagues, Sally shows how nursing leadership influences and co-ordinates the team to facilitate nursing care. The facilitator and co-ordination role Sally refers to, is like an orchestral conductor, with nursing leaders co-ordinating the team, their skills and expertise interpreting the clinical situation and setting the tone or tempo in which nursing work occurs, whilst relaying their vision or expectation for nursing actions and outcomes.

Sally is claiming that she is one of the team by situating herself within these practices, which is congruent with her senior role within the nursing team. Sally's references to "leading from the front" and "the top" talk to where nursing leaders are positioned in the nursing team. This is similarly reflected in the layout of the nursing roster where the most senior nursing leader on the ward, the CNM, is listed first and at the top of the roster. Other SNs follow, then RNs, ENs, and finally HCAs. Such hierarchical positioning comes with expectations of responsibility and accountability and Sally refers to these expectations when she talks about being "the person who holds that all together at the top".

All but one of the 10 SNs identified various leadership traits or attributes of nursing leaders, along with the behaviours and actions they expect of nurse leaders. The 10th SN solely focused on the functions and interactions of nursing leaders. Leadership attributes identified by these senior nurses included generosity, trust, integrity, respect, and approachability. One third of the SNs noted that the sharing of skills and knowledge, and consciously making time and sharing this with others, is part of nursing leadership. This speaks to the nursing profession's expectations of service. Whilst this was also an expectation outlined in all nursing role descriptions, SN participants held nursing leaders and themselves, to a higher standard (DHB, 2011, 2014, 2015a, 2015b).

Elle describes leadership attributes and personal values, the need for reciprocal relationships with others, and functions of nursing leadership.

Nursing leadership to me is allowing them, the nursing team, to develop in their role. It's my role to support them in whatever direction they want to go. I don't see myself as

> *a leader to hold all the skills and knowledge…but to know what direction we are going in and be there and help steer it. It's about allowing people to have a say in that and valuing people's opinions. For me, being trusted as a person, being able to maintain confidentiality, that what you say is what's going to happen. Providing good support and mentoring and stability in the team. To look at issues and…being able to talk to my senior team that I work alongside and with, or that may be further up the ladder, to allow my opinions to be voiced as well. I need to be able to say what the team is feeling or is occurring in the team.* (SN Elle, 19.12.18)

In Elle's opinion, nursing leadership facilitates nurses' development, nursing care and teamwork and provides stability. As a SN and nursing leader, Elle appreciated that it is her role to listen to and advocate for the team and to provide direction "steering" the team by being trusted, maintaining confidentiality, and having integrity. This also means providing opportunity and the freedom or autonomy for others to grow in the areas that they needed to. To support her, Elle acknowledges her reliance on her peers to explore the issues. She points out the need to be respected by those more senior to her, so that her thoughts and ideas are heard particularly in relation to the team.

In Elle's example, she did not need to know all the answers, however, another senior nurse acknowledged herself to "be a bit nosey because if someone asks me a question, I need to know the answer, so I don't look stupid" (SN Anne, 13.12.18). In addition to the curiosity to search for an answer, Anne did not want to look stupid or rather, that she wanted to be knowledgeable. This suggests that Anne had a vision or expectation in her mind that leadership or leaders are respected because they know the answers. Below Anne refers to her pain specialist nursing role which utilises her nursing leadership and expert skills between services.

> *I like to keep an overview of what's going on in the ward whether I am directly involved with the patient or not because, being part of the team but not part of the team, I have, I suppose, an outsider's perspective, a fresh pair of eyes that some other people may not necessarily see.* (SN Anne, 13.2.18)

Here Anne refers to the transient nature of her membership within this nursing team and how she uses her "outsider" status to advantage, whilst ensuring she has an overview of issues within the ward. Through enquiry or "being nosey", her relationships with the team and her overview of ward patients, Anne could draw on her knowledge of clinical deterioration patterns, to help others think innovatively about the challenges they were facing and intervene in issues including pain management. Anne's statement demonstrates her leadership traits of curiosity and critical integrity by considering issues from different viewpoints with "fresh eyes" and then acting to respond.

Being able to build trust quickly and maintain it overtime is part of nursing leadership for senior nurses. Senior nurse Margaret, during interview, talked about the expectation of trust placed in her by others because she was appointed into a senior role. She said, "there is an element of trust before I even arrived, just by walking into the room" (19.12.18). This implies that SNs are trusted because of their role, yet this trust needs to be maintained with congruent actions and behaviours. In these wards, trust was sometimes observed by nurses choosing to follow recommendations of SNs without question. The following example demonstrates this.

> *On a weekday morning shift at 1140hrs, Daniel* (RN in first year of practice) *returns to the nursing station having assessed a patient in his care. Daniel tells the ACNM that his patient's blood pressure is lower than previously and indicates he is going to page the house surgeon* [junior doctor]. *The ACNM tells Daniel to work out the EWS* [Early Warning Score] *before he contacts the house surgeon. Daniel reviews the patient's vital sign data on the clipboard in his hand. The EWS indicates that he needs to escalate the call for assistance to a MET* [Medical Emergency Team] *call and he tells the ACNM this. She responds reviewing the data on the observation chart and then heads away at pace to the patient bed space telling Daniel to bring the dynamap with him, to check the observations again. Shortly thereafter the emergency bell is pressed inside the cubicle and Daniel returns to the nursing station to make the MET call.* (FN:25.11.18)

In this scenario Daniel is seeking support for his decision to call the doctor despite the EWS score requiring such a call. It could be that Elle's presence prompted Daniel to share his findings with her due to her hierarchical leadership position or that she was approachable and had clinical expertise caring for post-operative patients which meant he sought her out. It may have been she was the first person he saw and was alarmed by the clinical data. Without knowing his thought processes, and not being able to interview him following the MET call due to other clinical demands, what is evident is that Daniel respected Elle to seek her support.

Sometimes, it was trusting another's judgement or word about the status of a patient or patients Patricia's leadership style is based on such trust. By returning to her administrative tasks at different points in the day, Patricia demonstrates confidence in the competence of the nurses to seek out support when they need her (FN:13.4.18). This form of trust was seen across all four wards; senior nurses trusted their colleagues and nurses conferred with them as needed.

Trust was not only evident when overseeing patient care. At other times trust was expected when information was passed confidentially to senior nurses. Sometimes this was private information to enable the other to understand at a personal level, what was going on. Concern about a colleague's

welfare was also shared with the senior nurse, with the expectation that the senior nurse would act to support the colleague but not divulge the information. These scenarios were mainly observed occurring away from others, though this did occur in both public and private spaces around the wards, as opportunities arose. The leadership responses to such information sharing set these interactions apart from other responses.

> *Asking to speak with Jane* (SN), *an RN steers Jane away from the nursing station and into the corridor toward the ACNM office which is empty. The RN is concerned that a colleague's workload is "too heavy" and "beyond her skill set, given the acuity of the patients and the time available". Jane lowers the documents in her hand and comes closer to the RN as she listens. Jane then asks what the RN is doing to support the colleague and agrees with the RN's plan to share the tasks and regularly check how she [colleague] is progressing but adds that she "will keep an eye on her and help out where I can. For now, I will ask the nurse educator to join your team for a spell".* (FN:7.5.18)

Now knowing that a nurse is struggling, Jane utilised the opportunity to both collaborate with the RN who was supporting her colleague, but also draw on the expertise of the nurse educator as such scenarios can be learning opportunities. Going to the educators' office, she says to the educator "one of the team is in need of your expertise and role-modelling – can you come?" The educator follows and Jane says that "there is an opportunity for learning for a particular nurse in the team". Jane does not say any more and the educator nods as she moves away to find the nurses. Being trusted, Jane gained insights about what was occurring for a nurse in the team, involved the RN in a strategy to support the nurse and gained support from the educator, whilst maintaining the confidence placed in her.

Nursing leadership practices were presented by SNs in a positive light. These included high standards of practice, knowledge and use of personal skills and attributes to influence, direct and facilitate nursing teamwork, and the provision of nursing care. Alice's (SN) lens on nursing leadership is: *"I have a way of how I like to see things being done and that being respectful to, not only to each other but to the patients, and I also have quite a high standard of practice*" (10.12.18). Her statement links respectful interactions to the expectations and observance of standards of practice. However, there is an implication here that Alice's standards are not necessarily shared nursing standards. This suggests SNs hold themselves to a high standard of practice and have expectations that others will do the same.

Though not spoken about directly, the correlation between having high standards and that of integrity or being "true to your word" (SN Elle) threaded through many aspects of nursing leadership described

by the senior nurses. This was observed in relation to interactions with nurses and more widely with the multi-disciplinary team (MDT), admitting doctors, and organisational colleagues. This correlation was first observed by me at an organisational bed meeting when the number of patients in beds was reported against the number of nurses the wards had rostered and those who were absent due to sickness. Nicole (CNM) talked to me after the meeting about the need for transparency so that risks could be accurately assessed across the organisations. Another example similar to this scenario, was when Nicole advised to an admitting consultant that the wards did not have any isolation beds available for an admission. However, she noted there were high visibility beds available if this was required by the patient (CNM Nicole, 18.4.18). By providing options, and honest and truthful information, the doctor could determine whether to admit the patient at this time. In both scenarios, the nurse resource was under pressure however, by not hiding or blocking information that might reduce the workloads for nurses, Nicole presented the information as it was, showing integrity and leadership as she worked to resolve this regular leadership challenge.

5.2.2 Registered Nurses

Registered nurses made up the bulk of the nursing teams in each ward. These nurses are both exposed to nursing leadership and involved in practices that result in leadership. Grace (RN) acknowledged the differences between the leadership required at a senior nursing level and from within the team. Having been a SN previously, Grace said about nursing leadership when at the senior level:

> *It gives you a broader sense of the ward, of just people in general, HR* [Human Resources], *the hospital and budgets. I think about leadership from that perspective, it's quite different to leadership on the floor. In that role you set the tone for the ward. You have a massive responsibility to resource the ward so that your staff can do their job. If you get to know your staff and roster it, sick leave goes down. If you get to know their life, what is important to them, they are more likely to do an extra here or there. They come to work happier. It was important that the staff saw you working double as hard as them. It's really important because you set the tone. And you oversee everything.* (3.3.19)

Here Grace refers to the need for awareness of the activity and dynamics across the ward. Using this awareness and oversight to inform reactions and proactive practices influences the climate on the ward. With this awareness came responsibility and Grace points to the gravity of resourcing the ward safely. Grace talks about the connections and relationships necessary in leadership to gain buy-in from staff when extra shifts are required to be filled. Knowing staff and their needs in their life outside

of the ward is pivotal to this and in Grace's experience, this results in contented staff. In addition, Grace refers to the reciprocal nature of leadership practices when she talked about observed "work ethic" of those in appointed roles and the influence this has on the climate of the ward. Just as SNs observe and have oversight, ward nurses notice actions and behaviour when it came to work ethics of their leaders. As such, Grace identified the significance of role-modelling expectations resulting in both nurses and SNs contributing to the "tone for the ward" (RN Grace, 3.3.19).

Like the SNs, RNs connect nursing leadership to being about a person or role, referring to this person as 'someone' or rather, not including themselves in relation to nursing leadership. When asked what nursing leadership is to her, RN Diana's (11.7.19) response is typical of her colleagues' responses:

> *It means someone who can lead a team. Someone who can listen, problem solve and coordinate the team. It would involve somebody who can lead in times of crisis and lead the team on an everyday basis. Feel comfortable with problem solving. Support other team members, the less experienced team members.*

Registered nurses work in teams and lead nursing teamwork in these wards. In the exemplar above, Diana refers to a leader's ability to create and support teamwork and individuals, in both everyday situations and during times of crisis. Diana's words show that nursing leadership includes recognising individuals and the team, listening to others, and collaborating, and that such leaders coordinate the team which can require leaders stepping up to support junior colleagues. The leader is not there for themselves but to get the most from the team. Central to this is the leadership practices that enable such teamwork and role-modelling, to occur.

For RNs, nursing leadership is about knowing their colleagues, where support is needed and getting involved to lead, role-model and support. All RNs in this study expected this of their leaders, of their peers and of themselves. Sometimes this was through decision making, or by taking control and setting the tone, and at other times, by stepping up or into a gap where leadership was needed. Due to the position of RNs in the nursing team (between SNs and ENs and HCAs), RN leadership practices change depending on the situation, context and who is involved. Charissa's (RN) comments about nursing leadership summarise this well.

> *It's someone who can lead from the front. In the position that I am in now, I lead my competent and new grad nurses that come into the ward. We care for the patients, and I do the work and they watch and then you're leading not just delegating work…but you are involved. I'm involved in making her work with me and I work with her. I work alongside with most of our nurses and HCAs and even the allied health team as well.* (10.7.19)

Charissa's explanation shows the movement and positioning of leadership practices from leading at the front of a nursing team, to working in a team by role-modelling nursing practices and then sharing out the work. Remaining engaged and involved in teamwork and doing this alongside colleagues is part of how nurses influence and led others. Thus, nursing leadership practices are dynamic and dependent on the context and positionality of what is needed, along with different team-members and situations. Further examples of how nurses position themselves to provide leadership are presented in the 'Patterns of Leading' section of this chapter.

5.2.3 Enrolled Nurses

Enrolled nurses in this study also acknowledged leadership as relating to a person in a leadership role such as the senior roles of CNM, ACNM, CNE or CNS. These ENs recognised that anyone can demonstrate leadership including administrative staff. Being able to demonstrate leadership came from an individual's experience, and knowledge in their specific areas and team, and is shared through interactions, behaviour, and role-modelling.

> *Me being an Enrolled Nurse, I take leadership from my RNs as well. And even just senior members of my office staff. People that have been there longer, even if they are enrolled nurses or even HCAs, I still take leadership from them if they know, if I can ask them advice. Advice is what I see leadership in*. (EN Emma, 12.2.19)

Here contextual experience of her colleagues affects how receptive Emma is to advice which influences and led her nursing practice. Emma considers length of service as a credible measure of leadership. However, Emma also provides a caveat around the reliability of colleagues' advice - 'if they know', indicating questions about integrity and trustworthiness.

Similarly, Jeanne talked about leaders when asked about nursing leadership. She recognised the significance of nursing leadership and drew on her experience discussing the duality of being a team member and a leader of the team.

> *Leadership in nursing, it's a wide thing, its massive. To be a leader is to be an educator, it's to be a facilitator, to facilitate different roles and people's skills. A leader is someone who can guide, someone who can walk with. You don't need to be the one that's doing all the guiding; you can walk the same pathway and walk with a person. A leadership role is a multitude of things. It's being an understander, its being a listener. You can't just say that a leader is someone that is in charge because being in charge is not being a leader. Being a leader is someone who leads by example so to be a leader is someone who can walk the same walk alongside colleagues but can lead in a certain area. I am a*

leader for TrendCare. I can help educate and I help encourage colleagues to ensure that they're doing it to the best of their capabilities. (EN Jeanne, 18.7.19)

Jeanne describes being alongside colleagues guiding them but then, when circumstance require, also being a leader. Without a formal leadership role, Jeanne had been asked to represent her ward in the organisation's implementation of TrendCare. Being approached for this role, Jeanne directed others, co-ordinated team responses and organisational progress and exerted assumed authority that came from knowledge about the topic and her perception of this role, to influence others. Jeanne's tone when speaking about leadership and her role as a leader, altered from conversational tone to a more purposeful and confident one, which created a distinct shift in emphasis from 'being alongside' to those actions she associated with leading from the front. This change in Jeanne's tone of voice indicates how Jeanne transitioned between being influenced, working alongside, and using leadership practices to influence others. The change is subtle and yet distinct. Dual roles within the nursing team demonstrate the complexity of nursing leadership. Leadership practices influence nurses and the nursing team, and simultaneously, any one of the nursing team could step up and demonstrate leadership practices to influence another. In this way leadership practices are seen at every level of the team with members being influenced by and being influencers of, nursing leadership practices.

5.2.4 Health Care Assistants

Health Care Assistants support the work of the nurses by working alongside them and through delegated direction to achieve patient care. Nursing tasks include assisting with patients' activities of daily living, mobilising patients, and ensuring patients had fluids. Housekeeping tasks include ensuring equipment and supplies are available on the shelves and beds are made and in working order. Alongside these tasks, HCAs could be asked to closely observe, monitor and engage with patients at risk of falls or harm due to their physical or psychological frailty. One HCA provided an example of how leading is demonstrated as she went about her everyday work.

Senior Nurse Elle sought out May (HCA) to ask her advice about a proposed time to run through how long it would take to make a bed. May stopped what she was doing and asked Elle for further clarification. Elle felt that the time needed to complete this process single-handled and according to infection control procedures, is inaccurately captured in the computer system. May agreed to the task. Starting the timer, May gathered the linen she needed to make a fresh bed on a trolley, assembled the cleaning equipment and took a linen skip to an empty patient cubicle. Choosing a bed following the discharge of a patient, May stripped the bed, cleaned, and then dried it, leaving time for it to completely air dry before adding the linen and making the bed ready for a theatre patient who

was coming later in the day. As she worked, May instructed Elle about the process as well as providing some observations she had of the variations amongst some nurses made. Bed cleaning and making is a simple task but if done in a hurried manner, and not to infection control standards, could compromise the next patient. May maintained a respectful distance between herself and Elle during this interaction and corrected Elle in an even toned voice, when the numbers written down did not reflect the policy and the time taken. Elle apologised for becoming distracted and corrected the times in each phase of the procedure. Elle respected May's experience in this area and drew on this to inform the process.

In this moment, May demonstrates leadership by influencing the conversation and interaction, the practices and processes, and speaking up to ensure the "right thing is done the right way" (HCA May, 15.6.18). As no other HCAs consented to participate, further evidence of HCA leading was not captured.

5.2.5 Everyday Nursing Leadership Practices

Everyday nursing leadership practices are those nursing behaviours, actions and social interactions which typically took place in the wards, and which resulted in another being influenced or lead by the practice. Such practices occurred day-to-day and were part of the fabric of the ward and not out of the ordinary. There are also leadership practices that were responsive to situations arising within the wards. Despite the commotion or drama that occurs due to the circumstances or number of people involved, these leadership moments have similar patterns to the everyday leadership moments. Sometimes these moments were brief or subtle and at other times, took longer and were in response to explicit and unusual situations. These interactions varied between being loud and full of laughter with multiple voices being heard, to hushed whispers depending on the confidential nature of the communication and the location where the interaction took place. Common to these interactions is the leadership practices that influence those involved and the wider nursing team.

Nurses worked in teams within these wards and therefore leadership occurred at and between the nursing team members. Leadership practices were observed influencing clinical rationale and decision making of nurses and others, responding to the need for support, and guiding and supporting nursing interventions and evaluation of the same. In addition, nursing leadership practices responded to social dynamics across the nursing teams. Examples of these leadership practices occurred regularly throughout each day. In the following example, leadership practices are demonstrated through Patricia's appointed authority of her formal nursing leadership role as an ACNM and through the influence the nurses had established with each other to lead clinical nursing practice.

Every morning, seven days a week, between 0730-0830hrs, the MDT would assemble on each of the wards, to receive and contribute to patient updates as the patients progressed towards discharge. On this Thursday morning, Patricia was convening this routine meeting in the nursing station of her ward, with other nurses attending between providing care to patients.

> *Patricia* (ACNM) *is standing in the nursing station to the side of the electronic ward census for patients, as a member of each nursing team comes in to deliver an update on each patient in their care. Positioned around the station are 12 members of the allied health team including two occupational therapists and their assistant, two physiotherapists and their two assistants, two social workers and three house surgeons from the medical teams. They are all standing or perching against desks and filing cabinets and turned toward Patricia as she begins. Patricia encourages the first nurse to share their observations and updates on their assigned patients. The MDT ask questions if clarity is needed and then the nurse leaves the station to be replaced soon after by a nurse from the other team and the process starts over. When all patients have been discussed, Patricia starts talking about one of the four patients* [Patient A] *she has reviewed for discharge, asking for input from the respective disciplines. A doctor responds with his information about the patient. Patricia asks the team for an expected date for discharge for this patient. When one is not volunteered, Patricia puts a date in the electronic whiteboard. No one argues or disagrees, so this remains. Patricia asks the doctor to complete the discharge documentation and prescription by saying "you will do the paperwork by the end of this week won't you?" A nod is observed in response. This similarly occurs for the other three patients with some discussion about the transport home for one patient. Patricia asks the social worker to finalise arrangements with Patient B's family. The social worker nods in agreement. Patricia then asks the group if anyone has had a conversation with Patient C about his decreased functioning and the prospect of going to a rest-home. No one has and Patricia says that she will talk with the patient. Patricia thanks the team for their input and moves to leave the station in search of one of the nurses. The team behind her begin to disperse.* (FN:1.11.18)

In this example, Patricia provides ward oversight, co-ordination of ward nursing activities and care and sets expectations for other members of the MDT to support patient care. With her position she possesses authority and directs the MDT. Having seen the routine of this process, I then move to observe the leadership practices of the ward nurses beyond the nursing station.

Working in teams, the ward nurses influence and lead each other, by justifying their critical thinking about clinical scenarios and the actions needed to respond to these. In these interactions, leadership is occurring as the nurses discuss with each other to prioritise care, support learning and role model standards of practice and behaviour.

> *Whilst the morning patient-update meeting is going on in the nursing station, the two teams of nurses are moving about the ward and darting in and out of the medication room. Two nurses from one team come to the front reception desk on the edge of the nursing station. Standing close, one gets out her patient list. They whisper between themselves pointing to the paper. As they talk, their conversation becomes more audible. There is an issue for a patient with pain management and the nurse is waiting for the administered analgesia to take effect before helping the patient to mobilise to the shower. She then asks her colleague about her patient. The second nurse is not happy with her patient's blood pressure and seeks support from her nursing team-mate to withhold the prescribed betablocker until a medical review. The first nurse agrees with the second but suggests that a fuller set of vital sign observations is taken meanwhile and suggests that her colleague review the trends in the patient's data over the past 24 hrs, prior to talking confidently to the doctor. The first offers to help and the second declines saying she'll do this and check the trends and come back to her for advice. The first nurse says that she'll update the MDT and walks into the nursing station.* (FN:1.11.18)

Each nurse in this scenario raises concerns for the patient they have just assessed. The first is updating her colleague that she is awaiting analgesia to take effect before mobilising. By raising this, the first nurse creates an opportunity to be influenced by the other if there is something she has not considered and thereby sets the expectation that the second nurse will also share her patient's update. The second nurse talks about needing to get a medical review of a patient as the patient's blood pressure is lower than what is therapeutically required to receive a betablocker. The first nurse hears this and recommends a fuller set of current observations be available to the doctor to help inform a judgement. The conversation continues with the offer to help do this, which speaks to supporting her colleague. With the second nurse declining saying she will do this; the second nurse is wanting to manage the tasks. This nurse is re-establishing that she has the situation under control, has heard the advice and will seek support if needed. Whilst this scenario is about nursing assessment and decision making, the leadership practices of providing information, rationale and seeking or offering guidance demonstrates the reciprocal nature of leadership in the ward. Each nurse is

influencing the other through the interaction, with each determining their leadership and management of their patient care in response to the interaction.

Shortly after this, leadership practices were also observed occurring in the other team of nurses on the same ward.

> *Two nurses caring for patients on the opposite side of the ward, come out of the medication room and separate. They enter different patient cubicles to administer the medication they have dispensed for specific patients. One nurse has a student nurse working with her and the student nurse is taking the lead with the medication administration. A healthcare assistant is also working in the team. After giving the patients their medications, all four members of this team assemble in the staff corridor between the nursing station and the medication room, to review the team plan for tasks. A discussion about the prioritisation of tasks occurs with the expert RN Talia asking the graduate nurse what she thinks should happen. RN Kelly* (the graduate nurse) *suggests what she thinks needs to happen next and offers a rationale for her thinking. Talia agrees and nods at the HCA "we've got work to do – can you help with Mr B and I'll attend to Mrs C" and the two leave the corridor. Kelly enters the medication room with the student nurse as between them, they have decided that the student nurse will give the intramuscular injection of Vitamin B12, and Kelly will support and oversee this. As the student begins to draw up the medication, Kelly says "you will feel resistance, don't stop, keep pulling…alright". Giving the student encouragement whilst drawing up the sticky substance from the vial, Kelly asks about the student's experience of drawing up and giving an injection. The student has not done this before except for in a practice laboratory and never to a patient. Kelly asked the student to talk through, step by step, what she would do, once in the room with the patient. Kelly filled in steps that the student brushed over and then, carrying a green plastic medication tray with the medication drawn up in a labelled syringe with a newly applied needle, the student and Kelly walk to the patient cubicle with the medication chart. Kelly whispered to the student "you don't get many opportunities to give intramuscular injections here. I have been here 10 months, and this is only my third one…You've got this…I'm right here with you." They entered the room and pulled the curtain around the patient bedspace. Kelly's voice is confident and reassuring toward the student nurse, as Kelly also maintains a conversation with the patient about his morning. Once administered, Kelly and the student nurse retreat from the cubicle, with Kelly praising the student: "great job, well done! You did it". Kelly is smiling and her voice is bubbly. The student looks to*

be relaxing and is managing to smile too. "Now we need to dispose of this properly and sign that we have given the medication". Kelly follows the student into the nursing station to do this. (FN:1.11.18)

This exemplar demonstrates where leading happens amongst nursing team members. Talia seeks Kelly's opinion about the prioritisation of nursing tasks and by doing so, enables Kelly to influence the prioritisation order, in consultation and with the safety net of having a more experienced colleague's expertise. This is particularly useful should the rationale or considerations about the scenario, be off the mark. By inviting Kelly's participation, Talia is role-modelling expectations that Kelly should step forward whilst she, herself, stepped back and did not direct what should occur. Likewise, Kelly then shows similar role-modelling by providing a learning opportunity for her student nurse. Kelly could have done this task herself (especially as it would likely have been more time efficient). Yet Kelly demonstrates leadership by offering the opportunity for learning. Through coaching, support and encouragement, the student nurse is guided through a new nursing task. This is done with Kelly seeking clarification of the process from the student and Kelly providing a safety net so the student nurse (and the patient) could be assured that she is doing this correctly.

Similar scenarios to the ones outlined above occurred across the 24-hour period, seven days a week. Whilst leadership did not occur all the time, leadership practices were observed each day in different situations and amongst different nursing team members. Nursing leadership did not reside in a single formal role. It is complex and multi-dimensional and was seen in the practices of nurses across these wards. In the next section, a closer look at how nurses engage with each other to influence and lead, is presented.

5.3 Patterns of Leading

Leadership has been noted by nurses at all levels of these nursing teams as relating to a person or role. This indicates that the nurses saw leaders as leadership. However, from both observation and discussions, leadership is more than this. Nursing leadership involves practices which combine behaviours, actions, and interactions. For this reason, the data were examined specifically looking for the activity of leadership or the practices that nurses engage in for leadership to occur. This section presents the patterns of leading that emerged in the data.

The repetitive occurrences of leadership practices meant that patterns developed. Four patterns of leading emerged from the analysis, demonstrating how nurses socially interacted to influence and lead their colleagues and nursing care. The first pattern 'being present' was signalled by nurses during recorded individual discussions and was talked about informally on the wards. By being present in the

ward, nurses were able to engage and interact with one another to lead. Being visible to others, combined with being actively engaged in what was going on in the ward and with patients and staff, signalled being present as a leadership practice. The second pattern is 'being alongside'. This was both observed and spoken about at all levels of the nursing team. To lead and influence, nurses reduced the distance between themselves and others, positioning themselves alongside their colleagues to lead. This created togetherness especially when being alongside also meant attempting to level any power differential between the nurses. 'Being apart' is the third pattern of leading and was used by nurses to stand apart in difficult situations or to manage tensions. The fourth pattern of leading is 'role-modelling and enabling followership', in which the focus of observation was also on the responses of the others to leadership practices. Nurses discussed this as a professional expectation of nursing and described and demonstrated different approaches which had varying results. These patterns of leading are presented in more depth with examples from the field, that demonstrate the nuances that occurred in these wards.

5.3.1 Being Present

Nursing leadership occurs by being present. Presence took the form of nurses being in the wards, being seen, and being aware and actively engaged to explore and problem solve scenarios and lead others. There were many examples where leadership practices occurred because of being present. Seven nurses across the teams explicitly talked about 'being present' 12 times, though many other references to presence were made. Common characteristics and actions were described as relating to nursing leadership presence and influencing the quality of interactions resulting in leadership. For example, RN Diana's comment that "people see me and come to me and ask questions" (11.12.19) and SN Sally's, that leadership "involved listening and questioning to understand, and collaborate" (21.2.19) were common. Being present is demonstrated through active listening with appropriate and authentic responses indicating the message(s) have been heard. Being present also concerns the way interactions occur, as with the quality of the responses and follow-through when the interaction ended.

Sometimes being present occurred in incremental moments as in this exemplar:

> *Coming from the staffroom after morning tea, Sera noticed a student nurse who appears to be a bit lost. The student seems confused and hesitant to act. Sera* [RN] *asks "Are you OK sis? What are you looking for?" On hearing what was needed, Sera leads the student nurse into the sluice room. "Here we are sister". The student responds "Oh! thanks!"*

Sera leaves the sluice room following the student who turns left and goes around the corner with something small in her hand. Sera heads straight on into a patient cubicle and can be heard enquiring how her patients are.

Later Sera spots the same student as she was heading toward the nursing station. Sera is walking at speed but slows to ask the student "Are you alright sister?" and laughs gently as the student says she is fine. (FN:17.10.18)

This typical ward scenario demonstrates how by being present, RN Sera engaged with a student nurse who appeared to be looking for something in the unfamiliarity of the ward. Sera chose to support the student, engage with her as a colleague through the term 'sister' and then ensures that she had what she needed and is alright. This demonstrates that Sera is present in the situation by proactively taking the opportunity to lead. She role-modelled how to respond when help appeared to be needed and then followed-up to ensure that everything is satisfactory. Sera was aware and actively engaged with what was going on for this student in that moment, and proactively demonstrated leadership. Leadership was particularly evident when the student was approached again by Sera. Through reconnecting and ensuring the student felt comfortable, Sera gave the student opportunity to reveal any further concerns whilst validating the student's role as a learner and part of the team. Building up a bank of such moments creates increasing influence and opportunity for nursing leadership.

The practice of being present was repeatedly observed in the wards. It is by actively engaging and being present, that nurses build rapport and collegiality with their colleagues and students, enabling them to reconnect across the shift or even the next shift and beyond. Presence increases influence and leading, as nurses can show attention and influence the other in that moment.

Beyond being present, nurses also placed importance on 'being visible' in the ward to undertake or engage in leadership practices. Forty-seven data excerpts from fieldwork and interviews indicates how significant 'visibility' is for nurses across these teams. Ward nurses were rostered onto the wards to co-ordinate and provide patient care 24-hours a day thereby ensuring nurses were present on the ward. The nurses' distinctive white tunics were frequently seen as nurses darted between patient cubicles, and staff spaces, and nurses interacted with colleagues and patients to achieve patient care. Being seen by others meant that nurses were visible and therefore, they were likely available for support as needed.

By being present and visible, nurses interact with others and maintain connections across the team. Being present was also referred to by nurses as 'being aware' (22 data references) and 'being engaged' (24 data references). These states of being refer to the active engagement of the nurse and resultant

presence this created in interactions on the ward. Through these connections and interactions, leadership practices are visible in proactive and reactive ways.

In the following exemplar, RN Kelly is caring for a patient who is to transfer to another service for a medical intervention. By being seen by the ward clerk and thinking about the implications of the ward clerk's message, Kelly demonstrates the leadership practices of being visible, being aware and being engaged.

> *Coming out of the patient cubicle, Kelly tucks the medicine and observational charts under her arm as she goes to dispose of the medicine pottle. As prescribed, Kelly has administered the pre-medication for the patient's medical intervention and signs the medicine chart once in the nursing station. Kelly then continues to sort the last of the paperwork for the same patient's transfer to the intervention department.*
>
> *The ward clerk turns to Kelly having just put down the phone and says that the ambulance is running late and so the patient's intervention appointment time has been rescheduled. The ambulance will now be here an hour later than originally planned.*
>
> *Kelly informs her patient and patient's spouse of the delay. They both appear to appreciate the update saying, "thank you for letting us know."*
>
> *Returning to the nursing station, Kelly calls the medical intervention department. Whilst the message about the ambulance delay has been passed on to Kelly, Kelly is not sure that the staff in the department are aware that the patient has already received the prescribed pre-medication for the originally scheduled intervention. Kelly speaks directly with the nursing staff letting them know that they may need to revisit the pre-medication and its effects, depending on the eventual arrival time of the patient. She also asked if there was anything further, she needed to do for the patient whilst waiting to transfer. This was declined. Kelly then documents the phone call to the department and that the pre-medication had been administration. She does this clearly in the patient's notes and adds a note to the front of the medicine chart before sealing all the documentation in a patient transfer envelope. She then tells the temporary ward clerk that should the ambulance arrive sooner, then she would want them to know that the patient has had a 'pre-med'.* (FN:18.11.18)

Receiving the message that there was a delay for a patient transfer is not unusual. However, it is what Kelly did after getting this message that demonstrates leadership. Kelly could have received this message and continued with her tasks. Kelly is a graduate nurse with less than a year of clinical nursing experience, yet her ability to think through the patient's journey and act when she realises that an

issue may arise, demonstrates that leadership is not solely borne out of experience. Being intellectually present, Kelly acted. Anticipating that the effects of the pre-medication would begin to reduce by the time the intervention was to occur, Kelly then demonstrated leadership by informing the department that the pre-medication had been prescribed and administered. In doing so, Kelly was ensuring that the patient's anxiety about the intervention would be assessed on arrival and that further medication may be required. Kelly's communication with the patient, and the receiving department and the ward clerk, demonstrates awareness of the implications of the delay for the patient's care regime and the influence Kelly made by 'being present'.

The SNs were less visible in the wards, as their roles require them to split their time between clinical and administrative functions, taking them away from the ward at different times of the day. Senior nurses balance being visible to the ward nurses with being visible to the organisation. By being visible in daily organisational bed meetings and working group committees, the SNs can maintain connection with colleagues in the wider organisation and influence policy and the flow of patients to their wards, whilst advocating for nursing resource to support patient care. When SNs spent significant time in office spaces, other departments or hospital sites, and were therefore less visible in the wards, some ward nurses talked about being trusted to get on with it, whilst others felt that support had been withdrawn and so were less likely to engage with that senior nurse. This indicated that being present and visible is a balancing act of leadership depending on the role of the nurse and expectations.

For SN Alice leadership is "not only being present but being there and helping and working through issues that some staff may have, helping support them where they need support" (10.12.18). Like others with a formal leadership role, Alice was looked to for her leadership and responsiveness when unusual scenarios occurred. On a Wednesday morning just before lunchtime, a scenario occurred which showed how Alice reacts to an unusual situation, and how she demonstrates leadership to respond.

> *Alice comes out of the drug room and makes her way to a computer in the nursing station collecting a patient file as she goes. The station is empty but for Alice and an HCA standing outside the reception desk. A playful melody is on the radio as nurses attend to patient cares in the cubicles. The HCA calls to Alice to look at a scrappy piece of paper that she has been given by the patient she has been observing closely to maintain his safety, and that of those around him. He has gone to the bathroom and another RN is currently with him. The HCA appears to have taken this opportunity of seeing Alice to share the paper. Looking down for a moment at the piece of paper, Alice then looks toward the HCA and then down again at the note. She appears stunned*

initially then says, "Did he do this?" The HCA confirms this with a nod. Verifying this, Alice stands straighter and appears to become more tense. Her demeanour which was relaxed takes on a purposeful stance, as she begins to set in motion a plan of action to support the nurse about whom the sexual references in the note, refers. Alice directs the HCA to maintain her observation of the patient and checks that the RN concerned is not currently with the patient. Then she takes the note and walks at pace to the empty ACNM office and makes a phone call. In a confident and firm voice, Alice can be heard talking.

"I don't want to expose (RN XX) *to this patient; he has unsavoury intentions. We need to keep her away from the patient. She is currently working in the other team on the other side of the ward but has been seen by the patient in passing. She has cared for him before. We can't let that happen again."*

Coming out of the office, Alice looks around and spots the RN concerned. Asking to speak to her in private, Alice takes the RN into the drug room where she shares the note with her. The RN looks surprised and momentarily scared but then her jaw tenses and her eyes fix with a frown. Alice talks about speaking with the CNM and outlines the strategies that they have collectively decided upon to keep her and the patient safe. This included that the RN should not care for the patient or work in the nursing team allocated his care, and to stay away from the patient to avoid an escalation in his behaviour. The RN says that "I've not done anything wrong, and I am angry about this. How am I to give my patients care?" As the conversation continues Alice says that she understands the RNs response, but these measures are to keep her and the patient safe. The RN acknowledges the patient is unwell and agrees. "You won't have to re-allocate today's patient loads, but you will need to look at future shifts".

Alice asks the RN "are you ok to keep working?" and the RN says "I'm fine, nothing has happened. He has just been drawing and writing wee notes. I'm going to take care of my patients". Alice then leaves the RN and goes to the computer and adjusts the patient allocations for tomorrow. She looks around the ward and finds the senior RNs of each team to tell them of about what has occurred and the strategies she wants them to support. "So, this is what we are going to do…". After a brief discussion, the senior RNs agree.

> *Later when the ACNM returns from her offsite training session, Alice updates her with what has happened and the actions she has taken including involving the CNM.* (FN:25.6.18)

Leadership practices are evident within Alice's response to this situation. Alice being physically in the ward and visible to her HCA colleague, created an opportunity for the issue to be raised with her. The HCA demonstrates insight by recognising the seriousness of what is on the note and the potential for harm. She did not ignore the note but spoke up. Recognising that Alice and Alice's role could react to her concerns, the HCA shares what she knows. In responding to this, Alice sought support from the CNM, for her decision making and strategies to manage the scenario, before informing and supporting her RN colleague.

Alice demonstrated sensitivity when wanting to speak with the RN, by directing that the conversation occur in a private setting rather than a corridor or the nursing station. Providing an explanation and the evidence, Alice's voice was serious and somewhat strained. She stood close to the RN but there was also distance between them. Alice's non-verbal communication matched her language which addressed the sexual nature of the note. By providing an action plan of strategies that were being put in place, Alice demonstrates she was trying to protect the RN and the patient. Alice checked that the RN felt comfortable to continue to work and then looked to reallocate patients for the next morning shift as the RN would be working again. Making the senior ward RNs aware of the need to change the patient allocation, increased participation with the responsive strategies and meant that even in her absence after-hours, the plan would be followed. Updating the ACNM on her return to the ward also supported this.

These combined activities show leadership in action as Alice took this situation seriously and named the behaviour and the risks. Her response was from a managerial stance and was multipronged. She set boundaries or a safety net around the nurse, engaged the team and followed the line of command by alerting her nurse manager of the escalating risks and worked with her to develop a response. The effects of these leadership practices were felt beyond the immediacy of the situation. The nurse co-ordinating the on-coming shift was briefed about what had occurred and the plan and the expectation that this would be shared with the night staff. Such expectations demonstrate the lasting influence of some leadership practices beyond the presence of a leader.

Care was taken to manage this situation in a sensitive way by maintaining patient confidentiality and supporting collegial welfare. Given the mental health of the patient, during the time I was present, no observation was made of this issue being raised with the patient. While this scenario was only observed once, it is drawn out here as the same strategies were used to manage patients with

aggressive tendencies and violence in the workplace. In these other scenarios, nurses stepped up, challenged the patients and/or visitors and named the behaviours and actions as unacceptable. In the following situation, SN Elle describes how her uniform as a visual sign of nursing leadership, contributes to managing a violent visitor.

> *…a wee while ago when we had a lady who came from a violent background with an ex-partner, we needed to get a restraining order; an order where we had to go and have a talk to the ex-partner who had come to visit her. He had been quite verbally abusive to the house surgeon and then with me. So, we had to ask him to leave the hospital and got a trespass order so he couldn't come back. The uniform is really useful in that regard. But sometimes I think that sitting down and talking to patients…maybe the uniform is useful, then in some ways it probably isn't.* (FN:19.12.18)

Communicating with the nursing and medical staff involved, the security orderlies and the legal team, a plan was conceived to maintain the welfare of the patient and the staff in the ward. Once arranged, Elle (in the presence of security orderlies and a police officer) then spoke with the visitor before he came onto the ward. The unacceptable behaviours were named and the consequences of these for this visitor were that a trespass order had been put in place. Elle talked about how her uniform may have contributed to her visibility and her authority in this situation. The white nursing uniform with navy blue embroidered nursing role on the left breast and navy-blue trimmed sleeves and pockets, distinguished Elle as a formal nursing leader. Elle's leadership and co-ordination whilst wearing the uniform, contributed to the expectation of her role (DHB, 2011a), and signalled others recognised her authority.

There is another element of being present and visible that supported patterns of leadership engagement: nurses' approachability. Approachability was identified 51 times in the data as significant to nursing leadership. Leadership approachability includes behaviours and actions that were kind, friendly, open, and interested. A "collaborative approach rather than just top down" is the common approachable leadership practice the nurses found worked. Talia (RN) talked about "knowing how to approach" scenarios and people, identifying "calmness" and being "organised" as two qualities that contributed to approachability and leadership practices. One SN recounted a story in which calmness contributed to her ability to lead others. Another nurse said to the SN "you're just like a swan, you're all calm on the water but underneath you're going like this" (moving her hands up and down at a fast pace). In response SN Patricia stated:

> *I always try to remain calm, there is absolutely no point getting stroppy with people. You also need to know when to ask for help whether it's out there* [on the ward] *or from*

> *someone here* [in the office]. '*Cause I ask people's advice all the time out here, 'cause I'm not a lone person and we're all looking after the same group of people. Being calm and organised reassures people that everything's ok.* (FN:28.2.19)

Here Patricia draws on her own traits but also seeks to collaborate with others, role-modelling teamwork and that others can draw on her for leadership too. Being calm despite the busyness or number of tasks that required attending to, meant that nurses opened up and were honest with Patricia allowing her the ability to contribute to the milieu of the ward environment in a calm and controlled manner supporting safety.

Contrasting with this was unapproachable behaviour that meant that nurses were not inclined to seek support or ask questions or be receptive to leadership practices. This took the form of being hurried, distracted, disorganised or uninterested. A lack of consistency in behaviour contributes to being unapproachable as it creates hesitation for the nursing team. Victoria (RN) talked about feeling scared to approach some nurses who were known to be unkind and not interested (19.7.19). Similarly, RN Charissa described a scenario where the ward:

> *…was having a busy day. One of the other nurses said to the ACNM "have you booked the ambulance for patient X and patient Y?" She* [ACNM] *just spun around and said, "I can only do one thing at a time!" and turned away again. She's not the type of person that you can tell her a lot of things at one time and that's a hard thing to work with, on this ward. Other nurses saw this. All the other nurses and I, we talked amongst ourselves about how we were gonna approach her. It's just a way of how you're telling her the message, but it shouldn't be.* (10.7.19)

This was not an isolated example of the effect of abrupt, hurried behaviour that occurred in a public space within the ward, which was inconsistent with what nurses expected of leadership or the nurse in-charge. This response drew attention for the wrong reasons. Nurses came together to work out how to respond and manage the behaviour and the busyness of the ward and create a sense of control. Modifying their approach, Charissa talked about needing "to think about what I am going to ask this nurse and what I'm gonna tell her, beforehand". Charissa's solution to be thoughtful and purposeful in her communication clarifies how and what she will communicate. This demonstrates the flexibility of nurses to respond to scenarios and use their own leadership practices of being present and visible, to influence others including those in-charge, when leadership examples did not meet expectations. As these unapproachable behaviours did not meet the *Code of Conduct for Nurses* (NCNZ, 2012a), I felt challenged by what I had witnessed. Inappropriate behaviours included hanging up on phone calls

at the front desk and yelling at colleagues. After reflecting on this, I shared my observations with the CNM so this could be handled through line management processes.

The analysis showed that being present was a pattern of leading that included being physically present and actively engaged, being visible or seen and approachable to and for the nursing team. In the next section, the second pattern of leading: 'being alongside' is presented.

5.3.2 Being Alongside

A second main pattern of leading captured from the fieldwork and discussions with nurses, was evident in the engagement of nurses 'being alongside' colleagues. Over a third of the nurses (n=8) who were interviewed identified being alongside as part of nursing leadership with 11 others talking about the result of being alongside: that of 'togetherness'. Being alongside occurred in two ways in the wards. The first was in the way nurses came physically close to their colleague(s) in interactions in which leadership then took place. The distance amongst the two or more nurses, differed depending on the activity, and their previously established relationship with the other. It was in being alongside another, that the nurses talked about and were observed leading each other. Secondly, being alongside was observed of nurses who sought to create togetherness. There is a psychological element to this form of the leading. Perceived power differentials established by hierarchy are reduced by nurses' behaviours and actions and interactions to support nursing leadership practices. These two forms of being alongside are explored in more depth next, showing the nuances of the practices of these ward nurses in their leadership.

5.3.2.1 Physically Close

It was common to see nurses congregating in pairs or small groups in both public and private spaces within the wards. A typical example from practice was when the senior nursing team would 'huddle' together following the daily organisational team meeting to discuss issues, plan for the next 24-48-hour period, and address specific patient or nursing related concerns. The huddle was formed by whomever of the SNs were present. It involved moving their chairs out of the line (created to ensure they were visible for the virtual organisational meeting) and into a close circle around a table. Conferring around and across the table, the nurses reduced the physical space amongst them and talked frankly with each taking a turn to contribute. In reference to this, Elle (SN) said that she is:

> *able to talk to my senior team that I work alongside or with, or that may be further up the ladder, to allow my opinions to be voiced. I need to be able to say what the team is feeling or is occurring in the team, to be able to bring that to somebody else as well. That's kind of what leadership is for me.* (19.12.18)

By being alongside, Elle refers to her ability to share this information and gain support and advocate for her team. Discussions and decisions were made by being alongside. However, if a SN was not present, consideration was usually given to their probable perspective on an issue. Being absent could result in reduced information being shared and being told of decisions after the gathering, rather than contributing to them.

For the ward nurses, being alongside was seen when a nurse came beside a colleague(s) drawing them into an interaction to seek advice, support, information, or action. From this point, the two (or more) members of the nursing team, would physically move together or the direction of their conversation would shift in response to the factors being considered and the priorities and the strength of the line of argument of those involved. A typical example of this was when RN Leilani was approached by a RN who touched her on the arm and came close beside her. After greeting each other, together they moved toward the patient notes trolley inside the nurses' station. Stopping to pull out a file, Leilani turned toward the RN, so the discussion clearly became inward, between the two of them – they collectively plan for the patients in their care and the actions needed for a patient transfer and another's discharge.

For some, being alongside was a purposeful practice of leadership. One SN, Anne, talked about the approach she took when she was new to the team and how she prepared herself to be alongside.

> *I observed a lot. I observed what nurses were doing. I talked to the Charge Nurse Manager at the time and to the educator. I got an understanding of who the team were, but I could also see how they behaved, how they read notes and saw how they interacted with each other. And just mannerisms. I think you kind of get a sense of how people are going to take you.* (13.12.2018)

Anne demonstrates the conscious effort she made, to know and understand the nurses before engaging to change nurses' practice. Wanting to lead a change in analgesia management on the wards, Anne talked about "*drawing alongside them* [nurses] *saying 'you've done a great job up to this point but let's look at the evidence. Yes, the morphine PCA in conjunction with Panadol and a non-steroidal anti-inflammatory has worked, but I can show you an alternative to just stopping the pump and it works better for the patient*". Standing alongside the nurse and acknowledging their efforts and knowledge, Anne demonstrates respect for the nurse's knowledge before introducing an opportunity to advance practice by embracing new evidence which would see an improvement in analgesia management. "*The patient needs to maintain their analgesic levels to mobilise. Before withdrawing the pump, we need to ensure the patient receives an alternative. What do you think the options might be? Yes, that is correct, but the half-life is not ideal as the patient has decreased renal function.*

However, we have another option we can use." Coaxing and challenging the nurse by creating tension for change, Anne deliberately positioned herself alongside the nurse to create a sense of team. This is evident in the language she used as she referred to them collectively – "let's" or let us, and "we" show that Anne and the nurse are in this situation together, and together they can explore the options.

Being alongside was also used by others in a deliberate way. In her office, CNM Nicole purposefully moved away from the computer and desk, to sit alongside a staff member who came into the office. This happened frequently and was a deliberate act to focus on the nurse or visitor and reduce the distance between them. Nicole also used inclusive pronouns in her language to enhance the togetherness and being alongside. Sitting beside the nurse she said, "tell me so we can explore what we can do" (FN:19.4.18). The senior nursing team were likewise expected to adopt inclusive language that created team by being alongside. Role-modelled and led by Nicole, the SNs were expected to "sing from the same hymn sheet" (FN:7.5.18) by using language that created 'team' and unity. Collective pronouns such as "we", and "us", were vital to achieving this, with no room for 'they', 'them' or 'their' as discussed in Chapter 4.

Some nurses were recognised as leaders by others in the ward because of their actions such as. RN Sera said:

> *These nurses go that extra mile for people. They just come along and work with you to try and keep the other nurses positive. It's just the little things they do. One of them, she will come in and if she knows I'm doing co-ordinating, if I've got all these things to do, she'll just come and take over and do some things that she knows that I have to do when I'm busy with something else. Or if there are families that come in and are a bit upset, she'll take them aside and just talk to them. Other nurses don't do this.* (9.7.19)

These nurses talked about being alongside, to check-in with one another. Twenty-one data entries from fieldnotes observed nurses checking-in or enquiring how their colleague was, in daily practice. Concerned for nursing colleagues' welfare, achieving the nursing tasks, or ensuring patient safety and care, this pattern of leading is overt and proactive to identify and reduce potential harm but also to react as needed. This checking-in occurred in staff and public areas of the ward and in office spaces.

> *On a weekday morning shift, RN Daniel is approached in the nursing station by a nursing student* (who is working with another colleague). *She is having trouble ascertaining a blood sample to detect blood glucose levels. Having told her that 'the trick is to pump the phalange to get blood' Daniel moves away. Later he returns to the student nurse and enquires about what she is doing. She is attempting to write her first set of clinical patient notes. Confirming that the student has done a draft and discussed it with the*

preceptor, Daniel sits beside the student offering advice and support as she places her entry in the patient's notes. (FN:25.10.18)

In this example, Daniel, who had earlier been approached by the student, makes a deliberate effort to be alongside the student, guiding and influencing her confidence in writing her nursing documentation.

Being alongside also occurred in more passive or unconscious ways. Body positioning and body language contribute to nurses being alongside colleagues to influence and lead practice. Some nurses did not recognise that subtle body language also contributes to the visibility of this practice. For example, two nurses walking in opposite directions within the ward corridor look briefly at each other. In an instant, an eyebrow is raised by one with the other responding with a slight head nod. The interaction passes rapidly and silently, yet a connection is made, and a message passed on. Following up with the nurse heading to the sluice room, she says that her colleague was just checking that she was ok. *"We do this when we work together so that we can support each other. This is just what we do"* (FN:9.7.18). This nursing leadership practice demonstrates that by maintaining connection, one can influence, empower, or motivate a colleague through the briefest of interactions.

The SNs also demonstrated subtle passive ways of being alongside. For instance, when co-ordinating the daily ward rounds with the MDT, SN Elle would sit in the nurses' station. The nurses from the ward who joined the meeting between providing patient cares, always chose to sit in the chair closest to Elle even when other chairs were available. The nurses conferred with Elle and sought approval as they gave their patient updates to the wider MDT team. Elle's body positioning would change to be directed at the nurse who was reporting. Her crossed legs would turn toward the nurse, and she would lean in toward the nurse as they gave their report (FN:16.10.18). Likewise, in Ward Y, Patricia (SN) would support the ward nurses during MDTs and handovers. Prior to the MDT Patricia would meet with nurses whose first language was not English, to go through their report so that they were confident to make themselves understood. Patricia would then position herself close to these nurses or the student nurses as they reported patient updates to the MDT team. Patricia was observed turning toward the reporting nurses reducing the distance between them. The nurses would look at Patricia at times and she would add detail or give a nod of encouragement as the report was delivered. Occasionally Patricia would prompt the nurse with a question to elicit further information or intervene when nurses appeared to lose their way (FN:16.4.18).

Not dissimilar to the typical SN body language and behaviours described above, ward nurses were observed reducing the distance between each other to maintain being alongside, even when they were working independently across the ward. This was seen in all four wards across the shifts, when

nurses would pass each other in the public and staff corridors and in clinical or office spaces and staff rooms. Connections were maintained by a hand onto the shoulder or the back of the other, a quick head nod or the locking of eyes and an inaudible message being sent and received (FN:26.6.18). The significance of these brief interactions as leadership practices is the maintenance of connection and of team, that would result in influence between the nurses. These interactions contributed accumulatively to relationship maintenance, meaning that nurses did not need to establish connection to influence others or engage in leadership practices. By staying connected, nurses were able to read situations and people and respond pre-emptively or react as needed.

5.3.2.2 Togetherness

By being alongside their colleagues, nurses also sought to create an equalness or levelling between themselves and those they were wanting to lead and influence. Not wanting to stand out, nurses acted to reduce any power differential that others might perceive as standing out and creating a potential threat. Nurses had different levels of experience, knowledge, and skills and whilst using this to lead others, there was acknowledgement by them that they attempted to reduce or level the perception of power that this experience or role granted them. Nurses talked about doing this to reduce the threat such power had and to empower colleagues. Ironically, it was often this knowledge and experience that was sought by the other, that was used to influence the direction of conversation and resultant action coming from the interaction.

Talia (RN) talked about this form of being alongside:

> *You can hear many things about different people, but I tend to wait until I interact with that person to see how I find that person. I'm not someone who likes to throw her weight around. I like to encourage, you know the team together, working alongside each other. Rather than I'm up here and you're down there. I value them and their skills.* (19.7.19)

Here Talia talks about coming alongside a colleague in a manner which attempts to create an equalness between herself and the other, and that is not judgemental. This leadership practice can seek to temporarily level or reduce any power relations to equalise colleagues in a particular moment. Yet despite the attempts to temporarily suspend power relations, organisational structures within the ward maintained them. This included management reporting lines, nursing hierarchy (as evidenced in the roster structure), professional structures and group dynamics. As such power relations were always present despite attempts to ignore or suspend them and these did influence the interaction, engagement, or response. From observations and individual discussions, nurses used the pretence that these did not exist as a strategy to connect and lead.

Being alongside is a pattern of leading which contributes to the functioning of the nursing team. By reducing physical distance and attempting to level the power or authority of roles thus creating and maintaining connections and togetherness, leadership practices occurred. This occurred deliberately and passively to respond proactively and reactively to nurses and situations in the ward.

5.3.3 Being Apart

Whilst being alongside was a practice of nursing leadership in the ward that could be seen in the closeness and togetherness of nurses, there were also leadership practices where distance or 'being apart' from individuals or the team was observed. As RN Diana put it, *"you have got to have a bit of separateness. You can't be friends with everyone, as leaders need to be fair and need to be seen to be fair and doing the right thing"* (11.7.19).

Distance or being apart was observed in the practices of formal nursing leaders in the hospital nursing teams and supported their ability to lead the team. At times, hard or difficult decisions needed to be made when considering individual versus collective needs. Being alongside may have created opportunities for information to be known or shared but it was in being apart that boundaries were maintained, expectations set and maintained, and decisions could be viewed as fair.

For some nurses who were not in formal leadership roles, being too closely connected with others was not what they wanted nor needed, to be a nurse. Ironically in being apart, these nurses were able to demonstrate autonomy within their practice demonstrating self-reliance and independent thinking. This contributed to some colleagues respecting these nurses' ability to work more independently and seeing their actions as leading. Alternatively, other members of the nursing team saw this as not being a team player. For RN Erica:

> *how you portray yourself should be how you go about your everyday kind of life. Maybe you can get something more out of somebody if you give them a bit more. I just try and be me, and, yeah, I don't believe in a lot of small talk. If I've got something to say I usually say it. Or if I don't want to say it, if I don't believe in what is going on, I just don't say anything at all yeah.* (25.7.19)

In this example Erica draws comparisons between conduct of everyday life and nursing practice. She also talks to the point that she does not engage when she does not agree with actions or processes within the ward. This demonstrates that leadership can occur through choosing a different path from the majority and can look like abstaining or not participating. Such leadership behaviours and actions set these nurses apart in the moment, but the separation was short lived as these nurses readily

demonstrated expectations as team members. This separation could influence and indirectly lead others.

Stepping up was another form of being apart that different members of the nursing team demonstrated. It was common for someone in the team to step up out of the ranks of the team and lead. This happened in situations where the formal leaders were absent and sometimes when they were present. It also occurred when unexpected scenarios arose. In different moments, the actions of members of the nursing team demonstrated they were providing leadership, guidance, and direction by stepping up. Joy (RN) talked about being a co-ordinator on the afternoon shift and that when she was not a co-ordinator, she stepped up to help her colleagues with challenging scenarios or with tasks that required expertise and experience to resolve the issues. Joy also talked about the resultant effects of stepping up saying that:

> *My colleagues will come and ask me certain things, how to do these things, how to do that and asking can you help me with this and that…it's like advocating and really doing what you can for all the patients and the team as well.* (2.8.19)

This statement reflects that by stepping up and then stepping down and returning to the team, nursing colleagues sought Joy out, aware that she could be relied on as she had proven her abilities to interact and lead others. The team relied on her spontaneous moments of leadership. Emma (EN) commented on the effects of those who stepped up.

> *They run the ward; they don't need to because they don't get paid to do that, but the ward is just going to be chaotic. They step up and pick up other people's slack almost. I feel relieved when they do. If there is something going on, someone will influence to lead us as a team and that is always our charge nurse.* (12.2.19)

Here, Emma refers to the orderliness brought to the ward by those who step up and lead. By being apart from the team, the nurse who steps up can see and reallocate all the jobs that need to be done. There is relief experienced by those being led, that someone from within the team has assumed the role of leading and reduced the chaos. Emma also mentions that stepping up can occur when the formal leaders are present indicating that situations unfold and those who are best and immediately placed, may do the leading in that moment. This indicates that leadership can happen in unison across the team where formal leaders may be involved in some situations whilst other nurses step up and apart from the team, to lead in other situations.

5.3.4 Role-Modelling and Enabling Followership

Role-modelling and following occurs where one nurse's practice is ideal or of a high standard and another nurse attempts to mimic this behaviour, action, or trait. The ideal or new standard is then adopted by the second into their repertoire of practices. The first nurse may be in a formal role of demonstrating nursing practices such as a preceptor or may have been informally chosen by the second as a role-model. Whilst some may choose to be role-models, it is in the act of the other choosing to mimic or follow the first, that sees the nurse become a role-model. Being alongside another nurse or a team of nurses, is fundamental to role-modelling. Thirteen nurses discussed role-modelling as part of leadership with 16 fieldnotes capturing examples of role-modelling in the wards.

Formal arrangements of role-modelling were known in the hospital ward as preceptoring. A preceptor is a designated experienced nurse who is expected to role-model clinical nursing practices or aspects thereof, during orientation following employment and for student nurses. The preceptor works alongside the new staff member by taking them *under their wing* to *show them the ropes*. The preceptor directs teaching and learning through demonstration and explanation, and the acquisition of clinical skills and knowledge in addition to providing insights into team and organisational routines, dynamics, and expectations.

> *On this Wednesday morning shift, RN Talia is working in a team with a graduate nurse Kelly who has 10 months of experience. Talia has also been allocated to preceptor a student nurse for this shift. Following their lunch break, Talia regroups with the student in the nursing station. Talia walks to the patient cubicles with the student following. She goes in and out looking at and speaking with the patients. Coming back to the nursing station, Talia tells the student that she checks on her patients as she has these quick conversations. An ambulance officer arrives and asks if someone can come to take a patient to the toilet who has just arrived in the ward. "Oh yes we'll come" says Talia and she indicates to the student that the two of them, will help. Talia moves to help the patient stand up with the use of a mobility frame and gives clear loud instructions* (for the benefit of both the patient and student). *"Both hands on and push…push…stand up…we're going to the toilet". Talia keeps chatting with the patient and gently encourages her "good…keep going…only a little way further".*
>
> *Talia and the student come out of the toilet a little later and resettle the patient in her bedspace. Then they return to the nursing station. "Now where's the trolley gone with the patient notes?" And then answers herself "the MDT weekly meeting is happening*

> *in the dining room". Talia then turns to the student and says, "I bet you I'll get snagged at 2pm to do something with that wound, so I want to do the other jobs on this list". Reaching for the team task list, Talia leans over the bench inviting the student to discuss what is still needing to be done for their patients including writing in the patients' progress notes. Gathering notes from the now-returned-trolley, the student says she will write a draft of Mrs P's notes for Talia to review before these are added to the file. Talia nods. Kelly comes past the nursing station and Talia says "Oh Kelly, you go for lunch. I'm back and Mrs X is back on her bed now".* (FN:17.10.18)

In leading the care of her patients, RN Talia role models interactions with colleagues, other personnel, and patients. She changes her approach depending on who and what is needed and by being alongside, the student is exposed to Talia's practices. Talia checks on a colleague and her patients, makes herself available to help when a patient requires it (even though the patient was not in her allocated list) and seeks to plan for the unexpected by attending to tasks early. In response to this role modelling and inclusivity in the nursing tasks and nursing team, the student responds by following the lead suggesting what she is going to do to assist Talia. By doing so, following has been enabled and the leadership practices become reciprocal, with the student influencing and leading an aspect of care.

Role-modelling was also witnessed with others choosing to follow or mimic the practices, behaviours, language, or attitudes of others. In watching and following, individuals and the team identified nurses who maintained standards or shared similar visions, values, or aspirations. Aspects of other nurses' practices were chosen by team members and followed. By being followed, the nurse became a role-model influencing and leading nursing practices within the ward. Victoria (RN) (19.7.19) talked about the calmness and poise of a nursing colleague and how she was trying to adopt these approaches into her own practice. In this statement, the influence in role-modelling resides with the individual or follower who adopts the practice. Yet despite this, colleagues were directed to follow the role-model because their behaviour, actions or attitudes exemplified nursing values or standards of care and teamwork. Leadership was evident after following and the adoption of practices, occurred.

Hierarchy contributed to how role-modelling was viewed. Hierarchy determined that a junior nurse should follow the SNs yet as RN Beth pointed out, it was not always about being experienced and skilled. Nurses "do not always want to follow the designated leader" due to personality conflicts or not having faith in their abilities or their lack of currency with clinical nursing. "I can't always trust the advice if it's [from] a senior" (20.7.19). Beth's statement indicates that leadership and role-modelling was based on more than positions and assumed knowledge and skills.

Role-models earnt the respect of those following. Whilst respect is afforded to roles within the nursing hierarchy, respectful interactions where politeness and courtesy were present assist in maintaining respect for individual role-models. The following scenario demonstrates when this did not occur.

> *A ward cleaner has just mopped an area on the floor. A nurse working with a student walks right through the area. The student nurse turns back to the cleaner having walked around the area. The cleaner pulls a face at the first nurse and makes a disapproving 'tut-tut' noise.* (FN:14.5.18)

From this situation, the student nurse became aware that certain actions can meet with disapproval; they are therefore unlikely to be adopted into practice by that student nurse. This and previous examples demonstrate that role-modelling was not fixed to a single person or scenario but was shaped by situational contexts, and existing relationships and trust across the nursing team along with the professional and structural constraints of hierarchy and organisational systems.

Relationships and interactions are at the crux of nursing leadership. Being present physically and intellectually, and being visible to colleagues and approachable, nurses came alongside others in the team to lead. This was achieved by reducing the physical and psychological distance between a nurse and others and by creating a togetherness that enabled leadership to influence the practices of others. This happened through role modelling and mimicking but also through the responses to direction and cues in the interactions. In summary, patterns of leading in these wards were being present, being alongside, being apart, and role-modelling and enabling followership. In the next section the nursing leadership practices that occurred in response to the context within the wards are described.

5.4 Safeguarding Practices of Nursing Leadership

The leadership practices of 'safeguarding' is a key finding given the context and setting of the study. These leadership practices involved safeguarding nursing practice, the nursing team and patient safety. Details about how this occurs, and the impact of these nursing leadership practices completes this chapter before a wider discussion is presented in the discussion chapter about what this means for nursing, nursing leadership and the healthcare sector.

From the moment I walked onto the wards, I was confronted by the nursing dialogues of individuals, groups or teams of nurses talking about 'feeling unsafe', of expectations for 'keeping staff safe' and the paramount need for 'clinical safety' for patients and nurses. A day did not pass when one or all three concepts of safety were not raised. This made me question what was happening? My fieldnotes captured 29 direct references to safety and during individual discussions, nurses mentioned this in 65

excerpts. The next subsection describes what was occurring and how nursing leadership practices were responding or not, to the phenomenon of safety in the wards.

The term 'safeguarding practices' came directly from the CNM, when talking about a clinical scenario where practice policy was not followed resulting in significant clinical risk for a patient and the nursing team (though this was averted with the timely intervention of a senior nurse). Nicole (CNM) was making the point that "Nursing practice needs to safeguard nursing practice" (22.2.19) and thereby protect or defend or avoid harming others. It became clear in observing and hearing directly from nurses, that nursing leadership practices were intentional to safeguard the patients, nursing practice, and the nursing team.

The safeguarding practices of nursing leadership are presented in four parts. Part 1 demonstrates the leadership practices that were used to anticipate areas of tension or challenges to the normal functioning of nursing, the nursing team and hospital ward – the anticipatory practices of nursing leadership responded to risk. Part 2 identifies the nursing leadership practices of 'shielding' which countered or reacted to reduce or avoid harm. Part 3 presents the safeguarding practice of protecting nursing's identity in response to the monotony and complexity of the hospital ward. In Part 4 the resilience building strategies that were adopted to safeguard professional and team boundaries are demonstrated.

5.4.1 Anticipatory Leadership Practices

Every day and every shift, nursing leadership practices were responding to situations, dynamics, and pressures where safety and risk were in the balance. This required leadership practices which could anticipate where tensions might develop or stability might be compromised, and act to reduce or avoid this occurring. These practices included assessing the ward(s), the team dynamics, and the clinical stability of the patients to identify risk and respond. Due to the nature of the anticipatory action required to do just this, anticipatory leadership practices have been so named, as they sought to reduce risk and thereby safeguard patients and nursing, in these wards.

Assessment of the wards and team climate was one way in which nurses sought to identify and anticipate risk, and act to safeguard situations and care practices. Margaret (SN) acknowledged that:

> *when there are concerns on the ward, being able to take time to address them as opposed to just parking them* [so] *they never really get resolved and it continues. So being able to respond to the needs of the team and patients in a timely manner was needed and expected*. (22.12.18)

Anticipating risks and averting them is part of nursing leadership. Whilst it might appear innocuous to go around the wards each morning to greet members of the team, CNM Nicole did this routinely to serve two purposes. Nicole talked about being able to gauge the climate on each of the wards, by the manner of the interactions she had when greeting team members (FN:19.4.18). Secondly, the rounds enabled her to react immediately to situations arising within the wards and to anticipate issues that were likely to be brought to her attention later. She made decisions to attend to some issues immediately whilst deferring others to a later moment, so that assessments or processes could be completed. Hearing multiple sides of a situation as she made her way around the wards, created time to consider possible strategies to address issues. By assessing the situation and gathering information, Nicole was arming herself to be able to respond to situations and influence others to reduce risks or avoid them altogether. For example, upon seeing two cleaners, Nicole was able to confirm she had purchased some cleaning products that were not on the supply list. She had them available in her office and the cleaners could come for them after 0900hrs. The response to this news was a relaxing of body posture and a jovial conversation from the cleaners about what it took to keep the bathrooms clean. This reduced the risk of confrontation about lack of equipment and supported the maintenance of hygiene standards in the bathrooms on the ward. Additionally, as a leader, Nicole set a time boundary to allow herself time to continue with her ward rounds and to provide direction for access to the products.

Identifying a risk, RN Grace who was managing a patient load and co-ordinating a Sunday morning shift called each member of the nursing team into the sluice room to find out who had overfilled the linen skips. She had previously created a health and safety poster to remind her colleagues about not overfilling the linen bags, as this practice exposed orderlies and the nursing team to heavy bags of contaminated linen. Speaking with each colleague in turn, Grace's usually relaxed demeanour altered to one of focus and intensity. Grace's tone was direct as she pointedly enquired about who had done this and asked how this had occurred. "Did you do this? Was this you? Well, this is not right. It's not good enough...it's too full and it is not fair to nurses or the orderlies". The nurses individually dodged responsibility for the overfilled bags before Grace called them all back to the sluice room, together. Grace became direct again with a slight increase in voice volume. Again, she used short, pointed statements:

> *This is unacceptable (pointing to the bags) …it's unclean, there is faeces on those towels at the top and it's too full and heavy…and will hurt someone and that someone could be you when you try and move this linen bag from the skip...stop doing this…stop overfilling the skips*. (FN:3.3.19)

Grace's tone softens slightly as she asks that they all work to sort the bags. "The orderlies will come soon, and they shouldn't be having to deal with this. We need to do it right from the beginning and then we wouldn't waste time now". Putting on gloves, all the nurses help to move linen from the overfilled bags into emptier ones remedying the situation before returning to patient care.

In this example, through Grace's leadership practices (behaviour, actions, body language and voice) health and safety standards are outlined, and expectations are reinforced. Grace was an equal with her proficient colleagues, yet she challenged all her colleagues individually and then as a group, to agitate for a change in the way current practice did not meet health and safety standards. This is an anticipatory nursing leadership practice as Grace knew the standards, and she was prepared to step up and speak out, gathering the team about her to seek a change in practice. Grace had taken the opportunity to influence them individually and then remedy the issue as a team. Both Nicole's and Grace's examples demonstrate on-the-spot leadership to reduce risks by addressing the issues. Such leadership actions and behaviours anticipate the possible effects of not engaging or of avoiding the situations, thereby safeguarding nursing practice.

Education and skill acquisition to help develop nurses to recognise clinical risk and respond appropriately, was noted by the nursing hierarchy in the ward to be essential. Preparing nurses to recognise and detect risk was an anticipatory leadership practice. Education enabled and empowered nurses across the teams. Through formal and informal education sessions, coaching and developing knowledge and skills to competently provide care and role-model expected nursing standards, all nurses contributed to this.

It was typical that in responding to one aspect of care or a clinical question, guidance and teaching enabled others to assess for risk. The common scenario below demonstrates nursing leadership practices which responded to and anticipated further risk.

> *An RN comes into the nurse educators' office seeking specialist wound products from the cupboard. Whilst the RN is looking in the cupboard, SN Sally asks her what she needs. The RN responds that the ward is down on the number of HCAs needed and so the nurses are struggling to ensure the timely provision of care. Sally asks if she needed a wound dressing done and the RN says "the wound products are for a patient that the casual nurse is caring for. She* [the casual nurse] *has more need of help than me". Sally follows the RN to the ward and finds the casual RN is in fact a nurse that has been 'shared' from the surgical ward upstairs. Sally discusses the plan for the wound dressing with this nurse, finding that she is not familiar with this wound dressing technique. Establishing that this RN has time now, Sally says that she is available to support her*

> *through the process. She instructs the RN and a student nurse who is working with the RN, to gather the equipment needed. They then head into the patient cubicle and pull the curtain. Sally is heard beyond the curtain and cubicle, coaching, and guiding the RN and student nurse in the application of the wound dressing. Having completed the dressing and left the patient cubicle, Sally instructs the RN and the acting ACNM that the patient requires an assessment for the risk of pressure areas – "the patient needs a Braden scale done for an air mattress which I am going to order". Sally's tone is both assertive and directive. Sally then picks up the phone. Identifying herself, she asks the receiver to bring an air mattress to the ward for this patient.* (FN:7.6.18)

Responding to hints that care may be compromised due to limited numbers in the nursing team, Sally created an opportunity to help the nurses on the ward, whilst also teaching and guiding knowledge and skill acquisition around wound products, application, and anticipated effects. Then she directed what needed to happen next. A risk assessment was a clinical expectation but was also needed to justify the budget associated with the use of a hired air mattress. Drawing on her knowledge of the assessment tool, Sally requested the air mattress knowing that the patient met the threshold required. By guiding the learning and responding to anticipated risk, Sally safeguarded the patient and the nurse and student, using her leadership practices.

Similarly, during weekdays, one SN would hold the medical emergency pager which meant that in a medical emergency, SNs could respond to such events and support nursing colleagues. Afterhours this responsibility fell to the duty nurse managers. Having SNs competent and confident to respond to medical emergencies including resuscitations, provided ward nurses with leadership and support during stressful situations. It also offered the opportunity to identify the trends of deterioration and learn to anticipate these in the future.

Nursing resource across the organisation was constrained. Anticipatory leadership practices sought to predict the nursing care requirements of patients and match this to the resource available. Whilst some of the challenges of the electronic system TrendCare have already been described, a favourable aspect is that this system enables nurses to contribute to identifying the risks posed when the balance is out. By doing so, anticipatory leadership practices could respond and therefore, became visible. Attempts could be made early in the shift to address expected pressures.

As a whole system approach was favoured across the hospital over ward specific needs, at times these risks were identified and not averted. So instead of providing a solution, the system provided evidence for the stress that was being felt by nursing team members. In such moments, nurses turned to the designated nurse leaders of the wards and those informal nurse leaders who were approachable and

provided support, seeking out those who were calm, maintained oversight of the ward and the acuity of patients. Direction was taken where patient allocations required modification and teamwork created to best reduce risk and ensure patient care and safety.

The examples provided were typical of leadership practices used to anticipate risk and mitigate this where able. Whilst some of these practices are process- or structurally driven, these would not have been effective without nurses engaging in these practices. Looking on, nurses at all levels utilised anticipatory leadership practices in their everyday work but this was not the only safeguarding leadership practice occurring. The safeguarding leadership practices of shielding were also observed in the wards. These are presented next.

5.4.2 Shielding and Being Shielded

'Shielding' and 'being shielded' refers to leadership practices nurses used to lead and cope in the contexts they faced. The purpose of these practices was to minimise the impacts of what was occurring. This included the psychological impacts of the ongoing pressure of working in an under-resourced environment with reduced organisational support and which contributed to desensitisation and burnout. For nurses leading in these wards, shielding or being shielded, was used to avoid or minimise harm. Shielding refers to the action and practices that nurses used to protect themselves and being shielded is the leadership practices of protection that others provided to support nurses.

Sheltering or providing a metaphorical protective cover over individual nurses, the nursing team, or patients, was one method of being shielded to screen them from harm. This often meant that nurses, whilst expecting to be safeguarded, were unaware of the shielding practices others used to keep them safe. Yet the dialogue about being safe was deafening in the wards resulting in nuanced shielding practices which adapted depending on relationships and situations. Shielding practices included the use of 'leadership masks', gatekeeping access and information, role development and providing stability and reliability by supporting and having each other's backs.

5.4.2.1 Leadership Masks

A typical shielding practice was observed in nurses' demeanours on these wards. Individual nurses used leadership masks to portray that everything was under control. Diana (RN) referred to the mask of calmness she used as a shield when facing challenging situations. This was both a personal shield and one which Diana used to generate collective calmness across the team, even when she did not feel calm herself (11.7.19). In contrast, those nurses who were not calm or in control or had not developed this shielding practice of leadership were observed being indecisive, panicking and not maintaining the overview that other nurses expected of them. Jeanne (EN) said of such nurses: "I

hope nothing goes wrong tonight because they couldn't put a fire out in a fish shop" (18.7.19) referring to the disorganisation and lack of control felt by the nursing team when nursing leadership practices were not skilfully implemented and responsive to the challenges.

Authoritative or confidence masks were adopted by some. This included those who adopted a façade of confidence or a "fake it till you feel it" mask (FN:1.11.18) to inspire self-confidence and shield themselves from what they perceived others expected of them. Graduate nurses talked about these masks indirectly as "needing to be confident for the patients' sake" as they saw the effects of this from experienced nurses (FN:2.11.18). Other nurses adopted masks of confidence when speaking up to resolve challenging practices or contribute to decisions or advocate for their colleagues. Nurses were observed appearing confident in their approach, using a commanding tone of voice and sound rationale to demonstrate their thinking. When asked later about how they felt, nurses talked about feeling compelled to 'step up' or 'speak out' or advocate for their patients or their colleagues, even though they were not always comfortable or confident to speak up when more senior colleagues might disagree.

Another mask that was observed being adopted by nurses was one used to navigate relationships with other members of the MDT, to shield patients and colleagues. Along with a mask that appeared less confident and more curious, body positioning also reflected an inquisitive stance with shoulders lowered and head rolled to the side with the ear closer to the shoulder and the chin up. Like others, RN Grace was observed adopting this mask. Grace talked about having to play the doctor nurse game to get what she wanted, and this was the mask that she used. Talking about this mask Grace said:

> *It's being slightly submissive. "I would really love your opinion on this." You already know what you need from the doctor, you already know that you're guiding them into it, it sounds very manipulative, but I don't mean it to be that. I just need a doctor to see this patient now. It's getting to know people, and how I get from that person what I need.* (3.3.19)

Here Grace talks about her approach of coming alongside the doctor to direct and steer them towards a patient to shield the patient from harm.

5.4.2.2 Gatekeeping

Shielding was also observed when nursing leadership practices filtered or buffered organisational pressures. A regular example of this is the actions and behaviours taken by nurses in response to the pressures to admit patients beyond resourced beds. Advocating to maintain safe nurse-to-patient ratios, deferment of admissions and the timely discharge of current inpatients was observed seven

days a week. This leadership practice was particularly adopted by nurses who were co-ordinating wards (either ACNMs or RNs); these nurses shielded the nursing teams from the pressures until decisions were made and resourcing was found.

Beyond shielding the nursing team, shielding occurred to reduce potential harm to patients. Grace (RN) demonstrated shielding when she greeted a uniformed police officer coming into the ward on a Sunday morning, to interview a patient in relation to her injuries. Having determined his purpose, she asked him to wait in a side room and then went to the patient's cubicle to ascertain the patient's readiness for an interview (FN:3.3.19). Gatekeeping access to the patient, Grace shielded the patient from the pressure to participate by removing the expectations that would be inferred with the officer entering the patient's cubicle unexpectedly, and by protecting and enabling the patient's right to decline her visitor at this time. This is a typical shielding practice observed in these wards.

Shielding practices of leadership also occurred in response to specific clinical scenarios where nurses determined that patients, others in the nursing team or themselves, needed shielding from harm.

> *Afterhours when the SNs had left the surgical ward, ward nurses were adjusting the patient allocations to ensure that the male nurses in the team were not allocated to care for post-operative gynaecology patients. This meant that the male nurses were not gaining experiences to develop their skills and knowledge of this patient group which was an expectation for career progression. This was brought to the attention of the ACNM (Elle) by one of several male nurses who was feeling the inequity of opportunity and felt he was being singled out in the delivery of the message. Talking with the ward nurses involved, Elle found that their motivation was to shield their male colleagues and the patients from situations in which patients might feel vulnerable. Elle drew on the expertise of the gynaecology department, organisational policies and procedures and sought advice directly from the legal team about patient and staff rights in relation to this. Presenting the gathered evidence to the nurses who had taken issue with the workload distributions, she spoke directly with them to make her expectations clear. It was the organisation's expectation that male nurses could work with post-operative gynaecology patients, as with any other patient, providing consent was obtained. Elle acknowledged that the nurses had been acting to shield patients yet their actions, which were done covertly, were causing harm within the team. By addressing the issues that arose, Elle demonstrated she was shielding the individual nurses from the limited caring responsibilities that the re-allocations afforded, and the rest of the nursing team from sole responsibility for this patient group. Patients continued to receive optimal care*

whilst organisational policies and the patients' code of rights were being upheld. (FN:19.12.18)

Elle could have gained advice from the CNM however, Elle talked about wanting to resolve this for herself. She talked about wanting to get information directly from the sources, and policies, so that she was in a better position to address the issues. Elle was shielding herself from the vulnerabilities of not knowing as a leader and wanting to be informed to support the nursing team and the patients.

Shielding leadership practices sometimes resulted in half-truths being told to colleagues or information being withheld to shield colleagues from missing out on opportunities, and disappointment. These shielding practices occurred sporadically in scenarios such as the organisational bed meeting, where the nursing resource was occasionally not presented as it was, to enable the resource roles within the team to achieve their roles and functions as discussed in Chapter 4. Using different roster codes to disguise the nurses in these roles, a half-truth was presented. In shielding the resource nurses, these nurses were protected from providing patient care so that they could achieve the work expected of their resource roles.

Nurses sometimes became aware that information was not always fully disclosed, creating challenges as suspicion was created. In turn, this affected the credibility of nurses and how their actions to shield, were interpreted. Sometimes information or individual nurses were shielded from discussions either due to timeliness for decision making, or by accident or purposeful omission. Once realised, nurses' suspicion about the reasons for this were heightened creating doubt about the reliability of colleagues to be inclusive or ensure relevant information was passed on. For example, when Ward Z was being considered for closure with Christmas looming and limited anticipated elective surgical admissions, a meeting was scheduled for the four ACNMs, the CNM Nicole (who was offsite), and the operations manager. This meeting did not take place. Instead, a meeting occurred between two ACNMs (one who was deputising for the CNM) and the operations manager and a decision was made to immediately close Ward Z. The operations manager told Nicole and the two experienced ACNMs went to Ward Z to inform Elle (ACNM Ward Z) of the decision. On hearing this news (which was announced just outside the nursing station) Elle's body language gave away her surprise and disappointment. Elle's eyes widened and eyebrows rose creating a questioning look on her face whilst her shoulders slumped. A moment later, her posture restored as members of her team had also just heard the news. Elle's language indicated she was on-board with this decision as she called all her team together to plan the measures needed to close the ward and transfer patients. Later, away from her team and the other senior nurses, Elle questioned why she had not been involved in the meeting when it had been agreed she would be and about how the decision was delivered by her two colleagues in an

abrupt but conciliatory manner. Elle spoke about how this confirmed to her that they recognised her omission from the process was unpalatable and not what was expected.

Elle shielded the nursing team by creating a collaborative team response to the decision, despite feeling excluded from the decision-making process. The reason for the earlier meeting was not established, but Elle recognised that by delivering the decision in such a manner, the two ACNMs behaviour shielded themselves from the response of the team, and Elle from all the information that was used to make the decision. She talked about whether "they were trying to protect me from having to make the decision…it wouldn't be mine to make alone anyway" (FN:10.12.18).

5.4.2.3 Shielding Role Responsibility

Another form of shielding from harm that was observed, was the staggered acquisition of role responsibility. Nicole (CNM) shared that she had had previous negative experiences when new senior staff had quickly become overwhelmed and disillusioned by the complexities of the role, which ultimately resulted in them leaving. To avoid this, Nicole had adopted an approach which shielded the two recently appointed ACNMs from the full responsibilities of their role. This included doing the rosters for two wards whilst the ACNMs grappled with the daily co-ordination expectations of their specific wards, including the facilitation of the MDT and patient flow.

> *Several months after having started, ACNM Lavender met with Nicole for her usual monthly meeting. This was held off the ward in a meeting room. Here Nicole asks how everything is going? Lavender is co-ordinating and has taken three independent patients and is preceptoring a student, to show the nurses that she is able to manage a patient load. Reviewing Lavender's monthly report, Nicole gives guidance about what and when to pull data out of TrendCare to inform the report. Nicole also informs Lavender about the Operation Manager's current focus – that of ensuring Estimated Dates of Discharge (EDDs) are in all patient's electronic records and 'Observations and Engagement' documentation (for those patients requiring close supervision to maintain safety) is correctly completed. Nicole goes on to ask Lavender if she would like to develop an 'Observations and Engagement' portfolio to support both the senior nursing team but also the wider team regarding documentation, support, and training. Lavender smiles and says she will think about it. Further training opportunities for Lavender were then introduced by Nicole with audit training set up to occur next month. Lavender contributes that she now has a login and password for Oracle, the supplies requisition computer application and Nicole asked her to access this. Tomorrow, she will show her how to create an order. Nicole then says she has already done the ward's*

timesheets for this pay period and will sit on her hands next fortnight to let Lavender do it. They go on to discuss specific nurses and their welfare and rostering requirements. (FN:14.5.18)

This example demonstrates how Nicole shielded Lavender from the full extent of her role. Skill and knowledge acquisition were paced as were expectations to fulfil specific tasks of the role. This shielding was to support confidence building and maintain Lavender within the senior team.

Shielding leadership practices were called into question when they were perceived to favour individuals or groups of nurses. Perceived as over-involved leadership practices or micro-managing, some in the nursing teams interpreted the staggered acquisition of responsibility by new senior nurses as the CNM not wanting to relinquish control. Likewise, shielding some nurses over others was viewed as over-involvement and caused issues around impartiality and equity in the teams. One SN "was so protective of this other person, that nobody felt safe to talk to the senior nurse" (RN Sera, 9.7.19). Nurses were unsure about their safety to approach this SN especially when it related to concerns about the other nurse. Observing this hesitation amongst nurses at different times, contributed to leadership appearing to be compromised. Boundaries were needed to be maintained to ensure that overinvolvement did not compromise team functionality. Nurses' leadership practices needed to create and maintain the balance between enabling nurses, shielding them from harm, and the perceptions of the team. This was an ongoing challenge.

5.4.2.4 Reliable Support – Having your Back

Nurses talked about others in the nursing team 'having your back', meaning that they felt supported and could rely on colleagues for their leadership to stand by them. Thirty-three interview excerpts and 27 fieldnotes captured scenarios where support was expected or offered to protect them from working in isolation, and from the psychological pressures that many were feeling. Similarly, nurses talked about the importance of having the support of their colleagues and seniors in relation to their leadership and resultant clinical decision making so they were not undermined. This included being provided with all the relevant information about a patient or situation to be able to prioritise and decide on a way forward. Enrolled nurses, RNs and SNs expected to feel supported in their work and in their role within the team by nursing leadership. They talked about this during formal discussions or spontaneously during fieldwork.

Kelly (RN) (who was nearing the end of her first year of nursing practice) talked about working alongside another newly graduated nurse in the ward. About her colleague she whispered "she's really stressed so I'm waiting on an HCA to help me, and I am happy to do so. I don't want to stress her out any more than she is" (FN:1.11.18). In this example Kelly has recognised her colleague's

vulnerability and looked to someone else to help her thereby shielding her colleague from further stress. By whispering, Kelly demonstrates that she wants her rationale to remain private or hidden from her colleague and does not want to exacerbate her colleague's stress further or undermine her confidence.

Sally (SN) also pointed out during her individual discussion that reliable support was contingent. "They give you support because they think that you are doing a good job" (21.2.19) implying that team support would come if their previous experience of leadership practices had positive impacts for the nurse(s). In contrast, RN Charissa talked about the need for credibility between words and actions. She drew on a scenario where her ward ACNM wore the 'speaking up for safety' t-shirt (as did other SNs) during this hospital's campaign. On the back of the t-shirt was written "I've got your back" which caused ironic humour within this nursing team as "we feel that they don't have our backs" (10.7.19). The team felt a lack of credibility and reliability from those wearing the t-shirts, as they had had experiences of the reverse. A lack of human resource within the nursing teams was central to this scepticism.

It is evident from the data that shielding as a safeguarding practice of leadership was occurring through adaptive approaches dependent on the foci of vulnerability and the relationships involved. Ironically in trying to influence nurses, the success of shielding was dependent on the credibility of the nurses using these methods and the congruence of the messages with actions in practice. Without this, suspicion and distrust created ineffective leadership practices.

5.4.3 Protecting Nursing Identity

In these ward settings, protecting nursing identity was another function of nursing leadership practices. In the following subsections, the leadership practices of protecting team membership, the development of nursing knowledge and skills within nursing specialisations and protecting nursing identity are presented. Through the nursing leadership practices of advocacy, courage and the 'use of voice' (stepping up), these practices were revealed.

5.4.3.1 Protecting Nursing Team Membership

Nursing leadership practices advocated for and protected the membership of the nursing teams on the ward rosters. Team membership was important to the nurses in these wards as it contributed to the culture of the wards and the collective nursing team identity. *Ad hoc* teams were created shift to shift, day to day. This meant that the identity of the nursing team was dynamic and changing based on its membership. This along with the diversity of the nurses and social dynamics contributed to each nursing team having a unique team culture which modified according to who was rostered to

which shift. Leadership practices sought to support a nursing team identity of collective unitedness which reflected this dynamic team membership.

Advocating for diversity in the nursing team membership meant that nurses were representative of New Zealand's multi-cultural society. The teams included nurses of varying ages and experience, from diverse ethnic and cultural backgrounds. Recognising that "this place is like the league of nations" (RN Grace, 3.3.19), and that "having mixed cultures in the team is good for us because our population is diverse" (CNM Nicole, 22.2.19), was the acknowledgement and celebration of difference, and part of the fabric of these four wards. This took the form of celebrating National days and language with flags, the inclusion of music and sometimes dance performances by staff or outside groups for patients and nurses and the wider team.

Nurses were aged between 20 years and the late 60s. Assumptions within nursing teams were sometimes made about levels of experience in nursing based on age and this affected how leadership practices were interpreted and responded to. Senior nurse Margaret who became a nurse five years prior, was noted by the teams as having expertise beyond her experience. Whilst Margaret had attained a senior nursing role, Margaret suggested, this was largely due to her age (she was over 60 years old), and "I don't correct them on this" (19.12.18). In contrast, some younger nurses who had more nursing experience and expertise than their older colleagues were not recognised for their leadership. Lavender (SN) pointed to "the generational thing that makes quite a difference. I will use words that they won't understand, or they will use terms and I will say 'I have no idea what you are talking about'" (5.2.19). Other nurses also talked about the distance between the generations. Graduate RNs talked about being viewed as baby nurses with some patients saying they looked too young to be nurses (RN Beth, 20.7.19; FN:1.11.18). Despite the generational differences of the nurses in these teams, leadership practices brought the teams together. This included advocating for the specialisations of nursing practice of each team, and the expectation of teamwork and unity.

Conflicts between ward teams arose when an individual ward roster was not seen as distinct but as contributing to the collective resources available to the four wards. Additionally, the wards were expected to share nurses to ensure that gaps in other wards' rosters, which arose due to illness or absence or recruitment, were covered. In contrast, nurses on the roster saw each ward as distinct with its own membership, ways of working, and knowledge base to support care decisions and therefore, nursing identity. Leilani (RN) discussed the challenges of making SNs and duty nurse managers understand the different models of care between medical, surgical, and rehabilitative nursing and the specialty skills and knowledge needed to safely deliver care in each specialty.

TrendCare was often drawn on to argue where nursing resource was needed, ignoring the different models of nursing care and specialty knowledge needed in each ward.

> *I just feel that we are always losing out and especially with staffing, to every other ward. Because their TrendCare is saying that they're so much in the negative. I've encouraged our staff, don't lie on our TrendCare, because we, you know, we'll just stoop down to their levels. We have to let it reflect our work.* (Leilani, RN, 20.7.19)

In this excerpt, Leilani argues that TrendCare does not accurately capture the nursing work and that there is a perception that other wards manipulate the numbers. Leilani's statement reflects a standard of conduct and transparency and demonstrates the frustration of being penalised or threatened by the other wards and their cultures. Another RN from the same ward as Leilani spoke directly to me saying:

> *They don't understand the numbers of nurses we need to enable us to look after the post-operative patients. One patient goes off and then who looks after the rest of the ward if we have five or six post-operative patients and then there are those from yesterday or the day before, and they have taken away our nurses?* (RN, 13.11.18)

In response, nursing leadership was drawn into a negative light. Of this ongoing scenario SN Sally said:

> *That's just poor leadership. I don't think that's a missed opportunity. It's an opportunity that's there, every day to be managed properly. I just think that this is poor management, and this is what's happened when we've come down to just trying to put the finger in the dyke. This is the result of that. We got x number of nurses so we just have to shift them around and that's why you have a resource pool of nurses who are particularly skilled and are very highly experienced nurses where you can say, X is very experienced mainly in orthopaedics but is also really good in general medicine and feels very comfortable in general surgery so we can send her to this area. I think that's why having a pool for specific areas is a really good idea. Unfortunately, again because of resource a lot of that has fallen away. I think it's just become "well we need a pair of hands there, so we'll just send that nurse".* (21.2.19)

Some nurses considered themselves specialist nurses but when needed, the organisation and management saw them as a resource to be moved to address a gap. Speaking up and advocating for specialty teams and nursing models of care took energy which was often lacking due to the incessant pressure and lack of previous responses, and it took courage to challenge the hierarchy. Ward nurses

and senior nurses engaged such leadership practices both publicly in the wards, in offices and in meetings in attempts to protecting team membership between and across the wards.

There were nurses who 'stepped up' and put their head above the parapet reminding senior nurses including the CNM, that moving nurses to other wards devalued the skills and knowledge and the sense of team that the wards were building. It was also noted that *"the regular sharing of nurses made it challenging to ensure that competency development and education sessions could be delivered to those who needed it and that other projects and changes to practices could be embedded"* (FN:15.6.18). In contrast, other nurses felt being part of a different team and having new nursing experiences that required the translation and transference of skills and knowledge to another area, was an opportunity to develop themselves further. Advocating the different perspectives helped define the line.

Between these two perspectives was another, that of the ACNMs. The ACNMs were caught between these perspectives as they were named on the ward rosters and formed their own subgroup. They were expected to follow the direction of the CNM despite this potentially resulting in nurses from their own team being sent to another ward leaving their ward short. Team boundary lines became blurred at times such as this. The differentiation between individual or collective teams, and specialty and generalist knowledge and skills, created tension across the ACNM group though this was largely reserved for private off-the-ward conversations so as not to appear divided.

Despite the focus on resourcing the wards, nursing leadership practices also sought to protect and develop role boundaries. This was informed by role descriptions, standards of practice, scopes of practice and local policies and procedures. Application of these in daily practice varied dependent on the situation and who was involved.

5.4.3.2 Protecting Nurses

Nurses expected leadership from others to help define boundaries and contribute nursing identity. Using their voice by speaking up for themselves and others, nurses were observed advocating for the memberships of their teams. Whether on a personal level or a team level, nurses banded together to avoid vulnerability and unsafe environments and practices. Leadership practices that protected nurses were observed or discussed included using your voice or speaking up (n=30), "stepping up" (n=25), "sticking your neck out" (n=21), advocacy (n=20) and having courage or being brave (n=5).

In her individual discussion, RN Beth provided a scenario in which an RN colleague who was handing over her patient care to the next shift required understanding of the shift she had had. Leadership

came from unexpected quarters to protect the nurse's contribution and nudge senior colleagues to play their part.

> *The nurse was questioned about why they had or hadn't done something. It was kind of more about finding out what's happened during the shift and why things have happened…for their knowledge of what they're going to do for their shift. Sometimes it goes well and others…you should have done this. Depends on the person. I've seen it happen where they* [other RNs] *have, you know, it was with a new grad, they weren't long off orientation. And they said, you know, well you should have done this. She said "I asked this senior nurse and that senior nurse, and they both told me to do this, you know, do what I've done. So that's why I've done it and don't shoot me. I was advised by the seniors" and there wasn't much of a response. The questioning was disheartening for her, I think. They probably felt like they were being told off. And they possibly felt that they were being a bit picked on. Later I heard one of these same nurses saying, "wow she had a really hard patient load today…who gave her that?" but they didn't say that to the nurse. I am sure she would like to hear that. Because it doesn't mean anything coming from me, I'm pretty much the same level as her. But for the senior nurse who told her off for doing something, to then go "actually I acknowledge that you've had a really hard shift. Good work on what you've managed, you know, on what you've done, would have been really good". I did the hint and hope thing – "it would be really good for her to hear, you say that". But it didn't work. So, I pretty much repeated what they said, "look it probably doesn't mean much coming from me, but you have had a really hard shift, with lots of challenges and you made it".* (RN Beth, 20.7.19)

Stepping up and offering appreciation of her colleague's contribution saw Beth's leadership practice in action. Beth helped restore the nurse's contribution and identity within the team and reminded her colleagues that acknowledging others, particularly when you have been critical, can have positive effects for those concerned.

Other leadership practices attempted to overcome some of the negativity that affected the reputation of the team, its membership and identity. This hospital site was sometimes referred to as "a second cousin" hospital (EN Emma, 12.2.19) and "the place where nurses go to die" (SN Patricia, 28.02.19). This contributed to varying perceptions about the nursing identity of those working in these wards.

> *I do find it, it's like a roller coaster and you have sometimes where we are awesome at care with dignity towards each other as well as the staff, patients and then it will go down the roller coaster and then we can be pretty awful…cyclic. It's got to do with, well,*

> *staff morale, and it's got to do with winter pressures. It is always hard, because not only do we increase our bed numbers, we don't get any extra nurses, really, and also being in winter everyone is always sick or the children are sick, and then we can't find staff….For example,…sometimes we have mental health patients on the ward who, really, we actually need mental health support workers looking after them and not physical health people because it's a completely different ball game and when we can't find any support for them, the nurses take it quite hard and that's where morale comes down.* (SN Alice, 10.12.18)

Building on and promoting successes was one way to counter such negativity. Profiling individual and team achievements in the organisational newsletter and at the organisation's annual awards were examples where pride and satisfaction were evident. As SN Jane points out "We are all in this together and we're going to do the best that we can" (21.2.19). Building momentum, one step at a time also contributed. As SN Alice observed "it's quite a lot of energy to try and get them to show how good they can be, and it's their choice, and I focus on the ones who want to progress" (10.12.18). Developing those nurses who wanted to engage meant that results came more easily as there was no resistance. This in turn re-energised those involved and positively influenced others to be involved. Nicole (CNM) noted "it's a win-win" situation although "you'll get some quick wins but they're not all quick wins" (22.2.19) indicating that not all situations are readily managed or that there is choice in what or how certain challenges are handled.

Gaining acknowledgement for successes created positive news and influenced reputation. "Winning awards lifts up the profile" (Patricia, SN, 28.2.19). By pointing out the distinct contributions these teams made to patient care, nurses began to claim their nursing identity over the time that fieldwork was taking place. Alice talked about how she supported this.

> *For probably the first year, I only addressed them as specialty rehab nurses, and I'd have to get through to them saying "you work in a specialty area; you are really specialised. I can't get a nurse from the surgical ward* [at the other hospital] *and bring them here and expect them to do what you guys do; it's complex; you are amazing at what you do, and this is who you are, so be proud of it". And it's funny, I was talking to another nurse just this morning who was talking about the new EN we've got starting and she said to me that one of the RNs had said "we shouldn't actually have a new grad EN working on such a specialty area" and that made me smile because these guys are now realising that they work in a specialty area and that was awesome.* (10.12.18)

The data revealed nurses appreciated leadership practices that provided them with the permission (n=29) or autonomy (n=5) to determine their own practice decisions and actions. Protecting the line or the boundaries was common to all these practices. Nurses who did this were recognised as leaders within the nursing team.

Based on the use of language in the wards, membership in these nursing teams meant that nurses were possessions. Permission language was an example of possessing nurses or nursing practice. Enrolled nurses, RNs and SNs talked about "allowing" (n=18) and "letting" (n=11) nurses or nursing practice to occur. At times this meant that "things are done to us" and that "they're just asking to just be polite, but they don't really want to hear the answer" (EN Emma, 12.2.19). The language of 'possession' or ownership had a custodial role over space and roles and implied a level of control and a lack of accountability of the nurses to adjust this notion. Despite this aspect of language use, promotion of the nursing perspective or voice was strong. For example, nursing leadership practices involved processes for nurses to lead and facilitate MDT meetings, contributing nursing diagnosis and care outcomes. Medical teams found the focus on nursing diagnosis puzzling as they were accustomed to medical diagnosis and the medical model leading MDT meetings. However, nurses were encouraged by the CNM to continue to lead the meeting presenting the nursing diagnosis and interventions for each patient and the ACNMs of each ward facilitating this and leading the discussion of the patients in their care. In this example expectations were set down for the wider MDT, and ACNMs were expected to put this into practice. This was risky and it did take courage to adjust what had previously occurred and needed continual advocacy to ensure nursing's contribution was present. By doing so, power relations changed within the meeting and after four months became embedded within the structure of the meeting.

For team membership and identity, having additional nurses join the team casually to cover absences, meant that support and mentoring was needed to enable the casual staff to work effectively. This too contributed to building team reputation and the identity of the nursing team, as individuals showed leadership by demonstrating a willingness to share and support skills and knowledge-acquisition. Some nurses were not ready nor willing to be involved in supporting newcomers or casual staff, however, others stepped up thus avoiding the reputation of the nursing team being put at risk.

Nursing identity was about both an individual and collective identity which nurses aspired to, and which others expected of them. It was influenced by how nurses perceived themselves and how others perceived nurses (including by reputation). Nursing leadership practices contributed to the collective identity of the family, and of the professional nurse. Some nurses in these nursing teams saw the teams as a family (n=9) with a further three references establishing nursing as a sisterhood

with regular use of ‘sister’ or ‘sis’ heard on the wards. Recently graduated nurses were sometimes referred to as “baby sisters and baby brothers” and SNs were labelled “the mother hen”, relating to the supportive and nurturing role of mothers who set expectations for behaviours and practices including following the rules, as might happen within a family dynamic.

The identity of the professional nurse was visible through leadership practices. This was seen in nurses following the professional and organisational rules, meeting practice standards and using the evidenced based policies to inform clinical decision making and clinical leadership day-to-day. Protecting this identity was a core role of leadership practice as this affected the reputation of nursing locally and more broadly. As with all reputations, it takes time to create and build a reputation based on good outcomes and very little time to damage that reputation. The nursing reputation in these wards had been exposed to negative publicity through social media prior to this study being undertaken. Nurses adopted leadership practices to protect the reputations of nurses and the nursing teams of this public hospital. This was done by promoting positive media coverage to build good news, profiling nursing teams and the work they were doing and continuing to ensure collaboration in processes that affected other services and patient care delivery. This meant needing to be nimble in responses and flexible in thinking. These nursing teams gained reputations for ‘dealing with complex discharges’ and having a ‘can-do’ attitude. This strategy made nurses feel valued.

Having the courage to follow or to not follow was significant to enabling leadership practices. An EN, and two SNs talked about this as “not being afraid”, “being brave” and “having the courage and belief to stand up”. Finding your own path and sometimes not going with what everyone else did, was also demonstration of this. By diverging from the crowd and being apart, nurses demonstrated the leadership practice of courage which could in turn influence others and lead them in other directions. This was not a daily occurrence but did happen with some regularity. A typical situation was at the team handover prior to the bedside handover at 0700hrs. In this example, RN Monica cut off the conversation of her two colleagues who were not listening to the handover from the night shift graduate nurse. They were whispering between themselves and distracting others so the handover could not be heard. In a clear and raised voice Monica says “Can we all focus on what needs to be heard? This is important patient information”. Monica stared at both nurses for a moment, so they understood she was talking to them. They stopped and turned to face the graduate nurse who continued the report. Whilst this might be considered a small gesture, here Monica set the expectation of and for her colleagues about the behaviour and respect expected during handover. It also indicates that Monica was not scared to call her colleagues out should standards not be met. For those looking on, Monica was someone who speaks up and can influence others. This required standing apart from the team, for a moment.

Getting the balance right in the leadership approach taken, was a challenge for some nurses in certain circumstances. Trying to lift the standard of an aspect of nursing care using the care guidelines and organisational policy, one SN used a forceful approach to create tension and agitate for change. However, this approach resulted in the nursing team feeling apprehensive and persecuted and the SN fearing she could not do her job, without being labelled a bully. This situation arose rapidly resulting in distress for all parties and the CNM being called to listen to and address the arising concerns. The burden of this was made heavier by historic claims of hierarchical bullying (occurring prior to the current CNM). Managing this sensitively to retain everyone's dignity was challenging. It required distance to ensure that all were heard and respected and to find a way forward that preserved everyone's dignity and met professional and organisational expectations (18.4.18). Time and space were created initially and then the issues were discussed collectively with the CNM facilitating the conversation, presenting the viewpoints, and setting the expectations for standards of practice, behaviour and interactions moving forward.

To protect nursing identity, advocacy, courage, and use of voice played a significant role in the leadership practices of nurses in these wards. The analysis showed that autonomy and granting agency through language contributed to influencing the attitudes and practices of others in the team. Team members appreciated others speaking up for them or nursing issues, and regarded this as leadership within the team, especially when the ideas raised aligned with personal or professional values.

The fourth safeguarding practice, the resilient practices of nursing leadership are presented next. In these wards where team dynamics were everchanging due to the rostering and the ongoing pressure of limited resourcing and clinical complexity, nursing leadership practices took a significant amount of energy. This final section of the chapter reveals how nurses utilised nursing leadership practices to manage the effects and impact of everyday practice.

5.4.4 Resilient Practices of Nursing Leadership

The impact of everyday nursing in the wards was visible and talked about. One RN said, "managing the stress of the job and not cracking" is the challenge (Talia, 9.7.19), in comparison CNM Nicole noted that "if we burn them out before we get to winter, we're not going to be in a good place" (22.2.19). Pressure, stress, and burnout were significant challenges for the staff in these wards. Therefore, it was imperative to maintain personal and team wellbeing. This was challenging for many who had developed and used leadership practices in their everyday nursing. It was easy for some to become

overinvolved or self-sacrificing to ensure that the team and nursing practice ran smoothly. The data showed that others used strategies to manage themselves and maintain wellbeing. This included creating support networks and restoring leadership energy and wellbeing. Each practice is presented with examples from the field to demonstrate how these occurred.

5.4.4.1 Creating and Maintaining Support Networks

Support networks were vital to leadership practices in these wards. Giving support and taking support was part of maintaining support networks for all levels of the nursing team. Fifty-five data excerpts confirmed this with 10 excerpts revealing "no support", or "that colleagues won't support others". Overwhelmingly, support was relied upon to keep nursing practice on track and to maintain personal wellbeing.

Support came from within the team. It came from different roles and personalities depending on who was working and the circumstances in which support was required. Sources were somewhat fluid but relied on developed and maintained social relations whether these had just been established or were long-standing. For those who were leaders or saw themselves providing leadership, support was a key feature. Leilani (RN) talked about when she was "not in-charge, and they are, I can relax, but I still provide support" (20.7.19), indicating the fluid relationship between giving and gaining support. This could be seen with nurses coming together in the nursing stations, the medication room, in the corridors, staff spaces or heard in the patient cubicles. Jane (SN) acknowledged that in creating and maintaining support within the team:

> *We need balance. That's what makes healthy teams. We all have strengths and weaknesses. We need happiness and community. What's made me survive nursing is that I've always had good buddies. You know you have this at home, and you come here for this beautiful career, but I survive it with buddies, with good people. It's a village.* (21.2.19)

Jane's comments acknowledge the differences in skills and traits of nurses in the team and that through support, friendship and community, nursing and nursing leadership is achievable. Nicole (CNM) acknowledged the networking and support that came from huddles or the coming together of the senior team:

> *for just five minutes to consider how there might just be a different way of doing staffing or something else. They're the kind of things that does help. We just problem solve or confirm that now we're doing good. There's a couple of times when we'll go for a walk*

around the grounds and things like that. I'm not very good at joining them for that, but I know that they do it which is good. I need to role model that a bit more. (22.2.19)

Some nurses sought support for their leadership outside of the nursing team. One SN admitted that she needed additional support beyond what was available across the team and in the wards. To manage generational differences at the SN level, Lavender joined an organisational peer group of nurses who started in similar positions around the same timeframe as her and were of a similar age to her. "We used to meet on quite a regular basis…it meant we know we have this support crew behind us if we want it" (5.2.19).

Without support, leadership practices did not gather traction or influence a wide range of staff and practices. Therefore, ensuring that key supporters were onboard was vital to ensuring effectiveness. This included those recognised by nurses and managers as the informal leaders and gatekeepers. These were the nurses that SNs looked to gain buy-in from the team and ward nurses looked to for leadership and support for their needs and voice.

Nursing leadership practices sometimes meant that nurses needed to be apart from their team or colleagues as discussed earlier in the chapter. Being apart from others did create loneliness for those who maintained this practice of leadership. Registered nurses and SNs noted that some aspects of nursing leadership required this isolation from others and so individuals sacrificed being part of the team to be able to carry out their role and responsibilities. This distancing was not fixed for all time but was bounded to situations or scenarios. Formal leaders still engaged closely with other formal leaders and used being alongside when appropriate for the situation; but this co-existed with being apart. Five nurses talked about the isolation, or loneliness in their roles when leadership was required. In response to the loneliness, nurses appeared to counter this by seeking out support or collegial connections. An example of this was nurses raising key issues or issues that were of less consequence, to find commonality with others in the team. Whilst this was not necessarily a leadership practice, it was used to create and maintain connection and support networks. Nicole talked about this, suggesting that "this did not replace feelings of aloneness when it came to making hard or unpopular or unpleasant leadership decisions" (FN:18.4.18).

5.4.4.2 Restoring Leadership Energy and Wellbeing

Nurses are known for caring for patients however, it was evident from observations on the ward, that 'taking care of yourself' was much lower in the priority list of these nurses. Nurses admitted to doing this poorly but recognised the need to do this better, to be effective in their leadership. Techniques that some nurses talked about that provided them with energy to keep going, included creating a

sense of teamwork amongst the nurses. Care, compassion, and kindness contributed to a sense of team and created a feeling of energy within the wards.

Nursing teamwork became a focus to maintain the wellbeing of staff. With the organisational adoption of team nursing, this model of care offered a way for nurses to work together to meet the needs of patients. Each ward adapted the principles of team nursing to suit their membership, culture, and the leadership styles within the local nursing hierarchy. Within the work teams and across the teams, attention was paid to 'playing to each other's strengths'. This meant that by relying on others for expertise, knowledge, and skills, and through role-modelling, gaps in areas could be addressed. Nursing leadership practices that ensured fair and equitable workloads, and a distribution of nursing expertise across the shift to support patient acuity, contributed to encouraging teamwork and "looking after your team" (CNM Nicole, 22.2.19; RN Charissa, 10.7.19; RN Joy, 3.8.19).

The sharing of personnel was another strategy used to support resilience given the challenges in this monotonous and complex environment. Whilst RNs and ENs were shared on an as-needed basis, several ACNMs were also moved to a different ward, nursing team and nursing specialty to offer some diversity in their roles.

> *So, some of my teams were struggling. So* [this] *was a way to help them in their situation to make their job different,* [with a new] *team and dynamics. But this was also to give them some skills of working as a team, and that has made them stronger which worked.* (CNM Nicole, 22.2.19)

Acknowledging this was a gamble, Nicole was pleased by the results of swapping ACNMs between two wards for a four-month period. Nurses took time to adjust as did the ACNMs but generally it was felt to be a positive move for the ACNMs whose leadership practices strengthened as they learnt to lead in new situations and different teams. Whilst other SNs substituted for ACNMs to cover leave, no such longer-term swaps occurred amongst the educators or specialists.

Looking after your team also included the way interactions occurred (discussed earlier in the chapter) and the facilitation of breaks away from the ward including annual leave. Sometimes this meant planning for absences to give staff annual leave from the ward environment and at others, responding to the immediacy of an unfolding situation. Several times across the 18 months of field work, between 4 and 6 of the 10 SNs had planned leave simultaneously. This left skeleton senior nursing staff across the four wards (FN:18.4.19) and offered the opportunity to give new leadership experiences to the nurses leading the teams, and to others in the teams, to step up and work with different members of the senior team. Some ward nurses were deputised and were also exposed to new roles and

responsibilities. The outcome of which was that new learning took place at work and those that needed a break, were supported to do so. This contributed to energising the team, reducing burn-out and enhancing succession planning for the future.

Additionally, senior team planning days and monthly senior nurses' meetings, in addition to whole-of-team meetings, were created for the sharing of information and team collaborations. Keeping socially connected with the nurses and teams and staying informed of issues arising meant that situations could be pre-emptively managed or responded to early. This also meant that hope and positivity could be injected into the teams especially at times of hardship and pressure. This was often when caring and compassionate leadership practices became most visible. Having worked with patients through a 'care with dignity' programme across the prior two years, these nursing teams were now starting to turn some of the learning inwardly for themselves.

Below CNM Nicole is talking about filling up a metaphorical cup by replenishing physical, emotional and mental energy and recharging your batteries.

> *You have the tools to then fill your cup back up if that makes sense. So me and* [another senior nurse] *were talking about it probably just after Christmas, 'cause she said how did you make yourself feel okay again. I said I go and talk to a patient, or get some pills out, or take someone to the toilet. It might just be one task and I feel okay again, you know. And yes, it's lonely and you might do something really horrible for an hour, then go and do something nice, you know, that kind of thing. So, I suppose it's those strategies as well, of the things that we have to encounter 'cause not everything is nice. Sometimes it might be a relative who's distraught, but you're the one who gets all of the abuse and aggression and things like that. And, you know, we don't necessarily have all the right skills to do them jobs all the time.* (22.2.19)

Here Nicole indicates that nursing leadership has negative aspects to it and that developing sustaining practices to restore wellbeing takes time and active engagement in the process. It was important that through such actions to sustain the human factor and inner wellbeing, nurses could restore their energy for nursing leadership practices. Knowing yourself and your personal values is foundational to taking care of yourself. Juan (SN) said:

> *it is important to reflect on what happens and look at always striving to make improvements…no matter how big or small… [this included] being in touch with where things are at with you mentally and spiritually. That's kind of looking after yourself.* (18.7.19)

Participating in mindfulness activities also contributed to caring for yourself when particularly complex and challenging patients absorb a lot of energy. A social worker turned to RN Talia about considering the introduction of mindfulness exercises:

> *…to come together to help each other to cope with the levels of stress that this lady (patient) was giving off. One of the social workers she asked me did I think it would be a good idea to have a maybe three-minute session after handover where we just de-stress. And she would do various breathing exercises with us. She brought it to me and said what do you think? I said I think it's worth a shot. If you're happy to lead them, I will rally the troops. And sure enough people were going to it every day*. (9.7.19)

The leadership practice here is that of trial and error and calculated risk taking. Talia like others recognised the distress and by getting everyone together to try a strategy to help calm and destress colleagues, the outcome could have met with resistance or disinterest. Instead, through active engagement, Talia's support enhanced participation and resulted in a visible decrease in staff distress, nurses talking about the situation in circles and a calmness returning to the environment. Other ways nurses managed energy was by removing themselves from situations where they were not needed or required and disengaging or compartmentalising areas of practice to care for themselves. In effect shielding themselves from situations which could be harmful.

Letting go of issues is another strategy that individuals used to reduce stress and take care of themselves. One SN (Alice) said "I used to get more frustrated but now I have to let some of that go. I can't, I can't sit there banging my head against a brick wall." In this excerpt, Alice indicates that she is aware of what is within her control and what lies beyond it. This realisation helped many of the nurses recognise their limitations and so, reduced their own stress and frustrations. When discussing how she felt tense and stressed due to the large number of patient discharges on a weekend morning shift, Leilani (RN) said "I hate it, I don't like it and so I try to keep reminding myself, do what can be controlled and let go of what can't be controlled" (20.7.19). These forms of self-leadership demonstrated effects within the team. These nurses created impact and influence within the ward, creating a sense of pride and achievement in what they did. This contributed to satisfaction in their practice which had positive influence on how they viewed themselves as a nurse and within the nursing team.

Joy (RN) talked about "needing to stand up for yourself" (2.8.19). Others were observed doing this for their career development "by putting themselves out there and going for whatever, they wanted" (SN Alice, 10.12.18) by creating opportunities and being visible and determined. As a shielding and

resilient leadership practice, this often resulted in skill and knowledge development leading to career progression and the empowerment of the nurses who did this.

Nurses tried to care for themselves in many ways from ensuring they ate well and that they and others had their breaks, that they requested rosters that worked for their lifestyles and family, and that they maintained social connections with nursing colleagues. This was not always successful due to being pulled in many directions simultaneously whilst on the ward. Requesting assistance helped to manage the work and to take care of yourself. Twenty-four data excerpts related to another helping (whether requested or offered). Leadership occurred in both offering help and asking for help, as this required visibility, presence, being alongside and followership. By doing so, caring for yourself or the other, was demonstrated.

The findings presented here point to the resilient leadership practices of individual nurses and teams and how they cope in the contexts of these wards. By maintaining support networks amongst themselves and the wider nursing team, and utilising strategies to restore energy and wellbeing, nurses were using leadership practices to support and maintain teamwork and professional expectations and provide care for patients.

5.5 Chapter Summary

This chapter presented how nursing leadership practices occurred in these four wards. The chapter began by outlining nursing leadership and the nursing roles of SNs, RNs and ENs before giving examples of daily nursing leadership practices occurring across the levels of the nursing team (and not in relation to role).

Patterns of leading or the actions, behaviours and interactions of nurses engaging in leadership practices were presented. This included being present (both physically and actively engaged whilst being visible to others and approachable) and being alongside which saw nurses creating closeness and togetherness as part of leadership practices. Being apart or at a distance was also presented as a pattern of leading occurring in these wards. This included keeping distance, being separate and maintaining boundaries. Being apart was seen when nurses stepped up to lead and then returned to the team. Role-modelling gave rise to nurses following or shadowing practices and which influenced others.

In the third section, the safeguarding practices of nursing leadership were presented. These were the leadership practices that sought to respond to the context in which nurses were functioning – the monotony and complexity of the hospital ward. Anticipatory leadership practices aimed to anticipate

risk and act to reduce these risks. Shielding leadership practices sought to reduce potential harm for patients and nurses and included the use of leadership masks, gatekeeping, shielding role responsibility and having reliable support to deflect such harm. The leadership practices of protecting nursing identity were then presented in relation to team membership and the shared nursing identity of the team. Finally, resilient practices of nursing leadership were presented to mitigate the impacts of leading and working in such circumstances. Knowing the limits of practice and individual's ability and capacities begins this section. Then the focus moved to creating and sustaining support networks to build resilience before nursing leadership practices to restore leadership energy and wellbeing.

The culture of the wards and more broadly the organisation are considered in the discussion chapter. Nursing identity and these leadership practices are explored in relation to the literature presented in Chapter 2 with conclusions drawn about how the findings on nursing leadership practices contribute to the nursing culture and the hospital ward.

CHAPTER 6: DISCUSSION

6.1 Introduction

This study aimed to describe how the leadership practices of nurses occurred in the hospital ward. The focus was on nurses and not on patients and not on nurses' interactions with patients. The research was guided by four questions: what leadership practices occur within the hospital ward nursing teams? What influences these leadership practices? What are the effective leadership practices? And what are the effects of the leadership practices in the hospital wards? Using focused ethnography and a participant observer approach across an 18-month period in four hospital wards, data were generated. Fieldwork notes, individual discussions and a review of cultural artefacts and documents were managed using NVivo12. Ethnographically informed qualitative analysis techniques were used to generate findings. The findings reveal details of how and what nursing leadership practices occur in the monotony and complexity of the hospital wards.

In this chapter, I initially present the individual key findings and how they contribute to support previous research and add new understanding about the ways hospital nurses engage in practices of leadership before I proceed to discuss the collective findings and what these mean in relation to nursing identity. Building on what is known about formal and informal nurse leaders, the first key finding is that nurses at all levels of the nursing team engaged in leadership practices in everyday nursing with collective patterns of leading emerging. The second key finding is how the context of the hospital ward influenced and shaped nursing leadership practices. The focus on safety within the organisation was contradicted by a lack of investment in nurses, equipment and processes compromising professional nursing identity and safety. This created a paradox where nurses were expected to be agents of safe practice yet were not consistently supported by structures and processes to provide safety. This paradox shaped leadership practices. The third key finding is that safeguarding practices of leadership occur in response to the hospital ward context. This is a significant finding in the leadership-as-practice space and includes anticipatory and shielding leadership practices to reduce harm and protect nurses and the nursing teams, whilst building resilience to maintain nursing identity. In this chapter emphasis on key concepts and actions is demonstrated using italics.

In the discussion of the collective findings, this chapter argues that the findings illustrate how leadership practices are shared undertakings across the nursing teams. In response to the contexts, leadership practices create and maintain nursing identity in the hospital ward and these nurses are

responding to the context using safeguarding practices of leadership. My reflexive journey as a nurse researcher in the hospital ward is presented here along with the limitations to the study.

6.2 Leadership Practices and Not Nurse Leaders

The literature review demonstrated that there is no consensus on the definition of leadership, and that much is known about leaders with many leadership studies having focused on individual leaders and their traits and abilities. Similarly, in the profession of nursing, leadership is commonly associated with people and roles. In the hospital ward setting, research has described the leadership qualities, characteristics, and traits of senior roles such as charge nurse managers (CNMs) and specialty clinical nurses and, in the hospitals, of the executive directors of nursing. Much of this leader-centric focus has been on the influences of these positions on patient outcomes (Murphy et al., 2009; Wong et al., 2013), clinical errors, team effectiveness (Germain & Cummings, 2010; North & Hughes, 2012), and nurses' job satisfaction and retention (Cummings et al., 2018; Feather & Ebright, 2013; Larabee, et al., 2003; Rad & Yarmohammadian, 2006; Roche et al., 2015). My study was not focused on those in nursing leadership positions only, rather it was designed to examine nursing leadership practices generally in the clinical setting of the ward.

The study was positioned to describe and explore how nursing leadership is carried out in the hospital ward using a leadership-as-practice lens with a participant observer approach. The findings capture what nurses did and said and how they did this in the context of the ward. Leadership resided between and amongst individuals with collective patterns showing how the practices of nursing leadership were socially constructed within the context of the hospital ward.

In the recorded individual discussions and informal conversations, nurses on these wards said nursing leadership is about people and most often, these people are in appointed leadership roles. Descriptions provided are mainly positive in nature, describing the traits and characteristics similar to those of nurse leaders. This finding is akin to those of Cummings et al. (2009), O'Donovan et al. (2021) and Specchia et al. (2021) who also noted that nursing leaders were described positively. Asked to illustrate what leadership looked like, nurses in this study initially responded offering key functions of the roles of nurse leaders. This indicates that nurses were familiar with considering leadership from the leader-centric perspective.

With further conversational prompting, nurses provided scenarios of leadership but again, found it challenging to describe leadership practices including how behaviours, actions and interactions occur and how outsiders would recognise this as leadership. In telling their stories and giving their

perspectives, nurses returned to individuals and leadership roles and their many expectations of leaders. This indicates that leader-centric leadership as described in Chapter 2 is currently embedded within nursing and reflects the mainstream perspective that the profession of nursing has largely used to explore nursing leadership in the literature.

The finding that nurses in the ward associated leadership with those in formal leader positions and do not see their own practices as leading, poses a challenge for nursing. Whilst the findings demonstrate a dissonance between perception and performance of leadership practices, they also reveal a lack of awareness of nurses' collective agency in relation to leadership practices. Historically, women's roles in New Zealand society have not been recognised for their leading ability or practices. For example, women participating in leadership roles such as on New Zealand public sector boards and committees, only reached the 50% representation target in December 2020 (Ministry for Women et al., 2020). Nursing's ongoing reliance on roles within the hierarchy has influenced how leadership practices are seen; that is, in the roles within professional and organisational structures and frameworks in which ward nursing operates. This has meant that leadership practices are typically viewed as the property of leaders (Day et al., 2014). Nursing did have and continues to have an apprenticeship type model of skill development supported by hierarchical positions. Currently this model is known as preceptorship in New Zealand and is where a learning nurse follows the lead and direction of a more experienced nurse (Lafrance, 2018; NZNO, 2022). The hospital nursing hierarchy and the apprenticeship model both associate leadership with one's more senior colleagues and thereby offers some self-protection or self-safeguarding from standing apart from the team. This study builds on what is known by showing that leadership practices are carried out not only by nurses in senior roles but also by any nurse in the team; they are not restricted to the appointed leadership roles.

Further evidence of the dimensions and elements of leadership practices came from the clinical practice arena; in this case, the nurses in the hospital wards (Carroll, 2016). For example, nurses described clinical knowledge, making clinical decisions and role modelling standards of care and conduct, co-ordinating people, and processes, and undertaking administrative and management responsibilities. This is clinical leadership as described by Patrick et al. (2011) and nurses linked clinical leadership as a practice of nursing and an influence on practice. The example of the two nurses coming together to consider a patient's low blood pressure and the withholding of betablockers until review, showed that clinical leadership was occurring. One nurse influenced the next action of her colleague by advising further observations were needed to provide a fuller picture of the patient's clinical status including the vital sign trends. While this advice could be considered nursing assessment and care; it became clinical leadership when one led the other to consider another response and the other made a choice in response. Throughout multiple observations in this research, it was apparent that clinical

leadership was part of everyday moments of nursing practice, and as such, it was not recognised or isolated as leadership. Clinical leadership was so intertwined within daily activity that it was almost not visible. Such practices of clinical leadership were positively constructed descriptions which drew on the institutionalised notions (Alvesson & Sveningsson, 2003) of nursing leadership as described in nursing role descriptions and underpinned by patient safety (Boamah, 2018).

6.2.1 Patterns of Leading

The four patterns of leading identified in this research are being present, being alongside, being apart, and role-modelling and enabling followership. These social practices of leadership occurred in the spaces between and amongst people. I observed that practices were not always noticed or recognised by the nurses, or they did not have the language to describe them when asked. The patterns of leading happened in isolation, in combinations, in unison, or incrementally. The combinations of patterns were driven by the nature of the context and about the nurses and their experience. For example, when a junior ward nurse needs support and education, the leadership practices of being present, being alongside, and role-modelling and enabling followership were typically seen in response. The nursing leadership literature has not explicitly named these patterns of leading in this way, rather what the leadership practices involve is implied.

6.2.1.1 Being Present

In this study, *being present* involved being visible to colleagues and/or the organisation. This included being actively engaged physically, relationally, socially, and being aware of the individuals, dynamics, routines, and processes in everyday nursing practices. Nurses were seen by others, engaged with what was occurring around them, and demonstrated awareness of what had happened before, mindful of what was to come. Senior nurses and the ward nursing teams demonstrated these practices in different moments across the shifts.

Presence is closely associated with leadership influence. The more present the nurses were in the ward, the more opportunities there were to influence and lead each other. For senior nurses (SNs) who had offices off the ward, being present meant making time to be on the ward and interacting with nurses or for SNs and ward nurses who worked mostly inside the ward, being present included being visible and making time for others. In this study Nicole, the CNM, made this time and by being present, she was able to become aware, actively engage and come alongside the nursing staff. These findings are comparable with Rosengren et al.'s (2007) study of leadership in an Intensive Care Unit however, the focus there was on a single ward manager. Rosengren et al. found that being present and available is key to leadership and that staff relied on the leader's presence to improve care

standards and grow staff. These authors also reported that distance or absence of the leader influenced the work environment in a negative way referring to “an empty office” and “a worn-out ward manager” as examples of this negativity (p. 525). Similarly, Stoddart et al.’s (2014) study regarded visibility as a process and outcome of leaders’ confidence and role clarity and noted the time investment required to do this well.

Repurposing spaces both inside and outside these wards overtime to accommodate restructured nursing leadership positions, has meant that those in formal nursing leadership roles needed to actively engage in ward activities and with nursing staff to influence and lead. Nurses make do and flex to suit the environment. However, the ward and office layouts can be detrimental to nursing team culture as leading was significantly influenced by nurses being visible and present.

6.2.1.2 Being Alongside

Nurses talked about *being alongside* their colleagues to ‘do leadership’. The leadership practice of being alongside was seen as physical closeness and was discussed as togetherness by participants. This is a newly reported collective practice of nursing leadership as literature reporting such findings was not found, given the dominant focus in the literature on leader-centric nursing leadership. Rather, literature about nursing teamwork highlights the practice of being alongside (Kaiser & Westers, 2018), or nurse-to-nurse relationships (Weaver Moore et al., 2013). In my study, being close and creating a togetherness was in response to the team environment and the expectations to be a team and for teamwork. Nurses used a pretence of suspending power relations or hierarchical positions to engage others, get them alongside and close, to influence and lead.

The leadership practice of being alongside was common and occurred briefly, for longer periods where troubleshooting or collaboration was sought, or across the entire shift in the mentoring role of preceptoring. For example, the brief interactions between two nursing colleagues through touch or eye contact contributed to maintaining connection and direction. This is not leadership on its own but paired with interactions occurring prior to or following this moment, established that leadership was happening. Changes or maintenance in activity direction in conjunction with the brief interaction between the nurses demonstrates this. Nurses supported each other to maintain direction or considered other contributing factors and changed their thinking, action, or interventions in response. These interactions built and maintained the opportunity for leadership.

6.2.1.3 Being Apart

A balancing act occurred between distance and closeness in the patterns of leading. Keeping distance created the space from which to lead. By *being apart*, the nurse(s) could reflect on what was occurring

and make decisions based on personal and professional values. Being apart took courage as the leadership decisions could reinforce and set a nurse further apart. It enabled autonomy of the nurse in leading and role modelling. In addition, being apart supported perceptions of impartiality in leading.

Loneliness could result from this pattern of leading. Being apart has been found in other research. Solbakken et al. (2018) refers to this space as a leader's "secret room, where the leader's strength to hang on and persist, is nurtured" (E.1). Being apart in my research was structurally implied for senior nurses and therefore part of the job. Being apart was challenging for these ward nurses who were expected to drive care through team nursing. Being apart was counterintuitive to working together. Despite this, this pattern of leadership was observed at all levels of the team with varying levels of comfort. For example, by representing the team in an organisational project, EN Jeanne was both leading the initiatives within the team and maintaining her role providing patient care. This meant in different and unison moments, Jeanne was apart from the team as she taught her colleagues how to use the new computer system whilst also being a team member providing care to her patients.

6.2.1.4 Role Modelling and Enabling Followership

The leadership practice of *role modelling* was about enacting high standards of practice and others deeming that these practices warranted following. While the model of preceptorship in these wards assumed that role-modelling and followership happens between a preceptor and preceptee, this research shows that it happens between many other relationships including CNM to Associate Charge Nurse Manager (ACNM), RN to SN and EN to RN. *Enabling followership* occurred when opportunities were created or facilitated to support another to follow. Such practices included being approachable, working alongside and sharing knowledge and expertise to coach and guide nursing practice through leadership. These practices provide some support for Kouzes and Posner's (2013) exemplary leadership theory where 'model the way' seeks clarification of personal and shared values and setting an example to 'enable others to act' by fostering collaboration through trust and strengthening others. In this study as RN Daniel wrote patient notes for those he had cared for, Daniel demonstrated role-modelling and enabled followership when he offered to support a student nurse, who was preceptored by another staff member, to write her first entry in patient's notes.

6.2.2 Collective Patterns of Leading

The literature review highlighted that what is written about nursing leadership relates to roles and practices are performed by formal leaders or by informal leaders. In this study nurses at all levels of the nursing team demonstrated leadership practices. The nursing teams comprised of SNs who were appointed to formal leadership roles within the team, and RNs, ENs, and healthcare assistants (HCAs).

Through interactions, actions and behaviours, the leadership practices of nurses at all levels of the nursing team were observed. This contrasted with the leader-centric studies which favour formal and to a lesser extent, informal leaders in leadership studies (Boamah, 2019; Larsson & Sahlsten, 2016; Lawson & Fleshman, 2020; Whitby, 2018). Ward nursing was a team effort and so team context plays a part. Teamwork required interactions and collaboration. This created the space between individuals for leadership practices to occur.

The variability in the patterns of leading is a new insight into nursing leadership. The collective findings indicate that leadership practices happen in combination, in unison, in isolation or incrementally. They draw attention to nursing leadership that sometimes occurs in small moments which are subtle and at the time can be considered insignificant. Additionally, collective patterns of leading were also seen in overt displays of leadership where reactive and proactive practices contribute to what happens in the wards at different moments across the day. This was seen and heard in the change of voice tone and change from conversational language to directive, short or clipped words during unsafe scenarios. For example, in the scenario when Alice became aware of a patient's inappropriate sexual intentions toward a ward nurse, her response indicated recognition the gravity of the situation. Alice's actions and behaviour altered, and she investigated and evaluated the scenario and the risk, interacted, and collaborated with a colleague, and put a strategy in place. Triangulating this scenario with others, these incidents and moments were found to happen with and to individuals revealing the collective practices of leadership. The visible and reoccurring patterns of leading and safeguarding practices happened in response to gaps in leadership, to routines, to dynamics and to processes within the hospital wards. Practices were situated in the context (Carroll, 2016).

In these hospital wards, leadership practices occurred between and amongst people in day-to-day situations and moments. Similar to architectural work and organisational studies where patterns of leadership are part of everyday work (Kelly et al., 2006), in nursing, leadership did not solely reside in roles but in the interpersonal processes of practice (Chreim et al., 2013). For example, when RN Kelly, who was transferring her patient to another service, rang that service to discuss that the patient had been administered a prescribed pre-medication. She conveyed her concerns about the service needing to be aware of and manage this as the transfer had been delayed due to transport issues. In this moment, Kelly's actions and interactions with the receiver demonstrated leadership practices. Without such actions and interactions, these leadership practices may not have occurred or been visible (Crevani et al., 2010). Therefore, in response to situations and contexts, the social practices of leadership were visible, dynamic, and changing.

Findings highlight the profound difference between what nurses said nursing leadership is and what nurses did (Carroll, 2016) and provide some insights to this difference. Core to this finding is that the language and perception of leadership did not always capture the practices of leadership. The nurses talked about nursing leadership from their own perspective of nursing and role, and their descriptions of leadership practices were general and common. They talked about others as leaders rather than themselves and descriptions of practices were generally of the outcomes of leadership rather than on the activity or performance. Nurses could not articulate the social practices of leadership occurring in the space between and amongst people, as this was not always recognised, or they did not have the language to describe it. Therefore, nurses provided incomplete descriptions of their leadership practices.

My findings indicate there is significant reliance on both non-verbal communication and body language, and on oral communication and interactions, and that nursing leadership practices were relational in nature. This finding relates to the work of Uhl-Bien (2006) and Cunliffe and Eriksen (2011) who also draw on the relational engagement of leaders in the way they work in everyday occurrences. From my findings, spheres of influence expand and retract through leadership practices. Language, processes, and activity must assist in reframing our understanding of nursing leadership and celebrate leadership practices and these leadership moments. This finding is consistent with Bohl's (2019) critique of leader-centric definitions of traits and behaviours who reported leadership results from behaviours. Putting a case forward for leadership practice, Bohl argues that when more is known about leadership practices then this knowledge would influence the collective efforts of the leadership phenomenon rather than that of a single leader. My study demonstrates how ward nursing teams use relational patterns of leadership practices to influence each other and everyday occurrences.

It is clear from the many scenarios I observed that leadership practices take time. Recall for example, RN Grace's experiences of creating posters to draw attention to overfilling linen skips and following this up with each nurse individually on a morning shift when the skips had been overfilled. Not finding who was responsible, Grace then took more time to call the whole nursing team together in the sluice room to question the group and seek a team resolution to the immediate issue and lightening the linen skip loads. Nurses have a responsibility to be safe and keep themselves and others safe, and this takes time. Yet the systems in the hospital did not account or allow for this time. The TrendCare tool utilised in these wards (and the wider DHB) allocates time for nursing tasks for specified patients based on the patient acuity and clinical care needs. This timing is then used to inform ward rosters. However, the TrendCare tool does not presently have any way to plan or account for non-direct patient care aspects of nursing practice. Within the tool, there is no concept of team, interactions and the doing of collaboration and leadership, if was not directly associated with patient care (McKelvie,

2019). This means there was no time allocated within the system, to capture and facilitate leadership practices beyond the care needs of the patient. This absence contributes to the invisibility of leadership and undervalues the important contribution nursing leadership practices have within the hospital ward.

Nursing more broadly needs to articulate the collectiveness of leadership. Currently the nursing competencies and Professional Development and Recognition Programme (PDRP) (NCNZ, 2013) are focussed on the individual achieving and developing further. This includes leadership however, this research demonstrates leadership extends beyond the individual to the interactions, behaviours and actions that occur between at least two people as seen in this work. Therefore, the nursing competencies and the PDRP career framework need to be changed to also reflect group and teamwork to capture the leadership practices that are visible in these contexts. Individually focussed competencies support the leader-centric view of leadership but miss the collective nature of leadership. As ward nursing occurs in teams and teams create and support the identity of the nursing team membership, team competencies developed to capture the leadership practices makes sense. This should include expectations for proficiency in the leadership practices of social interaction, behaviours, and actions. Naming the patterns of leadership engagement and capturing a way to describe the quality of leadership practices in nursing is necessary to be meaningful. Maintaining the current individual focus reduces the ability to capture both the essence of nursing teamwork and the leadership practices that occur.

Nursing needs to take collective ownership of their leadership practices and how these contribute to the atmosphere in the hospital wards and the care in practice. Nursing leadership practices occur in moments right across the shifts and cannot currently be conveyed at a handover meeting where time is short, and the focus is on patient progress. The language used in current handover does not capture this. Whilst nurses at handover talk about some of the leadership practices, interactions, or conversations to keep nursing care provision going, it is largely not addressed in this forum. To address this, and strengthen nursing leadership practices, the nursing handover format needs to change to incorporate a focus on teamwork and leadership practices. The patterns of leading should frame this aspect of handover, with identification of examples of actions and behaviours, and verbal and non-verbal communication from practice which demonstrate the patterns of leading.

What is apparent in the findings and alluded to in the discussion thus far is that nurses' emotional intelligence plays a role in the use of leadership practices. The interrelationship between emotional intelligence and leadership was not examined in any detail in this study and warrants further research about the use of and interrelationship between emotional intelligence in nursing leadership practices.

The collective findings indicate that nursing needs to view leadership more widely. This includes recognising and naming leadership practices and being cognisant of the everyday moments and situations in which such practices occur. Without doing so, much of the leadership activity is missed, and leadership remains elusive or in the realm of formal leaders. From these findings, nurses at all levels within the ward nursing teams engaged in leadership practices and in turn, leadership practices shaped nurses understanding of their reality. By labelling them, leadership practices become increasingly visible.

6.3 Contexts and Nursing Leadership Practices

Context provides the backdrop for the social activity, processes, and outcome of leadership practices (Bolden, 2011; Bryman et al., 1996; Gronn, 2002). An incomplete perspective of how leadership is socially constructed is frequently presented in nursing leadership studies. Nursing contexts are not presented or considered in relation to leadership as the focus is leader centric. This study took a practice perspective through a leadership-as-practice lens, and new understandings were uncovered about how nursing leadership occurred within the context of the hospital ward. These included the contexts of the environment of ward setting and processes, organisational culture, of politics, and of professional expectations (Bolden, 2011; Chreim et al., 2013). In the next section a discussion is presented about the significance of contexts inside the hospital wards and the interrelationship with leadership practices, including power.

6.3.1 Inside the Hospital Wards

In this study, the ward setting included the public, and staff spaces of four wards within one hospital and included utility rooms, staff rooms, the corridors, and office spaces. I did not follow nurses into patient spaces though nurses' interactions with patients could sometimes be heard. These ward spaces contributed to how leadership practices occurred. For example, the distance and doors between the wards and offices meant that ward nurses and senior nurses had to either purposefully seek out the other or use opportunities as they presented themselves in either space or in between to engage in leadership practices. Some spaces and times were scheduled in the day for collaborative and interactive activity, such as the organisational bed meeting, and the multi-disciplinary team meeting to plan and evaluate patient care. In the context of these planned meetings, leadership practices were observed. These included patterns of leading and safeguarding practices of leadership. Nurses positioned themselves within the settings and contexts, so they were visible, present, and

approachable and their leadership practices served to anticipate and reduce risk, shield and avoid harm, and protect patients, nurses, and the nursing team.

Structurally the rosters incorporated the hierarchy of nursing roles and the role expectations for leadership. However, my findings show that leadership occurred beyond individuals and appointed roles. They demonstrate that ENs utilised leadership practices as did RNs and SN, in the space amongst people. Taking account of contexts in this study meant that leadership practices could be seen occurring beyond structures and roles. The literature review in Chapter 2 highlights that leadership practices are the activity of formal or informal leaders in nursing. In this study nurses across the nursing team, demonstrated leadership practices which provides new insights into the understanding of nursing leadership.

Revolving nursing team members on the wards created changing social dynamics across the 24-hour period. Due to the nature of rostered and rotating shifts, there was not a stable team, rather the typical membership of each shift was unique. Changing team membership meant the team were *ad hoc* (Valentine & Edmondson, 2016) or extemporaneous and put together based on who was available to fill roster gaps. On these wards, the nursing team rosters provided structured context to nursing team membership on different shifts but needed to be boosted by agency nurses or the sharing of nurses from other wards. At times, this created uncertain and even chaotic challenges for teamwork as the context of the team, the personalities, dynamics, skills, and competencies to practice were unknown and collectively untested affecting how well the team functioned (Edmondson, 2012). This informed the team dynamics and climate of the wards and contributed to how leadership practices occurred.

Daily routines provided the backdrop for much of the leadership practices that occurred. Between patient activities of daily living such as the 0800hrs medication round and organisational processes like the TrendCare census updates at 1100 and 1600hrs, these routine moments predictably used leadership practices to influence and negotiate actions and outcomes. Spontaneous scenarios also provided context for some leadership practices. Advocating and enabling a junior nurse to respond and manage a situation when patients deteriorated as described about Elle and Daniel in Chapter 5. The situation required a leadership response that was attentive and provided direction to ensure the safe delivery of care. Combinations of the leadership practices of being present and safeguarding the patient and Daniel, were evident in Elle's response. This response was repeated at other times and in other wards when patients became acutely unwell, thus establishing a pattern.

Another emergent scenario required shielding practices of leadership to avoid harm. The scenario emerged when Grace followed up on a situation where linen skips were being overfilled. Trying to

avoid harm to both nurses and orderlies, Grace's approach combined being collaborative and being apart from her colleagues, to be directive as she voiced the expected standards and actions. This example demonstrated how changing context informed Grace's leadership practices. Similarly, a pattern of leadership emerged that combined safeguarding and shielding. This happened when Kelly enabled the student nurse working with her, to undertake a new skill. Kelly used her recent experience as a student, now with the confidence and competence of a nurse, to oversee a student nurse to safely dispense and administer of an intramuscular injection for a patient in their care. By questioning, directing, and supporting the student, Kelly was safeguarding the patient by trying to avoid harm whilst also creating a protective shield around the student as the student undertook a new nursing skill. Role-modelling practice expectations and simultaneously anticipate risk and shield the patient and the student from this, demonstrated how context informed the leadership practices that occurred. In each of these scenarios, the leadership practices are effective. The patterns of leading were dynamic and fluid in that they were not static and bounded as a singular activity or practice, but evolved practice upon practice.

These hospital wards were resource poor. Evidence was presented in Chapter 4 that the ward environments were tired looking, the supply of assessment equipment was minimal, and equipment was often shared between wards due to items being borrowed beyond the wards. This meant there were many occasions in which leadership practices such as negotiation and role modelling of decision making and articulation of clinical rationale, were observed. As an onlooker, I felt encouraged to witness these leadership practices, but I also felt powerless in the researcher role as I was unable to remedy the issues with equipment. I was grappling with wanting to fix the issue as a nurse but as a researcher I had to watch on. My anxiety was calmed by witnessing the leadership practices that occurred in response to the shortfall. The sharing and collaboration may not have occurred had I spoken with management about my concerns about the lack of equipment. I increasingly became more comfortable being uncomfortable and letting circumstances unfold naturally.

There was evidence that artefacts other than dynamaps, contributed to the contexts in which these nurses worked. Carroll (2016) argues that even unexceptional artefacts signify how work occurs between people. In these hospital wards, cell phones and pagers, computers and applications, and access to printing and fax and printing capabilities through keycards all signalled formal leaders and contributed to functional expectations of leadership practices. Without these items, leadership activity slowed, wasted time or was ineffective. Access to these artefacts appeared to draw a line or boundary between SNs and ward nurses, that is, those that had access all the time and those that needed to be granted use of fax machines, printers and so forth to fulfil their roles. However, for the ward nurses whose roles did not have direct access to such artefacts, other artefacts contributed to

leadership practices. I draw attention to the equipment and supplies required for daily nursing such as wound care products, and assessment equipment including dynamaps, blood glucose monitors and oxygen saturation monitors. Whist this equipment was not leadership equipment, leadership was visible in the interactions that negotiated access to limited supplies or equipment, and in arguing the clinical rationale for a particular wound care intervention, and in volunteering to support and come alongside a colleague in routine, new or unusual situations using these artefacts. The public inquiry into the Mid Staffordshire NHS Foundation Trust pointed to the need for clinical decision making to be informed at the point of care and for nursing to inform "the resources and support available for the job" (Francis, 2013b, p. 1520). In these wards, leadership occurred in the process of obtaining and using artefacts.

Berlin and Carlström (2015) said that hidden artefacts conceal meaning rather than convey meaning. In this study, concealment added to the meaning of the artefacts. This was the case with the removal of communication books. I noted tension amongst the nurses and the senior nurses when these were mentioned and this caused me to question in my reflexive journal, what was going on in the wards for this to occur. The official line as shared in the findings, was that the four wards were one team and that having separate ward communication books did not support one team. The communication books had been used for three purposes prior to their removal. Firstly, to capture when nurses were shared to other wards, secondly to single out individuals about clinical issues and thirdly, to build momentum for industrial issues. Combined, these contributed to some dysfunction and competition amongst the wards and with the senior nursing team, resulting in the decision to remove the books to support one team. However, below the surface, tensions brewed. This unease felt by nurses contributed to adoption of new ways of managing communication. One ward used group emails for ward-specific communication and another ward started a closed group on a social media application. Both approaches were not available to those outside the mailing list or group membership, thus defining and reinforcing the boundaries of the nursing team membership. This was an early sign in the research that subtribes or subgroups as described by Martin and Siehl (1983) existed within the wards. This one artefact contributed to the creating tribal lines in the teams. Ignoring the negative effect that the removal of the communication books created, leadership interactions and behaviour demonstrated cultural camouflage by consciously concealing the significance of the books. Leadership practices responded to re-establish harmony within the team amidst the camouflage (Berlin & Carlström, 2015).

Leadership practices were affected by and responsive to the TrendCare tool that informed nursing resource within the wards. The TrendCare tool accounted for nursing tasks for specified patients by estimating the acuity of the patient and the hours of care each patient required (nurse hours per

patient day). This meant there was no time allocated to leadership beyond the individual nurse and patient within the system. This absence contributes to the invisibility of leadership practices and undervalues the important contribution nursing leadership made within the wards. The hospital system needs to establish ways to appreciate the significance of nursing leadership in practice. This may lead to changes in the TrendCare tool to allocate time for leadership practices especially in a team environment.

6.3.2 Beyond the Hospital Ward

Organisational politics, structures and processes influenced the way in which leadership practices occurred in the hospital wards. This included meetings, centralisation of resource allocation processes and the competition for staff resources. Examples are explored in the following paragraphs to uncover what was occurring in these processes that involved leadership in practice. Meeting attendance was expected three-times-a-day to confirm patient planned admissions, transfers, discharges, and nursing requirements to manage these patient movements and care needs. These meetings were followed by emails, pagers and texts between the wards, central resourcing, and bed management to action the decisions made. The communications created time consuming activities in which leadership practices were observed and discussed by nurses. With the goal of ensuring that patients received the care they needed and that sufficient nurses were available to do so, nurses engaged in leadership practices beyond the hospital ward multiple times a day.

The centralisation of the processes gave the hospital management oversight of the whole hospital and reflected the New Public Management values of efficiency (Fast & Rankin, 2018; Newman & Lawler, 2009) described in Chapter 1. However, these processes were resource heavy and not efficient as paper and electronic forms of the same data were required to be submitted to inform the reliability of this new live census programme and electronic messaging. Similar to handovers that occurred at every change of nursing personnel, the meetings to establish clinical and resource needs required face-to-face nursing input to provide a fuller picture of the state of the units, wards, and procedural areas, beyond numbers shown on the electronic screens. Leadership was visible in the interactions during these meetings through tone, body language and articulation of the rationalisation of requests for more staff and the negotiation of patient transfers. Yet the need for these fuller explanations and justifications demonstrates that the centralisation processes devalued nursing knowledge and patient safety by not addressing the needs identified by the competing voices (McKelvie, 2019). Rankin and Campbell (2009) also reported health reforms in Canada's healthcare system resulted in nursing knowledge and work being diminished by processes of centralisation and identified the use of computerised systems and surveillance activities as contributors. The need to be efficient competed

with nurses' professional judgement and rationale about care needs (Fast & Rankin, 2018; Rankin & Campbell, 2006). Based on the evidence provided through my study, I argue that while leadership practices were visible in this forum, the need for centralisation and efficiencies created a context where tensions between safety and unsafeness were visible.

The national shortage of nurses was seen in this study. The complement of nurses for these wards' rosters was sometimes short between three to six full-time staff as calculated by the TrendCare system. This meant that nursing teams had casual staff fill in or cover for sickness or seconded for a longer absence. For nursing leadership practices, this impacted the ability to create calmness and resulted in a 'make-do' climate to support both ward nurses and the casual nurses. The shortage of nurses threatened the delivery of care and created safety concerns for the nurses when they felt the care they provided was compromised (McKelvie, 2019; North, 2010). This added to dissatisfaction and the challenges for nursing leadership practices.

The casualisation of nurses to support nurses work-life balance also created challenges for the nursing profession (Becker et al., 2010) and contributed further to the nursing shortage as the concept of temporary fill became accepted (Ministerial Taskforce on Nursing, 1998; Sargison, 2018). This casualisation, the ageing workforce described in Chapter 1, the strategies that have negatively impacted recruitment and retention internationally (North, 2010), and the restructuring of senior nursing roles (NZNO, 2018) have impacted leadership practice as they contribute to the constant turnover of nursing staff and detract from shared understandings about patient safety.

Organisational campaigns during fieldwork included the 'speaking up for safety' campaign. Like others before it, the campaign focused on the individual yet the systems to support it were not robust beyond the immediacy of the programme being implemented. In a climate where nurses were expected to support and adopt the messages, there were times when the nurses' practices indicated apprehension and conflict. This was especially when challenged by insufficient resourcing compromising nursing and patient safety (Nursing Advisory Group, 2022). At a micro level when nurses spoke up making it clear they felt unsafe and unsupported due to too few staff being available to care for the acuity of the patients, senior nurses used leadership practices such as working alongside their colleagues or shielding them from the organisational dialogue until decisions were finalised. These practices were to safeguard and reduce the stress for nurses.

When staffing concerns were elevated to the organisation, and the organisation was unable to meet that need, the organisation management argued that the nurses' needs in these wards were less than elsewhere in the hospital, creating a competitive climate with other wards for staff. This resulted in nurses being exposed to an increase in potential physical and psychological harm and risk due to the

pressures to keep patients safe, without the number of nurses deemed to be a minimum. Faced with this and the vulnerability that this created, some nurses expressed a futileness in speaking up, choosing to focus on managing in the moment.

The Francis report (2013a) which examined the care delivered at the Mid Staffordshire NHS trust in the UK recommended that healthcare staff be enabled to speak up and speak out when scenarios that compromise safety or care practices occurred. It was following this report that the *Speaking up for Safety* programme began and was introduced to hospitals in New Zealand (Cognitive Institute, 2023). In these hospital wards, this programme occurred during the fieldwork period in 2018 and nurses were encouraged to speak up. Yet nurses did not always speak up, as there was a growing acceptance that speaking up did not change the resourcing or the ongoing pressures around safe workloads. As a result, energy waned at times resulting in the campaign losing traction and nurses not always reporting when they felt care was compromised.

Failing to raise concerns has been associated with patient harm (Kim et al., 2020). Preserving their energy, nurses' leadership practices focused on what nurses had control over and what could be achieved. This meant that nursing leadership practices sometimes did not move beyond a particular point and became circular in nature as nurses focused on their circle of influence and control (Covey, 2004). Whilst organisational tensions impacted leadership practices in the ward, the leadership practices of nurses from within the ward were less visible to the organisation beyond the wards.

The cyclic nature of leadership practices was repeated day-to-day in different guises across the wards. Nurses Charissa and Talia talked about being able to mobilise their colleagues which they did to support junior staff and senior staff. They did this by demonstrating courage, using their connections, and advocating for their perspective. When a social worker colleague wanted to support stressed and vulnerable nursing staff caring for a complex patient, it was Talia who was approached as she had been gifted authority by the nursing team and was trusted. When Talia convinced her colleagues to try mindfulness exercises to help their emotional wellbeing, she demonstrated courage to try something new and used her interactions to role-model the activity. Adopting exercises such as mindfulness, the nurses would return to their work within the team calmer and stronger. Examples of this form of stepping up were particularly evident amongst the ward nurses' leadership practices as these nurses negotiated their place and identity within the teams. Setting and maintaining boundaries is part of leadership practices in healthcare settings (Chreim et al., 2013).

Politics in nursing in New Zealand influences leadership practices in the clinical areas (Donovan et al., 2012) such as wards. Discontent with national nursing contracts and work conditions in the public hospital system led to unease and dissatisfaction with the workplace (Roy, 2018). The organisational

and public expectations that patients would be kept safe should strike action occur, shaped leadership practices in the wards prior to the strike. Senior nurses were expected to remain working and ward nurses were to decide how they individually felt about striking. The collective notion of keeping patients safe influenced collective planning for a strike yet everyday these nurses juggled this tension in their practice. Leadership practices occurred in response, with individuals and the collective being supported, safeguarded, and protected to nurse to their fullest extent in each moment.

In each of the preceding paragraphs in this context section, the question of structure versus agency can be posed (Sewell, 1992). Agency refers to an individual's capacity to act on and change the world around them (Bandura, 2001) whilst structures are "the properties which give coherence and relative permanence to social practices in different times and locales" (Trowler & Knight, 1999, p. 182). The leadership practices in this research show the integration between the collective agency of nurses within the structures and rules of the nursing profession, hospital organisation and health system giving rise to the question about forms of power and control.

In nursing, the concept of power has been linked to organisational hierarchy and authoritative leadership (Kanter, 1977; Kuokkanen & Leino-Kilpi, 2000). Taking a critical social lens which looks for constraints that might impede participation, or where participants are unable to act freely and are considered oppressed or underprivileged (Fulton, 1997; Habermas, 1972), forms of power include coercion or domination (Kuokkanen & Leino-Kilpi). Focused on the individual, Kanter's (1977) theory of structural power in organisations purports that power is empowerment or the "freedom to make decisions with authority and have choices" (Fulton, 1997, p. 534). Turning the focus on organisations, power is efficacy and goal-orientation through opportunities and information within the system rather than through roles or people (Kuokkanen & Leino-Kilpi). French philosopher and historian, Michel Foucault, did not personify power rather he argued it is omnipresent originating from everywhere (Kuokkanen & Leino-Kilpi, 2000). Foucault (1975/1977) draws on hierarchical observation, normalising judgement, and examination as features of control. This includes the observance and non-observance of rules and standards as disciplinary control and normalisation.

From the findings chapters, there is evidence that structures including the team composition and size, organisational and professional processes, and the embedded hierarchy within nursing teams all contributed to reduce or impede the leadership practices of nurses. Whilst the focus in this research was not on power and control, the contexts in which nursing leadership practices occurred, collectively constrained, held power or control over nurses' leadership practices. This included within the patterns of leading where positional hierarchical power was levelled to come alongside another to lead. Also remember the limited dynamaps and SN Jane leading a conversation with medical colleagues to

ensure assessment equipment was returned promptly for nurses' use, and tools such as TrendCare which were intended for organisational oversight, and which became tools of control of the limited nursing resource where the data was inversely used to support centralised decision making. Similarly, the safety campaign to encourage notification about safety issues and risks, normalised the ongoing pressures faced by staff, requiring leadership practices to adapt and create security and safety where possible. In the next section the safeguarding practices of leadership are examined and how these contribute to nurse identity.

6.4 Safeguarding Practices of Leadership and Nurse Identity

Safeguarding is not a term commonly connected with leadership practices. Safeguarding is usually associated with the protection of children and young people, and vulnerable adults, to keep them safe from harm or potential abuse (Brown, 1992; Chambers et al., 2021). Safeguarding has been associated with safety culture in complex contexts to protect patients (Farag et al., 2017; Lee et al., 2019; McKeon et al., 2006) and increasingly with nursing. As a result of the COVID-19 pandemic Bookey-Bassett et al. (2020) recognised the critical dual roles nursing managers play in safeguarding and inspiring staff and patients. In the peri-operative specialty, nurses were identified as safeguarding patients' humanness and nurses' welfare to develop a caring culture in the setting (Rudolfsson et al., 2007). Bondas (2003) argued that caritative leadership in nursing is underpinned by a caring service to another human being. I argue that the nursing leadership practices demonstrated in this study extend nursing values beyond patients, to include safeguarding and care for nurses and the nursing team. Safeguarding practices of leadership were the practices that nurses used to anticipate and minimise risk, shield nurses from harm, protect nursing identity and build resilience within the nursing team. Different from the management discipline which looks to minimise risk and find efficiencies and increase productivity (Newman & Lawler, 2009), nurses' safeguarding leadership practices were situated in everyday moments of nursing and responded to the contexts within the hospital wards, to enable nurses to be and feel safe and supported, and thereby create safety for others. For example, safeguarding practices of leadership occurred when Diana and other nurses, used authoritative confident masks to inspire calmness amongst the nursing team when exposed to challenging scenarios including limited staff. Similarly, the safeguarding practice of shielding was used to reduce the exposure to challenging workloads such as when ward nurses were reallocating gynae patients to maintain patient rights and protect their male colleagues from perceived risk, and when Elle intervened in the same scenario to ensure that hospital policy was maintained and learning opportunities were fair and supported competency development and skill acquisition for all.

The findings from this research indicate that the purposes of leadership practices were to provide care through behaving, acting, and interacting and by safeguarding patients, nurses, and nursing values. These practices were underpinned by nursing actions and principles including care and compassion, communication, protection from harm, and courage to step up. The actions are similar to the 6Cs of nursing adopted in the UK as part of a strategy to address the high-profile cases of poor-quality care in England (Baillie, 2017). The Cs are Care, Compassion, Communication, Commitment, Competence and Courage. In New Zealand, the Nursing Council of New Zealand (2012a) *Code of Conduct for Nurses* contains four core values and eight principles. The values are respect, trust, partnership and integrity and the principles are shown in Figure 7.

Figure 7. ***New Zealand Nursing Values and Principles***

Nursing Values
• Respect • Trust • Partnership • Integrity
Nursing Principles
1. Respect the dignity and individuality of health consumers 2. Respect the cultural needs and values of health consumers 3. Respect health consumers' privacy and confidentiality 4. Work respectfully with colleagues to best meet health consumers' needs 5. Maintain health consumer trust by providing safe and competent care 6. Maintain public trust and confidence in the nursing profession. 7. Work in partnership with health consumers to promote and protect their well-being 8. Act with integrity to justify health consumers' trust

Note. These are presented in an adapted format from the original source: Nursing Council of New Zealand (NCNZ). (2012a). *Code of conduct for nurses*. https://www.nursingcouncil.org.nz/Public/Nursing/Code_of_Conduct/NCNZ/nursing-section/Code_of_Conduct.aspx

These values and principles relate to health consumers', patients', and community safety. Nurses and nursing practice are not specifically identified beyond identifying colleagues as a tool to ensure health consumer needs are met. Collectively these values and principles underpin the conduct and practices of nursing in New Zealand, setting the expectations for quality care which resonates with those in the UK.

This study found that leadership practices safeguard nurses and nursing identity. Nurses grappled with being an instrument of safety yet were not always safe themselves. To avoid compromising their

nursing values which presupposed “nurses’ responsibility to nurture and protect, to heal, to cultivate healthy behaviours and attitudes, and to be present (physically and intellectually) during times of vulnerability, illness or injury” (Rook, 2017, p. i), nurses acted to safeguard and protect themselves from the pressures through leadership practices.

The vulnerability contributed to an identity struggle for the nurses in these wards. This struggle can be illustrated by Karpman’s (1968) drama triangle which captures the inter-relationship and transactions between the roles of persecutor, rescuer, and victim when people are in conflict or experiencing consistent pressures and tensions. The rescuer seeks to rescue those whom they see as vulnerable and needing help. The victim may feel overwhelmed, powerless, and inadequate and looks for someone to take care of them and protect them. The persecutor is unaware of their own power, which can impact negatively on others. The levels of awareness and responsibility in each of the assumed roles changes dependent on the context (Karpman, 1968). At various times, nurses could be seen moving between these roles due to the practices they demonstrated, despite some being unaware of the roles that they played through their actions, behaviours, and interactions. Jane (SN) frequently rescued her colleagues, attempting to protect them from anxiety and distress due to the lack of staff. By taking this on herself, Jane became overwhelmed and described feeling helpless to change the available nursing resource. This was observed by nurses as reducing Jane’s approachability and availability and her ability to lead was negatively perceived. This pattern continued whilst the persecutor in the scenario, I believe to be the organisation in this scenario, remained remote to the distress that was being experienced. Organisational reporting captured numbers not human affect or vulnerability, and this enabled the triangle to continue. The nursing teams’ values and identity were challenged regularly due to the persistent nature of the context and pressures, impacting on the way nurses felt about themselves and how they felt they were perceived.

Nursing leadership practices were also observed as a vector that transformed the roles within Karpman’s drama triangle to those of the winner’s triangle. In 1990, Choy developed the winner’s triangle as a solution to the drama triangle. This triangle shifted the emphasis to each person being responsible for “their position, their actions and their feelings” (McKimm & Forrest, 2010, p. 263). In the winner’s triangle, the role of persecutor is replaced with an ‘assertive’ position where a person asks for what they want and adapts to get their needs met. Replacing the rescuer, a ‘caring’ position is concerned for the vulnerable person and uses listening skills and self-awareness and does not become over-involved or take over. The victim is exchanged for the ‘vulnerable’ position where suffering may still occur, but the person is able to use their self-awareness to think and problem solve (Burgess, 2005; McKimm & Forrest, 2010). Outlining the characteristics and skills needed in each position in this winner’s triangle (assertive, caring, or vulnerable) the person does not take on a role

but a position allowing for adaption to different scenarios depending on the amount of engagement, awareness and responsibility taken. Emotional Intelligence is key to this though this was not assessed in this study.

Both triangles relate to daily human experiences (Burgess, 2005) and have been used in social work and family therapy (Karpman, 1968), enhancing individual and organisational learning (Burgess) and clinical and educational supervision (McKimm & Forrest, 2010). An alternative to the Karpman Drama Triangle, is the Empowerment Dynamic Triangle (Emerald, 2005) which is sometimes referred to as the coaching triangle or the positive change triangle. Drawn from psychotherapy and life coaching, leadership practices contribute to the persecutor role becoming one of challenger in the empowerment triangle. The challenger set clear expectations, listened, and created impetus for change by agitating and creating tension. The victim became a creator taking control and initiating positive change whilst the rescuer became a coach, supporting others and allowing others to solve problems. The example of the nurse who became the focus of a patient's attention chose not to be a victim instead continued to care for her patients. To safeguard a student nurse, SN Kelly took on an assertive position and a coaching role working with the student to teach, empower and recognise success.

Leadership practices of individuals and of the teams were observed at different points of time moving between these roles and positions of these triangles. Leadership practices were adapting to contexts and contributing to nursing identities. Although signalled above as pertaining to individuals, these patterns of interaction and behaviour were collectively demonstrated, resulting in shared experiences and shared norms contributing to a shared nursing identity that was under constant remodelling.

6.4.1 Identities

Organisational, professional, social, and individual identities existed for nurses within these wards. At times these identities conflicted resulting from boundaries being drawn and redrawn dependent on situations. Kirpal (2004) draws on the work identities of nurses and the strong attachment they have with their team and nursing specialisation, along with their professional community. Work socialises individuals creating social and individual identities (Kirpal, 2004). Leadership practices were vehicles to establish and maintain identity boundaries and I draw attention to those of the nursing team and nursing specialties where interactions contribute to these identity boundaries (Chreim et al., 2013). For these nurses, the nursing team identity was strongly associated with the physical ward (Hochschild, 2010) and the nursing roster from which the nursing team membership could be identified.

Belonging was important to nurses' identity. Belonginess can be understood as a collective accomplishment of feeling comfortable in the social world where self and identity develop (Hochschild, 2010). In this way, belonginess is linked with identity and place (Hochschild). Some nurses recognised their team as a family unit and by using language such as 'sis' or 'sister', 'little brother' and 'mother hen', situated their leadership practices within this family structure with hierarchy and idiosyncratic relationships. Aspinall et al. (2021) also found that the social relationships between colleagues when leading was significant. Of three social identities, the 'mum hat' signified nurses constant and recurrent relationships with colleagues. My research shows that belonginess included the use of language to capture all those within the team as family.

Like tribes, the boundary lines of the nursing teams became blurred as organisational perspectives viewed nursing staff as a resource to be placed where need was greatest. "Teammates tend to be related to one another by bonds of reciprocal dependence and reciprocal familiarity" (Goffman, 1959, p. 83). In these wards, the bonds of dependence and familiarity were evident in nursing leadership practices yet were challenged by context. Whilst the one team approach used by the CNM aimed to address this fragmentation, the approach was not fully successful at doing this due to competing processes. Nurses' collective identity became fragmented when nurses were shared between the wards. This fragmentation resulted from the paradox of feeling unsafe and being expected to create safety for others and as such, nurses grappled with shifting boundary lines of their identity (Sveningsson & Alvesson, 2003).

Leadership practices contributed to building resilience to preserve nurses, their identity and maintain optimism despite the complexity of the wards (Traynor, 2017). Nursing resilience is known to be built by leadership strategies including relational support, meaningful recognition, self-care and establishing and maintaining relationships and boundaries (Kester & Wei, 2018). Other innovative opportunities were created to develop a resilient team in these wards. Strategies included promoting well-being through mindfulness in response to a specific challenge, creating and maintaining teamwork and trust, and creating new team dynamics and experiences by assigning different senior nurses to co-ordinate the day-to-day functions of the ward. Traynor (2018) argued that in contrast with superficial resilience where the individual "bears responsibility to cope" (p. 7), resilience strategies must be active and not passive and do more than mitigate systemic issues from an individualistic perspective. In these wards, local level leadership initiatives attempted to lift the resilience levels to manage the complexity and pressures, beyond the individual to the collective. Nurses recognised both the proactive efforts made to support the teams such as creating a change in SN co-ordination of the ward. This meant new energy and ways of working provided a fresh approach.

This was supplemented with reactive resilience strategies that were created in response to changing coping abilities and mechanisms of the nurses.

Organisational focus on resilience would have gone further to develop and sustain the collective critical resilience of nursing teams. Accounting for political and organisational perspectives, nursing scholar Michael Traynor's (2018) critical resilience considers nursing's professional identity and situates the collective understanding and experiences of nurses within the contemporary contexts of healthcare to foster survival and change. Franken's (2019) study of leadership and employee resilience reported the need for resilience development and adaptability, arguing that organisations have "a social responsibility to focus on resilience development" (p. 175). The mixed method research in human resources and leadership identified resilience-enabling leadership, specifically growth, trust and collaboration were key. The findings in my study complement Franken's leader-centric study as my findings demonstrate that nursing identity is enhanced by leadership practices that involve creating and maintaining social networks and restoring energy and wellbeing. Traynor's (2017) ideas on critical resilience would be useful to adopt within these wards and the hospital, to cement the support the nurses collectively need, to adapt and respond to the challenging and complex work that nursing has become.

In summary, leadership practices do not solely reside in a role as the nurses themselves suggested, but are practices that any member of the nursing team can engage in. The types of leadership practices nurses engaged in adapted and responded to the different context in which nursing occurred. There was incongruence between individualism and collective approaches to leadership issues, creating the need for safeguarding practices of nursing leadership. These leadership practices largely looked for unity, togetherness and to reduce risk and harm.

6.5 The Researcher's Journey

This written representation of the study shows the stages of the research journey I have been on. However, it was in my research journal that my growth and poignant learning as a researcher, was captured. Reflecting on my journal entries I have found that the patterns of leading are a symbolic representation of my researcher journey. This is explained in this final section of the discussion in which I reflect on the process and my growth.

Being present and becoming aware of the forms of leadership scholarship and how this had informed what was known about nursing leadership in practice, helped shape the research question and my thinking around this to inform how this might be practicably addressed. Being present also captured

my researcher role within the wards. I needed to be present and visible to engage with participants to gain their interest in the study and consent to participate. I was surprised at how keen nurses were to be involved in the study and to share their perspectives, experiences, and observations. As a researcher, being present and engaged during the fieldwork was necessary to observe the leadership practices, activity, and interactions and to hear what was said, to understand it and make the connections to other events or scenarios, and to follow the practices of the nurses.

Being alongside meant grappling and coming alongside the literature to identify that leadership practices were not well understood from a collective perspective. Being alongside also captures my change of position as a researcher. At the beginning of the study, I was an outsider with insider knowledge of being both a ward nurse and senior nurse within the hospital ward setting. Based on my reading, I expected this to continue through the fieldwork and I worked hard to maintain distance from participants. My perspective changed. The data collection and analysis processes meant I was questioning the data, to understand and capture the collective worlds of these nurses and their leadership practices. In this way, I was no longer an outsider. I became an alongsider with my position during the process, moving along a continuum. The quote by ethnographers Atkinson and Hammersley (1994) captures this articulately: "We cannot study the social world without being part of it" (p. 249).

To observe these practices, and the influences on these and their effects, I was often physically close to the nurse participant I was observing. I moved around the ward so that the nurses I was observing were predominantly in my view but for when they were inside the patient cubicles. Individual discussions also brought me physically close to the nurses participating. This distance became metaphorically even closer as I analysed the data to understand the behaviours, actions and interactions that were occurring to and by the nurse in the ward. Through the analysis and written representation of the findings, I metaphorically drew alongside the participants as the patterns of leading revealed themselves.

Being apart also summarises my researcher role inside the ward. I often took up a position in the wards and was still for periods of time as I observed. This separated me from the nursing team who were engaging in the activity of nursing. Being apart enabled me to observe intently, capture observations rapidly and think about what I was seeing and hearing. This last part was captured on every second page of my fieldnotes. Be apart enabled the analysis to begin during fieldwork and was maintained to ensure that the written representation of the analysis and findings could be achieved. Being apart whilst also being present as a researcher showed that practices of leading as a researcher also occurred in various combinations, including in unison.

Being apart also meant being comfortable being uncomfortable. On several occasions, I was witness to actions, behaviours, or interactions where I caught myself judging what was going on. It felt awkward watching on as Grace tried to find who had over-filled the linen bags. On another occasion I felt tense when the usually honest and transparent report about the status of the wards and bed availability, was misrepresented in the organisational bed meeting. As with other observations, I noted down my response to these scenarios and added further detail to the fieldnotes when time allowed. My feelings had alerted me to my values and judgements but also that practice standards had been called into question. Exploring the context of such scenarios, the influences and effects provided understanding and revealed that leadership practices were occurring.

Role-modelling and enabling followership contributed to this. I had research role-models in the form of my supervisory team who enabled questioning and provided guidance and coaching across the study. This was vital due to the significant amount of personal learning that needed to occur. Feeling vulnerable and like an imposter researcher at the beginning, I drew confidence from my ethically approved research plan and my role-model supervisors. I had to believe I could do this and share this belief with potential participants. This meant planning how I would be in the ward, where I would situate myself, practice my skills in observation and recording of fieldnotes, and navigate my researcher role in interactions with others in the ward.

A specific example of role-modelling and enabling followership that was poignant was during the open coding phase of the data analysis when my primary supervisor sat with me as we checked cross-checked my codes against hers for credibility. This was a learning process but was enabled by my supervisor role-modelling the expectations through actions and the critical thought processes during discussions

Finally, I draw attention to the research processes of **safeguarding** practices. The ethics processes supported anticipating the risks to participants, the study, and the researcher, shielding all from potential harm. This is also seen in the rigour initiatives developed within the study to shield the research findings. Protecting the nursing identity of participants and my registration. For example, when I became aware that ENs were directing and delegating to junior RNs as part of an orientation process. This was discussed with my supervisory team and then brought to the attention of the CNM. This scenario was rectified due to the need for delegation accountabilities to remain with RNs. Being a novice researcher, I became aware of the standards and principles required for a focused ethnography and meeting these in my conduct of the study would provide confidence. This meant needing to be clear about the rules and parameters of fieldwork and that the conduct of the research and my own conduct, met the standards that would provide quality data for analysis. This clarity

increased the rigour of the study. It also meant role-modelling both professional nursing conduct as defined by my Annual Practicing Certificate for nursing, and as a student of a reputable research-focused university, my research conduct needed to comply within these expectations.

It was a privilege to be alongside nurses as they showed me their world and their collective construction and reconstruction of their leadership practices and their meaning.

CHAPTER 7: CONCLUSION

This primary research into how nursing leadership practices occur in the hospital wards has put the spotlight on the leadership actions, behaviours, and interactions of nurses. Internationally, nursing leadership has been found wanting and complicit in a lack of care for hospitalised patients. There is a clear need for deeper empirical understanding of everyday leadership practices and interactions, in contrast to the current preoccupation with individual leader competencies and grandiose deeds (Chreim et al., 2013).

The research questions guiding this work sought to describe the leadership practices of nurses in these hospital wards, identify the influences on leadership practices and the effect of these. The findings and subsequent discussion show that leadership practices are occurring in the behaviours, actions, and interactions of nurses at all levels of the nursing team. Ironically, some nurses were unaware or had not recognised patterns of leading and safeguarding practices of leadership, instead describing a politically correct version of leader-centric leadership and what nursing leaders did in the hospital wards. Despite this, leadership practices occurred irrespective of role.

The influences on leadership practices included the different dynamics and scenarios which gave rise to situations and contexts in which leadership practices occurred. In these moments, leadership practices were shaped by the context both inside and beyond the hospital wards. The repeated nature of these practices occurred across the four wards resulting in the patterns emerging. In response to these safety conscious contexts where complexity and routine co-existed, nurses demonstrated leadership practices to safeguard patients and nurses from the pressures and vulnerabilities that had become a normal everyday part of nursing practice.

Safeguarding nursing identity and team boundaries, nursing leadership practices responded to the organisational, professional, social, and individual influences within the wards. The correlation between how leadership practices occurred, the nurses and all they brought into interactions, and the context, draws attention to the interdependencies existing in leadership practices and from which, the profession of nursing needs to reconsider its view of leadership.

This chapter begins by summarising the contribution that this research makes to the knowledge about nursing leadership. It then identifies the methodological contributions of this focused ethnography including the pluralistic perspective of leadership-as-practice. Strengths and limitations of the study are outlined in the methodological critique before implications for healthcare practice and for education are presented. Recommendations for future research are made prior to my closing words.

7.1 Contribution to Knowledge

This study contributes new knowledge about nursing leadership behaviours, actions, and interactions that ward nurses engage in, in their everyday nursing work. Given that little was known of the collective leadership practices of the whole nursing team, the description and exploration provided in this thesis provides new knowledge of leadership practices amongst the nursing team within the ward setting. The finding that all members of the nursing team including those with formal leadership roles and informal leaders including registered nurses, enrolled nurses, and healthcare assistants used leadership practices in their everyday nursing practice is new. The activity of leadership did not rest solely with those in authority.

Four patterns of leading emerged. These are being present, being alongside, being apart, and role-modelling and enabling followership. These patterns of leading show how nurses were leading and influencing one another. The previous chapter showed that some of these patterns of leading have been reported in the leadership literature pertaining to formal leadership role, but that they have not been described as patterns related to collective nursing leadership. The finding that these patterns of leading occur in different combinations, in unison, in isolation or incrementally also contributes a new insight into nursing leadership. These practices are everyday acts of leadership.

With a global focus on safe healthcare and safe nursing care, it was distressing to find that these hospital nurses were juggling delivering safe care and being personally safe. In response to this context, the previously unrecognised safeguarding practices of leadership were utilised in the wards. These nursing leadership practices are cognisant of the nursing values of care and protection of others, and of nursing teamwork. Responding to the complexity and resource-challenged contexts of the hospital wards which exposed nurses to constant pressures and vulnerabilities, nurses used safeguarding practices of leadership in conjunction with patterns of leading, to maintain safe patient care, nursing identity and teamwork. Their actions included anticipatory leadership practices, shielding and being shielded, protecting nursing identity and sustaining nursing and nursing care with resilient practices of leadership. Safeguarding practices occurred in everyday nursing when patients, nurses and nursing leadership were vulnerable to the context of the hospital ward.

7.2 Contribution to Methodology and Research Design

From this research, three contributions are made to methodology and research design. Firstly, the leadership-as-practice lens is applied to nursing leadership research for what is thought to be the first time, and secondly, the use of individual discussions to illicit data directly from nurses. These first two

contributions lead to the third contribution, the researcher's position within the research as an 'alongsider'. These contributions are explained in more depth in this section.

This is the only known study of nursing leadership practices using the pluralistic view through the leadership-as-practice lens. Departing from the heroic leader-centric approaches, Raelin and colleagues (2016) have pointed to another perspective for considering how leadership occurs. Rather than looking solely at individuals in roles or at the leadership that people do in isolation, the focus in the leadership-as-practice approach is on to the leadership nexus of praxis (the hospital ward context), practitioners (the nurses), and practices. The findings provide a multi-dimensional understanding of what was happening and how the interplay between nurses, contexts and practices influenced nursing leadership practices. This perspective enabled the researcher to look at the collective construction of nurses' social worlds, so that nursing leadership practices were identified.

In nursing practice, professional and social conversations are an everyday occurrence (Traynor, 2020). In this research, individual discussions as opposed to interviews were purposefully used, recognising the oral nature of nursing practice. This is the second contribution to methodology and method that this work makes. Using an inquisitive approach in informal situations and a semi-structured format during formal discussions, the aim of everyday discussions and the recorded individual discussions was adopted to reduce the formality of an interview and the space between researcher and the researched to reveal what might be hidden beneath the surface.

This informal approach to individual discussions required trust and rapport. As a nurse researcher I had experience of developing trust and rapport quickly with patients and used this to my advantage in the role of nurse researcher. The recorded individual discussions began once these were established, and the Hawthorne effect managed. This meant that I was able to draw on observations to delve deeper to understand and describe nursing leadership. This is particularly useful in ethnography (or focused ethnography) where the intent is to uncover and describe what is going on. This means there is not just one interview but moments of discussion depending on what is happening.

The third contribution to methodology is that of the alongsider position. This position which is neither emic (insider) nor etic (outsider), exists due to familiarity of the researcher and the participant(s) within the research contexts. Echoing the words of Atkinson and Hammersley (1994, p. 249) "We cannot study the social world without being part of it", I argue that over time during fieldwork, it is difficult to remain an outsider given that the researcher is increasingly part of the setting even when the researcher is not interacting but is a complete observer. A new perspective develops; that of the alongsider.

It has been argued by Collinson (2018) that the researcher is in a position of power when undertaking research such as this. My research did not indicate this, rather my experience was that participants made conscious decisions about what they would share in an interaction or individual discussion. This is similar to my observations where the participant has control over the behaviours, interactions, and practices they perform and which the researcher sees. The researcher does have influence over what observations are captured as data. However, the relationship has a reciprocal nature bringing the two alongside each other. The researcher and participant come metaphorically and literally alongside each other in the research process.

Arriving to the wards, I found I recognised several staff from my clinical nursing days. This could have facilitated or been a barrier to the insider, outsider, alongsider positions. My previous roles as staff nurse, nurse educator and nurse specialist might have created barriers for some especially if I had questioned knowledge, standards of practice or conduct. My approach was to take my time and be me and authentic to the research process. It relies on trust which builds over time, candour, and authenticity.

Being an alongsider takes place with ongoing exposure to the field, data, and the analysis process. For me, a turning point during the fieldwork was when I recognised that I was coming alongside the participants or vice versa. This included when nurses sought me out to confide observations, thoughts and ideas about leadership and other issues pertaining to nursing in the ward and leadership practices. This also included inviting me to shadow them (rather than me instigating the process).

I suspect that in becoming an alongsider, different data was available and captured beyond what might have been captured as an insider or a pure outsider. I no longer believe an outsider can entirely remain an outsider through the research process of ethnography. This position of the researcher as an alongsider is not new (Chalachanová et al., 2020; Wickins & Crossley, 2016) however, these nurse participants contributing to the alongsider position is new and this warrants further investigation. This should also include focused ethnography and the role of the individual discussions.

7.3 Methodological Critique of the Study

Choosing to do a focused ethnography to describe how the phenomenon of nursing leadership practices occurs was a strength. Episodic and focused site visits over an extended period resulted in nurses being observed directly and indirectly. Combining observations with individual discussions about nursing leadership enabled nurses to provide their perspectives and experiences on nursing leadership. This helped identify the gap between what is understood about the phenomenon and

what occurred, such as who was doing the leading and the influences on and of the leadership practices. Using focused ethnography meant these insights could be tested over time and with the nurses during individual discussions, to gain clarity about the practices and gauge what was known and what was unnoticed or taken-for-granted.

Recruitment of some participants within the nursing team was challenging. Of the population of 111 nursing team members working in these wards, I met with resistance from the healthcare assistants (HCAs) who declined to participate, as they said they were not leaders. The HCAs demonstrated the most suspicion toward the research. Explanations of how the study was framed did not persuade this group, except for one experienced HCA who consented to being observed. During the period of observation, this HCA demonstrated many of the practices identified in this research and so having more HCAs within the study may have revealed more about the phenomenon of leadership from this perspective.

The study had two Māori nurses who volunteered to be participants. At the time of the study, the CNM did not have access to data identifying the ethnic backgrounds of ward nursing staff as the hospital systems did not collect this. To recruit purposefully, I asked directly if the CNM could name those on the rosters who she knew to be Māori as I had hoped to get Māori representation comparable to that in the general population (16% in 2018). She could not do this with accuracy, though she suspected only a few staff identified as Māori and not the 18 staff I would need given the 111 staff. This is a limitation of the study as analysis of the data from Māori nurses is combined with all participants.

Both a strength and a limitation of this study is that the definition of nursing leadership was not clearly formed as the research started. As a strength it meant participants were able to contribute their thinking and knowledge to inform what nursing leadership is. However, when it came to re-examining nursing leadership and leadership (generally) in the literature, the number of definitions and volume of literature was overwhelming and a challenge to navigate. The varying complexity in the literature provided support for my decision to not define leadership before entering the field.

No nurses were observed working on nightshifts as part of the study, though nurses talked about nursing leadership on the night shift in informal and formal discussions. This means the context of the night shift and its reciprocal influence of nursing leadership is an area that requires further investigation.

Direct nurse-patient conversations and interactions were not observed, nor was the delivery of direct nursing care at the patient bedside. This was due to the challenges of gaining ethical approval for such

undertakings and was therefore another limitation in this study. Leadership practices may be similar or different when providing patient care and during patient interactions but gaining ethical consent for the changing patient populations in four wards is difficult. This is a potential opportunity that was missed in this study. However, there were many examples in this study where patients were central to the leadership practices that were being exhibited.

7.4 Implications for Healthcare Practice

Leadership has been said to be missing in nursing practice (Walker & Clendon, 2013). This study found that it is present in the space between people, and that this presence has been overlooked, as the main methods to identify leadership practices have been individually focussed, when leadership in healthcare is a collective phenomenon. This has implications for healthcare practice, education, and the profession of nursing.

In healthcare practice, leadership becomes more visible when leadership practices are recognised and named. In these wards, nursing handover occurred a minimum of three times over the 24-hour period. Handovers are a critical meeting time when two teams of nurses interact with one another to pass patient care from one shift team to the next (Tacchini-Jacquier et al., 2020). The findings from this research draw attention to an opportunity to change the focus and structure of hand-over to include leadership practices and teamwork as these are vital for the functioning of the team and nursing care. The format of the handover needs to include patient care, leadership and teamwork, and safety. Some of this may be covered in the bedside handover but the teamwork and leadership aspects can be discussed beyond the patient cubicles.

Healthcare organisations rely on nursing teams. At a time when there is a shortage of nurses (Sahil, 2021), hospitals need to recognise, support, and invest in the culture of nursing which is collective and can be seen in leadership practices. The nurses in this study were under pressure and vulnerable and their leadership practices created and maintained connection, directed care, and developed resilience in individuals and across the teams. At times, these nursing teams were compromised by the casualisation and shortage of the nursing workforce. However, leadership practices developed and were visible when casual nursing staff joined the team for a shift and when staffing numbers were affected by vacancies and sickness. Whilst creating opportunity, the casualisation and shortage of the nursing workforce is also a threat creating vulnerability to nursing teamwork and nursing culture and reinforcing the paradox in which nursing and nursing leadership, occurs. The hospital needs to invest in nursing to reduce the pressures created by the casualisation of nurses and reduce the need for 'sharing' of staff. It will take a recruitment and retention strategy beyond that of the hospital and New

Public Management principles and could start locally with a focus on nursing culture, and the influence of structures and processes and the benefits of leadership practices to the organisation, nurses, and patients.

Healthcare organisations need to reassess how organisational structures and processes contribute to collective leadership practices within organisations. One example is that of the TrendCare tool that calculates the nursing hours needed to provide care (McKelvie, 2019). In retaining such a tool, a field(s) needs to be added to account for the time taken for leadership activities and to lead others. It takes time and energy to be present and engage collaboratively to inform clinical decision making, to be or come alongside colleagues to guide them, to be apart from the team to challenge standards and assumptions, and to role model and enable others to follow by lifting the standards and coaching and preceptoring other nursing team members. Incorporating the four patterns of leading in TrendCare would also make these practices visible to healthcare organisations, thereby enabling the organisations and the nursing profession to recognise, anticipate, and plan for the occurrence of leadership practices within nursing care to enhance patient outcomes and nursing team identity.

Healthcare organisations such as hospitals also need to recognise the effects of the safety paradox nurses face in the caring for patients in under-resourced wards, amidst the complexity and mundane context and the resultant effect this is having on the resilience of nursing. Nurses are using safeguarding practices of leadership to anticipate risk, shield from harm, protect nursing, and develop resilient leadership practices to mitigate the effects of the contexts in which they work.

7.5 Implications for Education

Building a resilient nursing workforce during nursing shortages is pivotal to manage the staffing shortfall. Expecting nurses to be resilient without training and support will only exacerbate the challenges (Traynor, 2018). Therefore, there is an opportunity to build on the leadership practices identified here, to strengthen the nursing workforce. As nurses use leadership every day in their nursing and interactions, leadership practices need to be recognised and supported to develop. This includes teaching about it in clinical practice and providing pre- and post-registration education opportunities in this area of nursing leadership.

For undergraduate nurses, nursing education programmes in New Zealand need to recognise that leadership exists beyond people and roles. Nursing students need to receive education about their professional interactions, behaviours, and actions in teams, and be exposed to opportunities to develop the patterns of leading to influence others. Currently, informed by the respective

competencies, nurses are educated about their role and scope including supervision and leadership skills (NCNZ, 2022). Nursing should not shy away from calling leadership practices what they are. More explicit commitment from the regulator (NCNZ) for tertiary providers would go some way to ensure leadership practices beyond what is already named (direction, delegation, and supervision), are recognised given the contexts in which nursing is taking place. This education should include nursing teamwork which is underpinned by nursing values. For example, learning opportunities can be provided using simulation and activities in which problem solving is achieved through leadership practices. In clinical practice, the preceptorship model for student nurses is also an opportunity to model and explore and examine leadership practices as part of teamwork. Professional nursing associations and the healthcare organisations also have an opportunity to educate regarding nursing leadership practices as does postgraduate studies.

As a lecturer of postgraduate health leadership and management students, and in response to my PhD journey, the courses I teach are now framed by the principles of leadership-as-practice. Students in these courses are exposed to collective ways of thinking about leadership and leadership practices beyond the leader-centric notions that pervade the New Zealand healthcare sector and society more broadly. Students are challenged to refocus and to consider the collective nature of leadership in terms of the day-to-day processes and practices, organised by people and responding to situations within the healthcare context.

The online teaching platforms for the courses are set out with three modules guiding the learning. These are Praxis, Practitioners and Practices from leadership-as-practice. In each of the modules, students' learning is guided by learning tasks about values, culture, challenges, and emerging trends as well as additional or contemporary issues that arise in each specific area. The thinking behind using the leadership-as-practice perspective recognises "the need for leadership to be viewed as a widely dispersed activity which is not necessarily lodged in formally designated leaders" (Parry & Bryman, 2006, p. 455). In addition to these courses, I share these ideas when I am a guest lecturer, in my role on local committees and national health leadership and management groups, to challenge the status-quo so that leadership in all its guises does not remain elusive.

7.6 Implications for the Nursing Profession

Nursing needs to have systems that recognise and name leadership practices, and nursing needs to be cognisant of the everyday moments and situations in which such practices occur. Without doing so, much of the leadership activity is missed, and leadership will remain elusive or only in the realm of leaders. The findings showed that nurses at all levels within the ward nursing teams engaged in

leadership practices and in turn, leadership practices shaped nurses understanding of their reality. By labelling them, nursing leadership practices become increasingly visible.

Leadership practices maintain connections between the nurses in the team and contributes to nursing identity. It is the culture of nursing and nursing teams, and leadership practices that supports nurses returning to work (Cummings et al., 2018; Germain & Cummings, 2010). The nursing profession must recognise that leadership does not solely exist in formal roles and acknowledge this in guiding nursing documents. As the largest workforce within the hospital setting, nursing needs to actively engage and lead the development of their own professional and nursing team cultures. Celebrating the collective expertise of leadership practices in everyday nursing scenarios on the wards, is one way this should be done. This would create a spotlight on the performance and activity of leading, demonstrating that this does indeed occur.

Historically, New Zealand nursing leadership roles have been undermined by New Public Management principles adopted by the health system (Ministerial Taskforce on Nursing, 1998; Wilkinson, 2008). The reduction of roles in the nursing hierarchy has created opportunities for leadership to filter beyond the roles and to nurses without specific authority to use leadership practices in the spaces between nurses, as this study has found. Having the language to describe what is occurring through the patterns of leading and the safeguarding practices of leadership, acknowledges the contribution nurses are making to leading others in the hospital wards. Language makes leadership practices increasingly visible as the activity of leadership can be articulated in response to everyday nursing care provision. This means that nursing can provide evidence of these practices and have these recognised and accounted for by healthcare organisations, as contributing to quality teamwork and safe patient care.

International nursing regulators need to consistently identify collective nursing leadership practices within scopes of nursing practice and competencies. In this way, leadership practices are identified, the activity of leadership is quantified and the expertise of leadership practices at differing levels of nursing are outlined to guide the expectations and development of these practices. The consistency will set expectations for performance and provide evidence toward attaining formal leadership positions should these be wanted.

New Zealand nursing needs to be explicit about the leadership practices expected in nursing scopes of practice, competencies, and career frameworks. These guiding documents need to name the collective leadership practices revealed in this study. By naming and using leadership practices as part of and for competency assessment tools, the collective practices of leadership which include working with others and in teamwork can be captured. In addition to individual nurse career paths, teams

would benefit from ongoing assessments of the leadership practices that are occurring, the reasons for these, the influences, and the effects of these on patients, nursing team members, and the collective teams. This will give nurses and the profession of nursing a gauge of the areas for further leadership practice development in response to the contemporary issues in hospital wards.

7.7 Recommendations for Future Research

Using the leadership-as-practice lens to research other nursing contexts may reveal variations in nursing leadership practices as leadership practices respond to the contexts in which they occur. Further research in various healthcare settings would provide the opportunity for comparisons of nursing leadership practice, identifying similarities and divergence in practices. This could begin with further examination of the after-hours periods in hospital wards, or the leadership practices that occur in units in which nurse practitioners and medical staff are largely onsite across the 24-hour period such as intensive care units or emergency departments. Additionally, nursing leadership practices of rest-home teams is an important area for research as the team consists of more unregulated care staff and fewer registered nurses and has decreased exposure to medical personnel. Understanding HCAs' contribution to leadership practices within the nursing team is also an area for further research. Researching specific healthcare organisations and their leadership practices will offer insights into the cultures and subcultures that exist and contribute to the organisational perspective of leadership practices in healthcare.

The safeguarding practices of leadership are newly identified activities of nursing which occurred in these hospital wards. These practices are used to anticipate risks, shield or be shielded from harm, protect nursing identity and the resulting resilient practices of nursing leadership used in response. Further exploration of the nature of these leadership practices is needed to understand if and how these safeguarding practices occur in other nursing settings and contexts in New Zealand and internationally. Comparative analysis of the safeguarding leadership practices across settings in New Zealand and internationally would add to this new nursing leadership knowledge, as would understanding the effectiveness of these safeguarding leadership practices.

In support of building a platform of understanding about safeguarding practices of leadership, several other research areas have been identified from this study. The relationships involving nursing identity, nursing values and safeguarding practices of leadership warrants further exploration as does nurses' emotional intelligence and the relationship to leadership practices. How power and control and leadership practices intersect warrants further exploration and analysis. Circles of influence beyond the ward provide another dimension to understanding nursing leadership practices given the social

nature of these practices and so social networking provides yet another lens in which to explore nursing leadership practices.

Leadership-as-practice offers new insights into the intersection between praxis, practices, and practitioners. In New Zealand, nursing is trying to increase the workforce populations of Māori and Pasifika nurses to be representational of the general population. The leadership-as-practice perspective may provide valuable insights as this approach supports the focus on practitioners and leadership practices, to inform this.

The methodological contributions to this study have given rise to questions about the alongsider role of the researcher and the alongsider role of the participants. This warrants further exploration; ethnographic researchers should consider how their presence and methods contributes and shapes their changing position as an insider, outsider and alongsider. This would be further supported by continuing to develop individual discussions as a method of talking with and being alongside participants. In practice disciplines such as nursing, teaching, and police, being alongside and having individual discussions may garner new knowledge different from processes which are more formalised and removed. Further research in this space is needed.

7.8 Closing Words

This study has described the leadership practices that occur in hospital wards of one District Health Board in Aotearoa New Zealand. Leadership is an expected part of nursing, and it is visible in the hospital wards. The findings challenge notions of leadership pertaining to appointed leaders by revealing that nurses of all levels use leadership practices in their everyday practice. Four patterns of leading emerged as did the safeguarding practices of leadership that nurses used in response to situations and contexts to keep patients, themselves, and their nursing colleagues safe.

Nursing leadership practices are pivotal to nursing care provision, teamwork, and nursing identity. Referring to nursing terminology, Clark and Lang (1992, p. 109) said “if we cannot name it, we cannot control it, practice it, teach it, finance it or put it into public policy”. By naming the practices and patterns of nursing leadership, nursing leadership becomes visible and in so doing attracts the attention it needs, to no longer occur in the shadows of appointed roles but to be recognised as a collective practice of nursing.

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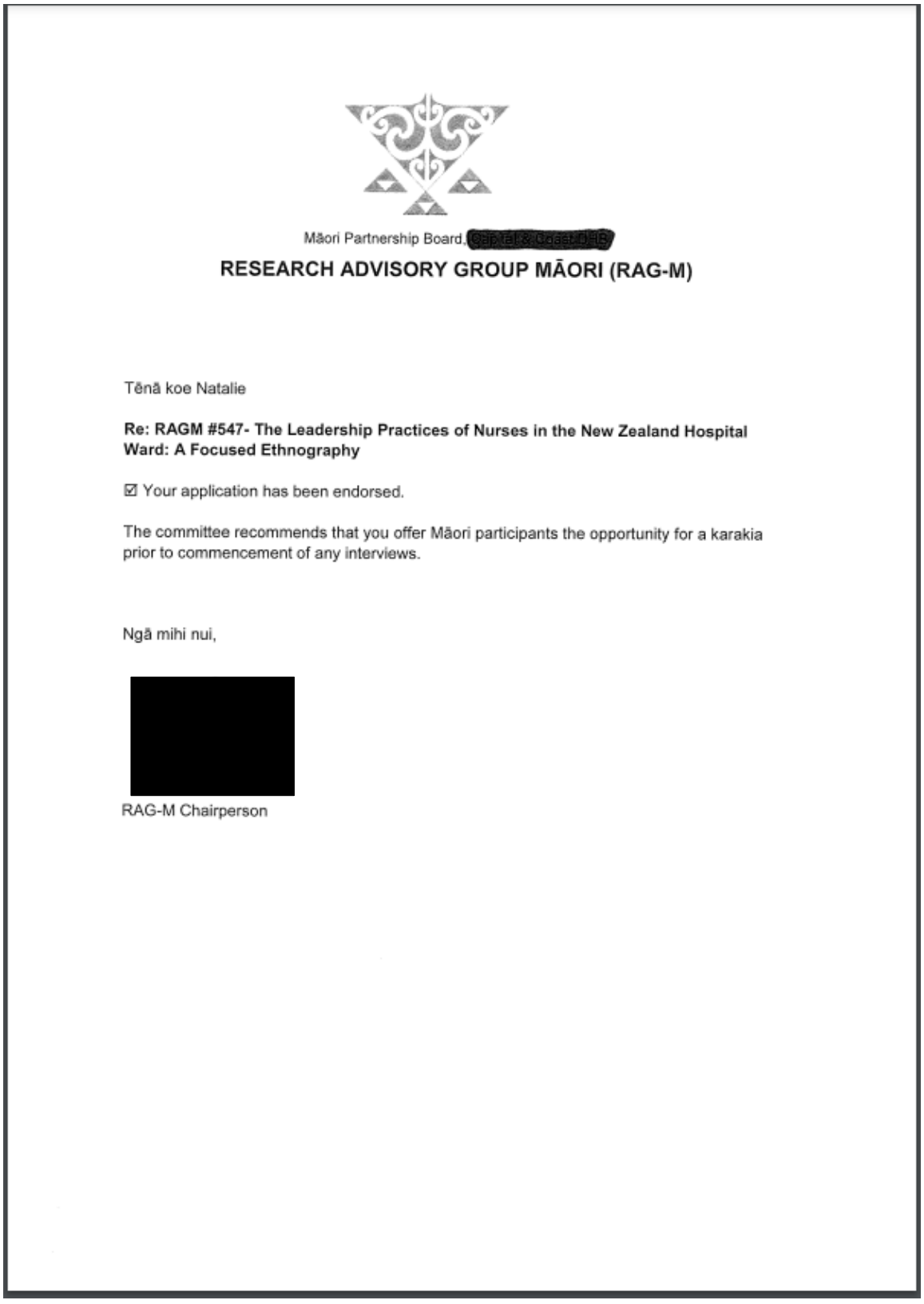
APPENDICES

Appendix 1: Research Advisory Group for Māori Consent



Māori Partnership Board, [redacted]

RESEARCH ADVISORY GROUP MĀORI (RAG-M)

Tēnā koe Natalie

Re: RAGM #547- The Leadership Practices of Nurses in the New Zealand Hospital Ward: A Focused Ethnography

☑ Your application has been endorsed.

The committee recommends that you offer Māori participants the opportunity for a karakia prior to commencement of any interviews.

Ngā mihi nui,

[redacted]

RAG-M Chairperson

Appendix 2: Out of Scope – National Health and Disability Ethics Committee

Health and Disability Ethics Committees

Health and Disability Ethics Committees
Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington
6011
0800 4 ETHICS
hdecs@moh.govt.nz

16 October 2017

Natalie Lindsay
c/- Graduate School of Nursing
Midwifery and Health
PO Box 7625
Newtown
Wellington 6242

Dear Natalie,

Study title:	The Leadership Practices of Nurses in the New Zealand Hospital Ward: A Focused Ethnography

Thank you for emailing HDEC a completed scope of review form on 12 October 2017. The Secretariat has assessed the information provided in your form and supporting documents against the Standard Operating Procedures.

I have considered the information provided and, on the basis of this information, it does not appear that your project is within the scope of HDEC review. This scope is described in section three of the Standard Operating Procedures for Health and Disability Ethics Committees.

This project is an ethnographic study with a focus on leadership practices of nurses in the hospital ward. Participants in this study are consenting nurses. As this project does not involve any participants recruited in their capacity as consumers of health or disability services, as relatives of the aforementioned, or as volunteers in clinical trials, health information, or tissue it is outside the scope of HDEC review.

Health and Disability research requires HDEC review if it involves one or more of the following in New Zealand:

Human participants recruited in their capacity as:

- consumers of health or disability support services, or
- relatives or caregivers of consumers of health or disability support services, or
- volunteers in clinical trials (including, for the avoidance of doubt, bioequivalence and bioavailability studies)

The use, collection or storage of **human tissue** (as defined by the Human Tissue Act 2008), unless:

- informed consent (which may include informed consent to future unspecified research) has been obtained for such use, and tissue will not be made available to researchers in a form that could reasonably be expected to identify the individual(s) concerned, or

- one or more of the statutory exceptions to the need to gain informed consent set out at section 20(f) of the Human Tissue Act 2008 (or Right 7(10)(c) of the Code of Health and Disability Services Consumers' Rights 1996) applies.

The use or disclosure of **health information** (as defined by the Health Information Privacy Code 1994), unless:

- this use or disclosure has been authorised by the individual(s) concerned, or
- health information will not be disclosed to researchers in a form that:
    - could identify, or could reasonably be expected to identify, the individual(s) concerned, or
    - would allow for the information to be matched with other data sets (for example, through the use of non-encrypted identifiers such as National Health Index numbers).

Your project does not contain any of these features and is therefore outside the scope of HDEC review.

If you consider that our advice on your project being out of scope is incorrect please contact us as soon as possible giving reasons for this.

This letter does not constitute ethical approval or endorsement for the activity described in your application, but may be used as evidence that HDEC review was not required for it.

Please don't hesitate to contact us for further information.

Yours sincerely,

Advisor
Health and Disability Ethics Committees
hdecs@moh.govt.nz

Appendix 3: VUW Ethics Approval

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

Phone
Email [redacted]

MEMORANDUM

TO	Natalie Lindsay
COPY TO	
FROM	[redacted] Convener, Human Ethics Committee
DATE	22 December 2017
PAGES	1
SUBJECT	**Ethics Approval: 25476** The Leadership Practices of Nurses in the New Zealand Hospital Ward: A Focused Ethnography

Thank you for your application for ethical approval, which has now been considered by the Standing Committee of the Human Ethics Committee.

Your application has been approved from the above date and this approval continues until 22 December 2020. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Kind regards

[redacted]

Appendix 4: Locality Agreement

[redacted]

Locality sign off for Hospital/Ethical Approval

Full project title:	The Leadership Practices of Nurses in the New Zealand Hospital Ward: A Focused Ethnography
Short project title:	Leadership Practices of Nurses

1. Declaration by principal investigator

The information supplied in this application is, to the best of my knowledge and belief, accurate. I have considered the ethical issues involved in this research and believe that I have adequately addressed them in this application. I understand that if the protocol for this research changes in any way, I must inform the ethics committee. I have read and understood [redacted] research policy

Name of Principal Investigator (please print):	Natalie Lindsay
Signature of Principal Investigator:	[redacted]
Date:	

2. Declaration by Clinical Leader or CNM in which the Principal Investigator is located

I have read the application, and it is appropriate for this research to be conducted in this department. I give my consent for the application to be forwarded to the ethics committee.

Name (please p[redacted]			
Signature:		Institution:	[redacted]
Date:		Designation:	

- Where the Clinical Leader is also one of the investigators, the Clinical Leader declaration must be signed by the Clinical Executive Director.

3. If the application is for a student project, the supervisor should sign the declaration.

If study conducted across several clinical areas, please have CL/CNM of appropriate clinical area to sign in this space.

I have read the application, and it is appropriate for this research to be conducted under my supervision. I give my consent for the application to be forwarded to the ethics committee.

Name (please print):			
Signature:		Institution:	
Date:		Designation:	

Version 2.0 dated 16th of September 2015

[redacted]

4. **Declaration by Operations Manager/Executive Director in which the Principal Investigator is located**

I have read the application, and it is appropriate for this research to be conducted in this department. I give my consent for the application to be forwarded to the ethics committee.

Name (please pri[redacted]

Signature: [redacted] Institution: [redacted]

Date: 19/1/18 Designation: ~~Executive Director~~ Operations Manager [redacted]

Please include the flowing items with your application to the [redacted] Research Office:

1. Study Protocol with the outline of will be required from the [redacted] with specific details such as Medical records will be requested, access to system will be required and so on)
2. Information and Consent Form
3. Evidence of Maori consultation
4. Ethics approval letter; if approved by the HDEC- request authorisation from [redacted] by using the following email address- Res-Research@[redacted]org.nz
5. Any other relevant paperwork such as financial arrangements, study contract etc.

Appendix 5: Participant Information Sheet

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

The Leadership Practices of Nurses in the New Zealand Hospital Ward: A Focused Ethnography

INFORMATION SHEET FOR PARTICIPANTS

You are invited to take part in this research. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to participate, thank you for considering this request.

Who am I?

My name is Natalie Lindsay and I am a Doctoral student in the PhD in Nursing Programme at Victoria University of Wellington. This research project is work towards my thesis.

What is the aim of the project?

This project aims to examine the everyday leadership activities, social interactions and influences of nursing leadership within the hospital ward. The study's purpose is to identify shared beliefs, behaviours and actions of nurses providing leadership and what influences these. This will be done by observing consenting members of the nursing team, working together in the hospital ward and through individual discussions with them. The focus of the observation will be on how these members of the nursing team interact with others including Health Care Assistants, Enrolled Nurses, Registered Nurses, and other health professionals and will be noted as observations in field notes. Individual discussions with each consenting nursing team member will occur following this. I will not be focussing on nurse-patient interactions

This research has been approved by the Victoria University of Wellington Human Ethics Committee (Reference: 25476).

How can you help?

You have been invited to participate because you are a member of a ward nursing team. If you agree to take part, you will be part of the nursing team I will observe working together in the hospital ward. I will be making field notes of what I observe. The kinds of information that will be noted includes behaviours, use of voice and language, the atmosphere across and within the team and more broadly the organisation. For example, how you request assistance; how you seek opinions, how you take into account others views and how you influence others and how you direct care.

Following this, you will be invited to have an individual discussion with me at a location suitable to you such as an office or café on-site or off-site. I will ask you questions about leadership practices and nursing leadership in the hospital ward. The individual discussion will take approximately 40 – 60 minutes and you are welcome to have a support person/ whanau member accompany you. I will audio record the individual discussion with your permission, and it will be written up later. You can choose to not answer any question or stop the individual discussion at any time, without giving a reason.

You may choose to participate in both phases of data collection, or only be observed in the hospital ward, or participate in an individual discussion. You are welcome to consult with family and whanau prior to agreeing to be involved in the study.

You can withdraw from the study by contacting me at any time before 30 June 2018. If you withdraw from the study, your individual discussion will be cease to be part of the data for analysis, but it will not be possible to remove notes taken during team observations.

What will happen to the information you give?

This research is confidential. This means that I will be aware of your identity but the research data will be combined and your identity will not be revealed in any reports, presentations, or public documentation. However, you should be aware that in small projects your identity might be obvious to others in your community. Confidentiality will be maintained unless I am alerted to a serious breach of the Nursing Council of New Zealand's Code of Conduct (2012), which requires me to take the matter to a manager.

Only my research supervisors, the transcriber (who will be required to sign a confidentiality agreement) and I will read the field notes made during observations and notes and transcripts of the individual discussions. The field notes, individual discussion recordings, transcripts, and summaries, will be kept securely in a password protected file and destroyed five years after collection.

What will the project produce?

The information from my research will be used in my PhD thesis, academic publications and conference presentations and summaries of aggregated findings to interested parties.

If you accept this invitation, what are your rights as a research participant?

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

- choose not to be observed at a particular time or answer any question;
- ask for the recorder to be turned off at any time during the Individual discussion;
- withdraw from the study before 30 June 2018;
- ask any questions about the study at any time;
- receive a copy of your Individual discussion transcript should you want it;
- be able to read any reports of this research by emailing the researcher to request a copy.

If you have any questions or problems, who can you contact?

If you have any questions, either now or in the future, please feel free to contact either:

Student:
Name: Natalie Lindsay
Email address: [redacted]

Supervisor:
Name: Dr Jane Bryson
[redacted]

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research you may contact the Victoria University HEC Convenor [redacted]

Appendix 6: Informed Consent – Observations

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

The Leadership Practices of Nurses in the New Zealand Hospital Ward: A Focused Ethnography

CONSENT TO OBSERVATION

This consent form will be held for five years.

Researcher: Natalie Lindsay, Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington.

- I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.
- I agree to take part and be observed as a member of the nursing team in the hospital ward I understand that observational notes (field notes) will be made by the researcher.

I understand that:

- I may withdraw from this study at any point before 30 June 2018. I understand that any information gathered through observation will remain part of the data for analysis, as the observations are of the consenting nursing team members in the hospital ward (not solely individuals).
- The identifiable information I have provided will be destroyed five years following collection.
- Any information I provide will be kept confidential to the researcher, the supervisors and the confidential transcriber.
- I understand that the results will be used for a PhD thesis, academic publications and conferences and in summaries of aggregated findings to interested parties.
- My name will not be used in reports, nor will any information that would identify me.

Signature of Participant: _____

Name of Participant: _____

Date: _____

Contact details: _____

Appendix 7: Informed Consent – Individual Discussions

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

The Leadership Practices of Nurses in the New Zealand Hospital Ward: A Focused Ethnography

CONSENT TO INDIVIDUAL DISCUSSION

This consent form will be held for five years.

Researcher: Natalie Lindsay, Graduate School of Nursing, Midwifery and Health, Victoria University of Wellington.

- I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time. I understand that I may have a support person/whānau member present during the individual discussion.
- I agree to take part in an audio recorded individual discussion.

I understand that:

- I may withdraw from this study at any point before 30 June 2018, and any information that I have provided in the individual discussion will be removed from the study and destroyed.
- The identifiable information I have provided will be destroyed five years after collection.
- Any information I provide will be kept confidential to the researcher, the supervisors and the confidential transcriber.
- I understand that the results will be used for a PhD thesis, academic publications and conferences and in summaries of aggregated findings to interested parties.
- My name will not be used in reports, nor will any information that would identify me.
- I would like a copy of the transcript of my Individual discussion: Yes ☐ No ☐
- I would like to receive a copy of the summary of aggregated findings and have added my email address below. Yes ☐ No ☐

Signature of participant: _____

Name of participant: _____

Date: _____

Contact details: _____

Appendix 8: Individual Discussion Schedule

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

The Leadership Practices of Nurses in the New Zealand Hospital Ward: A Focused Ethnography

Individual Discussion No.
Name:
Pseudonym:
Date:
Time:

Discussion Area 1 - Background

1. What is your role in the team?
2. How many years have you been a nurse /or member of a nursing team (HCA)?
3. When did you qualify?
4. How many years have you worked here?
5. What is your PDRP* level?
6. Which ethnicities do you identify yourself with?
7. What is your age?

Discussion Area 2

Leadership can mean different things to different people. Can you tell me about what leadership means to you in regards to the nursing team and nursing practice? Has this changed as your practice has developed? How so?
What are the effects of leadership? What does this mean to you?

Discussion Area 3

In a nursing team there are those in leadership roles and there are those who display leadership in everyday interactions, though not in a formal role. I am interested in exploring what leadership is in the ward nursing team. What does it look like; how do you see it? How would anyone know who the leaders are?

Whilst some in the team are formal leaders, there are everyday acts of leadership that others within the nursing team perform – can you tell me about both of these? What do these look like? What are the effects of these?

Discussion Area 4

I'm interested to know about the influences of and on leadership within the ward nursing team. Can you tell me about this?
Some nursing teams have a reputation in regards to leadership. What happens in those nursing teams? What is known about the effect of this?
What of the broader influences such as societal values, cultural expectations or expectations in politics?

Observation clarification

This is an opportunity to seek clarity in regards to moments, interactions noticed during field-work observation and for participants to add commentary to their experiences of being observed.

*The Professional Development and Recognition Programme (PDRP) is a competency based framework designed to develop and recognise the expertise of nurses in clinical practice.

Appendix 9: Transcriber Confidentiality Agreement

TE WHARE WĀNANGA O TE ŪPOKO O TE IKA A MĀUI
VICTORIA
UNIVERSITY OF WELLINGTON

Transcribing Confidentiality Agreement

Project Title: **The Leadership Practices of Nurses in the New Zealand Hospital Ward: A Focused Ethnography**

Principal Investigator: Natalie Lindsay, PhD student, Victoria University of Wellington

I, [redacted], agree to ensure that the audiotapes I transcribe will remain confidential to Natalie Lindsay, her research supervisors and myself.

I agree to take the following precautions:

1. I will ensure that no person, other than Natalie Lindsay and her research supervisors, hears the recording.
2. I will ensure that no other person has access to my computer/device.
3. I will delete the files from my computer/device once the transcription has been completed.
4. I will not discuss any aspect of the recording with anyone except Natalie Lindsay

Signature: [redacted]

Date: [redacted]

Appendix 10: Individual Discussions Lengths

Senior Nurses	**Individual Discussion length**
Alice	63mins
Anne	68mins
Elle	85mins
Jane	70mins
Juan	89mins
Lavender	51mins
Margaret	80mins
Nicole	91mins
Patricia	80mins
Sally	63mins
Ward Nurses	**Individual Discussion length**
Beth	47mins
Charissa	45mins
Diana	51mins
Emma	54mins
Erica	45mins
Grace	59mins
Jeanne	62mins
Joy	55mins
Leilani	39mins
Sera	65mins
Talia	51mins
Victoria	31mins

Appendix 11: Data Management Audit Trail

Date	hours	focus	Uploaded Nvivo12	1st Code	2nd code & Memo	3rd code & Memo
8.3.18	4.5	Nicole	18.10.20	18.10.20	20.11.20 & 27.11.20	4.12.20
12.4.18	3.5	Nicole & Patricia	18.10.20	19.10.20		
13.4.18	4.5	Patricia	18.10.20	19.10.20		
16.4.18	4.5	Patricia	18.10.20	20.10.20		
19.4.18	4.5	Nicole	18.10.20	20.10.20		
27.4.18	4.5	Jane & Alice	18.10.20	21.10.20		
7.5.18	3.15	Jane	18.10.20	21.10.20		
11.5.18	6.5	Lavender	18.10.20	22.10.20		
14.5.18	3.25	Lavender	18.10.20	22.10.20		
15.5.18	3.75	Elle	18.10.20	23.10.20		
23.5.18	4.15	Alice	18.10.20	23.10.20		
24.5.18	3.75	Patricia	18.10.20	24.10.20		
28.5.18	3.25	Jane	18.10.20	24.10.20		
31.5.18	5.75	Sally	18.10.20	24.10.20		
7.6.18	4.5	Sally	18.10.20	26.10.20		
14.6.18	4.5	Juan	18.10.20	26.10.20		
15.6.18	5.0	Elle	18.10.20	27.10.20		
25.6.18	4.0	Sera	18.10.20	27.10.20		
26.6.18	4.5	Sera	18.10.20	27.10.20		
9.7.18	5.75	Monica	18.10.20	27.10.20		
10.7.18	3.5	Talia	18.10.20	28.10.20		
16.10.18	3.0	Senior team	18.10.20	28.10.20		
17.10.18	4.5	Talia	18.10.20	29.10.20		
18.10.18	2.5	Ward W X Y Z	18.10.20	29.10.20		
25.10.18	4.35	Daniel	18.10.20	29.10.20		
26.10.18	3.5	May	18.10.20	30.10.20		
1.11.18	4.5	Kelly	18.10.20	30.10.20		
2.11.18	4.5	Kelly	18.10.20	30.10.20		
13.11.18	4.5	Leilani	18.10.20	31.10.20		
20.11.18	4.75	Patricia	18.10.20	31.10.20		
22.11.18	4.0	Erica	18.10.20	31.10.20		
4.12.18	5.75	Jeanne	18.10.20	31.10.20		
5.12.18	6.15	Jeanne	18.10.20	1.11.20		
9.12.18	3.6	Jeanne	18.10.20	1.11.20		
10.12.18	2.25	Diana & Elle	18.10.20	2.11.20		
12.12.18	2.0	ward Y & Z	18.10.20	2.11.20		
15.1.19	5.0	Emma	18.10.20	2.11.20		
19.1.19	2.5	Candice	18.10.20	3.11.20		
26.2.19	4.0	Grace	18.10.20	3.11.20		
3.3.19	5.25	Grace	18.10.20	3.11.20		
Individual Discussion	**Transcripts accuracy**	**Add annotation**	**Uploaded Nvivo12**	**1st Code**	**2nd Code & Memo**	**3rd code & Memo**
Senior Nurse					20.11.20 & 27.11.20	4.12.20
Alice	14.01.19	14.01.19	2.8.20	3.8.20		
Anne	20.1.19	20.1.19	2.8.20	3.8.20		
Elle	28.1.19	28.1.19	2.8.20	5.8.20		
Jane	4.8.19	3.8.19	2.8.20	5.8.20		
Juan	29.7.19	29.7.19	2.8.20	6.8.20		
Lavender	17.8.19	17.8.19	2.8.20	7.8.20		
Margaret	18.3.19	18.3.19	2.8.20	7.8.20		
Nicole	25.8.19	28.9.19	2.8.20	8.8.20		
Patricia	15.9.19	16.9.19	2.8.20	9.8.20		
Sally	30.3.19	30.3.19	2.8.20	10.8.20		
Ward Nurses	**Transcripts accuracy**	**Add annotation**	**Uploaded Nvivo12**	**1st Code**		
Beth	2.7.20	2 .7.20	2.8.20	11.8.20		
Charissa	3.7.20	3.7.20	2.8.20	11.8.20		
Diana	4.7.20	4.7.20	2.8.20	14.8.20		
Emma	9.7.20	10.7.20	2.8.20	14.8.20		
Erica	12.7.20	12.7.20	2.8.20	18.8.20		
Grace	12.7.20	12.7.20	2.8.20	18.8.20		
Jeanne	14.7.20	14.7.20	2.8.20	19.8.20		

Joy	14.7.20	15.7.20	2.8.20	20.8.20		
Leilani	20.7.20	20.7.20	2.8.20	22.8.20		
Sera	22.7.20	22.7.20	2.8.20	23.8.20		
Talia	29.7.20	30.7.20	2.8.20	25.8.20		
Victoria	30.7.20	30.7.20	2.8.20	25.8.20		

Documents	**Uploaded Nvivo12**	**1st Code**	**2nd Code & Memo**	**3rd code & Memo**
Role description – Charge Nurse Manager	7.01.21	7.1.21	8.1.21	10.1.21
Role description – Associate Charge Nurse April 2011	7.01.21	7.1.21		
Role description – Associate Charge Nurse April 2015	7.01.21	7.1.21		
Role description – Nurse Educator 2014	7.01.21	7.1.21		
Role description – Nurse Educator 2015	7.01.21	7.1.21		
Role description – Registered Nurse Ward Z	7.01.21	7.1.21		
Role description – Registered Nurse Ward X, Y, Z.	7.01.21	7.1.21		
Role description Enrolled Nurse	7.01.21	7.1.21		
Role description Health Care Assistant	7.01.21	7.1.21		
Preceptor policy	7.01.21	7.1.21		
Dedicated Education Unit policy	7.01.21	7.1.21		
Dedicated Education Unit Handbook	7.01.21	7.1.21		

Photo	Stickers for patient notes (ward Y)
Photo	Team nursing chart
Photo	Ward W corridor
Photo	Ward W infection control in corridor
Photo	Ward W infection control in corridor 2
Photo	Ward X ACNM office wall
Photo	Ward X ACNM office
Photo	Ward X ACNM office 2
Photo	Ward X ACNM to-do list
Photo	Ward X from inside nursing station
Photo	Ward X nursing station 2
Photo	Ward X Nursing station
Photo	Ward X staff tearoom
Photo	Ward X staff tearoom focus board - Nursing
Photo	Ward X staff tearoom table
Photo	Ward X ward information poster
Photo	Ward Y corridor (public)
Photo	Ward Y manual handline equipment for stair evacuation
Photo	Ward Y nursing station space
Photo	Ward Y nursing station
Photo	Ward Y nursing station office
Photo	Ward Y Pyxis drug room 2
Photo	Ward Y Pyxis in drug room
Photo	Ward Z team notice board opposite reception