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A journey of leadership

Exploring the design and evaluation of a health leadership programme for registered nurses at Health New Zealand (Te Whatu Ora) – Waikato district

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Abstract

Background: Contemporary nursing leadership extends beyond traditional hierarchical structures and focusses more on leadership enacted at the point of care. This re-conceptualisation recognises clinical nurse leaders as essential change agents who bridge frontline care and organisational priorities, advocate for equitable health services and foster team cohesion in increasingly complex environments, all without holding formal authority. To grow and sustain such leadership requires education and development programmes that are designed to be contextually relevant and responsive to the realities of point of care nurses.

Objective: The aim of this research was to explore the design and evaluation of a health leadership development programme for registered nurses delivered at a tertiary hospital.

Participants: There were two key population groups: Purposive sampling was employed to recruit an executive nurse leader (n=1) for the initial interview, followed by three focus groups with representatives from executive, operational and designated senior nurse leadership roles (n=13); and the second, pre- and post- intervention surveys with the participants of the education programme (n=12). All intervention participants responded to the survey (response rate = 100%).

Methods: This mixed methods study involved an interview and three focus groups, which informed the development of the programme as well as pre-test / post-test online surveys of leadership programme participants. Both the interview and focus groups were thematically analysed using a general inductive method to develop key themes. The initial interview and focus groups were used to design the education intervention, which was evaluated using pre- and post- surveys, which included Likert scale type questions, which were analysed using a Paired Sample T Test.

Findings: Thematic analysis of the interview and focus group transcripts revealed five key themes: (i) Leading in real life; (ii) Becoming future ready; (iii) Power, people and perspective; (iv) Owning the journey; and (v) Connection culture. Analysis of the survey data showed statistically significant results in: (i) Current leadership ability - leadership knowledge; (ii) understanding different leadership styles; (iii) Knowledge of leadership skills & attributes for effective health leadership; (iv) Understanding of health leadership in equitable healthcare delivery; (v) Understanding of relationship knowing self, cultural identity and leadership; and (vi) Development of skills for challenging conversations.

Conclusion: This study provides evidence that leadership development initiatives for clinical nurse leaders are most effective when built on the acknowledgement of cultural, relational and emotional knowing and intelligence. Programme participants responded positively to this approach showing marked improvements in self-assessed leadership confidence.

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Contribution

I, the researcher undertook all aspects of this study under the direct guidance of my supervisors. This entailed selecting the appropriate research design, the data collection and analysis and the publishing of the findings in this thesis.

Dedication

Thank you to my family who walked beside me on the journey of this research. Your steadfast support and belief in me mean more than you can ever imagine.

Table of contents

List of tables and figures

Chapter I: Introduction

If you change the way you look at things, the things you look at change.

Wayne Dyer, 1940 – 2015

Leadership as a concept remains complex and evolving, shaped by diverse theoretical, sociocultural, organisational and professional contexts. There is no fixed or universally agreed upon construct definition, but rather a perception of a multifaceted phenomenon influenced by changing societal needs and disciplinary perspectives. The breadth of leadership theories, from early trait and behavioural models to the more contemporary transformational and distributed leadership frameworks, reflects ongoing scholarly attempts to understand what leadership entails and how it manifests across settings. Recent scholarship increasingly emphasises culturally responsive leadership, particularly in health professions and contexts, where responsiveness to diverse populations and the integration of indigenous knowledge systems are critical for equitable care delivery.

An enduring challenge in leadership studies is the distinction between leadership and management. These terms are often conflated, leading to ambiguity in both academic literature and professional practice. While theorists such as Kotterman (2006) highlight conceptual differences, portraying management as focussed on planning, organising and maintaining stability and leadership as energising people and driving change, the practical overlap between these roles complicates clear separation. Empirical investigations reiterate this nuanced relationship, indicating that leadership and management may be viewed as distinct yet interrelated domains, sharing some functions but differing in emphasis on influence, vision and people-centred motivation.

This conceptual ambiguity has important implications for leadership development. If leadership and management cannot be rigidly delineated, developmental programmes must adopt flexible and contextually relevant approaches. Leadership development is widely recognised as a dynamic, lifelong process cultivated through a combination of

formal education, experiential learning, mentoring and reflection. It demands deliberate strategies that balance theoretical knowledge with practical application, preparing individuals to lead effectively in complex, real world environments.

Nursing leadership presents a unique and rich field of study. Leadership in the profession has historically drawn from both ecclesiastical tradition and structured military hierarchy, with historical figures such as Florence Nightengale embodying the shift from caregiving as informal service to professionalised, strategic leadership. This legacy continues to influence nursing leadership practices today, however, enduring stereotypes and underrepresentation of nurse leaders in scholarly discourse highlight ongoing challenges to fully recognising the professions leadership contributions.

Modern nursing leadership extends beyond formal managerial roles to include leadership enacted at the point of care. This re-conceptualisation, expressed through terms such as clinical leadership, informal leadership and emergent leadership, recognises that nurses throughout the workforce exert significant influence on patient outcomes, team functioning and healthcare culture without holding formal authority. Clinical nurse leaders are described as visible, professionally credible role models who integrate evidence informed practice, support multi-disciplinary collaboration and embody values such as communication, advocacy and integrity. Clinical nurse leaders serve as pivotal change agents who bridge frontline care and organisational priorities, advocate for equitable health delivery and foster team cohesion in increasingly complex environments. To sustain and grow such leadership requires education and development programmes that are accessible, contextually relevant and responsive to nurses' realities at the bedside.

Despite the recognised importance of clinical leadership, literature reveals persistent barriers to its development and recognition. These include unclear role definitions, insufficient resourcing, limited formal development opportunities and cultural norms that undervalue leadership occurring outside hierarchical structures. Many nurses do not self-identify as leaders and their leadership efforts often go unacknowledged, constraining the potential benefits of distributed leadership within healthcare. These insights have profound implications for designing nursing leadership development

programmes, with the design embracing inclusive, accessible and culturally responsive approaches that reflect clinical realities and align with professional, organisational and constitutional strategy. Structured programmes present the opportunity to incorporate diverse learning modalities, including coaching, mentoring, theoretical and experiential learning and project management skills. Moreover, cultural competence and self-awareness are increasingly identified as essential components of leadership identity and practice, underscoring the need for programmes that promote cultural humility and safety. Development models advocating scaffolded development trajectories, with an emphasis on readiness rather than tenure, recognise that leadership growth is contextual and non-linear.

The method and duration of leadership education remain debated, with consensus favouring blended approaches that balance formal teaching with experiential opportunities and reflective practices. Mentorship and communities of practice emerge as critical supports, although implementation may face challenges such as availability and accessibility to mentors. Leadership development is often a self-directed, ongoing journey, requiring organisational commitment to provide time, resources and environments conducive to learning and development.

Nursing in Aotearoa New Zealand (Aotearoa-NZ), much like global nursing trends, has been shaped by evolving interprofessional dynamics, political reforms and social and scientific advances (Gage & Hornblow, 2007). From its informal, unregulated origins, nursing has undergone formalisation and professionalisation, particularly through the 20th century with the establishment of structured education and nursing's disengagement from medical oversight. Yet, despite these advancements, the profession has faced significant systemic disruptions, such as the dismantling of nursing's national representation under the State Sector Act 1998 and workforce challenges in the 1990s (Donovan et al., 2012). These historical shifts have contributed to persistent difficulties in securing consistent nursing leadership development and presence within clinical settings.

This backdrop of change and challenge remains salient today. The health sector reforms and fiscal pressures described by Weston (2024) further complicate leadership

pathways, with proposed reductions in nursing leadership roles threatening to diminish the profession's strategic influence. Conversely, these reforms also create a crucial window of opportunity to reimagine and reinforce the need for leadership development for nurses, especially those providing direct clinical care. National legislations such as the Pae Ora (Healthy Futures) Act 2022 and strategic frameworks like Te Mauri o Rongo explicitly affirm leadership as a cornerstone for equitable, culturally responsive and sustainable health service delivery (Parlimentary Counsel Office, 2022) (Ministry of Health, 2022). Concurrently, regulatory changes by the Nursing Council of New Zealand elevate leadership to a fundamental competency expected of all nurses, signalling a shift away from hierarchical notions of leadership towards a more inclusive, practise-based model (Nursing Council New Zealand, 2025).

Furthermore, addressing this need for leadership development aligns with the principles of Te Tiriti o Waitangi and the ongoing commitment to culturally responsive nursing practice. Leadership that honours Tiriti obligations is essential not only for improving Māori health outcomes but also for embedding equity and partnership into health service delivery. Therefore, leadership development initiatives must be culturally grounded and inclusive, enabling nurses to enact leadership in ways that reflect and respect Aotearoa-NZ unique cultural context.

These converging policy, regulatory and strategic signals necessitate intentional, structured approaches to developing clinical nurse leadership. However, despite recognition of its importance, clarity remains elusive around how best to cultivate leadership competence in the clinical context. Previous and existing leadership programmes in Aotearoa-NZ and internationally tend to vary in design, target audience and evaluation, with few specifically tailored to point-of-care nurses working outside formal leadership roles. The lack of robust, contextually relevant evidence highlights a critical gap in workforce development literature and practice.

This research responds directly to this need, focussing on two interconnected questions. The first explores how clinical nurse leadership is currently developed and supported from the perspectives of those holding designated senior nursing roles. This inquiry aligns with earlier findings from Donovan et al. (2012) who identified the

absence of systemic leadership succession planning and reliance on informal opportunities for leadership growth. It also resonates with ongoing concerns about austerity driven constraints outlined by Weston (2024) and with national strategic priorities emphasising leadership as a collective responsibility for nurses (Nursing Council of New Zealand, 2025; Parlimentary Counsel Office, 2022). Understanding senior nurses' perspectives is vital, as these individuals often shape or influence local leadership cultures and educational opportunities.

The second question examines the impact of leadership development programme on nurses' self-perceptions of leadership competence. This focus is supported by previous programme evaluations, such as those conducted by Miskelly and Duncan (2014), Spencer et al. (2018) and Alreshidi et al. (2024), which demonstrate that leadership education can enhance nurses' confidence, self-awareness and organisational and system knowledge. Yet, many such programmes either target formal leadership aspirants or lack rigorous evaluation, particularly within frontline clinical environments in Aotearoa-NZ. By investigating a tailored programme designed specifically for point of care nurses, this study aims to contribute evidence on effective educational strategies that can be embedded within clinical settings to nurture leadership capabilities. Together, these research questions are situated within a broader imperative to reposition nursing leadership not as an occasional or hierarchical role, but as an embedded, everyday practice that requires deliberate cultivation. This paradigm shift has profound implications for workforce planning, organisational culture and ultimately, patient outcomes.

The aim of this research was initially to investigate the need for nursing leadership at the point of care from the perspective of designated nurse leaders in a tertiary hospital. More specifically, this research seeks to address the following questions:

1. How is clinical nurse leadership developed from the perspective of those in designated senior nurse roles?
2. What is the impact of the early leadership development programme on participants perceptions of their own leadership competence?

Chapter II: Literature review

Wisdom is universal and is not confined by generations, by oceans or by cultures. It is part of the legacy of humankind

Sir Hirini Moko Mead, 1927 -

2.1 Introduction

A literature review is a comprehensive interpretation and summation of available literature related to a topic (Aveyard, 2014). Undertaking a literature review involves a systematic approach to searching and analysing literature, seeking to answer a research question (Aveyard, 2014). There are several steps that must be undertaken when conducting a literature review, including the literature search, identifying the relevance of the literature to the research subject, assessing the rigour of the literature found and subsequent documentation of the resulting findings (Borbasi et al., 2019). This process contributes to the development of new insights which address a research question or identifies gaps in current knowledge, suggesting that additional research is required (Aveyard, 2014).

A literature review synthesises knowledge through a systematic and iterative review of existing and emerging literature relating to a specific area of interest. There are numerous ways of conducting a review, though a scoping review was identified as being most aligned with the research approach. The primary benefit of a scoping review is its ability to map the breadth, scope and nature of the literature, to support the identification of gaps in the available literature (Mak & Thomas, 2022). Arksey and O'Malley (2005) provide a methodological framework for conducting a scoping review. They argue that unlike systematic reviews, which are driven by narrowly designed research questions and study design, a scoping approach aims to capture all pertinent literature exclusive of the study design. This allows the researcher to refine the search terms as they become more familiar with the literature and subsequently conduct more specific searches (Arksey & O'Malley, 2005). According to Arksey and O'Malley (2005), the process is inherently iterative, in that there is a requirement for researchers to remain reflexive, revisiting and adjusting steps as needed to ensure a

thorough exploration of the literature. The five step framework for conducting a scoping review presented by Arksey and O'Malley (2005) was adopted for this study which begins with identifying the research questions followed by identification of relevant studies. This is then refined with study selection followed by charting of the data. The final step is the collation, summarisation and reporting of results (Arksey & O'Malley, 2005). The flexibility and iterative nature of a scoping review and this framework allowed the researcher of this study to progressively refine search terminology as results were reviewed to support a comprehensive literature review related to the research questions.

Throughout this chapter a definition of terms related to this study will be provided followed by the search process employed to conduct the review of literature. The literature review will be discussed in two parts: Part I – Leadership; Part II – Nursing leadership. Combined, these will identify the gap in the current literature which has informed the research aim and questions.

2.1.1 Definitions of terms

Within the context of this research, a Registered Nurse is defined as an individual who holds a minimum of a bachelor's degree in nursing approved by the Nursing Council of New Zealand or successful completion of a nursing programme which is equivalent to a Level 7 bachelor's degree in nursing as determined by the Nursing Council of New Zealand. As well as current registration through the regulatory authority, Nursing Council of New Zealand, evidenced by the attainment of a current practicing certificate (Nursing Council of New Zealand, (n.d.)).

2.1.2 Search methodology

This review was primarily conducted through two library databases, one academic and one health organisation. It draws upon both theoretical and empirical literature identified through subscribed databases, including DynaMed, ClinicalKey, Pubmed, EBSCOhost CINAHL Ultimate, Google Scholar, Cochrane Library, ProQuest, Journals@Ovid Complete and Elsevier Science Direct. In addition, a search of reference literature identified in included material was conducted and as well as an

open search of grey literature. Initial literature exclusion criteria were if full texts were not available and if the publication was not written in the English language. Search criteria were initially limited to literature published between 2014 and 2024. This date range was later expanded to enable identification of literature which evidenced the historical development of nursing leadership.

The initial search keywords were 'nurse' and 'leadership'" and 'development programme.' This produced a considerable volume of search results with 20,667 pieces of literature, of which the first 199 were reviewed. Following removal of duplication and filtering with screening questions for inclusion, which were, 'is it nursing specific,' 'what is/why we need nursing leadership' and 'nurse leadership development programme related,' 45 full text articles were identified as relevant to the research questions. A second literature search using the same databases was conducted with the same exclusion and inclusion criteria, using the search keywords "nurse leader" and "definition." This yielded 157 results, which were filtered for inclusion through screening questions which were 'is it nurse specific,' 'what is nursing leadership' and 'why we need nursing leadership.' Subsequent to this and following the removal of duplicates, seven full text articles were identified as relating to the research questions. These articles alongside a search of grey literature using the abovementioned keywords, identified a further 24 articles. Cumulatively, 76 articles were included within the literature review initially. As the writing progressed, gaps were identified in the literary evidence sources, hence a further broad database search was conducted using the key words 'nursing leadership,' 'history,' '1900' and '20th century, which resulted in a further 12 articles being included in the literature review congruent with the aforementioned framework for conducting a scoping review which allows for further data gathering. A further gap identified was related to terminology of early leadership development programmes for nurses. A final search was conducted using the search terms 'clinical nurse leader' and 'programme.' The results were refined to exclude material related to programmes for nurses already in a designated leadership programme and programmes which were designed and delivered nationally. This resulted in a further five which are reviewed later in this chapter.

Part I: What is this thing called leadership?

2.2 Introduction

Modern healthcare systems are dynamic, operating within intricate social, political and economic landscapes. Across the globe, healthcare professionals and consumers navigate challenges arising from multifaceted clinical, administrative and policy environments. Nurses, in particular, face increasing demands related to clinical service delivery, austerity measures and workforce shortages. Despite these challenges, the current healthcare landscape presents unparalleled opportunities for dynamic nurse leaders (Daly & Jackson, 2021). Modern healthcare systems have evolved beyond traditional hierarchical medical leadership, embracing a more inclusive and interdisciplinary approach. To drive innovation in care models, policy, practice and research, nurses must be empowered to take on leadership roles and shape the future of healthcare delivery (Daly & Jackson, 2021).

Defining what leadership is, how it differs from management, who leaders are and what they do is challenging (Grossman & Valiga, 2021). Grossman and Valiga (2021) refer to leadership as multifaceted and multidimensional hence it is difficult to clearly define. Benmira and Agboola (2021) concur with this position, describing leadership as among the most multifaceted and complex of phenomena. They argue that despite extensive research over years, there is no single or universally accepted leadership definition. Despite these difficulties, attempts to produce a universal definition continue, such as the definition provided by Northouse (2016, p. 45) who defined leadership as "a process whereby an individual influences a group of individuals to achieve a common goal". Whilst defining leadership presents challenges, these is widespread agreement that a key contributor to success of an organisation is effective leadership (Benmira & Agboola, 2021). There are numerous perspectives on leadership and studies into this concept enable the broadening and development of comprehension of the leadership process (Northouse, 2016). Over the years multiple attempts have been made to define and explain leadership, from these endeavours, leadership theories have evolved.

2.3 The evolution of leadership theory

One of the earliest leadership theories was the Great Man Theory, developed in the 1840s, which asserted that a leader was someone who possessed innate leadership characteristics, which are inherited (Benmira & Agboola, 2021). These inherent traits were strictly the provenance of males through representation of status, stature, affluency, religiosity and the Victorian belief that leadership was inherently masculine (Spector, 2015). This theory also gave credence to the notion that leaders are born, not made. Jogulu and Wood (2006) argue that this approach excludes women as potential leaders evidenced by the theory's name itself, which reflects the perception that women were not considered leaders in any capacity, as it was designed as a male-centric model during a time when women were largely absent from paid employment. Another limitation of the Great Man Theory was it did not acknowledge the potential for leadership proficiency to be learnt (Grossman & Valiga, 2021). In the 1930s and 1940s, theorists built on the Great Man Theory and focused on the traits which defined a good leader. Empirical evidence refers to these as Trait theories (Grossman & Valiga, 2021).

Proponents of the Trait theory support the notion that leaders can be made, asserting that the qualities of effective leaders can either be inherited or cultivated through training and practice (Benmira & Agboola, 2021). Theorists attempted to identify the universal characteristics that distinguished a good leader from other people (Grossman & Valiga, 2021). Trait theories primarily defined leadership traits in masculine terms, considering these characteristics essential for effective leadership (Jogulu & Wood, 2006). The result of this approach was a lack of evidence substantiating a universal list of traits which correlated to all leaders. It also did not consider the situational variance leaders are acting in (Grossman & Valiga, 2021). During this time period, only very small percentages of women were appointed into leadership roles and were more typically seen in roles associated with carer and assistant positions associated with nursing consequently perpetuating the rhetoric that the caring and nurturing traits associated with women were not regarded as suitable for leadership positions (Jogulu & Wood, 2006).

This gender binary limitation in thinking and inability to identify a universal list of traits led to the Situational era in the 1960s which encompassed consideration of both individual traits and situational aspects simultaneously as contributors to leadership effectiveness (Benmira & Agboola, 2021). The premise of Situational theories is that a leader is identified through being in the right place at the right time and facilitated the appropriate response (Grossman & Valiga, 2021). The strength of this theory was success is not contingent on hereditary features or traits of the individual (Grossman & Valiga, 2021). Rather, the premise is leaders must evaluate the context in which they work and determine which style is most suitable for the situation (Benmira & Agboola, 2021). During the period where Situational theories were the predominant leadership discourse, women were still significantly underrepresented in leadership positions, therefore the traits demonstrated associated with Situational theories were still associated with inherently masculine predispositions (Jogulu & Wood, 2006).

As theorists continued to attempt to define the complexity of the leadership phenomenon, the 1990s and 2000s represented the new leadership era (Benmira & Agboola, 2021). These more contemporary leadership theories recognised multiple contributors influence effective leadership, including situational uniqueness, the leader, the followers and organisational culture (Grossman & Valiga, 2021). Riggio, Chaleff, & Lippman-Blumen, 2008) cited in (Grossman & Valiga, 2021) states without followers, there can be no leadership. In 2016, Northouse built on this assumption describing the duality of the relationship between leaders and followers, highlighting the shared purpose and common goals increases the probability of collaboration and successful outcomes (Northouse, 2016). Jogulu and Wood (2006) suggest this shift in perspective led to researchers exploring leadership styles displayed by both males and females and encouraged the evaluation of the behaviours, actions and attitudes of women leaders. Additionally, more contemporary leadership theories such as transformational leadership and authentic leadership suggest success is contingent on having a clear vision, communicating this and collaborating with followers on how to translate the vision to reality whilst empowering others, suggesting individual leadership competency can be developed (Grossman & Valiga, 2021). Northouse (2016) proposes that success is based in the tenets of leadership being a process and is

not trait dependent, rather the reciprocal nature of the leader and the followers combined with interactivity of a group.

Northouse (2016) states that there continues to be a gender gap in leadership, with women being significantly underrepresented. While much of the research on gender in leadership has been conducted in Western contexts, studies in other cultural settings remain limited. Despite the persistent gender gap in influential leadership positions, there is evidence that it is gradually narrowing. However, women still face the challenge of balancing leadership competence with societal expectations of femininity (Northouse, 2016). Northouse (2016) proposes adopting behaviours such as individualised consideration and inspirational motivation presents a promising strategy for overcoming these biased perceptions in leadership.

With the ambiguity surrounding leadership definitions and contemporary leadership theories published more recently, each with its own advantages and disadvantages, Grossman and Valiga (2021) suggest there is agreement among theorists that leaders are made, not born. This then raises the question, how are leaders made? Leadership also cannot be viewed in isolation of the social and cultural context in which it operates as these are key considerations in the success or failure of a leadership process.

2.4 Cultural considerations in leadership

The advancement of globalisation, notably in the last ten years, has created challenges for multicultural organisations, including the necessity of identification and selection of appropriate leaders to manage culturally diverse workforces and health service users (Northouse, 2016). In 2004, a publication by Javidan, Dorfman and Gupta presented a focussed lens on culture and leadership, as a part of the Culture, Leadership and Organizations: The GLOBE study of 62 societies. The primary aim of this research was to increase understanding of cross-cultural interactions and the subsequent influence of culture on effective leadership (Northouse, 2016). The Globe researchers surveyed 17,000 managers within 950 organisations worldwide, representing 62 different cultural groups. There were both strengths and criticism of this work. Notably, a strength is the large scale of this study and insights gained, which make a compelling statement about how cultures across the globe perceive leadership. The

exploration of culture and leadership emphasises the complexity of the leadership process and the significant role culture plays in shaping it (Northouse, 2016). Data from the GLOBE studies reveal the importance of moving beyond ethnocentric perspectives; where leadership is viewed solely through our own cultural lens and instead 'opening our window' to appreciate the diverse ways leadership is perceived by people across the world. Though this research has identified strengths, there are also several limitations reported. One of these being, while the GLOBE study has generated numerous insights into how leadership is perceived across different cultures, it does not offer a clear set of assumptions or propositions that could form a unified theory about how culture relates to leadership or influences the leadership process (Northouse, 2016).

Research is dominated by the predominant discourse of Western-centric perspectives (Wang et al., 2014). As a result, Western assumptions about leadership are often embedded in leadership theories, such as those discussed within this chapter and these assumptions become ingrained in leadership rhetoric, reinforcing the notion of 'this is how leadership is', even as there is a growing recognition that culture and context play a crucial role in shaping leadership (Wang et al., 2014). In 2014, Wang published their findings from a study exploring the construct of leaders of Western companies with headquarters based in an Eastern country. The participants were comprised of 31 senior global leaders based in the Eastern country headquarters and 59 local, or indigenous, leaders employed across six companies. A significant finding in this study was a clear misalignment of expectations of leadership competencies between the two groups with 50 percent of the key constructs of leadership identified by global leaders absent from the local leaders, including emotional intelligence, communication and capabilities relating to team development. An implication of this finding is that Western leadership models may not fully capture the nuances of leadership in different cultural contexts (Wang et al., 2014).

Prince (2005, p. 106) argued that the Westernised view of leadership concerns "active and shaping control," whereas from an Eastern or Taoism perspective, leadership concerns "engagement and accommodation with circumstances as they are". Prince (2005) further asserts that Eastern perspectives of leadership may offer valuable

insights into understanding leadership by shifting away from traditional rigid constructs such as specifications and interventions and instead emphasising a more socially responsive approach developed through practice rather than theory, focusing on internal 'knowing' and personal experience as opposed to external guidance and instruction.

Aotearoa New Zealand (Aotearoa-NZ) is a bicultural nation and for te tangata whenua Māori (the indigenous peoples of Aotearoa-NZ) leadership is embedded within an indigenous perspective (Ruwhiu & Elkin, 2016). Leadership qualities are embedded within the cultural values and knowledge that define Te Ao Māori, the Māori worldview and are people-centred, designed to ensure the care and well-being of all, hence the leaders accountabilities are to the people, not hierarchical (Ruwhiu & Elkin, 2016). In 2013, Ruwhiu and Cone (2013) conducted a kaupapa Māori research study which drew from a pragmatic epistemology, using raranga kōrero, narrative enquiry, to portray the participants stories of leadership from an indigenous perspective compared with pragmatic leadership. Findings from this study evidenced that Māori leadership reflects a distinct mindset regarding the role and responsibilities associated with leaders. Moving away from structured characterisation of leadership where leaders are hierarchically positioned with process and outcome responsibilities and towards embracing the inherent experiences of being Māori, individually and collectively, playing a crucial role in shaping leadership practices (Ruwhiu & Cone, 2013).

Māori leadership is unique in nature as it offers a culturally grounded frame of reference embedded in a different cultural and social context from Western leadership approaches (Ruwhiu & Cone, 2013). Haar et al. (2019) published findings from their kaupapa based research which aimed to highlight the criticality and uniqueness of indigenous, specifically Māori, leadership values, beliefs and characteristics inherent in Māori leadership practices. A total of 22 semi-structured interviews were conducted of nominated leaders who identified as Māori. Emergent themes from these interviews identified five ideas which participants articulated reflected their leadership philosophies and values. One of which was cultural authenticity, "knowing and being true to ones tikanga" (Haar et al., 2019, p. 624). The authors concluded that it is

possible for successful leadership to be founded in cultural and traditional practices whilst navigating the societal and organisational contexts (Haar et al., 2019).

Leadership theories can help nurses reflect on their behaviour and assess the effectiveness of different leadership styles. Major (2019) suggests there is no single 'right' or 'wrong' approach to leadership; instead, adapting various styles may be necessary to navigate the complex challenges encountered in healthcare settings. Wiapo and Clark (2022) suggests there has been a growing shift toward rethinking leadership in Aotearoa-NZ, with emphasis on the importance of future leaders who reflect the diverse populations they serve and whose values are embedded in te ao Māori (Ruwhiu & Elkin, 2016). However, cultivating this type of leadership requires intentional efforts to develop and mentor a diverse workforce, providing them with the necessary skills, training and opportunities (Wiapo & Clark, 2022). Wiapo and Clark (2022) concluded that whilst Western leadership actions may share some cultural similarities, they can also differ significantly; with many traditional leadership theories failing to fully acknowledge or respond to the complexities of cultural diversity, depth and understanding.

The significance of cultural context and leadership practices cannot be underestimated. The growing cultural diversity in healthcare organisations, driven by globalisation and expatriation, has created a need to reassess leadership practices from different perspectives to ensure effective organisational leadership, both at the bedside and in designated leadership roles. This is particularly relevant in Aotearoa-NZ where almost half (46.8%) of registered nurses with an Annual Practicing Certificate in December 2024 were internationally qualified nurses (Nursing Council of New Zealand, 2024a). This is a significant increase from the 33 percent of registered international qualified nurses recorded in March 2023 (Nursing Council of New Zealand, 2023).

As previously discussed in this chapter, leadership has long been documented in scholarly writings, but it is often used in the same context as management and many contributions have been made from theorists and academics to debate if they are essentially the same concept or entirely different.

2.5 Are leadership and management the same thing?

Defining and conceptualising management and leadership has always been challenging, as the terms are often used interchangeably, leading to ambiguity (Kotterman, 2006). Porr (2010) concurs with this opinion, stating leadership theorists assert the two concepts have distinct differences but the frequency of interchangeability of these has led to uncertainty. Leadership has been the focus of scholars as far back as Aristotle, but management is a more recent concept with its emergence early in the 20th century, at the dawn of industrialised society (Northouse, 2016). The rise of large, complex organisations over the past century created a demand for a system to regulate work and address issues of authority and control. This led to the development of the modern workplace manager, whose role was to minimise internal chaos within these increasingly intricate organisations. Managers established order and consistency across various workplace processes (Kotterman, 2006). The primary function of management during this time was staffing, organising, planning and controlling (Northouse, 2016). Many scholars have debated the similarities and differences of leadership and management and it was proposed by Kotter (1990) that both roles are necessary for organisational success. Collins Ii et al. (2023) surmise there are three contemporary perspectives in the scholarly literature related to leadership and management. Some argue that leadership and management are entirely distinct concepts, while others believe they are fundamentally the same. Meanwhile, a third perspective sees them as somewhat different but with substantial overlap (Collins Ii et al., 2023).

Kotter (1990), cited in Kotterman (2006) advise there are few similarities between leadership and management and greater presence of distinct differences. Both leaders and managers play a role in setting direction, motivating people and aligning resources. Kotterman (2006) infers that managers focus on maintaining order, stabilising work, managing budgets, developing processes, delegating authority and organising resources. They ensure standards, consistency, predictability and control. In contrast, leaders influence, shape vision, energise teams and promote significant change. While managers focus on control and problem-solving, leaders inspire and motivate (Kotterman, 2006).

In 2006, Stanley conducted a qualitative study where 830 nurse participants completed a questionnaire, with 42 people participating in focused, in-depth interviews and a final eight interviews with clinical leaders. The aim of the research was to ascertain participant understanding of the perceived differences between management and leadership. Findings demonstrated a perceived reliance of managers on their position and hierarchical status, whereas leaders demonstrated an ability to inspire others, utilising their experience and knowledge. Another finding of note from the interviews was a consensus that managerial responsibilities hindered the ability to lead (Stanley, 2006).

In 2022, Collins and Algaze published findings from their prospective study where they explored if it was possible to effectively differentiate leadership and management actions. Two groups of scholars completed a survey questionnaire of the Leadership / Management Concept Scale (LMCS). The LMCS was developed based on previous work of Collins et al. (Collins Ii et al., 2023). They created a 54-point statement survey utilising published definitions of leadership and management with 206 participants; all of whom were identified as experts and / or scholars in the field of management and leadership. The statements were presented on a spectrum, ranging from purely managerial to purely leadership orientated actions. Each action was assigned a numerical value enabling the quantification of a respondent's perception of the action as leaning more toward management or leadership. The LMCS adapted the findings of Collins work into 11 actions that participants ranked on a scale of one, representing the most managerial to 11, being the most leadership orientated. The findings support the notion that leadership and management can be empirically distinguished while also highlighting specific areas of overlap. In this study, respondents demonstrated a clearer understanding of what defines leadership compared to management. The top four actions identified in the LMCS: influencing, coaching, ensuring the resilience of others and serving as a good role model were distinctly recognised as core components of leadership. In contrast, the aspects defining management were less clearly differentiated, as evidenced by the wide variation in respondents' responses (Collins Ii et al., 2023).

Literature provides evidence of a swinging pendulum of opinion and theory on the similarities and differences of leadership and management process, attributes and actions. If there is no clear delineation between the two, how is the optimal approach to develop leaders determined?

2.6 How do leaders develop?

Leadership development can be referred to as a purposeful process, which can be enhanced by numerous strategies. As a developmental learning process, the emergence as a leader can be enhanced through enacting leadership experiences, mentoring and formal education (Grossman & Valiga, 2021). Formal education, such as lectures and courses, all present opportunities for facilitated discussions leadership. The experiences also allow for an exploration of real world examples of leadership which can promote consideration of the diverse nature of leadership (Grossman & Valiga, 2021). Taylor and Webster-Henderson (2017) postulate that addressing leadership development requires a dual approach, utilising the knowledge and experience of current nurse leaders being one component, the other is through aspiring leaders who can propel a sustainable difference for future nursing practice.

In 2017, (Boerma et al.) published a point / counter point article debating 'Are outstanding leaders born or made?'. The premise of the debate was that in order to fully comprehend leadership, one must consider whether the foundations are based on intrinsic factors, such as in the premise great leaders are born, or extrinsic factors, where great leaders are made. The evidence presented for substantiating leaders are born is informed from results of genetic twin studies. A range of methodologies, such as questionnaires and mathematical models, have been employed in these studies to assess the shared genetic and unique environmental influences on twins in leadership roles. Most of the results indicate moderate genetic contributions to leadership-related personality traits, with genetic factors accounting for up to 30 percent of leadership influence overall. Critics of this view highlight statistical flaws in twin studies on leadership and point to numerous historical examples of exceptional leaders who lack a familial background in leadership (Boerma et al., 2017). They also argue that leadership skills can be cultivated through life experiences and structured leadership development programmes. The conclusion was thought to be the answer was likely a

combination of both perspectives, leaders are most likely shaped by a combination of genetic predispositions and their responses to environmental influences (Boerma et al., 2017)

This chapter has identified the complex nature of leadership through exploring the theoretical evolution of leadership, the cultural context in which leadership occurs, the leadership versus management conundrum and ways in which leadership can be developed. These discussion points were reviewed from a global perspective and now leadership in industry will be considered in the context of nursing.

Part II: Born in the church, raised by the military

2.7 Nursing leadership history

Nursing leadership has foundational elements from both religious and military influences. Early societies depended on nursing for the care of the sick and what began as a caregiving role grounded in religious duty evolved into a vocation within the military (Moiden, 2002). Over time, the role of the nurse has undergone profound transformation, expanding to include highly skilled professionals who contribute through clinical expertise and leadership, playing an active role in advancing societal health and wellness (Moiden, 2002). Despite significant literature referencing the healing practice of nursing throughout history, it is relatively young in its term as a profession. Now, more than ever, the professional identity of nursing is evolving rapidly and in response, nurses must be equipped to lead innovation to guide and shape nursing's collective future (Porter-O'Grady et al., 2019). Mahoney (2001) reiterates this by asserting future nurse leaders must possess a comprehensive understanding of the healthcare landscape.

Nursing has a long evolutionary history which highlights evidence of nursing leadership. A number of historical transitions have influenced the philosophical nature and public perception of nursing (Daly & Jackson, 2021). In very early societies, the provision of nursing care was traditionally held by females as an extension of their role as the family caretaker. There was no formal nursing education, knowledge was passed through the generations orally. Those who were lauded as experts due to proficient nursing care and positive outcomes were held in high esteem and arguably, were nurse leaders of their time (Egenes, 2017).

With the advent of the Christian era, religious institutions became primarily responsible for health care provision. The role of the 'deaconess' emerged, which were educated women who were tasked with the provision of nursing care of the sick. This ecclesiastical environment fostered a culture characterised by compassion, charity and service to others where the moral imperative to provide care was intrinsically linked to spiritual convictions (Egenes, 2017). Subsequently, early nurse leaders emerged from these religious contexts including the deaconess, 'Phoebe', who is referred to as the

first 'visiting nurse' in recognition of the exemplary nursing care she provided to people in their homes (Qiu, 2022).

As nursing as a vocation progressed in the 19th century, the influence of the military became prevalent. Building on religious beliefs and military structure, a now globally recognised nurse leader emerged. Guided by her strong spiritual convictions and visionary belief in the potential of nursing, Florence Nightingale created an enduring transformation for the nursing role from one of domestic duty to professional status (Selanders & Crane, 2012). At an early age, Nightingale discerned her Christian duty was to serve humankind and nursing presented a platform in which to fulfil this religious imperative. Early evidence of nursing leadership in literature can be found through the documented actions of Nightingale during the Crimean war in the mid 1800's (Selanders & Crane, 2012). Nightingale is lauded as being visionary far beyond her time and the concepts she penned of nursing are still evident in today's nursing context (Beck, 2010). Notably, her influence as a nurse leader during the Crimean war became apparent through her advocating for a transition from 'sick-nursing' to 'health-nursing.' A concept which she describes as moving from caring for the illness to encompassing a holistic view of human health, inclusive of individual and societal influences (Beck, 2010).

Not only did Nightingale provide what is described as exemplary direct nursing care to patients, she also fulfilled administrative, leadership, policy and diplomatic roles (Beck, 2010). Nightingale was famously a prolific writer and her writings substantiate her standing as a prominent leader in nursing and global health (Harper et al., 2014). Her advocacy in contributing to health education, policy-making and health reforms globally evidenced her developing beliefs in human rights and social equality (Harper et al., 2014). Nightingale's visionary view of leadership can be summarised with her statement "Let whoever is in charge keep this simple question in her head (not how can I always do this right thing by myself, but) how can I provide for this right thing to be always done" (Nightingale, 1860, p. 58). Nightingale has been described as a trans-visionary leader, combining both transactional and transformational traits. She pursued a vision to create significant, lasting change by utilising her intelligence, resources, creativity, connections and negotiation abilities, all while faced with

significant social, cultural and gender obstacles (Hegge, 2011). Daly and Jackson (2021) argues that nurses and indeed the nursing profession, has been the subject of mythological, folkloric and romantic connotations, portraying them as subservient to doctors. Daly and Jackson (2021) attributes many of these notions to the fabled work of Nightingale during the Crimean war. For example, the legendary image of the 'lady with the lamp' which was coined in response to Nightingales actions in the war-zone front line conveying calmness and peace in times of chaos and suffering.

Nightingale is one of the many 19th century nurse leaders whose actions and innovations have been instrumental in transforming nursing and contributing to the foundations that nursing stands on today. A review of 19th century nursing leadership by Lorentzon and Bryant (1997) illustrated distinctive leadership characteristics, specifically linked to the role of the matron. They found the initial emphasis of the matron's leadership role was defined by housekeeping and domestic duties but evidence describes a gradual transition to a broader nursing leadership context, which was propelled by multiple reform movements (Lorentzon & Bryant, 1997). One nurse leader of the 20th century regarded in literature is Dame Muriel Powell. Powell is described as an influential and innovative leader, role model and advocate for nursing ahead of her time, significantly contributing to improved patient care and the nursing profession (Harris et al., 2014). In the mid 1900's, Powell was the youngest nurse to be appointed as a matron in a teaching hospital in London. A qualitative thematic analysis of archived interviews of nurses who worked alongside Powell documented her significant influence with a particular focus on her leadership traits of open communication and innovative approach which pioneered changes within the organisation and nursing workforce (Harris et al., 2014).

Less investigation and evidence has been documented throughout the 20th century exploring nursing leadership which has resulted in a dearth of literature (Wildman & Hewison, 2009). Harris et al. (2014) reiterate this by stating inspirational nurse leaders have significantly shaped the development of nursing over the past century, though specific accounts of their impact are scarce, which diminishes the profession's influence and social legitimacy. What is evident in the literature is that the late 20th century marked an era of academic evolution and structured professionalism in nursing

contributing to a change in the features of nurse leadership (Lorentzon & Bryant, 1997). Entrenched stereotypes of nursing have, in part, been derived from the aforementioned historical portrayal of nurses which has perpetuated the status of the nurse as hand maiden rather than health professional (Daly & Jackson, 2021). The path to being recognised as a profession was a substantial undertaking by nurse leaders during the 20th century (Porter-O'Grady et al., 2019). A central component of professional identification is the shared unique knowledge inherent within the profession, the social mandate to provide a service to the community and the ability to continually advance in knowledge, practice and contemporary research in a way which retains the patient and their family as the centrepiece. This understanding is a professional obligation for nurses (Porter-O'Grady et al., 2019). Porter-O'Grady et al. (2019, p. 24) states "If a nurse is influencing a care-team member, patient, or other part of the health system, then the nurse is leading".

Throughout history, there have been nurse leaders who have pioneered significant changes in healthcare. However, such accounts are rare, suggesting that the achievements of nursing leadership may have been overlooked—possibly due to the historically subservient perception of the nursing profession. The actions of nursing leadership that have been documented throughout history talk of innovation, role modelling and being visionary but what does a nurse leader look like in today's healthcare context?

2.8 What defines a nurse leader?

Literature provides a multitude of definitions of leadership, but Mahoney (2001) suggests the one which most accurately embodies nursing leadership focuses on communication processes which drive the achievement of goals. While environments and circumstances may change, the fundamental qualities of a strong leader remain the same. Nursing leaders play a crucial role in providing inspiration, guidance and mentorship, whether directed toward patient care or advancing the profession (Mahoney, 2001).

Grant and Massey (1999), cited in Mahoney (2001) advise the function and responsibilities of a nurse leader encompass serving as a role model for peers,

delivering expert nursing care grounded in theory and research, exhibiting a strong understanding of organisational policies and collaborating with others to ensure optimal healthcare delivery. They are also accountable for providing patients with information and support, advocating for changes that enhance patient outcomes and healthcare systems and adhering to nursing codes of ethics and standards of practice as a framework for personal and professional accountability (Grant and Massey, 1999 cited in (Daly & Jackson, 2021). Hutchinson and Jackson (2012) cited in Daly and Jackson (2021) advise that transformational leadership is prevalent in nursing literature and has been widely, though often uncritically, accepted within the profession. Such leaders are often described as capable of creating shared visions, serving as role models inspiring and motivating others, providing intellectual stimulation and offering mentorship (Reinhardt et al., 2022). Effective leadership relies on specific qualities including advanced communication skills, self-awareness of personal values, beliefs, emotions and attitudes, as well as respect, dedication, adaptability and flexibility (Daly & Jackson, 2021).

Kitson (2004) argues that 'leadership is a process of drawing out rather than putting in'. Daly and Jackson (2021) suggests this implies all nurses hold a responsibility to demonstrate leadership qualities. Through cultivating such insights, Daly and Jackson (2021) suggest that leaders can gain self-awareness and self-acceptance and subsequently recognise the dysfunctions within organisations and workplaces, which in turn enables nurses to drive meaningful reform. This necessitates nurse leaders be politically savvy, well-informed about current literature and attuned to key issues like trust and employee engagement, which are crucial for effective leadership. Trust, based in the motives and integrity of others, as well as their perceived competence and ability, is a vital attribute (Clarke, cited in Daly and Jackson, 2021). Daly and Jackson (2021) propose these skills are inherent in nurses across all levels of the profession to varying degrees, which equip them to take on leadership roles regardless of their position or work setting.

2.9 Why do we need nurse leadership?

Effective leadership is crucial in healthcare, as it directly impacts both healthcare professionals and patient outcomes. Strong leadership fosters a positive and engaged

workplace culture, leading to improved patient satisfaction and better overall outcomes (Major, 2019). Nurses face challenges to maintain currency with the continually expanding body of knowledge, technology and sociocultural change inherent in today's complex healthcare system and it is necessary for nurses to be confident in navigating the various issues affecting the nurse patient relationship, including performance outcomes, safety, political policy and global health concerns (Roux & Halstead, 2018). Taylor and Webster-Henderson (2017) expand on this idea through the proclamation one of the most significant challenges affecting healthcare delivery today is to develop nursing leadership capability and capacity. Leadership is an essential responsibility for nurses, regardless of their position title or level of experience, from the moment they complete their training, nurses are expected to lead and manage patient care (Major, 2019). Porter-O'Grady et al. (2019) align with this concept, proposing it is becoming clear that nursing leadership is not only the remit of those in managerial or designated senior roles, but also a significant portion of nurses provide leadership in the clinical practice context. Given the fast-paced, complex and high-pressure nature of healthcare settings, nurses must possess strong organisational and communication skills to navigate diverse situations (Major, 2019).

In a time of significant health reform nationally as well as globally, the criticality of the role of the nurse leader in health systems and practice settings is becoming abundantly clear, evidenced by collaborative innovations in models of health service delivery, multidisciplinary collaboration and consumer engagement (Porter-O'Grady et al., 2019). In response to this, Porter-O'Grady et al. (2019) propose that it should be a requirement for all nurses to have exposure to introductory leadership competencies, including team focussed clinical practice and provision of feedback on quality improvement initiatives. Leadership is a constant requirement in nursing, as nurses must make decisions, delegate tasks, serve as role models and influence their colleagues during every shift (Major, 2019). Porter-O'Grady et al. (2019) state nurses lead in the coordination, facilitation and integration of care across the continuum of health services and stress it is vitally important nurses are leaders at the point of care with patients in clinical practice, as well as engaging in the evaluation of nursing practice and the design and delivery of new practices which meet the needs of the future. Daly and Jackson (2021) assert rather than being passively carried by change, nurses must

actively participate in shaping it as we navigate an increasingly globalised world, the impact extends beyond healthcare to influence professional practice as well.

Sherman and Bishop (2007, p. 27) proclaim that "the success of nursing as a profession in facing the challenges ahead will hinge on our ability to proactively recruit, develop and mentor future nurse leaders". Grossman and Valiga (2021) assert that all nurses are required to utilise their experience and knowledge to lead the improvement and advancement of the quality of care, patient safety and the reduction of patient morbidity and mortality. Organisations with strong leadership often foster positive patient experiences, characterised by respect, care and compassion (Major, 2019). Bohmer (2013), as cited in Chávez and Yoder (2015) infer the successful implementation of service improvement and health initiatives relies on the leadership of frontline clinicians or clinical leaders. Such leaders play a crucial role in shaping the effectiveness of teams contributing to patient care and providing oversight of local clinical operations (Chávez & Yoder, 2015). Similarly, Blumenthal (1996), as cited in Chávez and Yoder (2015) emphasised that improving healthcare quality fundamentally depends on leadership from those actively engaged in daily clinical work. Expert nursing practice goes beyond knowledge, skills and competencies to include the translation and application of best practices. This involves leveraging resources, energy and passion to bring the philosophy of nursing to life. Strong nursing leadership is essential for implementing evidence-based practice, enhancing patient outcomes and maximising the value of healthcare whilst upholding ethical principles (Daly & Jackson, 2021). Literature demonstrates clear links between effective nursing leadership and quality patient care outcomes, what it also demonstrates is the many variations in utilisation of labels for nursing leadership directly related to patient care delivery.

2.10 Leadership by any other name

Extant literature highlights a historical investment in research related to nursing leadership that is directly related to formal positions of authority. Notwithstanding this, it is only in recent years that a different type of nurse leadership has been considered; that all nurses involved in direct patient care are leaders (Stanley, 2017). Literature demonstrates different terminology related to this concept such as clinical

leaders, informal leaders and emergent leadership which will be explored in the following pages.

Nursing leadership and nursing management are frequently treated as interchangeable concepts in literature and as a result a significant proportion refers to leadership and leadership development as a way to support those in nursing management positions and consequently the result has been an assumption the literature offers transferrable insights for clinical leadership (Stanley & Sherratt, 2010). Aspinall et al. (2021) suggests the significance of both formal and informal nursing leadership is well recognised in nursing literature but expands to advise while formal leadership roles, often linked to management, are widely understood, informal roles, such as clinical leadership are less clearly defined (Aspinall et al., 2021). It is proposed by Chávez and Yoder (2015) that the concept of clinical leadership emerged to distinguish the leadership potential of bedside nurses from the traditional leadership roles associated with formal positions of authority. Mahoney (2001) advises whether it is a nurse in a designated executive position or a staff nurse providing direct patient care, both require strong leadership abilities. In order for nurses to comprehend and implement clinical leadership principles, greater effort is needed to clearly define what clinical nurse leadership entails and present it in a way that nurses in clinical practice roles can identify it in themselves and their colleagues, as they work to develop their skills as clinical nurse leaders (Stanley & Sherratt, 2010). In 2011, Downey et al. (2011) published a paper exploring informal leaders in acute healthcare settings, they echo the position of Stanley and Sherratt (2010) that minimal scholarship and research has explored the impact of informal nursing leaders and their subsequent potential for positive contributions to organisations and patient care. They expand on this to say health care organisations have the opportunity to develop and mentor these informal nurse leaders. To lead at the bedside and in moments of improved quality care, nurses need to be supported to foster and develop their bedside leadership aptitude (Stanley & Sherratt, 2010).

Stanley and Sherratt (2010) propose clinical leaders are nurses who employ an evidence-based approach to inform direct patient care, who are clinically present, approachable, serve as positive role models, possess clinical proficiency and are

empowered decision makers. Patrick et al. (2011, p. 450) define clinical leadership as "staff nurse behaviours that provide direction and support to clients and the health care team in the delivery of patient care". They go on to expand on this definition by stating a registered nurse is a clinical leader through influencing and coordinating patients and the wider health care team, integrating care interventions to achieve optimal patient outcomes (Patrick et al., 2011). Joseph and Huber (2015, p. 56) provide a definition of clinical leadership as "the process of influencing point of care innovation and improvement in both organisational processes and individual care practices to achieve quality and safety of care outcomes". They further state, this builds upon the foundational skills of registered nurses, incorporating general leadership abilities, care management expertise and a focused application of evidence informed practice for problem solving and outcome management (Joseph & Huber, 2015). A definition of clinical leadership provided by Stanley (2017) defines clinical leaders as those who demonstrate clinical expertise within their practice area and fellowship is directly related to their actions being informed by their beliefs and principles related to quality patient care. Though there is not one standard definition of clinical leadership in literature, there are some common themes. The first being the clinical leader is clinically present and involved in direct patient care, they are also role models who demonstrate clinical expertise embedded in evidence informed practice, they support the coordination of care with patients and colleagues and are focussed on quality and safety outcomes for patients. Less frequently in literature, this type of leadership role has been referred to as informal leadership.

Downey et al. (2011) advises informal leaders are noted to be individuals who influence the culture of the organisation, share their knowledge and expertise and facilitate team cohesion and are not employed in a formal position. Larsson and Sahlsten (2016) as cited in Major (2019) define informal leadership as leadership that is not tied to a formal position, such as a ward leader or senior nurse, but still requires strong communication, conflict resolution and adaptability. Informal leaders play a key role in fostering a culture of acceptance, support and trust within their teams, encouraging positive behaviours and continuous learning among team members (Major, 2019). Though there are similarities in the role definitions of informal leaders, through core competencies being related to knowledge sharing, team collaboration and not being in

a formal leadership position, there is no link to direct patient care in the mentioned literature. Another related concept found in literature is emergent leadership. De Souza and Klein (1995), as cited in Chávez and Yoder (2015), define emergent leaders as individuals within a group who exert significant influence over their peers, despite not holding an official leadership title.

Another term referenced in literature is staff nurse clinical leadership. Chávez and Yoder (2015) conducted a literature review using concept analysis methodology to provide a clear definition of staff nurse clinical leadership (SNCL). Findings identified a definition of SNCL as "staff nurses who exert significant influence over other individuals in the healthcare team and although no formal authority has been vested in them facilitates individual and collective efforts to accomplish shared clinical objectives" (Chávez & Yoder, 2015, p. 90). Of the alternate terminology's explored, SNCL role descriptor aligns most closely with clinical leadership as defined previously as it specifically relates to clinical objectives.

2.11 Leadership attributes

Despite the definitional ambiguity associated with clinical leadership, many scholars have attempted to identify essential qualities, attributes or characteristics for success as a clinical leader (Daly et al., 2014). Clinical leaders are often described as possessing strong advocacy skills and the ability to drive change. Additionally, they play a crucial role in fostering healthier workplaces by promoting cultural transformation among healthcare professionals. To achieve these positive outcomes, clinical leaders must be seen as credible, recognised by their colleagues for their clinical expertise and skills in supporting and communicating with the multidisciplinary team (Daly et al., 2014). Stanley and Stanley (2018) conducted a literature review to examine the concept of clinical leadership. Their integrative review identified 27 key findings, concluding that effective clinical leaders possess several essential attributes: clinical competence, strong communication skills, approachability, the ability to support and motivate others, values-driven, decisive, visible in practice and serve as role models. The authors also identified common themes around commitment to excellence and the delivery of high-quality care (Stanley & Stanley, 2018).

In 2020, Mrayyan et al. (2023) conducted a descriptive quantitative analysis to determine the attributes and skills nurses associated with clinical nursing leadership effectiveness. Of the 296 recruited participants, 66 percent responded and results identified the top three or 'most' important attributes respondents associated with clinical nurse leadership attributes were, they considered relationships valuable, are flexible and are caring / compassionate. The 'least' important attributes were they are consistent, has management experience and is a coach (Mrayyan et al., 2023). The most highly rated skill related to clinical nurse leadership effectiveness was to have high moral character, knowing what is right or wrong and acting accordingly and the least rated skill was be in a management position (Mrayyan et al., 2023). Interestingly, of all the attributes and skills that were rated within this survey, none relate to clinical knowledge and practice engagement which is contrasting to the main theme discussed previously in literary definitions of clinical leadership.

2.12 Connecting leadership and outcomes

Extensive evidence demonstrates the impact of leadership on nursing and patient outcomes (den Breejen-de Hooge et al., 2021). Joseph and Huber (2015) reported on Wong et al 2013 findings of their systematic review examining the relationship between nursing leadership and patient outcomes which identified 19 key variables relating to patient safety and quality, mortality, adverse events and patient satisfaction. The review concluded that "the current evidence suggests a clear relationship between relational leadership styles and lower patient mortality, as well as reductions in medication errors, restraint use and hospital-acquired infections" (Joseph & Huber, 2015, p. 56). Daly et al. (2014) report on a small-scale study of the impact of development of clinical leaders on the service from the perspective of nurses in formal positions of leadership in a large hospital. The findings demonstrated improvements in the quality of the nursing work environment, including strengthened interprofessional and patient centred communication, clearer structure and enhanced interprofessional collaboration (Daly et al., 2014).

The complexity, rapid changes, workforce shortages and persistent safety and quality challenges in healthcare underscore the critical need for strong clinical leadership (Joseph & Huber, 2015). Daly et al. (2014) echo this and argue that the growing

complexity of leadership demands reinforces the need for diverse and adaptable leadership approaches. Joseph and Huber (2015) states that to effectively fulfil their role, nurses must be equipped to address challenges at the intersection of clinical practice, healthcare systems and care environments. Daly et al. (2014) postulate that there is a need for a new phase of hospital leadership at the point of care that positions frontline clinicians as central to leadership within healthcare organisations. They further claim this conceptual shift moves leadership conversation beyond traditional leadership and managerial models to reflecting the understanding that whilst formal leaders play a critical role in health systems, they have limited capacity to fundamentally reshape clinical practice or drive change at the frontline (Daly & Jackson, 2021).

Supporting clinical leadership requires a deep understanding of the social environment and workplace culture in which nurses operate. Negative workplace cultures characterised by target-driven priorities, disengagement from management and low staff morale can disempower nurses and undermine patient care (Aspinall et al., 2021). Aspinall et al. (2021) further suggest a lack of strong nursing leadership further reinforces these challenges, making it crucial to cultivate an environment that enables and values clinical leadership. Patrick et al. (2011) research findings support this statement. Whilst conducting their research investigating the development and testing of staff nurse clinical leadership in 2011, results indicated staff nurses views of observed nurse manager leadership practices and structurally empowered environments impacted on their adoption of clinical leadership behaviours (Patrick et al., 2011). In 2021, Aspinall et al. investigated the relationship between nursing leadership, culture and empowerment in acute hospital environments, with a particular focus being if this setting empowers all nurses to embrace leadership within their social environment. Findings suggest that while nurses inherently practice leadership in their daily clinical roles, alongside traditional management and leadership positions, many do not recognise their work as leadership, nor is it widely acknowledged as such in settings where hierarchical leadership structures dominate (Aspinall et al., 2021). Daly and Jackson (2021) document that despite literature evidencing the positive role clinical leadership has on patient care delivery and outcomes, there are also significant barriers evident in literature to the implementation and success of clinical leadership. These barriers are related to a lack of incentive and remuneration, inadequate preparation for

the role, perception that leadership is not a component of the clinical role, poorly designed leadership development programmes and initiatives, as well as insufficient resourcing for these (Daly & Jackson, 2021). Aspinall et al. (2021) argues that there is a need to address the challenges and barriers evident in healthcare organisations to support successful implementation of clinical leadership, requires exploration of strategies that reshape existing structures within the profession.

Healthcare environments are often fraught with reforms and restructures that impact directly on team performance and service delivery. The need for clinical leadership in nursing is evident, given the numerous challenges in care implementation that create gaps in service delivery and addressing these gaps requires proactive, evidence-based action, teamwork, effective care coordination and strong clinical leadership competencies at the point of care (Joseph & Huber, 2015). Scully (2015) calls for a need for improved strategy in organisations designed to develop emerging leaders in-house. Findings from a cross-sectional survey conducted by den Breejen-de Hooge et al. (2021) with nurses employed in clinical wards highlighted an urgent need for expanded leadership training opportunities for nurses in clinical practice. This was emphasised by the assertion that strategic managers and team leaders must recognise the critical role of leadership in ensuring quality care and the importance of formal leadership programmes in supporting nurses on clinical wards in their leadership development (den Breejen-de Hooge et al., 2021). Aspinall et al. (2021) states that empowering bedside nurses and recognising them as key leaders in the patient experience is essential for fostering a more inclusive and effective leadership culture in nursing.

Enhancing the leadership capabilities of both current and future nurses is essential to ensuring their influential role in health policy, decision-making and the overall effectiveness of health and social care systems (den Breejen-de Hooge et al., 2021). Evolving healthcare landscapes have heightened the demand to enhance registered nurses' leadership knowledge, skills and abilities (den Breejen-de Hooge et al., 2021). Developing targeted competencies in care coordination and integration is essential to building a more adaptable and resilient clinical leadership workforce (Joseph & Huber, 2015). Daly and Jackson (2021) offers a word of caution though, suggesting evidence

from Australia suggests hospital reforms and restructuring have led to a reduction in nursing management functions and roles. As a consequence of this, Edmonstone (2009) cited in Daly and Jackson (2021) warns a risk of decreased management roles may shift responsibilities onto clinicians who may be unprepared and lack the necessary resources for these roles.

According to Weston (2024) investing in nursing is crucial for maintaining and enhancing healthcare quality Aotearoa-NZ. They also note the current status of the healthcare system strongly echoes the significant health reforms of the 1990s. Carryer et al. (2010) proposes that as a result of those reforms, patient outcomes suffered and there is a significant risk of this happening again as fiscal responsibility becomes the primary focus. Weston (2024) emphasises prioritising investment in nurses is essential to secure a healthier future for Aotearoa-NZ and that nursing leadership must remain firm in upholding the core values of nursing and Te Tiriti o Waitangi. To sustain the necessary paradigm shift toward health equity, strong leadership frameworks in nursing are essential (Nikpour et al., 2022). The literature explored within this section confirms the need for clinical leadership and associated development, but what still remains unclear is what the best approach to designing, facilitating and supporting clinical nursing leadership development for optimal utilisation in care.

2.13 What do we teach and how do we deliver it?

In 2000, Clarke, a Director of Policy and Communications for the Registered Nurses Association of British Columbia declared that there is a shortage of leaders and leadership and in response, there is a need for nurses to develop their leadership capability, assume leadership positions and contribute to shaping the future of healthcare (Mahoney, 2001). Scully (2015) writes the nursing profession has been slow to implement strategies for identifying and nurturing future nurse leaders and given the current state of health and challenges faced by the nursing workforce, addressing this gap is more crucial than ever before. In the past, experienced nurses mentored new nurses to support high-quality patient care practices, however, the transition to business-centred healthcare models has led to a reduced presence of nursing leadership at the point of care impeding sustainability of this approach (Marcellus et al., 2018). Daly et al. (2014) suggest significant global investment in leadership development

programmes and initiatives in recent years speaks to the recognition that ramifications and associated costs of poor clinical leadership exceeds the potential benefits and associated costs of formal programmes to develop clinical leadership capability. Al Hajri (2024) proposes an aging workforce, nursing workforce shortages and increased turnover, as well as an increase in expectation and responsibilities nurses experience, all highlight the necessity of implementing a leadership develop training programme designed to support nurses to transition into the leadership space. Inadequate nursing leadership has been recognised as a significant obstacle to delivering high-quality care (Al Hajri, 2024). Research has shown that poor leaderships negatively impacts patient outcomes, healthcare experiences as well as staff satisfaction; ultimately contributing to lower retention rates among healthcare professionals (Makepeace, 2023). Associations have been made highlighting the impact of insufficient education and support for developing leadership practices has on clinical leadership capability (Makepeace, 2023). There is a prevalence of literature pertaining to the leadership development of nurses stepping into formal positions with a focus on budgets, human resources, organisational and health care policy, but less so relating to leadership development for informal leaders. Hence, some of what is discussed in the next section will be a translation of what is available to this context.

Though this part of the review focuses on leadership in relation to nurses delivering direct patient care, these nurses are also the future workforce who will be employed into formal nurse leadership roles, therefore consideration of the impact on succession planning is an important aspect. In 2021 Manion et al. (2021) published findings from their research investigating the preparedness of nurses stepping into a Nurse Unit Manager role. They surveyed 125 nurses and the results demonstrated approximately half of the respondents received any form of leadership development training prior to appointment and there was a correlation between feeling ill-prepared for the role and competence and confidence in the leadership domains through being ill-prepared (Manion et al., 2021). A qualitative study utilising analytic induction was conducted by Bondas (2006) to explore the pathways nurses followed to becoming nurse leaders. Findings demonstrated a variance in the education supports the nurses participated in for leadership development, with some nurses not having undertaken any training at all (Bondas, 2006). The author concluded there was a need for an intentional and

focused approach to understanding the educational needs to develop competent nurse leadership (Bondas, 2006). Though the participants in this study occupied formal nursing leadership roles, it speaks to the need of educational and professional development for emergent leaders who may step into formal leadership roles.

Readiness to engage with educational opportunities for leadership development is also important to consider. Bleich (2016) recommends a planned leadership trajectory encompassing the continuum of the nurse's professional journey, starting with early careerist, followed by mid and late careerist. Professional focus, core content, achievement goals and learning strategies are identified by Bleich (2016) as central components off a scaffolded approach throughout the nurses career where years of practice are not assigned, meaning readiness to engage with each level may be influenced by subjective considerations of the nurses themselves and or their managers. A benefit of this approach is it removes the assumption an individual is ready to progress to a different stage of leadership development based on the career stage or years of practice which disregards the individual's willingness to engage in leadership activity (Bleich, 2016). Leaders who assume they can excel without formal training may achieve short-term success, but inevitably, they will face critical challenges they are unprepared to handle alone (Sonnino, 2016). Professionals who have undergone structured and experiential training are better equipped to thrive when stepping into leadership roles. Bleich (2016) suggests the benefits of a leadership development plan staged over a career will translate to more efficient utilisation of resources and contribute to multi-generational nurse retention. Similarly, Quinn (2020) critically applied Benners (1982) 'novice to expert' model of clinical competence to nursing leadership to enhance understanding of the concept. This work demonstrated applicability of Benners (1982) work to leadership domains, transitioning from novice leader to expert leader with each stage being measured by the nurses actions, application of prior experience, reflection, through to the ability to navigate complex situations, coordinating concurrent situations, allocating resources and considering social implications for patient care (Quinn, 2020).

Mahoney (2001) reports there are various approaches to gaining education in leadership, participating in leadership programmes, management workshops and

continuing education seminars are some of the recognised ways to acquire knowledge, but they suggest pursuing advanced degrees in nursing administration is perhaps the most effective way to deepen leadership expertise. They assert the functions of leadership can be acquired in the classroom and applied in the dynamic environment of the workplace. Mahoney (2001) further articulates nursing leaders are not born with greatness; rather, leadership is cultivated through acquiring knowledge, developing skills and, like any other discipline, extensive practice. The role of a nursing leader is not reserved for those who are naturally charismatic or persuasive, leadership qualities must be honed and refined over time (Mahoney, 2001). Mahoney (2001) suggests the education required to become an effective nurse leader involves gaining expertise and mastering key skills in management, communication and teamwork. Leadership education for staff nurses equips them with the knowledge needed to manage their work environment, solve problems more efficiently and make decisions autonomously (Mahoney, 2001). While various leadership frameworks exist to enhance knowledge, skills and competencies, few prioritise self-exploration or acknowledge the profound impact of culture and context on nursing leadership development (Nikpour et al., 2022). Nurses must first develop self-awareness and recognise how their experiences, environment and interactions have shaped them before they can engage as authentic leaders committed to supporting and advocating for others. Nurse leaders must recognise how culture influences their leadership style and in turn, how their leadership shapes the culture within their organisations (Nikpour et al., 2022). There is a need for nurses to step into a leadership space for the promotion and conduction of cultural humility and cultural safety for indigenous peoples (Marcellus et al., 2018).

The best approach to leadership development is a continuing concept of scholarly debate. Sonnino (2016) describes an effective leadership programme should feature a foundational curriculum covering essential healthcare concepts, delivered through a variety of methodologies, such as didactic teaching, mentorship, coaching and experiential practice. Additionally, they suggest the programme should include specialised components tailored to each individual's leadership focus. They also suggest understanding different leadership styles and the principles of situational leadership should also be integral to preparing emerging healthcare leaders for success (Sonnino, 2016). Makepeace (2023) writes it is essential to strike a balance between

organisational objectives and the personal career aspirations of individual nurses and furthers this to advise an effective leadership programme should integrate both structured components such as leadership theories and tailored elements that align with each nurse's job responsibilities (Makepeace, 2023). Nurses will gain the most from leadership development when topics like emotional intelligence, leadership styles and wellbeing are able to be customised and applied to their learning needs and clinical environments (Makepeace, 2023). A variety of teaching methods should be used to accommodate different learning styles, combining traditional classroom instruction with experiential learning to create opportunities for meaningful development (Makepeace, 2023). It has been suggested by Conner et al. (2023) the focus should be on leading people as opposed to leadership aligned with management roles and ensuring it enhances rather the detracts from the delivery of high-quality patient care. They go on to suggest programme structure should integrate formal education supported by mentorship, experiential learning and informal shadowing.

A qualitative study by Conner et al. (2023) explored nurses' perceptions of optimal leader development approaches. The authors reported that there was a tendency for leadership development to be self-initiated and opportunistic as opposed to structured and coordinated. Conner et al. (2023) proposed a national approach to programme design and delivery that could contribute to a decrease in inequities of access and encourage more nurses to engage in educational interventions to develop their clinical nurse leadership skills. Marcellus et al. (2018) advises from a pedagogical perspective, learning leadership extends beyond acquiring knowledge; it also involves engaging in deeper reflection on that knowledge. The metacognitive skill of self-regulated learning, understanding how to develop and embody leadership in practice and recognising its impact on one's identity as a leader is central to this process (Marcellus et al., 2018). In 2022 Guibert-Lacasa and Vazquez-Calatayud (2022) conducted a systematic literature review to explore the most effective approach to develop clinical nurse leadership in a hospital setting. Their conclusions advise the optimal approach to clinical nurse leadership development should be a multimodal and multicomponent learning experience, integrating theory with an individual's intrinsic sense of self and emotional intelligence are to be considered essential for clinical nursing leadership development. They expand on this stating, programmes structured to intentionally

include these components can equip nurses with the confidence and capability to engage in working groups, initiate projects aimed at improving daily clinical practices and contribute meaningfully to multidisciplinary team discussions. Leadership theory, taught in isolation, is insufficient to develop effective leaders and hands-on practice without proper foundational knowledge also falls short. Both must occur simultaneously for concepts to become ingrained, which requires the programme to span at least one full year according to Conner et al. (2023). Though there is a variance in recommended optimal approaches to leadership development there is a central theme that the nurse needs to be able to relate the outcomes to their intrinsic needs for self and professional development for any intervention to be successful. It is also clearly demonstrated that a mixed modality approach is the most recommended for engagement and application of learning.

According to Al Hajri (2024) establishment of a mentoring programme may be an effective approach for integrating and inspiring new nurse leaders into the leadership space but there is evidence in literature suggesting this may generate barriers for progression and succession planning secondary to a perception by the mentors the mentee may be more proficient in the role. Nikpour et al. (2022) also refers to mentoring as a leadership development structure for emerging leaders. They suggest establishing supportive and diverse mentor networks, underpinned by the development of a community of practice, can support development of confidence, self-reflection and insight into health equity for emerging leaders (Nikpour et al., 2022). Makepeace (2023) agrees with this, suggesting that incorporating a mentorship component into a leadership development programme can be highly beneficial. While the investment in mentoring and coaching varies, the primary requirement is the time commitment of both participants (Makepeace, 2023). Mentoring is a structured process that offers numerous advantages for nurses in leadership roles, such as enhanced competence, a stronger sense of belonging, increased professional confidence, emotional support and leadership preparedness. In contrast, coaching tends to be more informal and provides benefits like engaging in insightful discussions and opportunities for self-reflection on performance (Makepeace, 2023). Jantzen (2012) as cited in Marcellus et al. (2018) informs trends in the nursing workforce indicate that mentorship from experienced nurses is essential for nurses to develop

and apply leadership skills while adapting to the evolving landscape of technological advancements, changing health priorities and emerging care delivery models. Makepeace (2023) also suggests shadowing as an adjunct to leadership training, stating opportunities to shadow experienced leaders can result in more effective learning for nurses then traditional didactic teaching methods.

Discussed in literature is the consideration of a project initiative as part of a leadership development programme. Experiential learning can be gained through engagement with a quality improvement project, either leading or participating in, which allows the developing nurse leader to apply essential leadership skills such as team dynamics and driving practice change (Makepeace, 2023). Sonnino (2016) agrees with this stating creating a clearly defined project with a meaningful impact on the institution offers a hands-on opportunity to apply newly acquired skills in a real-world setting, making them more likely to become deeply embedded. There are challenges to this approach, specifically a lack of support from senior leaders to provide necessary resources and promotion of the projects (Marcellus et al., 2018).

Cummings et al. (2020) conducted a systematic literature review to assess the effectiveness of interventions aimed at enhancing leadership practice among nurses. Their findings led to an assertion that post the interventions, there was a reported self-assessed enhancement of leadership practices, with observed leadership improvements to a lesser extent. However, despite the overall self-assessed positive impact of leadership development interventions, the studies did not offer new insights into which specific components are most effective in fostering leadership development (Cummings et al., 2021). Conner et al. (2023) also identifies some challenges and barriers to leadership development programmes stating, not all leadership programmes address the specific competencies, such as emotional intelligence, that distinguish transformational and servant leaders, which they consider are essential for driving meaningful change in healthcare. Some shorter programmes may also lack essential components covered in more comprehensive curricula, hence participants may not develop necessary competencies which demonstrate aptitude in a leadership role (Conner et al., 2023). A second challenge is the cost associated with training, particularly in times of austerity, even short programmes demand considerable time

and resources from both faculty, participants and the organisation. This becomes even more of a consideration when the programme includes opportunities for application of learning to practice through the duration of the programme (Conner et al., 2023).

Mentorship is an oft mentioned component which is seen as beneficial in clinical leadership development for nurses, as well as involvement with quality project initiates to support application to the nurses practice context. Mentorship, quality projects, mixed modality and an integration of theory and experiential learning have all been identified in literature as highly recommended approaches to developing a leadership development programme. What is not clear, is the ideal length of the intervention and ratio of these components.

2.14 The Aotearoa-NZ context

The development of Aotearoa-NZ's nursing workforce, similarly, to nursing worldwide, has been influenced by interprofessional, social, political and scientific factors (Gage & Hornblow, 2007). In the early colonial period, nursing was largely unregulated, with many nurses working independently and often without formal training. However, by the early 1900s, registered nurses with hospital-based training began to take on more formal roles, working in a subordinate capacity to medical practitioners (Gage & Hornblow, 2007). In the mid to late 1900s, as the workforce expanded, nursing underwent further changes, including greater specialisation, restructuring of nursing education, health sector reforms and evolving social and political expectations (Gage & Hornblow, 2007). Aotearoa-NZ has experienced significant changes over the past 25 years, one of the most impactful transformations in the government structure that affected nursing was the State Sector Act of 1988 which effectively dissolved the nursing division within the Department of Health and reduced nursing representation at the national level (Donovan et al., 2012). During the 1990s, there was a notable increase in the replacement of registered nurses with unlicensed personnel which led to increased workloads and both senior and new graduate nurses leaving the country in search of better opportunities. This resulted in a dearth of nursing leadership presence (Donovan et al., 2012). Today, nursing encompasses areas of increasing autonomy, broadening opportunities and leadership roles (Gage & Hornblow, 2007). As the healthcare sector rapidly evolves, nurses play

a pivotal role and have numerous opportunities to take on new leadership positions in healthcare delivery (Gage & Hornblow, 2007).

A qualitative descriptive study was conducted by Donovan et al. (2012) in an attempt to understand the perceptions of nurse leaders in Aotearoa-NZ related to the impact of the political developments being experienced at the time. Many interview participants raised concerns about succession planning within nursing in Aotearoa-NZ. They felt there was a lack of clear, structured efforts to transition less experienced leaders into leadership roles (Donovan et al., 2012). While the concern was evident, participants found that solutions were not immediately apparent. Time and resource limitations were identified as key factors contributing to the gap. A consistent theme emerged that leadership development often occurs almost by chance. As a result, a recommendation was made that succession planning should focus on creating opportunities for new leadership to emerge and actively mentor emerging talent (Donovan et al., 2012)

More recently, Weston (2024) published an article reflecting on the current state of health in Aotearoa-NZ. Weston (2024) presented a rhetoric of a healthcare system in crisis due to decades of underinvestment by successive governments which has resulted in healthcare infrastructure being unprepared for the combined challenges of a global pandemic, economic instability and the growing impact of climate change. It was highlighted by Weston (2024) that in response to the healthcare crisis, the current government has introduced sweeping reforms that extend to health systems, education, legislation and budget cuts and these measures are expected to have significant consequences for the health and well-being of the people of Aotearoa-NZ, particularly in terms of equity. Concurrently, they also place additional strain on an already struggling workforce. Among the latest austerity measures is a proposal to restructure clinical leadership, including nursing leadership, by significantly reducing both the number of positions and the full-time equivalency allocated to them (Weston, 2024). All of which appears to be reminiscent of the previously mentioned work of Donovan et al. (2012) which demonstrated the impact of policy reform on the decreased presence of nursing leadership in healthcare.

Now is an opportune time for Aotearoa-NZ's nursing sector to develop a strategic plan for nursing leadership, establishing structured mechanisms to support and strengthen leadership development would help formalise existing, yet often invisible, networks of mentorship and career progression (Donovan et al., 2012). These structures should encompass all areas where nurses work, from bedside care to executive leadership (Donovan et al., 2012). There are legislative mandates that speak to this need and this positioning is only strengthened by the recent changes in the scope and competencies all Aotearoa-NZ nurses practice within.

The founding document of Aotearoa-NZ, Te Tiriti o Waitangi was signed by the British Crown and a number of Māori chiefs (Came et al., 2021). It stipulated the rights of the Indigenous peoples of Aotearoa-NZ, including tino rangatiratanga, absolute sovereignty, inclusive of health and as such it is a requirement for health policy and strategy to be te Tiriti compliant (Came et al., 2021). Pae Ora (Healthy Futures) Act 2022 is a government legislation with the overarching aim to achieve pae ora (healthy futures) for all New Zealanders, which the Ministry of Health is responsible for administrating (Parlimentary Counsel Office, 2022). Included in this Act is the funding of the public health system and the directive for provision of services designed to protect, promote and improve the health status of the population of Aotearoa-NZ. It also aims to eliminate health disparities and obtain equitable health outcomes, particularly for Māori (Parlimentary Counsel Office, 2022). The introduction of the Act resulted in the establishment of new health agencies, including Te Aka Whai Ora Māori Health Authority, which was later disestablished as a part of the newly appointed government health reforms in 2024 (Parlimentary Counsel Office, 2022).

Strategic documents were developed to deliver on the aims of Pae Ora, including the Ministry of Health's Te Tiriti o Waitangi Framework and Te Mauri o Rongo The New Zealand Health Charter (Ministry of Health, 2025). Both are informed by the principles of Te Tiriti o Waitangi as outlined by the Waitangi Tribunal through the Hauora inquiry (Ministry of Health, 2022) which investigated nationally significant health related issues (Waitangi Tribunal, 2023). The te Tiriti framework articulates the Crown's obligations under Te Tiriti o Waitangi for achieving health equity for tangata whenua Māori through intentional framing of te Tiriti principles in the health and

disability sector (Ministry of Health, 2025). The five principles of the framework are essential in informing and guiding the health and disability sector. One of these principles is equity which specifically relates to the obligation of the crown to purposefully engage in activities promoting equitable health outcomes, addressing systemic disparities (Ministry of Health, 2025). A second principle is active participation. This represents the mandate for the Crown to ensure all Tiriti partners are cognisant of the depth and breadth of health inequities and targeted approaches to address them (Ministry of Health, 2025). One of the principles and values included in the charter is Rangatiratanga (self-determination) which is expanded on with the statement "As organisations we support our people to lead" (Ministry of Health, 2022, p. 10). In extension of this, it further advises a commitment to ensuring the workforce is highly skilled with ongoing support and encouragement to grow and enhance their capabilities. It articulates a requirement for organisations to foster and empower health workers leadership aspirations. As well as a responsibility of organisations to acknowledge their role and responsibilities in the provision of training and education opportunities which enable workers to enhance their skills and support all health workers to lead (Ministry of Health, 2022).

The Nursing Council of New Zealand (NCNZ) is the regulatory body for registered nurses in Aotearoa-NZ (Nursing Council of New Zealand, 2024b). The NCNZ sets the scope of practice and standards of competence and is responsible for ensuring demonstrate current and ongoing competence to practise (Nursing Council of New Zealand, 2024b). Recently the NCNZ initiated a consultation with the sector to review the registered nurse scope of practice and standards of competence, with these having last been reviewed in 2016 (Nursing Council New Zealand, 2025). The rationale for the changes provided by the NCNZ was to "ensure registered nurses are equipped to meet the challenges of today's complex healthcare environment" (Nursing Council New Zealand, 2025, p. 1). The purpose was to increase attention on comprehensive assessment, critical reasoning and differential diagnosis, as well as Māori health, culturally safety and relational care (Nursing Council New Zealand, 2025). Significantly, the changes also specified "the nurse as leader is also emphasised, including the nurse's accountability for advocating on the behalf of people and whānau and speaking out when appropriate to do so" (Nursing Council New Zealand, 2025,

p. 2). The new competency structure contains six Pou which identify key areas of competence for nursing practice, one of which specifically related to leadership (Nursing Council of New Zealand, 2024b). Pou six – Rangatira and leadership is defined as "nurses proactively seek solutions and lead innovation to improve the provision of care. Leadership requires all nurses to act as change agents and lead change when appropriate. Fundamental to the integration of leadership is the need for nurses to intervene, speak out and advocate to escalate concerns on behalf of colleagues or recipients of care" (Nursing Council New Zealand, 2025, p. 9). This is expanded on by the provision of six descriptors outlining the requirements for nurses to demonstrate rangatiratanga and leadership as a member of the healthcare team highlighting collaboration, professionalism, continuous learning and ethical practice in healthcare. They further emphasise teamwork, adherence to legal and professional standards, quality improvement, risk management and sustainability in healthcare delivery are also required (Nursing Council New Zealand, 2025).

This shift in identifying a specific ongoing competence domain related to nursing leadership only serves to further highlight the need for leadership development programmes designed to support nurse leaders at the point of care. The identified rationale from the NCNZ to ensure nurses are equipped to practice within the complex healthcare environment of today aligns with the literature presented in this chapter. This is further supported at a governmental level through the legislative and strategic imperative to develop leadership capability of health workers in Aotearoa-NZ. Nursing leadership cannot be left to chance, it needs to be nurtured and developed for the success of the profession and health care organisations, but most importantly for the patients and whanau who are recipients of the care. But, during the current health reforms, how does the nursing profession live up to these new Pou and meet the required standards for demonstration in practice of leadership, without investment for education and training support?

2.15 Research underpinning the study

As has been demonstrated throughout this literature review, leadership development for nurse leaders in the clinical space is a crucial investment for contributing to positive patient outcomes and improvements in health care systems. What is not clear is the

most effective modality and curriculum content and duration for developing nurse leaders in the clinical context. The following provides an overview of studies investigating the efficacy of different programmes which have been designed to enhance and develop clinical nurse leaders.

In 2014, Miskelly and Duncan reported on the findings of an evaluation of an in-house leadership programme, called 'Pebbles', offered to nurses and midwives in a district health board in New Zealand (Miskelly & Duncan, 2014). The programme was developed by practice development coordinators in response to an identified gap in career development opportunities for nurses and midwives who had demonstrated leadership potential (Miskelly & Duncan, 2014). It was constructed as a six-day programme delivered over six months, incorporating structured group discussions, literature critique, case studies, nurse leader presentations, participant presentations and assignments. Content included global health care perspectives, new technologies, political astuteness, coping with change and balancing authenticity with performance expectations (Miskelly & Duncan, 2014). A mixed methods approach was undertaken for the study using grounded theory with the aim being to identify the influence and impact of the programme on participants and clinical services (Miskelly & Duncan, 2014). Purposive sampling was used with a response rate of 38 participants who had completed the programme. Quantitative data were initially collected through questionnaires using Likert scale statements. Emerging themes identified in these were then explored in the focus groups and interviews (Miskelly & Duncan, 2014). Thematic analysis of qualitative data illustrated that those who completed the in-house leadership development programme felt the programme created an opportunity for reflection of clinical practice, career aspirations and associated professional development. Participants also reported discussions related to organisational and political context enabled learning related to the healthcare system complexity. All culminating into a report of increased professional identity and maturity (Miskelly & Duncan, 2014). Limitations of this study included the small sample size and associated challenges generalising the findings to all of those who have completed the programme. Also, there was a recommendation for further study to confirm if the anecdotal evidence demonstrating links between knowledge and skill developed during

the programme and positive impact within the clinical units participants worked was accurate (Miskelly & Duncan, 2014).

McNamara et al. (2014) conducted a qualitative study also with a grounded theory approach to evaluate participants experience of the interventions of at national clinical leadership development pilot programme in Ireland. Coaching, mentoring, workshops and action learning interventions were provided to participants over the six months of the programme. The aim of the programme was to develop clinical nurse and midwife leadership competencies related to topics such as quality and safety, advocacy and self-awareness (McNamara et al., 2014). Seventy participants contributed to the study through a combination of focus groups, interviews and written reflections. A thematic analysis identified participants felt positively about all the interventions and did not rate one as more beneficial than the others. They did suggest mentoring contributed to specific competencies pertaining to clinical leadership and processes. Whereas coaching was aligned to developing individuals in a way that is tailored to the individual's role. Limitations of this study included the nature of qualitative data collection methods and the inherent potential for consensual evidence influencing a participant's response. Time constraints related to the study did not allow for a longitudinal perspective of the participants application of the skills learnt during the programme (McNamara et al., 2014).

Paterson et al. (2015) undertook a longitudinal study of a locally designed in house Developing Leader Programme which was delivered within a hospital in Brisbane. The programme was delivered over 12 weeks with three one-day workshops six weeks apart. Teaching modalities included face-to-face workshops and self-reflective application to practice activities. The aim of the programme was to enable and develop clinical nurses personal and professional development and clinical leadership, focusing on intra and interprofessional intelligence (Paterson et al., 2015). A descriptive statistical approach was applied to participant surveys which participants completed post workshop one and two and six-months following workshop three. The response rate varied at each data collection point from 79 percent to 28 percent then 31 percent respectively. The authors reported that there was observed incremental improvement in attendees' self-perceived leadership capabilities following each workshop.

Limitations related to the study included the subjective nature of self-reported behavioural changes as well as an inability to compare findings with a control group. Also noted was the potential for results to be influenced by those completing the surveys being those who felt most positively about the programme. The relatively small size of participant engagement with the study is noted to have implications for the generalisability of the findings (Paterson et al., 2015).

Although these studies are now rather dated, the programmes all align strongly and have informed the current study. More contemporary research of clinical leadership development programmes has been published in recent years. In 2018, Spencer et al. reported on a quasi-experimental study with a pre- and post-test design to evaluate the effectiveness of the Association Development and Professional Transformation (ADAPT) model for nurse leadership development in America. The ADAPT model involved a one day workshop attended by novice nurse leaders who were paired with experienced nurse leaders as mentors and activities were designed to encourage the novice leaders to engage with developing their innate leadership potential (Spencer et al., 2018). Convenience sampling was used through professional nursing association membership, consisting of eleven novice leaders and eleven experienced leaders, to determine if the ADAPT model influenced the novice leader's perceptions and behaviours related to leadership. Novice leaders completed surveys prior to attending the workshop followed by both groups completing a survey, two months after completing the workshop and the mentor sessions (Spencer et al., 2018). Descriptive analysis was used to determine the results which indicated the majority of novice's did not view themselves as leaders. It further showed the mentoring resulted in modelling behaviours and approaches, but there was no statistical significance in the pre- and post-survey results completed by the novice leaders demonstrating a change in leadership attitudes and behaviours post intervention. Mentors reported satisfaction with the role and a willingness to continue in this space supporting the development of upcoming leaders (Spencer et al., 2018).

More recently, in 2024, Alreshidi et al. published findings from their study investigating the impact of the Raedwoon Programme for enhancing professional practice and leadership skills of nurses. The programme ran over 25 days with the

curriculum incorporating group activities, role playing, scenarios, case studies and simulation. Participants also shadowed nurse leaders in formal positions, received coaching and completed a workplace project to apply their learning in context (Alreshidi et al., 2024). The 29 study participants were nurses from 16 public hospitals in Saudi Arabia who completed pre- and post-programme quantitative tests. The authors reported a significant increase in participants leadership practices post-intervention in all assessment points except for competencies related to a shared vision. Those that scored higher were related to self-reflective activities for identifying personal leadership philosophy, modelling, team dynamics and addressing challenges. Although interesting, drawing definitive conclusions is problematic as there was not a comparison group (Alreshidi et al., 2024).

2.16 Literature review, summary

There are numerous examples of research evaluating leadership development programmes and interventions, the majority of which aimed to support nurses transition into designated senior roles. Research evaluating programmes which are designed to support clinical nurse leadership are less prevalent. The 'Pebbles Programme' (Miskelly & Duncan, 2014) and the 'Developing Leader Programme' (Paterson et al., 2015) were in-house delivered programmes but these are both more historical programmes. More recent studies evaluating nursing leadership development programmes such as those published by Spencer et al. (2018) and Alreshidi et al. (2024) are designed to service multiple healthcare sites and appear to be primarily aimed at generic nurse leadership as opposed to nurses leading in the clinical care context.

2.17 Research aims and questions

The aim of this research was initially to investigate the need for nursing leadership at the point of care from the perspective of designated nurse leaders in a tertiary hospital. More specifically, this research seeks to address the following questions:

1. How is clinical nurse leadership developed from the perspective of those in designated senior nurse roles?
2. What is the impact of the early leadership development programme on participants perceptions of their own leadership competence?

Chapter III: Methodology

3.1 Introduction, methodology

> *Research is to see what everybody else has seen and to think what nobody else has thought*
>
> Albert Szent-Gyorgyi (1893 – 1986)

Creswell and Creswell (2018) state that research approaches encompass the strategic frameworks and methodologies guiding the research process, from foundational assumptions to collection, analysis and interpretation of data. They further state the decision to adopt a specific research approach is contingent on the research subject, the researcher's background and positioning and the target audience of the study. There are a multitude of research approaches and methodologies available and the selection of the most appropriate to utilise in specific research is informed by appropriateness to the right context and intentions, as well as those that can best answer they research question (Welford et al., 2012).

This chapter outlines the research approaches utilised to address the research questions. An exploration of the theoretical underpinnings of designs and methodologies informed the selection of the most suitable approach for addressing the aim of this research, which is to explore the design and evaluation of an early leadership development programme for registered nurses. This chapter will articulate the research approaches utilised in this study, including the overarching mixed - methods paradigm, as well as the quantitative and qualitative paradigms.

3.2 Mixed- methods research

Mixed-methods design refers to the combination of quantitative and qualitative research within a single study (Borbasi et al., 2019). Borbasi et al. (2019) highlight critical considerations when selecting a mixed - methods research approach and point to both the benefits and limitations, as well as the associated sequencing and prioritisation of the data collection, integration and analysis. Kajamaa et al. (2020) counsel that there is no single, universally agreed definition for mixed - methods

research. However, when used as the framework for formulation of a study's aim, design, data collection and subsequent data analysis, mixed-methods research can significantly strengthen and enrich the findings and contributions of a research study (Kajamaa et al., 2020). Pragmatism is a philosophical approach, also called a worldview, which underpins mixed - methods research. It refers to the consideration of the research question and preferred outcomes, followed by selection of the methodology which will best answer the question (Gray, 2020). Whilst quantitative and qualitative research designs provide a comprehensive view of the research topic, a pragmatic paradigm provides a philosophical worldview contributing to the study design and integration of the two methods (Sharma et al., 2023) which contributes rigor to analysis and discussion.

Broadly, quantitative research approaches are based on systematic and objective processes utilising structured instruments to collect data, which then enables the data to be measured and translated into numerical representation. The aim of qualitative research approaches are directed towards gaining insight and understanding of phenomena as it occurs in its natural context through the collation of descriptive data of the lived experience (Borbasi et al., 2019). How these are applied within the current study will be discussed in further detail in the later sections of this chapter. Bresson et al. (2017) suggests that the combination as a mixed - methods approach provides a sound strategy for comprehensively addressing the complexities inherent in healthcare related research questions. Further, they assert the two approaches will permit comparisons of findings from differing perspectives of the same concern and synergistically enhance the other (Bressan et al., 2017).

This research is being conducted within a tertiary healthcare institution, with the aim of identifying and demonstrating the impact of an early leadership development programme for nurses at the point of care. Therefore, to fully explore such, it is valuable to collect and analyse data from both a statistical and narrative perspective, to provide a more comprehensive understanding than quantitative and qualitative methodologies could individually provide.

A mixed – methods approach can be useful in healthcare research where the researcher is wishing to consider a phenomenon from multiple perspectives and system levels, for example, organisational, departmental as well as individual (Kajamaa et al., 2020). The approach has particular value when a comparison of findings from different perspectives and sources is required, in order to illustrate themes or consider interventions alongside outcomes (Kajamaa et al., 2020) as well as construct a deeper, more layered understanding of the topic under investigation. Further, mixed – methods approaches provide researchers with the opportunity to address multiple research questions simultaneously (Bressan et al., 2017); as is the case with the current research study.

A multi-phase mixed design was determined to be the most appropriate approach to address the research questions as it allows for a multi-faceted and iterative research design. This design is important within the current context as it enables data collection and analysis, which in turn informs the intervention itself. This iterative data collection / analysis / intervention design approach is well described in the literature as a method of intervention refinement and adaption (Sharma et al., 2023).

3.3 Quantitative research

Quantitative research can be best defined as the systematic, formal and objective process utilised to obtain data in response to a research question, which is then demonstrated through numerical representation (Gray, 2020). Quantitative researchers assert that human behaviour is objective, deliberate and measurable with the identification or creation of the appropriate instrument to measure the behaviour, generating numerical data. Gray (2020) asserts it is essential the quantitative researcher maintains objectivity to prevent personal values, beliefs and assumptions to influence the measuring instruments and subsequent interpretations of data. The approaches undertaken to maintain researcher objectivity are later discussed in the credibility and trustworthiness section of this chapter.

Predominant philosophical paradigms informing quantitative research are positivist and post-positivist paradigms (Davies, 2018). Positivism adheres rigorously to the principles of truth and logic (Gray, 2020). It is a scientific paradigm that was developed

in the 18th century and is based on the assumption reality is singular and objectivity and impartiality are fundamental in the investigation of a phenomenon (Davies, 2018). It is essential the positivist researcher employs objective methods, minimising the risk of bias influencing the outcomes of a study in order to identify the single reality, also referred to as ontology (Welford et al., 2011). Positivism has received criticism for its lack of consideration for the individuality of human experiences (Davies, 2018).

The positivism paradigm has evolved to inform the post-positivism paradigm, which ontologically asserts that reality can never be fully understood (Welford et al., 2011). Post-positivism emerged as an approach that acknowledges the complexity of human behaviour and the limitations of the positivist goal of achieving completely unbiased, objective research reporting (Clark, 1998, as cited in (Davies, 2018). The ontological imperative of the post-positivist paradigm aligns with the researcher's worldview that reality is individual, complex and biased by life experiences. In post-positivist research, triangulation of approaches is based on the understanding that no single method can definitively uncover the truth. By integrating various approaches, the limitations of one are compensated by the strengths of others. This triangulation can occur across methodologies, methods and data analysis. Consequently, post-positivist research often combines both quantitative and qualitative methods (Davies, 2018). The aim of this research is to identify individual experiences of participants engaged in the leadership development programme and post-positivism facilitates this in a collaborative approach of quantitative and qualitative methodologies.

3.4 Qualitative research

Qualitative research is a systematic exploration of social phenomena within their natural contexts. These phenomena may encompass a range of subjects, including how people experience different aspects of their lives, how individuals, groups and organisations operate and how interactions influence relationships (Teherani et al., 2015). Whereas quantitative research approaches focus on statistical and numerical indices, qualitative researchers seek to deepen the understanding of a phenomenon by focusing on the perspectives of the individuals experiencing it (Gray, 2020). Whilst qualitative research fundamentally begins with a different paradigmatic view then those underpinning quantitative research, qualitative researchers often develop their studies

from a post-positivist belief but conduct the research from a different approach (Teherani et al., 2015). Post-positivist was previously identified as the philosophical paradigm employed within this research; this is being built upon with a phenomenological qualitative methodology.

Phenomenology is the study of phenomena through the lens of the lived experience. In this approach, researchers collect descriptive data from individuals who have directly encountered a specific experience. The aim of phenomenology is to describe the essence of a phenomenon by examining it from the viewpoint of those who have experienced it, aiming to understand the meaning they attach to their experiences (Borbasi et al., 2019). The ontological belief of qualitative researchers is that reality is something constructed and interpreted by individuals within their unique contexts. Rather than breaking down phenomena into separate components to understand the whole, qualitative researchers embrace the notion that human reality and existence are interconnected and cannot be divided into isolated parts (Gray, 2020). The phenomenological approach within this study provides an opportunity to discover comprehensive answers to the research questions, that represents the experience of the leadership development programme participants.

3.5 Credibility and trustworthiness

Rigour refers to the extent in which a study was implemented consistently and within accepted standards. It is the product of the alignment of methodology, methods and analysis which results in an empirical research outcome. The credibility of quantitative and qualitative studies differs due to the underlying philosophies. The quantitative component of this research was based on positivism and as such, the rigour of the study was maintained through planned procedures, appropriate sampling and the maintenance of objectivity throughout (Gray, 2021). Preserving the rigour of quantitative research is accomplished through a well-structured study design, a sample that is representative of the population of interest and precise measuring tools. Deductive processes are rigorously carried out and conclusions are drawn using scientific methods. The logical reasoning employed to connect abstract concepts under study to concrete variables and their measurements needs meticulous conduction (Gray, 2021).

3.6 Researcher positioning

The researcher's personal worldview is a necessary consideration when selecting a research design and it is critical to consider and outline regarding Aotearoa-NZ's bicultural context. The researcher was raised in a European family, with historical connections to Germany and England, with no overt or obvious connections to cultural heritage. The researcher's paternal grandfather was Māori and adopted into family and raised in a European context. Knowledge of the cultural connections to iwi, hapu and whenua had been lost with the passing of the family members who held this knowledge. This has contributed to a lifelong journey of discovery of the researcher's identity and place in the world. The answers have not been obvious; there has been much supposition and generalisations. From this, the researcher has learnt they needed to find their own path, their own connections and sense of belonging. Throughout this journey, the researcher has met people who have provided guidance with manaaki, tautoko, aroha and mana.

The researcher identifies as European Māori. The names of the familial connections are not known, felt in all aspects of the researcher's life journey. They are felt when connecting with family, with others, in life and in work. They are felt when caring for patients and whanau, when walking alongside them in their journey in health, in their best moments and their most vulnerable moments and everything in between. The researcher has also, experienced the vulnerability felt when experiencing the health care system in a tertiary care setting as a patient. This lived experience resulted in feelings of being not heard or valued as the centre of the care journey rather then the organisational and system priorities.

In consideration of the research aim of this study, this is important context. To be authentic in life and work, the researcher acknowledged a need-to-know self-identity. To understand what is informing how they connect with others, their responses and how they view the world, and the expectations held of how the world should be is the filter in which this research is being conducted. The researcher believes all people should be the centre of their care. The belief that registered nurses have a professional, ethical and moral imperative to actively practice and advocate for patients in a way that

achieves this is an inherent belief. Nurses need to be leaders in moments of care and in designated leadership positions.

This research is being conducted to design and evaluate a leadership development programme for registered nurses at the point of care. The initial iteration is informed by the view the researcher holds of the responsibilities of nurses to lead. The journey to deeply know and connect with oneself is often uncomfortable and not something many actively make the choice to do. The researcher believes to be successful as an authentic leader this is a journey nurses must take. It identifies their positioning in the world, informs how they will lead and opens their eyes to the incredibly important and privileged position they are in to walk alongside a patient, to hold them at the centre of care.

Professionally, the researcher has two decades of experience as a registered nurse in primary and tertiary healthcare organisations. Since 2020, the researcher has held various roles in the Professional Development Unit at Health New Zealand (Te Whatu Ora) - Waikato district (HNZ - Waikato) with the current position held as a Nurse Educator, Practice Development at HNZ – Waikato. The researcher studied and graduated from Waikato Institute of Technology with a Bachelor of Nursing and continued her academic study at Auckland University of Technology with the attainment of a postgraduate certificate in child health sciences. This qualification was built upon with the completion of a postgraduate diploma in health sciences at the University of Waikato.

3.7 Methodology, summary

This chapter provided an overview of the philosophical underpinnings and research methodologies of this study. Through the selection of research paradigms, ontological assumptions are identified for how reality is perceived which are influential in informing the framing of research questions, methods, collection and analysis of data (Davies, 2018). This study is being undertaken using a mixed - methods approach, based on a pragmatic philosophical underpinning. This was built on with a post-positivist quantitative methodology and a phenomenological qualitative methodology.

Chapter IV: Methods

Our greatest strength lies in our ability to listen and learn from one another.

Dame Whina Cooper, 1895 - 1994

4.1 Introduction

The purpose of this study was to design and evaluate a leadership development programme for registered nurses in a tertiary hospital, specifically looking at nurses who are engaging in direct patient care at the bedside. As discussed in chapter III, the methodological paradigm underpinning this study is a mixed methods multi-phase design with a pragmatic approach, supporting the iterative design of this study. A post-positivist quantitative approach combined with a phenomenological qualitative approach creates a more detailed understanding of the research questions (Creswell, 2018).

Research methods are the systematic processes or techniques researchers use to obtain, analyse, interpret and report data to answer research questions. The methods will vary depending on the research aim and methodological approach taken (Borbasi et al., 2019). This chapter outlines the methods utilised, including the study design, intervention, data sampling population, data collection and analysis approaches, as well as related ethical considerations.

4.2 Study design

This study responds to an identified need by executive leadership at a tertiary hospital for nursing leadership development in clinical practice and builds on findings from earlier research conducted in 2014, which evaluated an in-house leadership programme being delivered at the time in the organisation, known as Pebbles (Miskelly & Duncan, 2014). The research findings will iteratively inform the development of the new education (INSIGHT) through iterations one to three (see Figure 1).

The mixed methods research will be undertaken through two phases: Phase 1 will be qualitative and involve interview and focus groups with key stakeholders. Up to nine nurse leaders will be invited to participate in a semi-structured focus groups, with up to three attendees per focus group. An interview will be held with the executive sponsor of the programme, with results being combined with the focus group participants for reporting to maintain participant anonymity. Interviews and focus groups will be audio recorded for later verbatim transcription. All attendees will be coded to preserve external anonymity. Interviews and focus groups will last up to an hour.

Phase 2 will involve pre- and post- education surveys (Appendix 3) with registered nurses participating in the programme. It is anticipated that a total of 12 nurses will attend the programme and surveys will explore leadership confidence using a series of five-point Likert Scales (Disagree Strongly to Agree Strongly). Survey data will be analysed statistically to determine the impact of the programme on the participants self-identified confidence in leadership competencies.

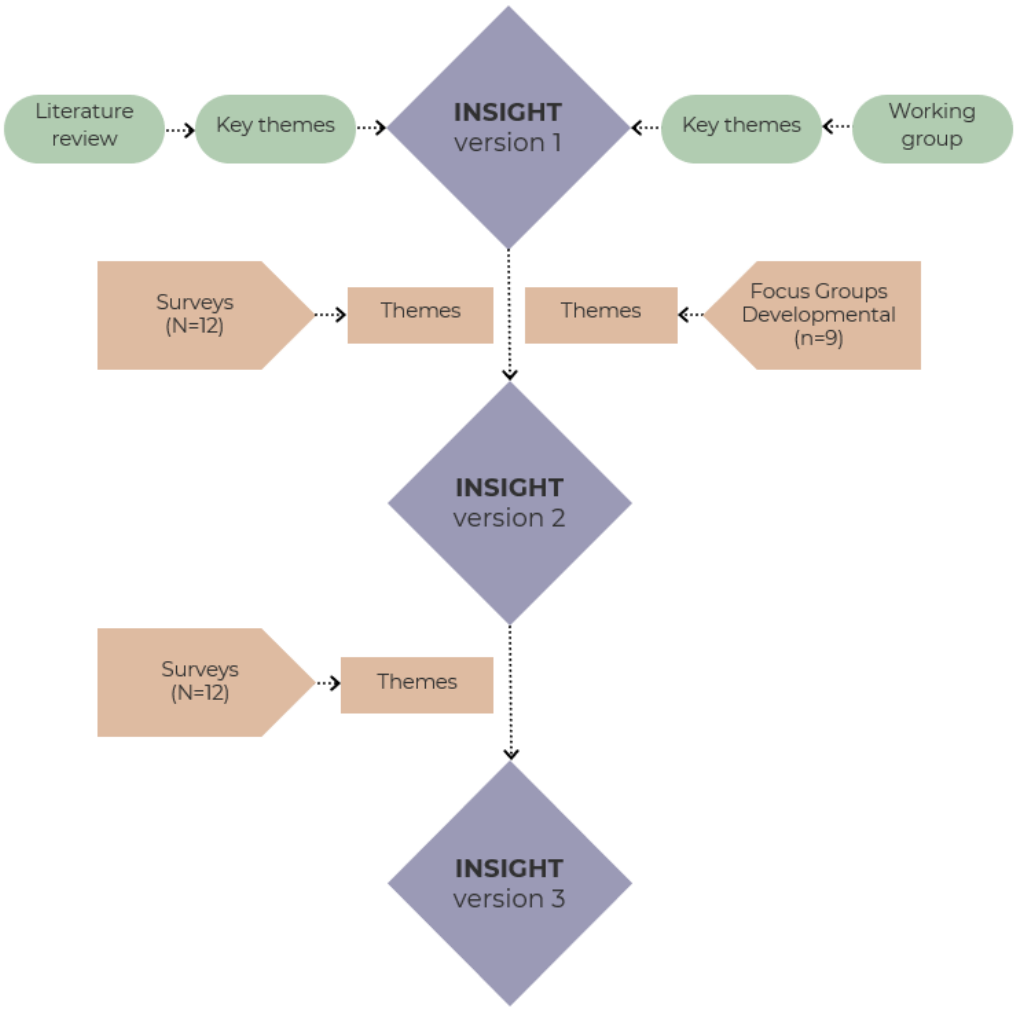


Figure 1: Study design

4.3 The intervention – Insight

The Pebbles Leadership Development Programme was established in 2007 by representatives of the Professional Development Unit at the then Waikato District Health Board (DHB). Its aims were to develop registered health professional's ability to lead and manage change in clinical practice, preparation for future roles in leadership and support succession planning. The programme was founded on practice development methodology and ran over six days. Participants undertook a small-scale quality project influenced by strategic priorities. A pluralistic evaluation of the Pebbles programme was undertaken in 2011, to explore the influence and impact the

programme had on participants individual nursing practice. Consideration was also given to the contribution of the programme to the general nursing environment at the Waikato District Health Board (Miskelly, 2011).

The pebbles programme continued to be delivered following the adoption of some of the recommendations from the evaluation. In 2014, a mixed methods study was conducted to evaluate the in-house programme and its aim to improve leadership capability in the clinical context (Miskelly & Duncan, 2014). The programme continued to be delivered utilising practice development principles, but the delivery time frame was decreased to four days. Programme delivery was paused in 2020 in response to the Covid-19 pandemic and a shift in priorities. This presented an opportunity to reenergise the programme to reflect today's health care context and thus 'Insight' emerged as the new leadership programme.

Insight is a four-day leadership development programme utilising practice development methodology designed to support health professionals to develop their leadership and cultural practice. Learning outcomes reflect a need for leadership in all healthcare services in recognition that health professionals lead episodes of care as well as maintain positions of designated leadership. The aim of the programme is to develop and extend an individual's critical thinking and understanding of leadership principles that empower every nurse as a leader in the clinical context whilst supporting career pathway planning. Local development of leaders allows for an opportunity for learning to be influenced by the local context. The new programme design is focussed on emerging leaders and scaffolds other learning opportunities provided at Health New Zealand Waikato such as preceptorship, coordination and quality improvement. It also correlates with other leadership frameworks and development programmes offered within the organisation.

The foundation of the programme is to provide an environment which enables the participant to deepen their self-awareness, with particular focus on cultural identity and values and support them to extend this knowing to application in professional practice and leadership. This involves exploring these concepts in relation to bias, emotional intelligence and communication, with activities designed to encourage application to

practice and critical reflection. Equity and Te Tiriti o Waitangi are explored in relation to the organisational and political contexts, complemented by activities to extend participant thinking about how these are demonstrated in practice. Theoretical underpinnings of leadership and management are reviewed then contextualised to embodied leadership. Activities associated with identifying leadership styles and approaches are designed to encourage the participant to consider how they align with their previously explored sense of self. A critical component of the Insight programme is the opportunity to observe organisational leaders as a part of their career pathway development. The opportunity to observe how others lead, communicate and advocate for equity in different clinical contexts is invaluable for the participants learnings.

Figure 2 provides a summary of the Insight programme outline; more comprehensive information can be found in the appendices.

Insight

Programme Aims

- The Insight programme for health professionals aims to equip emerging leaders in the healthcare sector with the essential skills, knowledge and confidence to support their leadership journey
- The programme focuses on building foundational leadership competencies and effective communication, fostering a culture of excellence and collaboration
- Experiential learning, mentorship and reflection expands participants awareness of the role of leadership in the bigger picture influences on health care delivery, outcomes and population health

Day 1

- Programme orientation
- Knowing self to lead self
- Emotional Intelligence
- Conversation navigation

Day 2

- Leadership – A theoretical perspective
- Leadership in context
- Equity

Day 3

- Mentorship in practice
- Self-reflection activity
- Career planning workbook

Day 4

- Group debrief of mentor experience
- Group presentations
- Team building activity

Figure 2: Insight programme overview

To meet the organisational priority to improve health equity for Māori and other vulnerable populations the Insight programme is designed to align with the strategic imperative Pae Ora (Healthy Futures) Act (2022) and the Health New Zealand nursing and midwifery strategic aims outlined in the Nursing at Waikato DHB 2017-2021.

4.4 Population

The population participating within this study is made up of two groups; current nurse leaders employed at Health New Zealand – Waikato district and participants of the early leadership development programme, Insight.

4.4.1 Current leaders at Health New Zealand – Waikato district

The current leaders identified were approached as representatives of the nursing leadership at Health New Zealand Waikato and were noted for their significant contribution to health leadership. The three groups were nurse executives, including the programmes executive sponsor, nurse directorate and senior nurses who had been mentors on the Insight programme.

4.4.2 Programme participants

Criteria for eligibility to participate in the study was enrolment in the leadership programme, Insight. The Insight programme was designed to support leadership development for registered nurses employed at Health New Zealand (Te Whatu Ora) - Waikato district who are not in a designated senior nurse role. There were no prerequisites to enrolment on the programme although manager endorsement to attend was required.

4.5 Data collection

Focus groups and surveys as mechanisms for data collection align strongly with the methodological framework of this research.

4.5.1 Focus groups

Focus groups are congruent with the research method for gathering qualitative data due to their capacity to engage participants through actively sharing their perspectives during the exploration of a topic. The facilitators expertise in conducting focus groups is essential for enhancing the depth and breadth of knowledge shared by the participants (Carey, M.A., & Ashbury, J.E., 2012). The configuration for the focus groups will consist of three groups representing nurse executives, nurse managers and

senior nurse leaders, all of whom are in a designated position with associated leadership capabilities. The senior nurse leader group participants will also have been mentors for previous programme participants. A separate interview will be conducted with the executive sponsor of the early leadership programme. The intent of these focus groups is to explore the optimal format of a leadership programme, including content and teaching modalities. They will also be conducted to gain insight into the need for nurse leadership and explore the relationship between nurse leadership, Te Tiriti o Waitangi obligations and equity focused care. These focus groups will be undertaken throughout the programme iterations to identify how the programme should be delivered (Education programme, version 1 and 2); allowing for enhancements to be incorporated prior to the delivery of the final programme to ensure that it meets the needs of the stakeholders.

These formative focus groups aimed to gather the perspectives and expectations of participants to facilitate a collaborative design and delivery of the content of the early leadership programme. The focus group was semi-structured with questions utilised outlined in Table 1, with provision of opportunity for open discussion.

Table 1: Focus group questions – Health professionals

Focus Group, Phase 2 Questions – Nurse Leaders
How do nurses learn leadership?
What difference does nursing leadership make to patient experience and outcomes?
In what ways could an in-house leadership programme support integration of the principles of Te Tiriti o Waitangi and equity within nursing leadership learning?
How and when would we measure the success of nursing leadership learning?
What delivery format do you think would be most effective for a nursing leadership development programme?
What content would be important to include in studies in a leadership development program to enhance learning and application of leadership skills?
Should mentoring or coaching be integrated into a leadership development programme to provide additional support and guidance for registered nurses and if so, how should this occur?
Focus Group, Phase 2 Questions – Extra for Nurse Mentors
How valuable did you feel your time with the programme participant was for their leadership development?
What benefit was there for you as the mentor of a programme participant?
What were the challenges?

4.5.2 Surveys

Participants of the Insight education programme will be surveyed pre- and post-intervention. The intervention will target 12 RNs and all will be invited to take part in the research. Surveys will take up to 15-minutes to complete and are posted online using Microsoft Teams Forms; selected as the preferred format at Health New Zealand. The survey includes Likert scale responses (5-point) across eight measures of leadership confidence and is included in Appendix III.

4.6 Analysis

The research process entails collecting data in response to a question. Data analysis inductively builds from emerging themes and researcher interpretation of the meaning and/or significance of the data (Creswell & Creswell, 2017). For the purpose of this

research, methods of data analysis were identified for qualitative and quantitative data analysis.

4.6.1 Qualitative data analysis

Qualitative data collection requires researchers to follow a sequential process encompassing various levels of analysis (Creswell, 2018). Moreover, this process involves the gathering and structuring of data for analysis, then reviewing the evidence to establish an initial general sense of the information. Subsequently, data coding enables the transformation of emerging themes into a theoretical model (Creswell, 2018). Qualitative data obtained through the focus groups will be analysed using a general inductive method of enquiry to generate codes, categories and key themes. An inductive approach enables key findings to emerge directly from raw data based on meaningful themes without being limited by predefined methodological structures (Thomas, 2003). This approach allows for condensing of raw data into a concise summarised format. Subsequently, leading to the establishment of connections between the research goals and the raw data summary findings and conception of a framework reflective of participants experiences identified in the raw data (Thomas, 2003).

Focus groups will be audio-recorded and transcribed. The coding process enabled analysis of narrative data to identify and describe themes from the participant perspective. As each qualitative researcher brings a unique perspective, the interpretations drawn from the data can differ among researchers, particularly in how they label key ideas, describe these concepts and articulate the relationship between them (Morse, 2018). The potential for the researchers' biases to influence the research process was acknowledged throughout the analysis and measures were undertaken to ensure trustworthiness of theming of the data including stakeholder checks with the supervisors of this research.

4.6.2 Quantitative data analysis

A paired sample T test approach was used for analysing the quantitative data obtained through participant surveys. The paired sample t-test is a statistical method used to

compare the means of two related groups to determine whether there is a significant difference between them and is often utilised in study designs requiring repeated measurements (Talikan & Dammang, 2024). The difference between the data obtained in the paired samples is then analysed and interpreted for the results (Jasrai, 2025). In a paired-sample t-test, hypothesis formulation focuses on determining whether there is a significant difference in the means of a dependent variable before and after a specific treatment. The analysis involves two mean scores derived from the same population with the assumptions related to the difference between these means being framed through null and alternative hypotheses (Jasrai, 2025).

Within this approach to data analysis hypotheses can be stated as either two-tailed or one-tailed, depending on the research objective (Jasrai, 2025). The hypothesis used within this research was the one-tailed, also known as one-sided, hypothesis. This approach is applied when the aim is to determine if there is a difference in mean scores in a particular direction. The results are determined through showing a null hypothesis, where there is no significant difference in scores or an alternative hypothesis, where scores are either greater or lesser after the intervention being investigated (Jasrai, 2025).

For this study, participants completed a pre-programme survey which gathered demographic information about the participants and a self-selected identifier code for comparing the results of the second survey. The second survey was completed by participants immediately after completion of the leadership development programme. Questions were replicated in both surveys as they were designed to assess participants confidence pre- and post-programme relating to their understanding and comprehension of leadership competencies and practice in context of the organisation. Questions also obtained baseline data of participants self-identified awareness of their leadership knowledge and practice.

4.7 Ethical concerns

In accordance with the Ethical Conduct in Human Research and Related Activities Regulations, research ethics approval was sought and received by the University of Waikato, Human Research Ethics Committee (HREC(Health)2023#36). Further ethical approval was received from Health New Zealand Waikato, research

department. Participants of the focus groups and surveys were provided a participant information sheet which outlined the purpose of the study and time commitment. Study participants were advised all contributions were anonymous and only used within the parameters of this research and its associated publication. To further protect survey participant anonymity, they self-selected an identifier code for allowing comparison of responses in the pre- and post-intervention surveys. Potential researcher bias and influence through pre-existing relationships with participants was acknowledged and mitigating steps employed by the use of an independent third party to invite programme participants participation in the surveys. Formal supervision was maintained throughout the study by an academic supervisor from the University of Waikato. The research did not identify any other ethical considerations for this study.

4.8 Methods, summary

This chapter outlines the design and implementation of this study aimed at developing and evaluating a leadership development programme for point of care registered nurses at a tertiary hospital in Aotearoa New Zealand. The study adopted a mixed-methods, multi-phase design grounded in a pragmatic paradigm, integrating both post-positivist quantitative and phenomenological qualitative approaches to gain a comprehensive understanding of leadership development in nursing. Data collection methods, focus groups and surveys were selected to align with the study's methodological framework and enable robust data triangulation. Ethical considerations were rigorously addressed, including ethics approval, informed consent and participant anonymity. The results of the study are expected to inform the iterative refinement of the leadership programme and inform the strategic development of nursing leadership capacity within the organisation.

Chapter V: Findings

You can carve your own path, be your own kind of leader. We do need to create a new generation of leadership.

Jacinda Arden, 1980 –

5.1 Introduction

Within this chapter, findings of the research data analysis will be discussed in two sections. The first part explores the qualitive data obtained through the focus groups and interview with nurse leaders and subsequent thematic analysis. This resulted in the identification of codes, categories and themes which are presented in Figure 1. Quotes obtained from participants are reviewed in further detail, demonstrating their connection to the five themes.

Quantitative data findings are displayed in Table 3 showing the paired sample T test results from participants pre- and post-programme surveys. Results are expressed through mean, standard deviation and P value indices. Figure 2 further expresses the quantitative results in an error bar graph depicting the standard deviation of the survey question responses.

Part 1: Qualitative findings

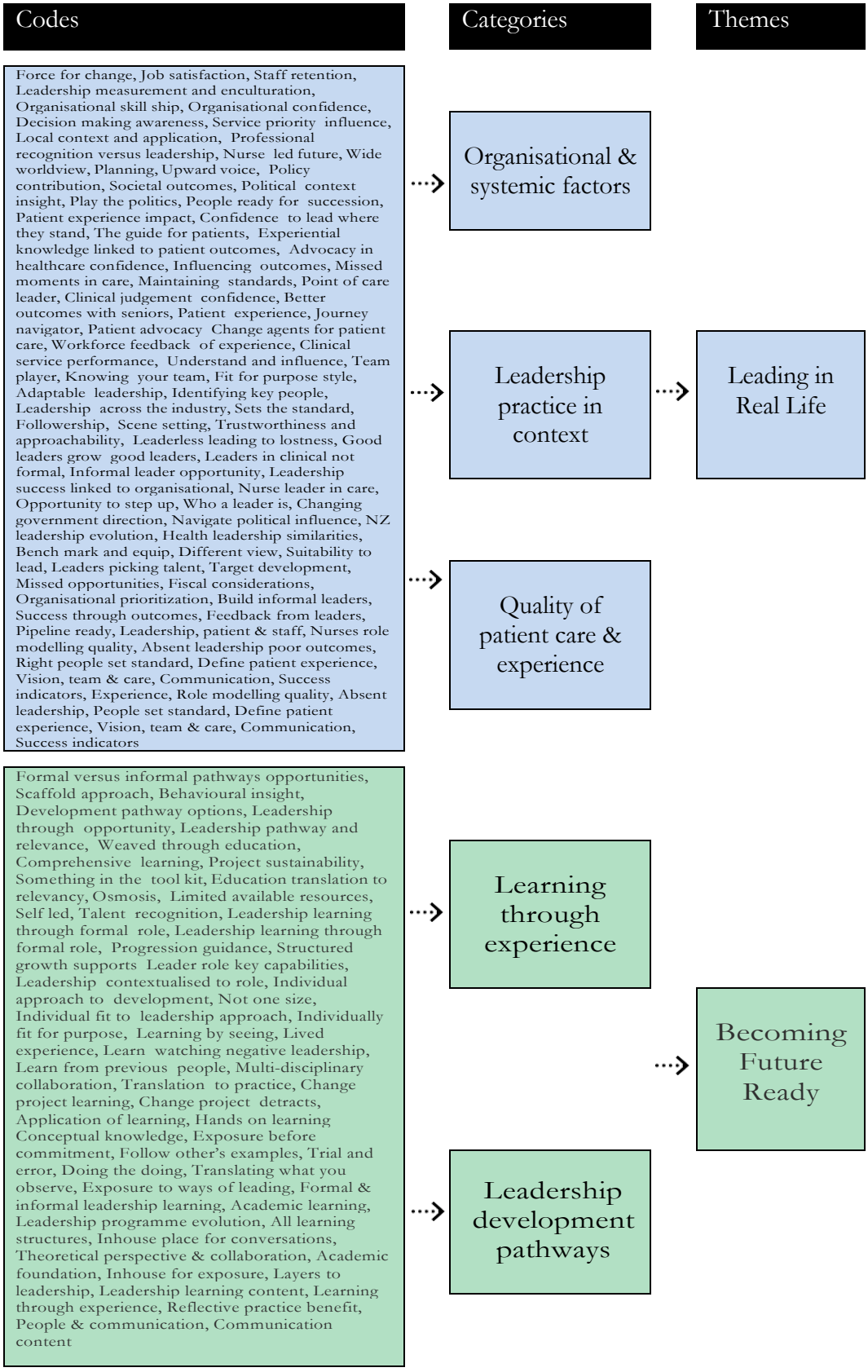
5.2 Thematic analysis

Qualitative data were collated from three focus groups and one interview with nurse leaders. Participant demographics are illustrated in Table 2 below. An initial interview was undertaken with the executive sponsor of the programme and the data collected has been incorporated into focus group four to ensure anonymity of responses.

Table 2: Focus group demographics

Interview 1 – Executive sponsor	
Pseudonyms	**Age (Years)**
Belinda	60 - 70
Focus group 2 - Senior nurse leaders	
Pseudonyms	**Age (Years)**
Rachel	40 - 50
Louise	20 - 30
Hannah	40 - 50
Focus group 3 – Operational nurse leaders	
Pseudonyms	**Age (Years)**
Brenda	60 – 70
Ashley	40 – 50
Julia	50 - 60
Focus group 4 – Executive Nurse Leader	
Pseudonyms	**Age (Years)**
Sally	60 - 70
George	50 - 60
Angela	50 - 60

Thematic analysis was undertaken which led to the generation of five themes illustrated in Figure 2.


Codes
Categories
Themes
Force for change, Job satisfaction, Staff retention, Leadership measurement and enculturation, Organisational skill ship, Organisational confidence, Decision making awareness, Service priority influence, Local context and application, Professional recognition versus leadership, Nurse led future, Wide worldview, Planning, Upward voice, Policy contribution, Societal outcomes, Political context insight, Play the politics, People ready for succession, Patient experience impact, Confidence to lead where they stand, The guide for patients, Experiential knowledge linked to patient outcomes, Advocacy in healthcare confidence, Influencing outcomes, Missed moments in care, Maintaining standards, Point of care leader, Clinical judgement confidence, Better outcomes with seniors, Patient experience, Journey navigator, Patient advocacy Change agents for patient care, Workforce feedback of experience, Clinical service performance, Understand and influence, Team player, Knowing your team, Fit for purpose style, Adaptable leadership, Identifying key people, Leadership across the industry, Sets the standard, Followership, Scene setting, Trustworthiness and approachability, Leaderless leading to lostness, Good leaders grow good leaders, Leaders in clinical not formal, Informal leader opportunity, Leadership success linked to organisational, Nurse leader in care, Opportunity to step up, Who a leader is, Changing government direction, Navigate political influence, NZ leadership evolution, Health leadership similarities, Bench mark and equip, Different view, Suitability to lead, Leaders picking talent, Target development, Missed opportunities, Fiscal considerations, Organisational prioritization, Build informal leaders, Success through outcomes, Feedback from leaders, Pipeline ready, Leadership, patient & staff, Nurses role modelling quality, Absent leadership poor outcomes, Right people set standard, Define patient experience, Vision, team & care, Communication, Success indicators, Experience, Role modelling quality, Absent leadership, People set standard, Define patient experience, Vision, team & care, Communication, Success indicators
Organisational & systemic factors
Leadership practice in context
Quality of patient care & experience
Leading in Real Life
Formal versus informal pathways opportunities, Scaffold approach, Behavioural insight, Development pathway options, Leadership through opportunity, Leadership pathway and relevance, Weaved through education, Comprehensive learning, Project sustainability, Something in the tool kit, Education translation to relevancy, Osmosis, Limited available resources, Self led, Talent recognition, Leadership learning through formal role, Leadership learning through formal role, Progression guidance, Structured growth supports Leader role key capabilities, Leadership contextualised to role, Individual approach to development, Not one size, Individual fit to leadership approach, Individually fit for purpose, Learning by seeing, Lived experience, Learn watching negative leadership, Learn from previous people, Multi-disciplinary collaboration, Translation to practice, Change project learning, Change project detracts, Application of learning, Hands on learning Conceptual knowledge, Exposure before commitment, Follow other's examples, Trial and error, Doing the doing, Translating what you observe, Exposure to ways of leading, Formal & informal leadership learning, Academic learning, Leadership programme evolution, All learning structures, Inhouse place for conversations, Theoretical perspective & collaboration, Academic foundation, Inhouse for exposure, Layers to leadership, Leadership learning content, Learning through experience, Reflective practice benefit, People & communication, Communication content
Learning through experience
Leadership development pathways
Becoming Future Ready

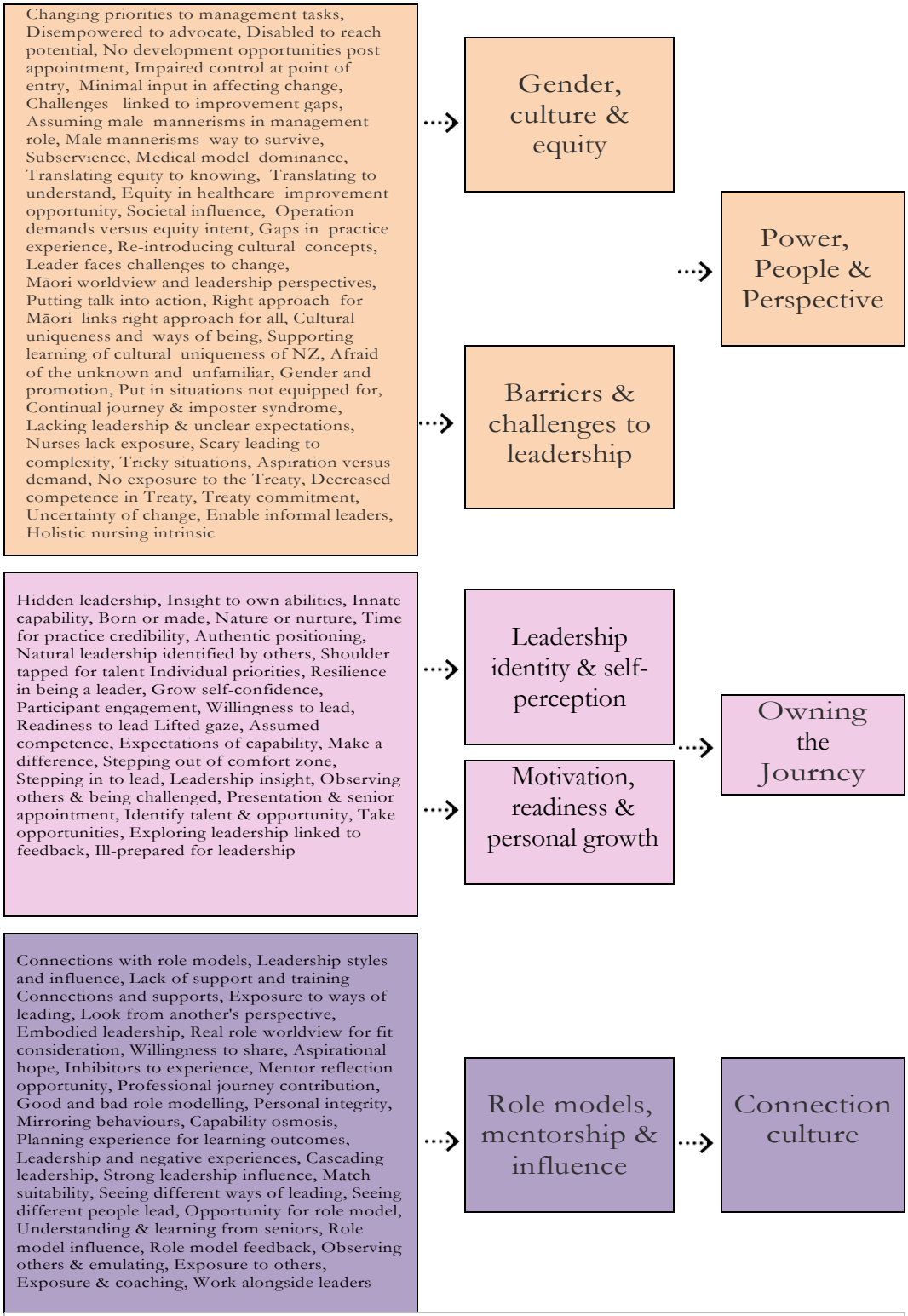


Figure 1: Thematic analysis of qualitative data

Theme 1: Leading in real life

The theme leading in real life arose from seventy-nine codes that informed 3 categories, being organisational and systemic factors, leadership practice in context and quality of patient care and experience.

Organisational and systemic factors

Participants reflected on the requirement for nurse leaders to possess political astuteness, particularly in light of governmental changes in health policy and legislation.

> *I think that there's a real space for our nurse leaders to be really politically savvy*
>
> (Operational nurse leader)

> *You have to be so savvy in a leadership role and have to be able to play those politics to some extent to get what you want*
>
> (Operational nurse leader)

The connection between politics and impact on health was also referenced.

> *That political impact, that political influence, has, is certainly kind of impacting health is a significant way … how do we now navigate that space, particularly within … leadership roles, for our leaders and our upcoming leaders.*
>
> (Executive nurse leader)

There was a connection between governmental direction and confusion in leadership focus.

> *There has been a big shift as well though … in respect of … if we look at the previous government and we had Te Aka Whai Ora and … now we have gone to a position where that was disestablished. Actually, the National government, it appears that the imperative is quite different than the previous government, so its very confusing. And particularly within health when we thought we were going in one direction, we're now going in quite a different direction.*
>
> (Executive nurse leader)

This quote also speaks to theme 4: Power, people and perspective, in particular equity and Te Tiriti o Waitangi influence in health services.

Connections were made when discussing the need for nursing leadership, linking clinical leadership to policy contribution.

> *We don't just stick into nursing, we can take those skills and go on and really change some really vital aspects of health and policy that we might not always think of on the shop floor.*
>
> (Operational nurse leader)

This was further supported with links to societal health.

> *You have the ability to move into policy change and ultimately really creating better outcomes … for society.*
>
> (Operational nurse leader)

This concept was also mentioned by a participant in relation to nurses having the opportunity to attend national meetings.

> *That doesn't stop someone … who's learning how to be a leader to actually hear what happens and how decisions are made and what influence the new developments for health have on the way nursing is going to be, I guess, developed and maybe a little bit controlled in the future.*
>
> *(*Executive nurse leader*)*

The organisational impact on nursing leadership and associated development also came through as a consideration. When asked about the best approach to an in-house leadership development programme there were connections between programmes and organisational resource.

> *The key requirement is that there is organisational prioritisation of developing leaders … across all the disciplines, because that's how it gets funded.*
>
> (Executive nurse leader)

> *It's how you build those influences and informal leaders and harness that group of people as well that I think potentially needs to be considered in any programme that we are … able to fund and resource.*
>
> (Executive nurse leader)

> *This is about resource and … we're in fiscal constrained times and … not just the release time, not just the education time, not just the time that's actually going to require of the individual to devote to this so I think you need to kind of consider those things as well.*
>
> (Executive nurse leader)

When considering what success would look like for an in-house leadership programme, it was less clear for the participants to identify. Some suggestions were linked to succession planning through an equipped workforce and patient related indicators.

> *In recruitment, that actually we've got a number of people that are putting their hand up you know, so actually we've got a pipeline.*
>
> (Executive nurse leader)

Leadership practice in context

When it came to determining if there was a need for nurse leaders there was a clear articulation of the importance of nurse leadership in the practice context.

> *I think you need every nurse as a leader. So necessarily I think it's … just ensuring that people know that a leader is someone who leads on the floor, who leads that conversation and it's as vital as having any designated leadership position.*
>
> (Executive nurse leader)

Every nurse as a leader was a reoccurring theme.

> *I absolutely believe that every nurse is a leader because they lead the care for a patient.*
>
> (Executive nurse leader)

There was evidence of the impact of nurse leaders in context, both positively and negatively.

> *A good leader can make a huge difference in people's lives and a lot of other really good leaders can come as a result of that, either into leadership itself or into other areas. A bad leader can obliterate a team in a short period of time.*
>
> (Operational nurse leader)

> *If you have a leader who has poor standards, then, not always, but a number of staff will follow your lead and they won't care either. So, if you're a leader who has standards that are known, they're communicated well, you pull people up when those standards aren't met, you let people know what your expectations are and you hold them to account. Then the care delivery will be better and the patient experience as a result should be better.*
>
> (Operational nurse leader)

There was also a link between leadership in context and organisational context.

> *I think you need really good designated leaders and a good strategic vision and philosophy and the education that enables those people who are the informal leaders to actually grow and then lead and mentor others that are coming through.*
>
> (Executive nurse leader)

A cross over with quality of patient experience and leadership in context was identified by participants.

> *What we do know is that if we have a group of nurses that understand leadership, understand how they influence how patients access and experience care, are to provide really good advice and interventions in a timely way, … then the patient experience improves.*
>
> (Executive nurse leader)

Quality of patient care and experience

Building on leadership practice in context was quality of patient care and experience.

> *What we've seen, is that if there are high numbers of nurses who feel uncomfortable to challenge a care plan then that patient is injured in some way and that's confidence about leadership. Thats clinical leadership, leadership where they stand, leadership not just in creating teams of people, but leadership in saying I think that's not right, let's go back to the drawing board and create a better plan of care for this patient.*
>
> (Executive nurse leader)

Participants noted a correlation between informal leaders and patient advocacy, care outcomes and influence.

> *It is in the point of care and you don't necessarily have to be a senior nurse or an expert nurse to be a leader in a patient's care.*
>
> (Operational nurse leader)

> *Nurses who are working clinically and are seen as the informal leaders and the influencers, I think that in the end defines what care and experience patients and other staff will have.*
>
> (Executive nurse leader)

> *As nurses' kind of gain their feet and get more comfortable with leading on the floor they kind of start to advocate a bit more on behalf of the patient and their family.*
>
> (Senior nurse leader)

It was also noted the absence of leadership can contribute to negative outcomes for patients.

> *The absence of leadership will give you poor outcomes.*
>
> (Executive nurse leader)

Participants identified the contribution nurses have and can collaboratively make in healthcare evolution.

> *I think nurses are a force for change. I think we've shown that historically when … we work together, we really get things done and I think strong nursing leadership at whatever level, it is really helpful in moving care forward and moving outcomes forward.*
>
> (Operational nurse leader)

Theme 2: Becoming future ready

Becoming future ready emerged from 62 codes which were refined into two categories, which were, leadership development pathways and learning through experience.

Leadership development pathways

Participants were asked for their thoughts on the optimal format and approach to leadership development for clinical leaders. There were multiple responses discussing the benefits and drawbacks of tertiary level education and in-house delivered programmes.

> *There's opportunities to learn about leadership models … whether that be in a formal tertiary space or like a education provider or maybe even just through reading and looking at different leadership model models and actually having a look at what aligns with you as an individual*
>
> (Executive nurse leader)

> *A leadership topic, so it's usually a high-end kind of generalisation of the leadership thing, like learning about styles or learning about or doing a reflective practice on an instance where you've had a poor leadership shown to you ... So I think … that's really the main positive I can see with doing postgraduate type leadership stuff*
>
> (Senior nurse leader)

> *I think there's also a place for where you've got a workforce who are looking at development opportunities and particularly in leadership and that work in the same organisation actually there should be a space where they can go and actually have that conversation and actually develop and grow and intellectualise these ideas, which is for like our in-house program.*
>
> (Executive nurse leader)

> *The only pro I can see with postgraduate leadership courses compared to in house leadership courses is that in a postgraduate paper you spend a lot of time writing an assignment on a topic and you get a massive amount of learning from that.*
>
> (Senior nurse leader)

> *Our in-house course, I feel like it's just the next level. It's like real, bringing all the general information in about leadership styles, giving people a place to discuss.*
>
> (Senior nurse leader)

> *The role of these in-house leadership programmes cannot be underestimated. They are incredibly important because it means that we as an organisation have confidence and place value in our staff that want to … become leaders or even just to feel more confident in leading wherever they are in the wards or the departments.*
>
> (Executive nurse leader)

> *The in house would provide really real information about how your organisation is working because each say, for instance, DHB, works differently and their leadership and management works differently. Whereas if you do it as kind of a postgraduate level, it's generalised and you don't know how that is applicable to you and your role... So I think it kind of would set you up for more success that you could make more direct changes that suits your organisation.*
>
> (Senior nurse leader)

When asked what the most effective format or delivery of an in-house leadership development programme for clinical nurse leaders would be, the responses were varied.

> *I think … it would be different for everybody, wouldn't it? … one size doesn't fit all … and I think that that's exactly right. So even if I said … structured program for like 6 weeks where I have to be for half an hour every week or something, you know definitely could advocate for that. But actually, that's not fit for purpose for the next person as well.*
>
> (Operational nurse leader)

> *There's not just a one size fits all model.*
>
> (Operational nurse leader)

> *We definitely need one. I don't know how that looks.*
>
> (Senior nurse leader)

Questions related to content that would be beneficial to include in a clinical nurse leadership development programme elicited varied responses.

> *There are so many different styles of leadership around. So … it's helping the people on the course to identify what leadership style really resonates with them.*
>
> (Operational nurse leader)

> *I would really want to make sure that in a leadership programme at this level is some … discussions on behaviours.*
>
> (Executive nurse leader)

> *You've got to learn about your finance and your budget … creating a team and setting expectations and understanding your quality and understanding your health and safety*

and all of those aspects … and what are the tools that you use to monitor and do all of that.

(Executive nurse leader)

If you've got an in house one when you're starting to talk about equity and things in in-house leadership programs, it means more and it's more likely to get translated into practice then. It's not just some airy fairy kinda, oh yes, we all think we should have equity, you know, but nobody does anything. If it's in house, then it's us, we're saying that and so I feel like that's more likely to be up taken.

(Senior nurse leader)

People management is probably the biggest one and for me that whole communication and communication styles, over communication, under communicating you know, pitching it at the right level to the right person, to the right group framing it correctly would particularly even when you're all of a sudden having to deal with family complaints or patient complaints now you're having to navigate all of that. You're having to protect your team.

(Executive nurse leader)

That real variety of exposure to different leaders I think would be really beneficial.

(Operational nurse leader)

You do the buddy system so people can actually go around and have a look and there's a lot to be said for that and I think rather than just having the one off, I think there is actually probably something for us within this organisation for those that aspire to be leader is actually to have a more formal program which allows individuals to work alongside kind of like that mentorship program.

(Executive nurse leader)

Having a real understanding about the higher decision making that goes on and the reasons why and the rationales.

(Senior nurse leader)

Learning through experience

Learning through experience was demonstrated through programme content associated with practical learning, observing leadership and opportunities to step into leadership roles. The uncertainty of the best modality for learning leadership led to

other opportunities to develop leadership capability through exposure and opportunity to step into a leadership space.

> *There's an awful lot of focus on education and to be honest I don't know how much that plays, how big a part that plays in becoming an effective leader*
>
> (Operational nurse leader)

The consideration of a change project learning as an experiential learning opportunity within an in-hose programme was raised with mixed responses.

> *I did like completing a change project as part of my leadership course that I did … because I think that is a lot of what you do as a leader and you want to make those small changes that are sustainable within your team. And so to learn how to do that well, sets you up for the future.*
>
> (Senior nurse leader)

> *Some sort of quality or audit or change project, I think all of those could be really key learnings to how to be a leader, you have to communicate with your team … at a higher level, you have to get your point across, you have to lead them in a common goal. It's really good learning. But, also, it's something that puts people off going to a leadership thing.*
>
> (Senior nurse leader)

> *I've seen lots of those sort of change processes over the years, particularly in the last area that I was in and nothing ever came of them … I wonder if maybe those change process were too big or they were decided by people that shouldn't decide on them. I mean, I often think it was the managers that decided. … I just wondered, particularly in the area I was in, what was the point? Because they lasted about 5 minutes.*
>
> (Senior nurse leader)

There was a strong connection between nurse leadership learning and observing others leadership in practice.

> *Witnessing and living others leadership, in nursing that seems to be how they do it.*
>
> (Senior nurse leader)

> *Definitely watching and observing, but often I think it's not such good leadership that you see that you also learn from.*
>
> (Senior nurse leader)

Opportunities to step into leadership spaces was linked to optimal methods to developing leadership.

> *Having those opportunities to step up and it doesn't even necessarily need to be senior leadership. … even maybe just on the floor … working in a more senior clinical role, having that opportunity to do that and buddy with another more senior person and for them to coach and support you in the role and give you feedback.*
>
> (Executive nurse leader)

This was also linked to application of learning to practice.

> *Most of the leadership courses that I've done … you learn about learning styles and all that kind of thing but what the disconnect is, ok, now what? What do I do with that?*
>
> (Senior nurse leader)

> *I don't necessarily think book works the only way. There's some components of that that are helpful, but doing the doing is really important.*
>
> (Operational nurse leader)

Theme 3: Power, people and perspective

Power, people and perspective developed through thirty-nine codes which were then refined to 2 categories, barriers and challenges to leadership and gender, culture and equity.

Barriers and challenges to leadership

The barriers and challenges identified by the participants were across the spectrum of categories and themes mentioned within this analysis. Challenges related to clinical leadership were connected with patient care.

> *It's very scary … the first time having to go in to manage a complex family situation that you are now the leader of.*
>
> (Executive nurse leader)

> *If you're 2 IC or you're stepping up or you're leading the … ward team … and then all of a sudden you may have to be the representative and … having to deal with those sorts of things, you know, they're really tricky situations.*
>
> (Executive nurse leader)

Barriers to clinical nurses' ability and confidence to lead was considered a reflection of senior management leadership styles which has the ability to impact patient outcomes negatively.

> *Can have really negative effects on the staff who will come to that. And then I think you'll see some negative patient outcomes due to that because then staff are too scared to make decisions by themselves. Staff are … not validated or not given empowerment to make their own decisions and acting as the advocate for the patient.*
>
> (Senior nurse leader)

Gender, culture and equity

Gender and professional historical norms were raised as a significant influencing factor in leadership competence.

> *Why I think nurses in particular still need a great deal more hours put in for leadership … because we have worked in a medical model that has been dominated for generations by doctors who tend to be male.*
>
> (Executive nurse leader)

> *I see a number of nurses adapting, male mannerisms and behaviours to survive.*
>
> (Executive nurse leader)

Gender was also linked to promotion opportunity.

> *For the most part, nurses are female, a lot of nurses are female … the men who get into nurse leadership tend not to stay there long because they apply for things quickly and they get promoted in different areas.*
>
> (Senior nurse leader)

When asked the ways in which an in-house leadership programme can contribute to equity and Te Tiriti o Waitangi within nursing leadership learning, significant factors were illustrated. One of which was nursing workforce demographics.

> *I think of particular challenges for us is that we have a blended workforce, significantly, a lot of people who haven't been exposed to any of Te Tiriti. How we do that?*
>
> (Executive nurse leader)

> *I do think that there has been a change over the last few years and I think that naively for me, I thought that kind of nursing assessment and partnership and individualised care was intrinsic, is part of what we did as nurses … but I trained here and I grew up here so for me that holistic nursing is based on that individual person and whanau.*
>
> (Executive nurse leader)

> *At the moment we have a very internationally focused workforce and it's vitally important that us as leaders and not just senior staff, but leaders throughout every walk of nursing really show that deep level of understanding of a really unique culture in New Zealand so that almost by osmosis the international staff are picking up on how we are so different and how that uniqueness to New Zealand actually is something to be treasured and not something to be afraid of.*
>
> (Operational nurse leader)

Another factor was a lack of understanding of what equity is and how to achieve it.

> *I think what we need to do is describe equity in a way and in language that the nurse … actually understands … we can say we've got equity, but nobody really knows what it is.*
>
> (Executive nurse leader)

> *When you talk about equity, it's a really difficult one from a leadership perspective to affect any real measurable quantifiable change.*
>
> (Operational nurse leader)

> *I think it's complex because … I don't feel greatly competent across that.*
>
> (Executive nurse leader)

> *From an equitable perspective … how can I affect change? There's very little I can do because that horse has already bolted by the selection of that patient to come into our service.*
>
> (Operational nurse leader)

The prioritisation of operational demands was mentioned as a contributing factor for promotion of equity in health care provision by management was also noted.

> *If it's not a particular priority then I think it just happens really haphazardly and things crop up as it, it's not prioritised … if I was to generalise in the clinical areas that I go to or visit … I would say that equity is not generally really prioritised across the board. I think it's more tick boxing and patient flow is highly prioritised by the clinical area leaders. So therefore, that's what they teach to be important to their aspiring leaders. That's what their managed on themselves.*
>
> (Senior nurse leader)

These challenges were also linked to the shifts in governmental direction.

> *It's a really challenging time and does require us to step up and lead within our structures to enable the informal leaders to feel comfortable and stepping into that space.*
>
> (Executive nurse leader)

Theme 4: Owning the journey

The theme owning the journey arose from twenty-seven codes. These were refined to 2 categories, leadership identity and self-perception and motivation, readiness and personal growth.

Leadership identity and self-perception

> *What I've seen in my career is that many, many nurses actually are leaders. They don't recognise that leadership in themselves and what I would want to do was to have a programme in place that would allow the registered nurse to lead where they stood, to influence their coworkers, whether they were other nurses, healthcare assistants, ward clerks, doctors and to develop and gain confidence that they could actually use the skills that were inherent in themselves to make a difference to that ward or that department that they worked in.*
>
> (Executive nurse leader)

There was consideration of leadership development for nurses related to inherent attributes and professional development.

> *Theres that old quote, you know, born to be a leader, so I think there's a little bit that's kind of innate, but also a lot's by watching and learning and kind other people role modelling it.*
>
> (Senior nurse leader)

> *Are leaders made or born. What's nature, what's nurture?*
>
> (Operational nurse leader)

Motivation, readiness and personal growth

A consideration of motivation, readiness and growth was in others recognising an individual's leadership competence from both a growth and redirection perspective.

> *For us to be able to tap them on the shoulder and say actually I think you should do this because I really see this talent in you.*
>
> (Operational nurse leader)

> *I think that a lot of us as leaders can see our staff that don't see their own natural talent that we can see.*
>
> (Operational nurse leader)

> *There are individuals who will never be a leader and that is perfectly fine. But not to encourage them to be a leader, because then what happens is they destroy themselves and they destroy the teams that they're in.*
>
> (Executive nurse leader)

Personal growth was linked to personal leadership awareness.

> *What is leadership? What does leadership mean to me? You know what's good leadership, what's bad leadership. How can you grow?*
>
> (Operational nurse leader)

A component of readiness was linked to self-confidence.

> *I think you need a bit of time to build your own confidence because to show leadership in a clinical situation, you have to understand and believe in your decision making first and then I think once you've kind of got that, I think it's really natural and I think it just improves exponentially from that point.*
>
> (Executive nurse leader)

> *It's those opportunities that are important in taking, those opportunities and the feedback in terms of positive feedback that gives you confidence to think and believe in yourself.*
>
> (Executive nurse leader)

Readiness was linked to the need for leadership development.

> *There is still space for more because I think …often … you can be thrust into these leadership positions and actually may not be particularly well equipped for them and you're just having to learn on your feet or learn through default or learn through you know bad practice or good practice.*
>
> (Executive nurse leader)

> *We put someone into a role like this, we expect them to hit the ground running on day one. Actually, why? You know, if we want better bang for our buck and we want these people to grow into really good leaders, why not support them? They're there for a reason because they've got the beginnings of great leadership.*
>
> (Senior nurse leader)

Measuring success of a leadership development programme was connected to workforce succession planning and readiness and personal growth.

> *You've got the success where individuals put their hand up and say, yes, charge nurse, I will participate and I will lead that project that you want and that ward.*
>
> (Executive nurse leader)

> *Success is the number of people that we can pull on to pull into some more designated senior roles.*
>
> (Executive nurse leader)

> *It's in that point of care in terms of … taking the lead, whether it's the lead … you know, a clinical practice or the lead of an escalation.*
>
> (Operational nurse leader)

Theme 5: Connection culture

Thirty-two codes informed the development of 1 category, role models, mentorship and influence, which informed the theme of connection culture.

Role models, mentorship and influence

This category was constructed through data referencing being a mentor to clinical nurse leaders as part of a development programme and role models and mentors seen in clinical practice.

> *I got to show what I do and feel like I had learnt a lot in this role and I did have something that I could share and it kind of reaffirmed that. And also I guess when they bought their questions to me it was nice to share my journey and actually reflect and see how I got to be where I was.*
>
> (Senior nurse leader)

> *It makes you feel like you've contributed to their pathways and their journey a little bit, which is kind of nice.*
>
> (Senior nurse leader)

> *Probably the most important value I think, for the people coming to … see us is that we actually wanted to share our role with them and we wanted to positively make a difference to them.*
>
> (Senior nurse leader)

> *I think this is a different model and it allows people to see people who are good at their jobs, who actually … like their jobs and … thrive on patient centered care. I think that's really valuable in itself to be able to get that snapshot of being able to work alongside someone who is already in those roles and it gives them hope and I'm really big on trying to drive that you know, the nurses that I'm working with that there's hope … and really the participants are going to get out of the value what they want to put in.*
>
> (Senior nurse leader)

A challenge associated with the mentor role within the leadership development programme was associated with trust and time.

> *It was just knowing how … honest to be really and trusting the person and making time.*
>
> (Senior nurse leader)

> *When you're organising that time to spend with them, you need to think about what … your day's like and think about what are they going to get out of spending time with me today.*
>
> (Operational nurse leader)

A consideration of this category and mentorship was also related to appointment to leadership roles.

> *Good people … who have got good personalities that go into leadership positions, but not necessarily with the trained element of external supports.*
>
> (Senior nurse leader)

Leadership development was associated with observing leadership behaviour's and approaches of others.

> *A lot of where I learnt leadership was from my peers who are my seniors and so the way that they … interacted with me, supported me, developed me, gave me feedback, was I guess, the early parts of my understanding what leadership look like.*
>
> (Executive nurse leader)

> *Observing their behaviours and observing…how they interact and how they demonstrate those kind of leadership skills…because I can certainly identify and remember those people that did it very well. I also can remember those that didn't do it very well and…you kind of pick and choose and work out actually, what aligns, aligns with you both professionally and personally.*
>
> (Executive nurse leader)

There was a challenge associated with mentorship related to resourcing required.

> *I think having exposure …is really important and whether … that sits within an in-house program … are what make good leaders and having some ability to access coaching, … something that I know as labour intensive and potentially costly, but invaluable from my perspective.*
>
> (Executive nurse leader)

Part 2: Quantitative findings

5.3 Survey sample characteristics

The survey characteristics are presented below.

Table 3: Survey characteristics

Pseudonym	Age	Gender	Practice area
Lucy	20 – 30	Woman	Surgical
Alise	50 – 60	Woman	Public Health
Shelby	50 – 60	Woman	Surgical
Florence	30 – 40	Woman	Critical Care
Maree	40 – 60	Woman	Medical
Lisa	20 – 30	Woman	Peri-operative
Courtney	30 – 40	Woman	Medical
Charlotte	20 – 30	Woman	Medical
Brenna	20 – 30	Woman	Medical
Tamsyn	20 – 60	Woman	Critical Care
Sienna	30 – 40	Woman	Medical
Amelia	50 – 60	Woman	Medical

5.4 Statistical analysis

Registered Nurses (RN) who undertook the education programme completed both a pre- and post-survey and were coded with a unique identifier. The survey questions were assessed using a five-point Likert scale, recorded as 1=Disagree strongly; 2=Disagree; 3=Neither disagree or agree; 4=Agree; and 5=Agree strongly. This allowed testing changes between the two time points, using a Paired Sample T test. This statistical test compares individual changes rather than group means and therefore achieves a higher level of confidence in interpreting the results. Table 4 shows the questions with associated test results.

Table 4: Paired sample T Test results

Questions		Mean	SD	P Value
1	Confidence in current leadership ability - leadership knowledge	0.67	1.30	**0.05***
2	Confidence in current leadership ability - leadership practice	0.10	1.20	0.40
3	Confidence in understanding different leadership styles	0.58	1.08	**0.05***
4	Confidence in awareness own leadership style	0.17	1.12	0.31
5	Confidence in knowledge of leadership skills & attributes for effective health leadership	0.50	0.91	**0.04***
6	Confidence in experience in health leadership role	0.33	1.07	0.15
7	Confidence in understanding of health leadership in equitable healthcare delivery	0.92	0.90	**<0.0001***
8	Confidence in understanding of communication styles related to leadership	0.33	0.89	0.11
9	Confidence in understanding of relationship knowing self, cultural identity and leadership	0.67	0.65	**<0.0001***
10	Confidence in development of skills for challenging conversations	1.00	1.28	**0.01***

*Note. * Significant at the 5% level of significance*

Table 3 shows that a variety of questions revealed differences from pre to post intervention. Specifically, questions 1 3, 5, 7, 9 and 10 showed statistically significant differences at the 5% level over the time points. These results are explored graphically in Figure 3, which reports the mean differences, and the extent of the change can be more fully examined.

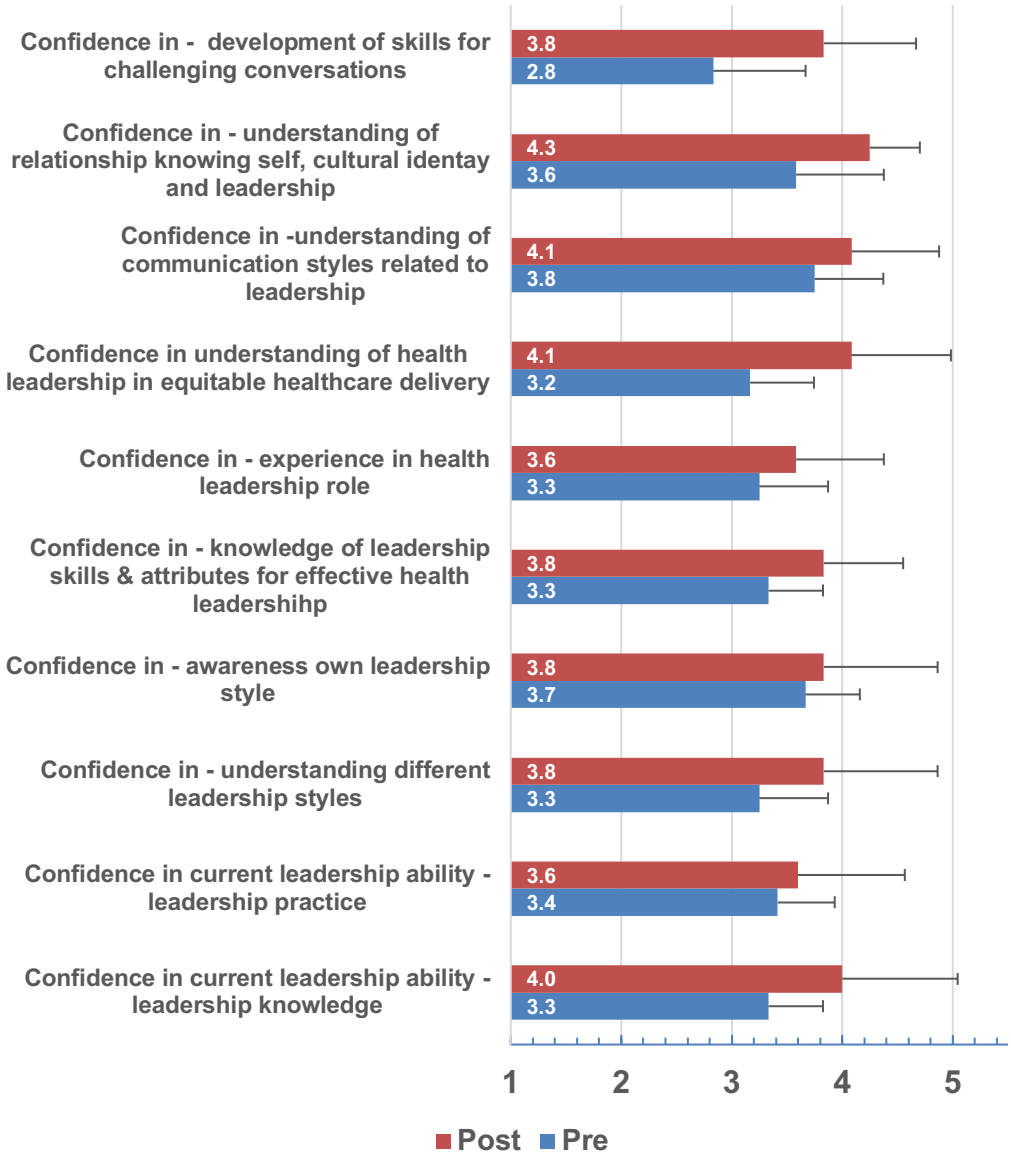


Figure 2: Mean pre- and post-survey responses (error bar = 1 SD)

The plots illustrate that there is an increase in values for all questions. Some questions had wider dispersal, as illustrated by the wider error bars, e.g. "Leadership Knowledge"

5.5 Findings, summary

Focus groups conducted with nurse leaders in designated senior roles and an interview with the early leadership development programme executive sponsor provided a

wealth of insight into the need for nurse leaders at the point of care. Thematic analysis of qualitative data obtained through the focus groups involved a process of coding then categorising, ultimately revealing five key themes related to how clinical nurse leadership is developed from the perspective of designated nurse leaders. These were leading in real life, becoming future ready, power, people and perspective, owning the journey and connection culture.

Registered nurses enrolled in the leadership development programme completed a survey immediately prior to commencing the programme and immediately following completion of the programme. The intentional interval between data collection points allowed for testing of changes between the two time points. Results showed an increase in value in all questions, with statistically significant results in five of the eight leadership competencies surveyed: (i) Current leadership ability - leadership knowledge; (ii) understanding different leadership styles; (iii) Knowledge of leadership skills & attributes for effective health leadership; (iv) Understanding of health leadership in equitable healthcare delivery; (v) Understanding of relationship knowing self, cultural identity and leadership; and (vi) Development of skills for challenging conversations.

Chapter VI: Discussion

Leaders become great, not because of their power, but because of their ability to empower others.

John C Maxwell, 1947 –

6.1 Introduction

This study set out to evaluate the need for clinical nursing leadership from the perspective of designated nurse leaders and evaluate a leadership development programme specifically designed for nurses involved in direct patient care. Specifically, two questions were asked related to this; how is clinical nurse leadership developed from the perspective of those in designated senior nurse roles; and what is the impact of the early leadership development programme on participants perceptions of their own leadership competence. Data collated from the designated nurse leaders focus groups informed themes demonstrating the need for clinical nurse leaders and the influencing factors for success or barriers in capabilities related to this role. These themes were identified in the findings chapter and were leading in real life, becoming future ready, power, people and perspective, owning the journey and connection culture.

This chapter will explore the results of the data collection and associated analysis in the context of the two research questions stated above. The findings will be evaluated in relation to the existing literature discussed within the literature review, with attention to both consistencies and differences between the study's results and the key themes identified in the literature review. The theoretical contribution this study provides will be discussed. This will be built on through exploring the educational and political implications of the findings from this study and potential future research opportunities.

Part 1: Research questions

6.1.1 How is clinical nurse leadership developed from the perspective of those in designated senior nurse roles?

Nursing leadership plays a critical role in enhancing patient safety and quality of care, prioritising equity focussed services, driving professional, organisational and policy change and strengthening team performance. The findings from this study provide valuable evidence supporting the essential role of clinical nurse leaders. The response to the above question was complex and arose from the themes leading in real life, becoming future ready, power, people and perspective, owning the journey and connection culture.

To better understand how clinical nurse leadership can be developed, it was important to explore the impact of the role and what knowledge, skills or exposure nurses require to optimise success. Leading in real life is the encapsulation of three categories being leadership practice in context, organisational and systemic factors and quality of patient care and experience. Participants were very clear in communicating clinical nurse leaders require support and education to develop political astuteness and be equipped with the skills to navigate health and political landscapes. This was particularly highlighted by a focus group participant who noted the change in government and position on health policy and resulting impacts on clinical practice, are notably different in direction then nurses have previously been operating in, which has resulted in confusion. Knowledge of the influence of the political landscape and skills required to operate in this space, advocating for meaningful change and contributing to policy development were reinforced by participants as essential for developing nurse leaders in the clinical context. The need for political knowing was also strongly positioned in both the international and domestic literature as a requirement for nurse leader and health system success. Focus group participants views aligned with key findings in the literature review suggesting nurses require aptitude in navigating political and policy concerns to maintain currency with advancements in healthcare and society (Roux & Halstead, 2018) and the need to build nurse leader capacity to navigate these changes (Taylor & Webster-Henderson, 2017).

Intentional exposure to these concepts equips clinical nurse leaders with the knowledge and insights to understand how decisions in health are made. In relation to clinical nurse leader development, focus group participants linked this to the ability to understand influences on new developments and shaping of nursing in the future. There was consideration by the focus group participants of the organisational and systemic factors which contribute to the viability of an in-house leadership development programme for clinical nurse leaders. There was a strong rhetoric that funding implications, organisational priorities and strategic intent and resourcing requirements significantly influence the viability of such a programme. Participants voiced viability could be established through organisational prioritisation of developing leaders and strategic operalisation of nurses who have completed leadership development training.

Leadership in the practice context was a significant finding of the focus groups, with participants clearly articulating the need for nurse leadership in the clinical context. Multiple participants referenced the theme 'every nurse as a leader'. This was linked to leading patient care, leading conversations and leading in the practice area. It was highlighted this version of leadership is as essential as having designated leaders. The impact of nurse leaders in practice was identified in both positive and negative connotations. The influence of a good leader, demonstrated through having high standards that are clearly communicated and promoting staff accountability can influence and grow future leaders positively. Whereas negative leadership expressed through poor standards was considered a contributor to poor team performance.

The category of quality of patient experience was highly emphasised in the focus group discussions and considered critical in the context of clinical nurse leader capability. Participants identified that demonstration in practice of clinical nurse leadership is displayed through exhibiting professional confidence to challenge plans of care and advocate for patients and families. This ability is not considered to be the sole domain of designated senior nurses, but it is the clinically based informal leaders who are heralded as the defining influencers of patient care and experience. Participants identified this positions nursing leadership as a force for change through progressing patient care and outcome advancements. This aligned with literature review findings,

including the position of Chávez and Yoder (2015) who stated health care quality is largely dependent on clinical leadership from those delivering care.

The second theme is becoming future ready which is a representation of two categories, leadership development pathways and learning through experience. There was a lot of uncertainty related to identifying an optimal programme for developing nurse leadership. There were two pathways identified by the focus group participants as options, tertiary study or an in-house programme. The focus group participants proposed the main benefit of tertiary programmes for leadership development was the depth of learning provided through academic assignments. The drawback associated with this approach was the generalised nature of the learning being theoretical and not contextualised. Participants emphasised the value associated with an in-house programme is an internal space for staff to grow, reflect and engage in conversations about leadership in context. A secondary benefit identified by the focus group participants was that an in-house programme provided a practical real-world step in leadership development which brings general leadership theory into applicable context.

The varied responses of benefits and drawback discussed by participants was consistent with the literature review findings, which also had advocates for both approaches. Mahoney (2001) advocates for advanced degrees for developing leadership development. Whereas Guibert-Lacasa and Vazquez-Calatayud (2022) whilst exploring the optimal in-house approach found it is the learning content and delivery modality that are essential for clinical nurse leadership development. However, the focus group responses indicate more strongly an in-house approach is the preferred mechanism of education as it offers multiple benefits which translate to the practice environment. This correlates with the quantitative findings of this study which shows statistically significant improvements in five of the eight leadership competencies from programme participants surveyed. An individualised approach to the format of a structured leadership development programme was viewed as optimal. It is clearly evidenced by the participants responses some version is required, but the 'one size fits all' approach was deemed as no longer fit for purpose. There is a preference for more consideration of developing a programme that can be varied in terms of time commitment and structure.

Focus group participants provided varied responses for what they considered appropriate content for a leadership development programme for point of care nurses. Leadership styles, behaviours, communication, finance, key performance indicators, team dynamics, quality, health and safety were some of the identified necessary components, but there were apparent challenges considering the learning content that should be prioritised for clinical nurse leaders. The responses tended to be from the perspective of what the focus group participants felt were necessary to know when stepping into a designated senior nurse leader role rather than as required of clinical nurse leaders. Their perspective aligns with current literature which evidences the frequent conflation of management and leadership. It was agreed that the acquisition of new concepts must be contextualised within and supported by the individual nurse's inherent identity and capability.

Linking to organisational and systemic factors in theme one, it was identified content needs to develop participants understanding of rationales contributing to higher decision making. The identified learning content was very operationally focussed whereas contemporary literature explored within this study state these objectives should not be the priority of leadership development. But rather, learning is better placed focussing on interpersonal competence and augmented with leadership theory and reflective practice. It does concur however that learning needs to be contextualised to the individuals experience. Learning about equity is a vital component of in an in-house programme from the perspective of the focus group participants through providing a space for reflection and translation to practice as learning is anchored to the practice context. Findings from the programme participants surveys corroborate the opportunity to learn and apply equity competencies through an in-house programme as beneficial as this scored one of the highest statistically significant findings pre-/post-programme.

Learning through experience incorporates practical application of leadership capabilities and observed behaviours. Consideration of the influence of focused education on becoming an effective leader is required according to the participants. Completing quality projects as a component of a leadership development programme was considered to support proficiency in leadership competencies, including

communication, team navigation and change processes. Conversely, some focus group participants stipulated this type of project can be a deterrent for nurses engaging in leadership development programmes. An individual's leadership development was frequently associated with observing leadership in others. This learning was often linked to observing and experiencing sub-optimal leadership. Opportunities to apply leadership learning in practice, whether on the clinical floor or in partnership with a designated leader provides context for the learning according to participants. This also provides opportunities for feedback based on performance to further augment ongoing development.

The third theme, power, people and perspective is the culmination of two categories from the focus group being barriers and challenges to leadership and gender culture and equity. Challenges related to clinical nurse leadership were linked to the previously discussed categories, quality of patient care and experience and leadership practice in context. Multiple participants identified the apprehension experienced by point of care nurses when required to assume leadership roles in complex patient scenarios and challenging situations that directly impact patient experience as a barrier to engagement with being a clinical nurse leader. Nurses not being empowered by designated leaders to have autonomy in making professional decisions was also voiced as disempowering to nurses and linked to potential for negative patient outcomes as a result.

Gender, equity and culture encapsulated very significant findings. A discourse that was identified within the focus groups was the relationship between health leadership positions and the perception that legitimacy as a leader requires the adoption of masculine traits. Leadership theories legitimising this perception have been discussed in the preceding literature review. These theories overtly reference leadership as an inherently masculine phenomenon, such as the Great Man Theory prominent in the 1840's as described by Spector (2015). Theory evolution continued to perpetuate this position and women less represented in leadership historically. A quote from a participant in the focus group evidences this is still the lived experience for some women in health, stating they observe nurses displaying male mannerisms and behaviours to survive. Senior nurse leaders also noted they observe males being promoted quicker.

Workforce demographics and limited understanding of the nature and significance of Te Tiriti o Waitangi were all considered significant to a lack of uptake and application in practice of equity informed care. One focus group participant stated they had held an assumption that partnership and individualised care was an intrinsic trait of all nurses whilst another questioned how healthcare organisations can state they have equity as no one understands what that is. A recurrent theme from focus group participants was the requirement to explain equity in a way that nurses understand, the implication being that this does not happen currently, therefore contributing to decreased understanding of the concept. Further to this was a statement from a participant stating they do not feel overly competent with understanding equity themselves.

The literature review provided evidence for the imperative to address health equity for the people of Aotearoa-NZ from a legislative and professional perspective. Strategic documents, including Te Mauri o Rongo the New Zealand Heath Charter and professional documents such as the Nursing Council of New Zealand Standards of Competence outline the need for nurses to advocate, promote, lead and deliver equity focussed care. While legislative and professional expectations regarding nurses understanding and implementation of the principles of Te Tiriti o Waitangi are clearly articulated, what does not appear as apparent is the understanding of how these principles are applied in practice across all levels of nursing. This gap is further evidenced by the responses from senior nurses, identifying a deficit in the knowledge, understanding and implementation of Te Tiriti o Waitangi informed, and equity focussed health care service and nursing practice.

When asked how an in-house programme can contribute to nurse leaders understanding of equity and Te Tiriti o Waitangi, a challenge identified from the focus groups was workforce demographics. It was identified the blended nature of the current nursing workforce presents significant challenges to the delivery of healthcare services grounded in the principles of Te Tiriti o Waitangi. This was attributed to the consideration that a substantial proportion of the workforce are internationally trained nurses, many of whom have had limited exposure to Te Tiriti and its application within the Aotearoa-NZ healthcare context. This demographic shift presents unprecedented

challenges for nurse leaders, both in designated leadership roles and in clinical practice, who are now tasked with fostering an understanding of Aotearoa-NZ's unique bicultural context. It was proposed by a focus group participant that it is imperative nurse leaders' model culturally responsive practice that supports new to Aotearoa-NZ nurses understanding and appreciation of this unique context, recognising it as a foundational strength of nursing practice rather than perceiving it as a barrier or challenge to nursing practice.

Nurse leaders participating in the focus groups perceived that their capacity to implement equitable care and service delivery was constrained by structural and organisational barriers that limited their decision-making authority. The prioritisation, or not, by managers in the clinical space was identified as a third aspect which influenced equitable care. Participants identified, at times performance indicators, such as patient flow, are prioritised as these are what the managers performance is being measured against. Therefore, consideration of what contributes to equity driven care is minimised. It was proposed within the focus group that this shift in priorities, driven by the changing landscape of health, necessitates the designated leaders to empower clinical nurse leaders to authentically engage with an equity focussed lens in clinical practice.

The theme, owning the journey, emerged from two categories, leadership identity and self- perception and motivation, readiness and personal growth. These categories were very closely linked with leadership identity being very strongly related to concepts, such as 'born to be a leader' and 'nature over nurture'. It was posed that often nurses do not view themselves as leaders and the benefit of a leadership development programme is to support the nurse to lead in place on the clinical floor, utilising their inherent abilities and developing their confidence that ultimately leads to improved patient experience. It was demonstrated in the literature review that historical leadership theories where founded on the assumption that certain inherited traits translated to leadership ability, promoting the idea of 'born to be a leader' (Spector, 2015). More recent investigation from academics proposes this is no longer the correct assumption, as leadership aptitude can be cultivated through the acquisition of new skills, knowledge and practice (Mahoney, 2001). Self-awareness was recognised by

some of the focus group as a component in the development of leadership identity and competency. It was proposed by some that nurses should engage in reflective inquiry, with the intent of fostering critical thinking about the nature of leadership, the distinctions between effective and ineffective leadership and the strategies through which they can enhance their leadership competencies and pursue personal growth in this domain. Interestingly, the literature also emphasised a requirement for developing nurse leaders to engage with self-reflective activities, but from a more comprehensive position. This included prioritising the exploration of the impact of one's culture on professional knowing and leadership practice, as well as environmental influences. Not only exploring how these influence the nurse's enactment of leadership, but also how the culture of the organisation shapes them in return (Nikpour et al., 2022).

There was a strong rhetoric from the participants of the focus group that identifying readiness to lead was often what they themselves did as senior nurses, recognising talent in nurses and 'tapping them on the shoulder'. This was linked to the above concept where nurses do not see themselves as leaders, but there was no reference to clinical nurse leaders self-identifying as wanting to develop in this space. However, the importance of not encouraging those who do not wish to be leaders was articulated, as the result of this can be detrimental to team functionality. It was also identified that leaders are often ill-equipped when stepping into leadership roles, with learning occurring as a situational response rather than in an intentional and structured way. Focus group participants identified this approach was not acceptable and there should be an expectation that if proficient leaders are required, then there is an obligation to support this. This opinion is reflected in the literature which advocates for intentional, strategic investment in structured mechanisms in Aotearoa-NZ for leadership development (Weston, 2024) as historically, political developments have precipitated chronic underinvestment preparing nurses for leadership roles resulting in ad hoc appointment (Donovan et al., 2012).

Participants perceived the success of a leadership development programme for clinical nurses is evidenced by the presence of nurses leading at the point of care through clinical practice and area quality initiatives. Succession preparedness was also identified as an indicator of programme success, reflected in a workforce that is capable and

equipped to assume designated senior roles. Literature review findings corroborate this position, with studies identifying nurses feel unprepared to step into formal leadership roles through lack of education and professional development related to leadership competencies (Daly & Jackson, 2021).

The fifth theme identified in this study is connection culture which represented role models, mentorship and influence. Several of the focus group participants had previously been mentors for the leadership development programme under investigation. They identified a feeling of personal and professional validation in sharing their journey on leadership and the professional role that they were in. Mentoring presented an opportunity for the mentor to reflect on their own growth and pathways, contribute to others development and demonstrate positive role modelling. This was summed up through identification of this relationship being mutually beneficial, with both parties gaining something from the interaction, reinforcing shared learning and professional growth.

The group were in agreement there are some challenging aspects associated with being a mentor. These included being intentional about the use of time to ensure mentees were exposed to varying aspects of leadership. This required intentionality on behalf of the mentor to ensure the time was spent constructively. A consideration was also the mentees level of engagement and interest with the activities the leaders was exposing them to on the day. Trust was also an important consideration for the mentors, identifying what was appropriate to share in these experiences and establishing an understanding of confidentiality with the mentor was a concern for the mentors. Whilst benefits for the mentee where clearly evident in literature as an adjunct to leadership development, the challenges varied between the literature and the focus group participants. The investment of time and mentor mentee mismatch was congruent, but the consideration of trust was not prevalent in the literature explored. Further to this, the literature did not strongly emphasis the personal satisfaction a mentor can attribute to supporting a nurses professional and leadership journey.

There was a connection between observing the leadership of others being a significant influence on a developing nurse leader's understanding of the concept. Relating personal experiences and exposure to different leadership approaches has the ability to positively or negatively be reflected in the learners developing leadership competency. Overall, focus group participants perceived exposure to leadership practices within an in-house leadership development programme as highly valuable. However, the sustainability of such initiatives may be limited by resource constraints, including financial costs and workforce capacity.

What was notably not discussed by focus group participants was the professional, strategic and legislative requirement of all nurses to demonstrate leadership. The documents discussed within the literature review including the Nursing Council of New Zealand standards of competence (Nursing Council of New Zealand, 2024b), Pae Ora (Healthy Futures Act) 2022 (Parlimentary Counsel Office, 2022), Te Mauri o Rongo The New Zealand Health Charter (Ministry of Health, 2022) and Te Tiriti o Waitangi (Came et al., 2021) and their relationship to professional practice as a nurse and in particular the responsibility to demonstrate leadership competence, were not acknowledged through any of the focus groups. This may be indicative of this aspect not naturally coming into the conversations had or a need to ensure all nurses at every level are provided support to develop their knowledge and application of the professional and legislative requirements in a practical way rather than strategic.

Understanding how clinical nurse leadership is developed from the perspective of nurses in designated senior roles is complex, multifaceted and requires further investigation. It is evident that effective clinical leadership is essential for shaping patient outcomes, experience and driving organisational change. Key themes such as leading in real life, becoming future ready and connection culture reflect this complexity. There is strong support for leadership development that is intentional and contextualised with a preference for an in-house programme that is responsive to clinical realities and organisational needs. While focus group participants identified a range of operational topics they felt were important in a leadership programme, the literature reviewed within this study indicates that leadership development should centre on interpersonal competence, self-awareness, equity and reflective practice.

Barriers such as gendered expectations, organisation constraints and a lack of understanding around Te Tiriti o Waitangi and equity informed care significantly impact readiness and conduct of clinical nurse leaders. Despite the high value placed on in-house programmes, challenges around sustainability and strategic alignment remain. Addressing this gap is vital to ensure that leadership development is not only effective but also aligned with national health priorities and professional expectations.

6.1.2 What is the impact of the early leadership development programme on participants perceptions of their own leadership competence?

Structured and intentional development of clinical nurse leaders is a necessity for advancing patient outcomes and experience, as well as health system functionality. The impact of an in-house programme is significant on clinical nurse leaders' confidence as evidenced by the response to this question. Quantitative data comparing programme participants self-assessed leadership competency prior to and directly after completing a leadership development programme for point of care registered nurses demonstrates the impact clearly.

Participants were asked to rate their overall confidence in their current leadership ability, specifically leadership knowledge, pre- and post-completing the programme. There was a small increase in participants leadership knowledge after the intervention with a P-value of 0.05. When asked to self-assess their confidence in their ability in leadership practice pre- and post-programme, participant results demonstrated a non-statistically different (P=0.40) mean difference of 0. The mean difference of pre and post results respectively being 0.67 and 0.10 demonstrates participants self-identified greater improvement in their leadership knowledge then in their leadership practice post the programme.

Alongside these differences in overall confidence in their leadership ability in knowledge and practice, the eight survey questions assessing confidence in specific learning content pre- and post-completing the programme identified contrasting results, with five questions demonstrating significant statistical improvements. Participants responses indicated confidence in understanding of relationship of

knowing self, cultural identity and leadership and confidence in understanding of health leadership in equitable healthcare delivery, as the two highest ranked improvements in confidence pre- and post-programme. With a P value of 0.02, participants identified statistically significant improvements in their confidence in understanding of the relationship between knowing self, cultural identity and leadership. Likert scale responses demonstrated participants pre-intervention self-assessment of this competency as a rating of 3.58, indicating neither confident nor unconfident to confident. Post -intervention the mean Likert scale response was 4.25 indicating confident to very confident. The mean paired difference between these scores showed an averaged increase of participants confidence of 0.67.

These results clearly demonstrate focussed learning content and experiences related to self and extending them to consider them in a leadership context was successful for learner engagement. This aligns with literature reviewed within this study, identifying exploration of cultural identity and relationship to leadership competencies is a necessity in today's multi-cultural world (Northouse, 2016). Literature suggest nurses must first develop self-awareness before engaging with leadership learning (Nikpour et al., 2022), engaging in cultural humility and safety for Indigenous peoples (Marcellus, 2018) particularly in light of the unprecedented multi-cultural workforce blend in Aotearoa-NZ currently (Nursing Council of New Zealand, 2024a). As previously mentioned, when addressing the question "how is clinical nurse leadership developed from the perspective of those in designated senior nurse roles," self-awareness and critical reflection was not a strongly identified theme by senior nurses as essential for developing leaders.

Similarly, participants self-assessed their confidence in understanding of health leadership in equitable healthcare delivery pre-intervention as 3.17 signifying neither confident nor unconfident. Following completion of the programme the Likert scale averaged response was 4.08 indicating a response of confident to very confident. With a resulting P value also of 0.02 and a paired differences mean of 0.92 this was a statistically significant improvement. As demonstrated through the focus group findings, understanding and application of equity informed care is not an area some senior nurse leaders self-identify as confident in.

Literature explored within this study has positioned equity as a critical professional and legal priority for all nurses, informed by Te Tiriti o Waitangi principles (Came et al., 2021) and intentional leadership development initiatives for point of care nurses is essential for service improvement and fundamental health quality improvements (Chávez & Yoder, 2015) particularly when the priority is equitable service provision (Nikpour et al., 2022).

Confidence in development of skills for challenging conversations had the lowest pre-intervention Likert confidence ranking of 2.83, indicating unconfident to neither confident nor unconfident. With a P value of 0.10 this competency was the second highest statistically significant result. The averaged Likert scale post-intervention showed significant improvement in this competency with a result of 3.83. Though this response represented neither confident nor unconfident to confident, the paired difference mean was 1.00 representing the highest self-assessed improvement ranking of all eight learning competencies. It was discussed within the focus groups that the participants felt one of the challenges related to stepping into being a clinical nurse leader was managing complex situations, requiring complex conversation and navigation skills to resolve. It is clear from the advancement in programme participant confidence there is huge benefit in educational interventions supporting aptitude in navigation challenging situations. Findings from the literature supports this finding, stating leadership development for nurses focussing on communication equips nurses with the necessary knowledge and skills to address complex situations and problem solve efficiently and effectively (Mahoney, 2001).

The remaining two statistically significant results were related to leadership skills, attributes and leadership styles. When ranking their pre-intervention confidence in knowledge of leadership skills and attributes for effective leadership participants averaged Likert score was 3.33, which increased to 3.83 post-intervention. The resulting P value of 0.41 indicated a statistically reliable effect. Supported by statistical evidence with a P value of 0.05, confidence in understanding different leadership styles was ranked as the fifth competency demonstrating a significant difference. Focus group participants response also evidence leadership knowledge as a central

component of a how nurses learn leadership, referencing supporting nurses to understand leadership approaches and how they align with themselves was an important aspect of development. Learning opportunities related to leadership theories and styles was also reference in literature as essential components of a leadership development programme. Noting that nurses will gain the most from these topics when they are able to contextualise them to their own needs and environments (Makepeace, 2023).

Pre- and post-confidence in understanding different leadership styles was the lowest of the statistically significant scores with a P value of 0.45. When considered in the context of the lower scoring of participants confidence in awareness of their own leadership style it can be assumed that understanding of the theoretical context of leadership styles was enhanced with the programme intervention but transferring the knowledge to their context and identifying what components align was more challenging for participants. This result is evidenced in literature which identifies learners will gain the most when able to align learning with their own needs and context (Makepeace, 2023). It is proposed in the literature that learning about leadership theories needs to be done in partnership with practical application to strengthen the learning and that this may need a minimum length of one year to achieve (Conner et al., 2023).

The remaining three learning competencies assessed where confidence in understanding of communication styles related to leadership, confidence in experience in health leadership role and confidence in awareness of own leadership style. None of the self-assessed Likert scale ratings for these competencies provide evidence of a statistically significant effect for the competencies. The lower ranking of confidence in understanding of communication styles related to leadership is interesting when considering the previously reviewed results of participants confidence in skills related to navigating challenging conversation was one of the higher ranked learnings. Given the interrelatedness of these to concepts, it could be presumed both would show equal improvements post-programme. Given that this has not been demonstrated in the results, the learning activities may require revision to support transferability of knowledge to learner context. Literature explored in this study emphasis the need for

nurses to demonstrate strong communication skills as leaders given the complex and fast-paced environment that is inherent in health institutions (Major, 2019).

The lower scoring of participants confidence in being in a health leadership role aligns with focus group findings where senior nurses identified often nurse do not see themselves as leaders or operating in a leadership space in the clinical context. There were very strong connections within literature that align leadership as a responsibility of all nurses, particularly those directly engaged in clinical care (Major, 2019). Literature refers to the requirement for programmes to be intentionally structured to enhance competence and confidence through multimodal approaches which anchor learning in daily practice (Guibert-Lacasa & Vazquez-Calatayud, 2022). The lower ranking of this competency outcome could be related to the short-term duration of the programme and confidence in a health leadership role may become more prominent after a longer period of time of application of learning to practice. Once again, the lower ranking of post-programme confidence in awareness of own leadership style could be attributed to the short-term context of the programme and responses may change if reassessed at longer interval post-programme. As previously identified when reviewing the scores for participant confidence in understanding leadership styles, the transferability of this concepts may require a longer period of application in practice to develop this awareness.

The apparent contradiction between participants perceptions of minimal improvement in their overall confidence in their leadership ability, knowledge and practice and the statistically significant results of five of the eight specific learning concepts may reflect a lack of awareness and understanding among participants about what constitutes leadership knowledge and practice. Specifically, that the programmes' learning content is itself made up of these key components. It may also reflect the learning activities associated with these components not supporting learner engagement and understanding of them. The literature review demonstrated nurses who have participated in structured and experiential learning and development are better equipped to step into leadership (Bleich 2016) and this position is clearly reflected in the programme participants survey results. Participant responses demonstrate the

successful and significant impact structured leadership development programmes designed for point-of care-nurses has on confidence of individuals.

Part 2: A journey of leadership

Why do healthcare organisations need to invest in developing clinical nurse leaders? Simply, it is because they are uniquely positioned to influence care planning, engage authentically with patient and whanau and advocate for equity focussed care and services that hold the patient at the centre. Political and legislative shifts, globalisation and organisational agendas, whether intentionally or not, have shifted the focus of care from the patient to performance targets. When a patient is made voiceless from the system, clinical nurse leaders are positioned to stand beside the patient and help their voice be heard. Competency in this aspect of advocacy cannot be left to chance. It needs to be nurtured and developed in a way that encourages the nurse to authentically lead. From the founding document of Aotearoa-NZ to the current professional mandates, nurses are obligated to demonstrate leadership in practice. For this to occur, health organisations are required to prioritise and include into strategic planning, intentional leadership development for point of care nurses. Nurses need to be equipped with the necessary knowledge and skills to navigate professional responsibilities, organisational strategy and governmental legislation. Leadership development approaches for nurses at the point of care is complex and multifaceted, it is a journey of ongoing development and reflection. It needs to occur in consideration of an individual's inherent sense of self, knowing and identity and provide a supportive structure that enables learning to scaffold on these factors.

It is apparent within the findings of this study, intentional leadership development for point of care nurses is essential and instrumental for influencing quality patient care. A structured in-house leadership programme is viewed as the preferred mechanism for this to occur from the perspective of designated nurse leaders but more importantly, impactful from the perspective of the learners. Findings of this study have been translated into a conceptual model using the analogy of a tree in Figure 3. The tree represents the nurse, growing, adaptable and deeply rooted. These roots, the foundation, symbolise the intrinsic and extrinsic factors that contribute to the foundations of the nurse. Culture, values, life experiences, pre-registration training, practice experience and professional development are the foundational concepts that clinical nurse leadership development is built upon. The individual's strength in

awareness and understanding of the influence of these factors will influence how the nurse leads. Surrounding the tree are the winds that shape the direction the tree grows in, that encapsulates the professional and personal influences. The wind represents the changeability of the supports that shape the growth of the nurse, the concepts remaining consistent, but the shape and direction they take changing at times. Te Tiriti o Waitangi, organisational strategy, professional body guidance, role models and mentors are professional influences and are critical elements for setting standards, promoting excellence and empowering nurse leaders. Leadership development programmes, leadership embodiment and reflective practice are the personal influencers the nurse themselves can adopt to support their development. Opportunities to step into leadership spaces, demonstrating leadership competencies and capabilities supports the translation of skill and knowledge into practice. The trunk on the tree is growing strong and in an upward direction as the external supports provide direction. The many branches on the tree symbolise the multitude of leadership skills, competencies and behaviours the nurse has developed and are able to implement in practice.

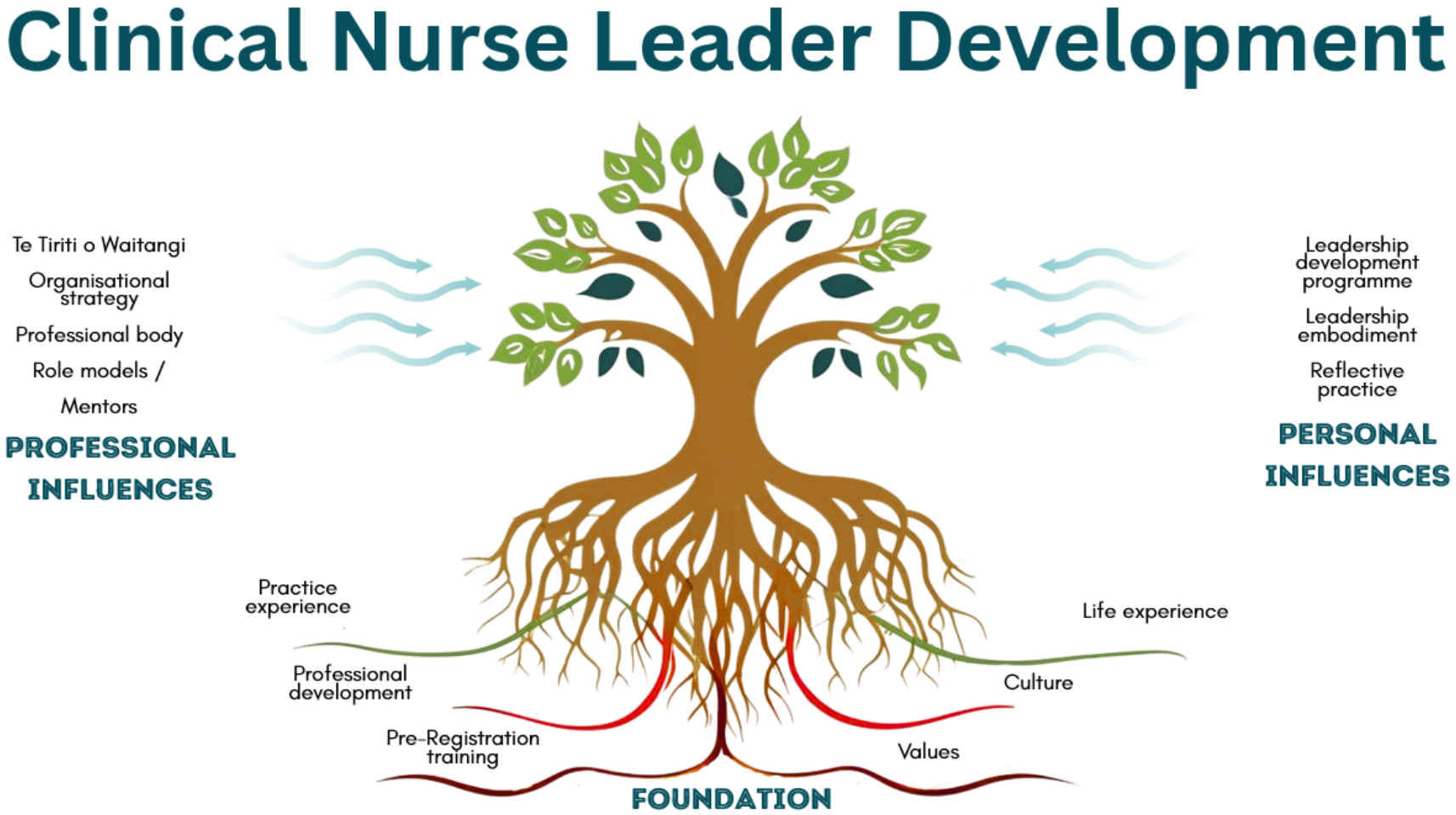


Figure 3: Clinical Nurse Leader Development

6.2 Foundation

The foundation, symbolised by the tree roots in the conceptual image, represents the underlying influences that shape an individual's identity and sense of self. An individuals personal and professional worldview, along with their lived experiences forms the basis for which all leadership learning and development is interpreted and constructed. For nurses, engaging in leadership development requires dedicated time and structured opportunities to reflect on and explore their culture, values, life experiences, pre-registration training, professional development and practice experiences. This process of self-exploration is essential for fostering self-awareness that underpins meaningful and sustainable leadership growth.

6.3 Professional Influences

Nursing and nursing leadership are shaped by a dynamic interplay of professional influences that serve as both guiding frameworks and evolving forces within practice. Foundational to nursing in Aotearoa New Zealand is Te Tiriti o Waitangi, which underpins a commitment to equity, partnership and culturally responsive care. Alongside this, organisational strategies, the regulatory and aspirational guidance of professional bodies and the informal yet powerful influence of mentors and role models all contribute to shaping the way nurses think, lead and practice. As symbolised by the wind in the conceptual model, these influences are ever-present, yet their impact is not static; they are interpreted and expressed differently throughout contexts, political changes and professional body developments. As healthcare systems shift and societal expectations evolve, so too does the way these influences are enacted, requiring nurses to continuously reflect on and adapt their leadership in response to changing environments.

6.4 Personal Influences

A nurse's leadership development is deeply shaped by a convergence of personal influences that build upon the foundational and professional elements previously explored. Central to this are the intertwined concepts of structured leadership development programmes, embodied leadership and reflective practice. Together, these elements form a pathway through which nurses engage with leadership in a

meaningful and practice-oriented way. A formal leadership programme provides a structured environment for acquiring knowledge and skills, which are then applied within the nurse's clinical context. Through the process of embodiment, this learning moves beyond theory, becoming integrated into everyday practice and behaviours. Reflective practice serves as a critical tool in this process, allowing nurses to make sense of their experiences, deepen their self-awareness and refine their leadership capability over time. This integration of learning, practice and reflection enables nurses to grow as leaders in ways that are both personally authentic and professionally grounded.

Part 3: Limitations, conclusions and implications

6.5 Study limitations

Limitations relevant in this study can be identified as internal and external limitations. Internal limitations are related to the considerations within the research process itself such as the design and execution. External limitations are factors affecting how the findings of the study are applied or perceived outside the research context.

6.5.1 Internal limitations

Internal limitations relating to mixed-methods research can arise from methodological imbalance when either qualitative or quantitative methods are emphasised over the other and incongruence between data sets. The result can be an incomplete capture of the phenomenon under investigation. Challenges may also emerge when integrating qualitative and quantitative data, given the fundamentally different methodological assumptions and analytical approaches underlying each research tradition. The small-scale nature of this study can also impact data analysis. As per Talikan and Dammang (2024) paired sample t-test sensitivity can be affected by small sample sizes. This analytical complexity can lead to challenges identifying meaningful findings across the methodologies.

6.5.2 External limitations

The participant sample size was limited due to the scope of this academic study and associated timeline. The small sample size of participants presents limitations as to the generalisability of the results as findings are often context specific therefore may not be applicable in other contexts or broader populations. Constraints associated with scale and scope may also present limitations in the capture and description of complex social phenomena. Smaller studies can present challenges related to the replicability of findings as these are generated from lower participant numbers and data points.

6.6 Conclusions

The Aotearoa-NZ health system is currently undergoing a significant regulatory transformation which is occurring in parallel with the evolution of professional nursing practice regulation. Within this context, nursing is strategically placed to advocate for patients, whānau and the wider community within this change process. Aotearoa-NZ's unique bi-cultural foundation, underpinned by its founding document Te Tiriti o Waitangi articulates a defined responsibility of all health professionals to honour its principles. Central to this is the prioritisation of advancing the health status of tangata whenua, Māori.

Though they hold no formal authority within organisational hierarchies, clinical nurse leaders are uniquely positioned to influence equity focussed clinical care, patient experience, team functionality and professional advancements. Findings from this study clearly demonstrates a clear position of senior nurse leaders that every nurse is a leader, enacted daily clinical practice. Furthermore, it evidences the substantial positive impact structured professional development has on self-perceived confidence of clinical nurse leaders. Despite extensive scholarly inquiry, a universally accepted definition of leadership remains elusive. The increasing globalisation and multicultural context of health, in both employee and patient demographics, necessitates a conceptualisation of leadership that accounts for cultural diversity. This encapsulates the cultural identity of the leaders as well as that of team members and health environment, each bringing distinct expectations and experiences of leadership. This complexity presents challenges in cultivating nurses' capacity and confidence to lead.

This research has demonstrated leadership development initiatives for clinical nurse leaders are most effective when built on the acknowledgement of cultural influence. It marks a shift from traditional theory-based approaches towards models that integrate emotional and relational intelligence, equity and cultural competence. This approach has been positively received by the programme participants, evidenced through the significant improvement in self-assessed confidence in leadership competencies. Consequently, leadership development for clinical nurses must be a strategic organisational priority. This imperative is further reinforced by the evolving

scope and competency requirements for registered nurses in Aotearoa-NZ, which explicitly identifies leadership competence as a core component of registration.

6.7 Implications for education practice

This study exploring the design and evaluation of an early leadership development programme offers several valuable implications for educational practice, even in context of the limited scale. These implications can inform both the content and delivery of professional development interventions in healthcare settings. Most significantly of these is the consideration of an evidence informed programme design. Findings from this study can guide the creation of tailored leadership curricula that addresses the specific needs and contexts of point of care nurses. Nurse educators and curriculum developers can incorporate skills and competencies that participants identified as most relevant.

A second implication for education practice is learner centred approaches. Insights gained through data analysis can demonstrate how nurses engage with and perceive leadership development activities. Educators can use this knowledge to refine pedagogical approaches, incorporating experiential, reflective or peer-supported learning to increase engagement and impact. This study has highlighted enablers and barriers to the delivery and engagement with a leadership development programme at the associated tertiary hospital. Nurse educators and managers can use these findings to advocate for protected time, institutional support, resourcing and / or policy change to foster the intentional leadership development for point of care nurses.

6.8 Policy implications

The policy implications informed by the findings of this study can be significant, particularly when aligned with broader workforce development and healthcare quality goals. While there may be limitations on the generalisability of the findings, they can be used to inform local, organisational and strategic level policies. Primarily, findings support investment in localised leadership capability building with allocation of funding for leadership development programmes as part of workforce planning. Healthcare employers are able to embed leadership development for point of care

nurses in strategic plans. Further to this is the ability to recognise leadership as a core component of nursing practice at the clinical level. As demonstrated in the findings of this study, nurses may report increased confidence and knowledge in leadership competency. Policy changes have the ability to position leadership development as a core component of professional practice, supporting policies that redefine leadership as relevant to all levels of nursing, not just designated senior roles. Policies that support the strengthening leadership pipelines in healthcare organisations may enhance long-term leadership readiness, retention and quality. Early leadership development may contribute to succession planning and retention policies.

6.9 Future research

While a study such as this provides valuable insights it also highlights opportunities for further related research. As noted in the limitations, the nature of this study being small scale may limit the generalisability of the findings. There is opportunity for a larger scale study which would be beneficial in validating the findings and generalisability of this research. Larger quantitative samples will strengthen statistical reliability of outcomes and larger quantitative data will possibly reveal other significant social phenomena that was not captured with the smaller data sample included in this study.

There is opportunity to conduct longitudinal research to assess the long-term impact of the programme interventions and application of learning to practice over time. Observing the practice application over time can offer valuable insights for how experience and confidence with leadership competencies develops and is manifests in practice. Observing the sustained influence of early leadership development on career progression, retention and leadership performance can offer valuable insights for future training programmes. This can be done through engagement with programme participant managers to assess how programme learnings are manifesting post the programme. There is further opportunity to explore whether early leadership training leads to greater involvement in decision making or higher quality patient care over time. Exploring these from the perspectives of the programme participants, managers and patients has potential to significantly inform health strategy, organisational priorities and patient experience.

Other research opportunities are related to programme expansion and evaluation of pedagogical approaches. Expanding the leadership development programme delivery across multiple sites and health disciplines, concurrently studying the impact of the programme intervention in a broader context. This study has also raised questions about the most effective teaching and learning methods for delivering the leadership development programme. Further research comparing different educational approaches such as face to face, online, mentorship as well as the optimal length of time the intervention is delivered over, evaluating how learning methods influence knowledge retention, skill application and learner satisfaction would enhance learning approaches in broader contexts.

Appendices

Appendix 1: Insight programme outline

Appendix II: Ethics permission

Appendix III: Pre- and post-programme participant survey

Appendix I: Insight programme outline

Outline: Insight Day 1			
Topic	Knowing Self-Leading Self	Date	2024
Number	12	Time	0830 - 1600
Online Pre-Learning			
Prior to the session participants will complete the below online learning: ▪ Unconscious bias ▪ Emotional intelligence ▪ Personality assessment			
Programme Orientation			
Time	Topic	Activity	
0830	Welcome Facilitator introduction Housekeeping	Facilitator lead	
0840	Whānaungatanga	Full group activity	
0940	Programme overview Aims and learning outcomes Schedule for the day Ko Awatea Platform	Facilitator lead	
0950	Framework for Interaction	Small group discussion – what are the guiding principles participants agree on for conduct and interaction during the programme.	
1000	What do you want to get out of this programme?	Write down in workbook 3 goals you want to achieve by attending this programme. Everyone feeds back and facilitators write it on white board	
1015	Morning Tea		

Section 1			
Knowing Self to Lead Self			
Learning outcomes for this section			
By the end of this section, learners will be able to: • Identify and explore own cultural values, beliefs and traditions and how these may influence engagement with people from culturally diverse backgrounds • Identify and articulate relationship of cultural identity and how this may influence leadership approaches • Identify and articulate links between unconscious bias and professional responsibility			
Time	Learning content	Learning activities	Assessment activity
1030	Self-awareness	Small group discussion to answer PPT questions then feedback to wider group Reflect on own conflict biography. Individual reflection activity to write about a situation where they had a conflict with a colleague using the questions on the PPT	Formative – assess current understanding and knowledge Formative – assess current level of self-awareness related to contribution of values and cultural identity in conflict
1045	Worldviews	Worldviews are like snow globes talk	
1055	Values	Think, pair share – identify your values, small group discussion, the present main 1-3 from the small group to write on whiteboard	
1110	Cultural identity	Activity – write down the cultural values, beliefs and practices that are important to you	
1120	Bias	Trusted 10 Activity – individual activity with group discussion. Group activity – what types of bias do we see in healthcare and in leadership? Activity – The Drs son	
1145	Reflect on self-awareness scenario	With what has been learnt through the session, revisit the conflict you explored earlier. Can you identify the values, world view, cultural identity, bias influences on how this event unfolded	
1200	Lunch		

Section 2			
Emotional Intelligence			
Learning outcomes for this section			
By the end of this section, learners will be able to: • Articulate what emotional intelligence is • Develop understanding of own emotional intelligence and apply strategies to build on EI • Explain the relationship between emotional intelligence and effective communication			
1230	Energy reviver	Human paper, rock, scissors	
1240	What is it?	Watch video describing EI. Group discussion on understanding of EI	
1255	EI Components	Explain EI table, link to self-awareness and learning from morning session	
1305	EI and leadership	Linking EI and success indicators in leadership	
1315	EI in leadership	Small group activity, identifying positive and negative interactions with leaders, translate into qualities then back to EI components	Formative – establish a baseline of peoples understanding of observable traits and characteristics of EI
1330	How to develop your EI	Activity – active listening. Pairs exercise, debrief post, how did it feel? Activity – a vocabulary if feelings. Individual activity reflecting on a scenario where they had a strong emotional response to something, identify the emotions involved	Formative – assess people's current level of awareness of their ability to actively listen. Formative – assess people's current ability to identify and label their feelings
1345	Emotion to behaviour	Flow chart of 5 steps from emotion felt to behaviour expressed	
1400	Unhelpful thinking styles	Discuss table of unhelpful thinking styles	
1410	Help, there is a sabretooth tiger	Discussion of amygdala hijack. Link to EI, self-awareness and self-management concepts.	
1430	Afternoon tea		

Section 3			
Conversation Navigation			
Learning outcomes for this section			
By the end of this section, learners will be able to: • Identify enhancers and barriers to effective communication • Identify and demonstrate the use of de-escalation frameworks			
1445	Communicating (Also acts as an energy reviver activity)	Activity – Communication Pictures Discussion post – we think we are being clear from our positioning, relate to escalating conversations	
1500	Knowing self, EI & communicating	Discussion – linking 3 concepts to how we respond to situations	
1510	Steps to regulate our emotions	Discussion of 8 steps to regulate emotions before responding	
1520	Tools	Individual activity – Identify a conflict, use CIA or sphere of influence model to analyse. Small group discussion then feedback to wider group	Formative assessment of current understanding of response to a situation, emotional intelligence.
1535	Personality assessment model	Overview of model, group discussion on their place in the model and where they can see it in action for themselves	
1545	Summary of day	Around the room, 1 thing learnt	
Online Post-Learning			
Following the session participants will complete the below online learning: • Understanding bias • Cultural humility • Whakapuawai (to flourish) • Personalities typing • Communication Hub			

Outline: Insight Day 2			
Topic	Leading Others	Date	2024
Number	12	Time	0830 - 1600
Online Pre-Learning			
Prior to the session participants will complete the below online learning: • Common leadership styles			
Programme Orientation			
Time	Topic	Activity	
0830	Welcome Housekeeping	Facilitator lead	
0835	Whānaungatanga	Full group activity	
0850	Programme outline	Facilitator lead	
0855	Day 1 recap	Facilitator and group speaking	

Section 1			
Leadership – A theoretical Perspective			
Learning outcomes for this section			
By the end of this section, learners will be able to: • Explore and compare leadership and management definitions • Describe the theoretical underpinnings of leadership • Articulate the relationship between cultural context and leadership			
Time	Learning content	Learning activities	Assessment activity
0900	Leadership & management activity	Group to complete questionnaire	Formative – identify current understanding and beliefs of leadership & management
0910	Leadership & management worldviews	Leadership evolution overview	
0925	Cultural context	Aotearoa-NZ context, Te Tiriti o Waitangi obligations overview	
0940	Defining leadership	Overview of various leadership definitions	
1000	Ways of understanding	Outline of various interpretations of leadership	
1015	Morning tea		
1030	Survival at sea	Activity – Survival at Sea, small group activity then larger group discussion	Formative – assess current understanding and knowledge of group dynamics
1050	The 6 P's	6 P's that can provide a leadership construct	
1110	Leadership approaches	Various leadership approaches	
1120	Leader Characteristics	Identifying leadership characteristics	
1130	Defining management	Outline of management definition	
1140	Comparing Leadership & management	Different authors comparison of traits of leadership and management	
1155	Developing yourself	Professional development opportunities	
1200	Lunch		

Section 2			
Leadership in Context			
Learning outcomes for this section			
By the end of this section, learners will be able to: • Apply leadership theory to real-world contexts by identifying and analysing leadership traits and behaviours in global and local leaders • Demonstrate active engagement in collaborative and reflective exercises to deepen understanding of effective leadership			
1230	Global leaders	Group to review global leaders and identify leadership styles that apply	Formative – demonstrate current understanding of leadership traits
1300	Local leaders	Group to review local leaders and identify leadership styles that apply	Formative – demonstrate current understanding of leadership traits
1320	Individual leading	Individual reflective exercise – identify positive and negative experiences of leadership	
1350	Development of leadership in nursing	Areas to personally develop leadership abilities	
1415	Afternoon tea		

Section 3			
Equity			
Learning outcomes for this section			
By the end of this section, learners will be able to: • Demonstrate a critical understanding of equity in health • Apply equity-focused approaches to clinical practice and leadership			
1430	Understanding equity	Explore definition of equity, difference to equality, equity in health	
1440	Video – equity perspectives	Ministry of Health discussion of equity in health	
1450	Equity activity	Small group activity – discuss own understanding of equity, leader responsibilities, equity focussed approaches in clinical context, changes that could be implemented in clinical context	Formative – demonstrate current understanding of equity, relationship to leadership responsibilities and equity in the clinical context
1530	Rapua Te Ara Matua Equity Report	Discuss narrative of Māori life journey of health	

Section 4			
1540	Day 3 planning	Discuss mentor questions, expectations for the day	
1550	Summary of day	Around the room, 1 thing learnt	

Online Post-Learning

Following the session participants will complete the below online learning:

- Wayfinding leadership
- Leadership videos
- Māori cultural practices
- Improving health equity
- Rapua Te Ara Matua Equity Report

Outline: Insight Day 3			
Topic	Leadership in Practice	Date	2024
Number	12	Time	0830 - 1600
Programme Orientation			
Section 1			
Mentor Experience			
Learning outcomes for this section			
By the end of this section, learners will be able to: • Critically analyse diverse leadership and communication styles • Evaluate the integration of equity principles in health leadership and project implementation			
Time	Learning content	Learning activities	Assessment activity
0830	In Practice 4 hours	Observe mentor in practice – leadership styles, communications styles, leadership journey, equity in health context, health project in context	
1230	Lunch		
Section 2			
Mentor reflection			
Learning outcomes for this section			
By the end of this section, learners will be able to: • Reflect on leadership journeys and their impact on professional identity			
1300	Written reflection	Write a reflection of mentor experience	Summative – apply learnings to observed practice
1430	Debrief	Online first impressions debrief of mentor experience	
1500	Afternoon tea		
Section 3			
Self-Directed Learning			
Learning outcomes for this section			
By the end of this section, learners will be able to: • Develop a personalised and strategic career planning pathway			
1515	Career Pathway	Complete career pathway planning book	

Outline: Insight Day 4			
Topic	Leading Teams	Date	2024
Number	12	Time	0830 - 1600

Programme Orientation		
Time	Topic	Activity
0830	Welcome Housekeeping	Facilitator lead
0835	Whānaungatanga	Full group activity
0850	Programme outline	Facilitator lead
0855	Day 1, 2, 3 recap	Facilitator and group speaking

Section 1
Practice Experience Debrief
Learning outcomes for this section
By the end of this section, learners will be able to: - Compare and present diverse leadership traits and communication styles utilised by leaders in practice - Assess and present the application of equity principles in health leadership

Time	Learning content	Learning activities	Assessment activity
0900	Mentor experience debrief	Small group discussions of mentor experience and findings	
1000	Morning tea		
1015	Presentation Preparation	Small groups prepare prestation based off day 3 learning outcomes for mentor experience	
1200	Lunch		

Section 2			
Group Presentations			
Learning outcomes for this section			
By the end of this section, learners will be able to: - Compare and present diverse leadership traits and communication styles utilised by leaders in practice - Assess and present the application of equity principles in health leadership			
1230	Presentations	15-20 minute small group presentation with question time	Summative – Demonstrate understanding of leadership and cultural practice in health setting
1400	Afternoon tea		
Section 3			
Team Building			
Learning outcomes for this section			
By the end of this section, learners will be able to: - Demonstrate foundational leadership behaviours that support inclusive team culture - Enhance communication and collaboration skills - Reflect on personal leadership style in a team context			
1415	Building bridges	Team building activity – Build a bridge followed by debrief session	Summative – Demonstrate understanding of team dynamics
1545	Summary of programme	Full group wrap up	

Appendix II: Ethics approval letter

The University of Waikato
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Hamilton, New Zealand

Human Research Ethics Committee
Roger Moltzen
Telephone: +64021658119
Email:humanethics@waikato.ac.nz

THE UNIVERSITY OF WAIKATO
Te Whare Wānanga o Waikato

19 December 2023

Melanie Wilson
Te Huataki Waiora School of Health
DHECS
By email: Melanie.Wilson@waikatodhb.health.nz

Dear Melanie

HREC(Health)2023#36 : Exploring Design and Evaluation of a Health Leadership Programme for Health professionals at Te Whatu Ora - Waikato

Thank you for your constructive and considered responses to the Committee's feedback.

We are now pleased to provide formal approval for your project.

Please contact the Committee by email (humanethics@waikato.ac.nz) if you wish to make changes to your project as it unfolds, quoting your application number with your future correspondence. Any minor changes or additions to the approved research activities can be handled outside the monthly application cycle.

We wish you all the best with your research.

Regards,

Emeritus Professor Roger Moltzen MNZM
Chairperson
University of Waikato Human Research Ethics Committee

Appendix III: Pre- and post-programme participant survey

Registered Nurse Leadership Development Programme Survey (Before Programme)

Dear participant,

Thank you for completing this survey (1 of 2) as a part of the research exploring the design and application of a health leadership programme for health professionals at Te Whatu Ora Waikato. Your responses to the surveys [before (1) and after (2)] are important to inform the continuing development of the programme and future iterations.

We appreciate you taking this time to complete survey 1 (of 2) to tell us a little about your current understanding of leadership and your expectations of the leadership programme you are about to begin. Everything you say in all of the surveys is completely anonymous and cannot be connected to you in any way.

By completing this survey (1 of 2) you are consenting to your anonymous responses being included in the research data and any dissemination to the research community.

1. I have read the information provided in the Participant Information Sheet, and willingly agree to participate in this survey *

- ◯ Yes
- ◯ No

2. I consent to my answers being used in a research project anonymously and understand they will be published in a research thesis *

- ◯ Yes
- ◯ No

3. Please enter your identifier (Note: This is for matching to post evaluation purposes only) *

First initial of your mothers name, eg. M for Mary
Number of the house/apartment etc where you live, eg. 14
Identifier code = M14

This code ensures your responses are completely anonymous and the researcher will not be able to identify you

Demographic Information

4. What is your age *

5. What is your gender? *

- ◯ Woman
- ◯ Man
- ◯ Non-binary
- ◯ Prefer not to say

6. What is your ethnicity? *

Choose as many options as appropriate

- [ ] Māori
- [ ] Pacific
- [ ] European
- [ ] Asian
- [ ] Other

7. Please indicate the cluster your clinical practice belongs under *

- ◯ Emergency
- ◯ Medical
- ◯ Surgical
- ◯ Critical Care
- ◯ Woman's Health
- ◯ Children's Health
- ◯ Neonatal
- ◯ Public Health
- ◯ Primary Organisation
- ◯ Peri-operative
- ◯ Mental Health and Addiction Services

8. What is your highest education level? *

Choose as many options as appropriate

- [ ] Bachelor Degree
- [ ] Graduate Entry Master's Programme
- [ ] Post Graduate Certificate
- [ ] Post Graduate Diploma
- [ ] Masters

Pre Programme Evaluation

9. Why did you enrol in the Early Leadership Development Programme?
Choose as many *
Choose as appropriate

- [ ] Recommendation from manager
- [ ] Recommendation from colleague who has attended
- [ ] Wanting to advance career opportunities
- [ ] Other

10. Indicate your level of agreement around the clarity of the information provided about the programme prior to starting the programme *
Use the scroll bar at the bottom of the question box for more answer options

	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
Programme intent	○	○	○	○	○
Learning outcomes	○	○	○	○	○
Access to course materials	○	○	○	○	○
Expectations of participants	○	○	○	○	○

11. Indicate what your preferred learning style is *
Choose as many as appropriate

- [ ] Audio
- [ ] Visual
- [ ] Written
- [ ] Kinesthetic

12. Indicate your level of confidence in relation to self-directed learning activities *
Use the scroll bar at the bottom of the question box for more answer options

	Very Unconfident	Unconfident	Neutral	Confident	Very Confident
Ability to identify learning goals	○	○	○	○	○
Ability to complete learning packages	○	○	○	○	○
Ability to apply learning to practice	○	○	○	○	○

13. To what extent do you believe the in class study days, mentoring day and self reflective learning activities will support you practice? *

	Very Irrelevant	Irrelevant	Neutral	Relevant	Very Relevant
In class study days	○	○	○	○	○
Mentoring day	○	○	○	○	○
Self reflective learning activities	○	○	○	○	○

14. How easy do you find being able to integrate theoretical knowledge and skills into practice? *

Use the scroll bar at the bottom of the question box for more answer options

	Very Challenging	Challenging	Neither Challenging or Easy	Easy	Very Easy
Knowledge	○	○	○	○	○
Skills	○	○	○	○	○

15. What do you want to get out of this programme? *

16. How confident do you feel in your leadership knowledge and practice currently? *

Use the scroll bar at the bottom of the question box for more answer options

	Very Unconfident	Unconfident	Neither Unconfident or Confident	Confident	Very Confident
Leadership Knowledge	○	○	○	○	○
Leadership Practice	○	○	○	○	○

17. Please rate your confidence in the following areas *

Use the scroll bar at the bottom of the question box for more answer options

	Very Unconfident	Unconfident	Neither Unconfident or Confident	Confident	Very confident
Understanding of different leadership styles	○	○	○	○	○
Aware of own leadership style	○	○	○	○	○
Knowledge of leadership skills and attributes for effective healthcare leadership	○	○	○	○	○
Experience in a leadership role in health care services	○	○	○	○	○
Understanding of the role of leadership in delivering equitable healthcare services	○	○	○	○	○
Understanding of how communication style relates to leadership	○	○	○	○	○
Understanding of the relationship between knowing one's own cultural identity and leadership	○	○	○	○	○
Development of skills to address challenging conversations	○	○	○	○	○

18. Please add any additional thoughts you may have in regards to the start of your Early Leadership Development Programme. *

Registered Nurse Post Leadership Development Programme Survey (Post Programme)

Dear participant,

Thank you for completing the below survey (2 of 2) as a part of the research exploring the design and application of a health leadership programme for Registered Nurses at Health New Zealand Waikato. Your responses pre-programme and immediately following completion of the leadership programme are important to inform the continuing development of the programme and future iterations.

We appreciate you taking the time to complete this short and anonymous survey to inform of your reflection of the leadership development programme you have just completed. We can assure you that we will have no way of identifying you from what you enter here.

By completing this survey, you are consenting for the responses to be used as part of the study looking at the design and evaluation of a leadership programme.

1. I have read the information provided in the Participant Information Sheet, and willingly agree to participate in this survey *

- ◯ Yes
- ◯ No

2. I consent to my answers being used in a research project anonymously and understand they will be published in a research thesis *

- ◯ Yes
- ◯ No

3. Please enter your identifier - the same you used in the pre-survey (Note: This is for matching to post evaluation purposes only) *

First initial of your mothers name, eg. M for Mary
Number of the house/apartment etc where you live, eg. 14
Identifier code = M14

This code ensures your responses are completely anonymous and the researcher will not be able to identify you

Post Programme Evaluation

Programme Satisfaction

4. The programme content was relevant to my role as an emerging leader *

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
◯	◯	◯	◯	◯

5. The time spent with a leader in the organisation supported my understanding of leadership in practice *

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
◯	◯	◯	◯	◯

6. What aspects of the programme are challenging to integrate into clinical practice? *

Post Programme Evaluation

7. How confident do you feel in your leadership knowledge and practice after completing the early leadership development programme? *

Use the scroll bar at the bottom of the question box for more answer options

	Very Unconfident	Unconfident	Neither Unconfident or Confident	Confident	Very Confident
Leadership Knowledge	◯	◯	◯	◯	◯
Leadership Practice	◯	◯	◯	◯	◯

8. Please rate your confidence in the following areas after completing the early leadership development programme *

Use the scroll bar at the bottom of the question box for more answer options

	Very Unconfident	Unconfident	Neither Unconfident or Confident	Confident	Very confident
Understanding of different leadership styles	○	○	○	○	○
Aware of own leadership style	○	○	○	○	○
Knowledge of leadership skills and attributes for effective healthcare leadership	○	○	○	○	○
Experience in a leadership role in health care services	○	○	○	○	○
Understanding of the role of leadership in delivering equitable healthcare services	○	○	○	○	○
Understanding of how communication style relates to leadership	○	○	○	○	○
Understanding of the relationship between knowing one's own cultural identity and leadership	○	○	○	○	○
Development of skills to address challenging conversations	○	○	○	○	○

9. The leadership programme has enhanced my skills and abilities as a leader *

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
○	○	○	○	○

10. The leadership development programme provided me with the knowledge and tools to effectively lead in healthcare *

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Statement 2	○	○	○	○	○

11. I have been able to apply the knowledge and skills gained in my practice *

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
○	○	○	○	○

12. I have an improved ability to communicate and collaborate with patients, whānau, colleagues and stakeholders *

Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
○	○	○	○	○

13. What specific recommendations or changes do you have to enhance the programme for the future? *

14. Please share any additional thoughts or comments you may have in regards to the programme. *

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