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- *Assess the evidence for current practice*
- *Develop best practice in nursing management and leadership*
- *Examine the impact of policy developments*
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Results – what were the main findings?

Conclusion(s) – what are the main conclusions and implications for practice?

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EDITORIAL

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Killing us softly with their wrongs: Nursing academia's 'killer elite' continue unabated

In our combined 90+ years in nursing, we have published over 700 papers. Nothing, however, evoked responses like 'Academic nursing's killer elite'' (Thompson & Darbyshire, 2013). To say that we 'touched a nerve' is an understatement, but we understated the malignant narcissist, corporate psychopath and dimensions of the 'killer elite', and extend that discussion now. We received then and continue to receive, harrowing 'testimonies' (Hartin et al., 2020) from nurses describing, not linguistically sanitized 'incivility', but sustained bullying, gaslighting and corrosive narcissism by some senior academics who made their lives intolerable. The voluminous literature on nurse bullying, revealing only 'the tip of the iceberg' (Hartin et al., 2020, p. 1624), emphasizes this vital concern for service *and* education nurse managers. We ask whether nursing is any closer to addressing this problem today than it was in 2013.

Some who contacted us were junior academics; others were seasoned academics. All expressed frustration and anger that senior members of the world's preeminent 'caring profession' exhibited such malevolence and duplicity, not only with impunity, but often with tacit or expressed organisational support. There seems no typical demographic of the 'killer elite'. Some are high profile, celebrated nurses, while others rose without trace to their senior positions. Previous critics accused us of 'judgmentalism' and of 'finger pointing'. We certainly judge 'killer elite' behaviour as reprehensible and cannot fathom anyone concluding otherwise. We also admit to 'pointing a finger' as this *is* an editorial viewpoint. We are privileged to do this without fearing retribution. Few academics or managers can safely raise these issues in any forum or journal. We cannot solve these problems, but can continue to highlight them.

The danger of revealing identifying details was inherent in including direct examples from our correspondents' conversations and communications, so we created a composite vignette (Spalding & Phillips, 2007), with their expressed permission, highlighting common 'killer elite' behaviours and their effects:

> Thank you for saying what many of us cannot. I joined nursing academia so excited and enthusiastic, thinking this was my dream job. Now, unless I can escape to a non-nursing school I am getting out. I can take no more gaslighting, bullying, marginalisation, dishonesty, favouritism, narcissism, mediocrity and deviousness from my supposed 'leaders'. I thought that being hard-working and collegial, having integrity while valuing and trying to develop scholarship would be enough. I never imagined I needed to join our Head of School's cult and coterie of acolytes where sycophancy and constant adulation are the only 'qualities' valued. As my profile improved, collegiality and support stopped, as I was now viewed as 'competition' and ostracisation began. I was shouted at in research meetings for asking polite questions about one of their student's methods, undermined constantly (even told 'the University has a wonderful mental health support service' I should contact), saw MY PhD research presented at a conference by our Head as theirs and was 'dropped' from grant teams without discussion. I tried 'bridge-building', inviting them as co-author on some of my papers. This magically became all 'their work' and they were now 'the experts', being increasingly feted for their 'transformative, inspirational leadership'. I stopped and they've published nothing since. I transferred my PhD studies to another University and my supervisor has moved also. It is endemic and getting worse. The final straw was our Head and Professor of Nursing asking genuinely, what 'nursing caring' meant.
>
> The toxicity is becoming normalised. Confiding in colleagues, I know I am not alone, but they too stay silent as they know speaking out will mean the end of their jobs, if not careers. Academic nursing's myopic, obsessional, self-absorption, will ensure a one-way trip back to vocational training. 'Nursing Science' is now embarrassing. We research 'mindfulness' and 'wellness' trivia instead of important health issues. My research into [leading cause of death] was deemed 'not nursing research'. The opposition that colleagues and I faced in redesigning a curriculum uncovering nursing's hidden curriculum was immense. It was painful watching it being sabotaged and dismantled.
>
> One 'star' professor's bullying, harassment of young females and questionable research conduct was formally reported, but nothing was done until an investigative journalist became involved. The professor was quietly 'let go' and is now in a plum position elsewhere. The problem is never tackled, just moved

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> elsewhere. Yet nursing remains utterly tone-deaf to its behaviour while our notoriety as a toxic profession grows. I cannot happily encourage anyone to join the nursing academy. How can you? I am sick of the same old clinical 'Matron model', but in academia. What makes me angrier, is that I have allowed it to hijack my career, which is all but dead.

Nursing used to 'eat its young' (Darbyshire et al., 2019), but now cares little about the age or experience of those devoured and millennial nurses now view nursing academia more negatively than older nursing faculty (Kemplin et al., 2017). The gaslighting and self-aggrandizing narcissism of one correspondent's head of school finally became intolerable, but worse, the person was told by a university mandarin they 'were not in the mould of the modern nurse'. This clinically experienced, research-active, well-published nurse is in their early 50s. 'How did we get to this point?' is a question many ask, but which nursing seems unable or unwilling to answer. Crucially, this managerial 'killer elite' are *not a majority*, but when research suggests 45% of faculty experience bullying (Wunnenberg, 2020, p. 579), neither are they unicorns. We have highlighted notable exceptions of inspirational, compassionate, collegial *leaders* (Darbyshire & Thompson, 2014), but these beacons are overshadowed by a minority's collective toxicity.

Corporate psychopaths are poisonous to organisations and colleagues. They create workplaces riven by fear, conflict, bullying, unfair workloads, poor job satisfaction, rampant favouritism, toxic communication and decreased retention. Regardless of an impressive CV, a corporate psychopath will cost the organisation far more in financial and reputational costs than was spent attracting them. Research into the 'toxic triangle' (Magwenzi, 2018; Pelletier et al., 2019) has deepened understanding of how the 'killer elite' are enthroned and enabled. The triangle requires destructive leaders, complicit followers and a conducive environment, all readily available in academia and health services. Today's neoliberal university is the perfect petri dish for organisational sociopathy. It welcomed the 'killer elite' when managerial 'head kickers' were needed to impose restructuring, downsizing, casualization or other 'modernising', because corporate psychopaths are 'totally ruthless' and 'without empathy or conscience' (Boddy, 2011, p. 23). What is so difficult for nursing to even contemplate is that such toxicity may not be accidental, but fuelled by 'narcissism, alongside psychopathy and Machiavellianism' (Milosevic et al., 2020, p. 132). Narcissists project a perfect image to the outside world who cannot believe that anything disturbing could underlie such carefully confected 'dynamic nurse leader' personae.

Orwell's Manor Farm needed Squealer and the 9 pack dogs, so the second arm of the toxic triangle is the killer elite's coterie of followers. These 'acolytes' or 'opportunists' (Pelletier et al., 2019, p. 408) are co-opted as deputies to control and manipulate, becoming the killer elite's 'eyes and ears'. They are 'the susceptible circle' of followers who exhibit 'passivity, deference, and obedience, rather than constructive questioning and challenging of leaders in the face of unethical leader behavior' (Thoroughgood et al., 2012, p. 900). This 'toxic triangle' exacerbates the global nursing shortage in academia, yet most workplace psychopaths enjoy uninterrupted career progression. It is a black swan event when a manager's toxic behaviour costs them their job, power, status or registration.

Incoming US President Joe Biden declared at his inauguration that:

> I'm not joking when I say this: If you're ever working with me and I hear you treat another with disrespect, talking down to someone, I will fire you on the spot. On the spot. No ifs, ands, or buts,

Many in higher education and health services heard this and thought, 'if only'. The US president is fortunate that he can hire and fire 'at his pleasure', while most public-sector organisations have copious layers of inaction and ingrained protection for powerful bullies that render such demonstrable decency unimaginable.

We may ask, why do nurses experiencing toxic leadership not speak up? This is akin to asking why women experiencing domestic violence do not 'just leave' their abusers. Faculty do not challenge because they know this will exacerbate their situation for, 'If anyone should dare to challenge [the narcissist's] self-image of perfection, they will be met with viciousness and deceit' (Germain, 2017, p. 82). Malignant narcissists are most dangerous when confronted and their anger will provoke revenge. Collegial difference of opinion is not a challenge to be explored but a threat to be 'crushed with overwhelming force' (Magwenzi, 2018, p. 148). Add to this, the extreme improbability that a university would support a junior academic over their star leader. As one correspondent commented, 'Why not stay and fight? As an academic with no PhD, I felt I had no credibility and no power compared to them'.

It is hard to be optimistic that nursing will stop enabling and tolerating its 'killer elite'. There is little that less powerful colleagues can do and even less that university and service leaders or nursing's representative bodies seem prepared to do. HR responses are doomed to failure as corporate psychopaths do not respond to education, counselling or mediation, having neither the insight nor inclination to change. These measures simply become their 'home ground advantage' where shapeshifter bullies welcome new audiences to manipulate with their charm, intelligence, faux reasonableness and feigned victimhood. Without robust whistle-blower protections and until academic leaders stop hiring them and start to demonstrate that toxic behaviours will result in dismissal, little can change. Fox's admonition cannot be over-emphasized:

> Bullies don't change their spots unless they're faced with loss of prestige, livelihood, or income. Unless managers at the highest levels of the organization commit to putting a halt to bullying, bullies will always have a platform. (Fox, 2013, p. 19–20)

Nurse managers may recognize only some 'killer elite' toxicities in their organisations but every nurse manager will understand the

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umbrella scourges of bullying and malevolent politicking and their damaging effects on nursing and services. The forces that drive and sustain the 'killer elite' in education threaten health services just as ominously. Nurse managers can lead by 'Biden example', making it clear that they will challenge and call out 'killer elite' behaviours and bullying machinations wherever and whenever they are encountered. Confident, open managers will also make it clear to staff that they themselves are similarly accountable. In an honest, healthy organisation, nurse managers, like any cabin crew on an aircraft, not only 'allow' but expect *any* member of staff, regardless of role and status to challenge any of their actions, processes and behaviours that do not live up to their and their organisation's values. How long nursing's toxic minority 'killer elite' will enjoy their platform, is a question confronting every nurse leader and every nurse manager can play their part in ending this reign.

CONFLICT OF INTEREST

No author declares any conflict of interest in relation to any aspect of this paper.

ETHICAL APPROVAL

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Philip Darbyshire RN, PhD, Retired Professor[1]
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[1]*Philip Darbyshire Consulting Ltd, Adelaide, SA, Australia*
[2]*School of Nursing and Midwifery, Queen's University Belfast, Belfast, UK*
Email: David.Thompson@qub.ac.uk

Correspondence
Philip Darbyshire, PO Box 144, Highbury, SA 5089, Australia.
Email: pdcltd@me.com

ORCID

Philip Darbyshire https://orcid.org/0000-0002-6875-7144
David R. Thompson https://orcid.org/0000-0001-8518-6307

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ORIGINAL ARTICLE

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Nursing and midwifery workforce readiness during a global pandemic: A survey of the experience of one hospital group in the Republic of Ireland

Mary Ryder Ph.D, Assistant Professor[1,2] | Paul Gallagher MSc, Chief Director of Nursing[3] | Barbara Coughlan Ph.D, Associate Professor[1] | Phil Halligan Ph.D, Assistant Professor[1] | Suzanne Guerin Ph.D, Professor[4] | Michael Connolly PhD, Associate Professor[1]

[1]School of Nursing, Midwifery and Health Systems, University College Dublin, Dublin, Ireland

[2]Department of Nursing, St. Vincent's University Hospital, Dublin, Ireland

[3]Ireland East Hospital Group, Dublin, Ireland

[4]School of Psychology, University College Dublin, Dublin, Ireland

Correspondence
Dr. Mary Ryder, School of Nursing, Midwifery and Health Systems, University College Dublin, Dublin, Ireland.
Email: mary.ryder@ucd.ie

Abstract

Aim: To explore the mobilization of nurses/midwives in a designated hospital group in Ireland during a global pandemic.

Background: The recent global pandemic has resulted in the large-scale worldwide mobilization of registered nurses and midwives working in the acute care sector. There is a dearth of literature reporting the mobilization of this professional workforce.

Method: Mixed-methods design using an electronic survey and facilitated discussion across one Irish hospital group.

Results: Eight of 11 hospitals responded to the survey. There was a 2% vacancy rate prior to the pandemic. Mobilization included reconfiguration of clinical areas and redeployment of 9% of the nursing/midwifery workforce within 2 weeks of the pandemic. A total of 11% ($n = 343$) of nurses/midwives were redeployed in 3 months. Nurses/midwives required re-skilling in infection prevention control, enhancement of critical care skills and documentation.

Conclusions: Three key areas were identified to enable the nursing workforce readiness. These are referred to as the three 'R's': Reconfiguration of specific resources, Redeployment of nurses to dedicated specialist areas and Re-skilling of nurses to safely care for the patients during the pandemic.

Implications for Nursing Management

- A centralized approach to reconfiguration of clinical areas.
- Redeployment is enabled by closing non-essential departments.
- Hands-on re-skilling and reorientating staff are essential.

KEYWORDS
education, leadership, management, mobilization, nursing, survey

Approach: A survey across one Irish hospital group to quantify the mobilization and education requirements of the nursing and midwifery workforce during the first surge of the COVID-19 pandemic.

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1 | INTRODUCTION

The coronavirus (COVID-19) global pandemic has resulted in the large-scale worldwide mobilization of Registered Nurses and Midwives working in the acute hospital sector, to meet the urgent needs of patients and families (Jackson et al., 2020). The first phase of the pandemic hit most countries, including Ireland, in Spring 2021. Research to date has examined various countries' response to increasing the health system capacity (Köppen et al., 2021). Health system strategies to expand the health workforce during surges in the pandemic have been compared across countries (Williams et al., 2020). It is widely known that the nursing and midwifery workforce comprises the largest numbers in most health care settings worldwide, the breadth and impact of this action has yet to be established. Adequate workforce or nurse staffing is a match of registered nurse expertise with the needs of the patients being cared for (ANA, 2012). Research studies have outlined an association between higher registered nurse staffing levels in hospitals with better patient outcomes and improved care quality (Griffiths et al., 2016, 2018). However, determining the appropriate nurse staffing requirements has been shown to be weak and major deficits (Griffiths et al., 2018). During Covid 19, nursing management teams were responsible to implement strategies to mobilize the large workforce to meet the unpredictable demands of a pandemic (Wu et al., 2020).

Mobilizing a workforce requires people to take on new roles and be re-deployed to an unfamiliar area of work, in the provision of direct patient care, with unfamiliar symptomatology, including rapid deterioration and high rates of death. Nurses are required to continually maintain their professional registration requirements, within an environment of uncertainty and fear. The degree of uncertainty related to COVID-19 resulted in increased difficulty in planning to meet unknown patient nursing needs (Fan et al., 2021). Anecdotal evidence gleaned from members of the research team who hold appointments in the clinical environment, suggests the process for redeployment is met with resistance, enthusiasm, compassion, commitment, anxiety, and understanding from the entire nursing workforce.

2 | BACKGROUND

Healthcare in the Republic of Ireland is governed by the Department of Health from a policy perspective, operationally the Health Service Executive (HSE), with devolved governance to seven Hospital Groups. One of the seven hospital groups is Ireland East Hospital Group (IEHG). The IEHG, comprises 11 hospitals, with a nursing/midwifery workforce of 4400. The group serves a population of over 1.1 million people. The IEHG acute hospital configuration consists of two model four hospitals, four model three hospitals, two model two hospitals and three specialist hospitals. Table 1 explains the various hospital model configurations (O'Reilly et al., 2015).

TABLE 1 Hospital model configurations

Model	Description
Model 1	Model 1 hospitals are community units with subacute inpatient beds that care for patients with rehabilitation, respite, or palliative care needs.
Model 2	This group includes small hospitals that provide inpatient and outpatient care for low risk, differentiated medical patients or are referred on to associated higher complexity facilities.
Model 3	The majority of hospitals in the country are Model 3 general hospitals, admitting 50% of all medical patients. Model 3 hospitals provide emergency department expertise, acute medical, surgical and critical care.
Model 4	There are eight Model 4 hospitals that function as tertiary referral centres in Ireland. They provide emergency department expertise, acute medical, surgical and critical care plus specialist and supra-regional care. A considerable volume of their patient workload remains inpatient admissions for routine specialist inpatient care.

While there has been plentiful literature related to nursing during the COVID-19 pandemic, there is a dearth of literature reporting nursing management roles to implement the strategy for workforce mobilization. That said, a recent study by Wu et al. (2020), in China, described the nursing management strategy to transform a hospital to a COVID designated site, which included the reconfiguration of clinical areas, creating a supply of nursing staff and preparing training for nurses to meet clinical demands of their roles. What is worth noting is that the limited literature that previously examined the mobilization of healthcare staff during the swine flu (H1N1) influenza crisis (Considine et al., 2011), and the severe acute respiratory syndrome (SARS) crisis (Fitzgerald et al., 2012) confirms that lessons have not been learned and there is an evident lack of research in this area.

A major emergency management plan is an approach used by organisations to ensure appropriate planning, preparedness, capacity, training and coordination are in place to enable it to meet any challenges posed (Health Service Executive, 2020). No current framework exists to support decisions related to the redeployment of staff, particularly for medium to long-term purposes. This is despite nurses and midwives in an organisation having a contractual obligation to accept redeployment in emergency situations. The current practice is for senior nursing and midwifery management to identify staff for redeployment to other areas of the organisation to deliver patient care. It is critical to address the gap in understanding the impact of redeployment on nurses to gain greater knowledge for workforce planning for potential future pandemics.

3 | AIM

The aim of the research was to explore nursing workforce readiness (preparedness) in one hospital group in Ireland during a global pandemic.

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The objectives of the study were as follows:

- To quantify staffing and mobilization of nurses/midwives across a large hospital group in the Republic of Ireland during the global pandemic
- To identify the extent of the reconfiguration of services across the hospital group
- To identify education priorities and resources provided for nursing/midwifery staff

4 | METHODS

This study used a mixed methods design. A specifically designed questionnaire was used for this study. Drawing from the literature and professional expertise the 20-item "Nursing Workforce Readiness Survey" was created by the research team, some of whom are senior nurse managers, using Qualtrics® software (Supporting Information S1). The survey was tested for face validity among an additional three Directors of Nursing. Reliability was checked at analysis. A second phase of the study included an additional reflective component, where the results from the questionnaire were presented to the Directors of Nursing (DON) and Midwifery (DOM), whose comments were recorded and included in reporting of the results.

A convenience sample of the DON and DOM in the hospital group was selected. A link to the cloud-based survey was distributed to the 11 Directors of Nursing/Midwifery across the hospital group during September to November 2020. The survey was circulated electronically, with an exhaustive sampling approach adopted and all possible participants in the hospital group invited to take part.

Qualitative data were recorded from participants at a scheduled meeting following a presentation of the survey responses. All eight participants were present.

4.1 | Ethical considerations

A review of a declaration of exemption from full ethical review was accepted by the University Research Ethics Committee, LS-E-20-84-Ryder. Participation information was provided at the beginning of the survey. Participants were informed that completion of the survey implied consent.

An additional declaration of exemption from full ethical review was accepted by the University Research Ethics Committee to collate anonymous feedback from the participants following the presentation of the results. Participants were advised in advance of the feedback presentation that their responses were recorded and were requested to state that they did not wish for their responses to contribute to the research during the discussion.

TABLE 2 Hospital configurations

Hospital model	Frequency
2	1
3	5
4	1
Maternity services	1
Total	8

4.2 | Data analysis

Quantitative data were downloaded from Qualtrics, and analysis was conducted using the software package IBM SPSS®, Statistics Version 24. Data were checked and cleaned for analysis. Four blank survey responses were removed. Descriptive statistics were used to describe, compare and summarize participant responses.

Qualitative data were recorded, transcribed and analysed by two members of the research team. Data were analysed using Braun and Clarke (2006) thematic analysis framework.

5 | RESULTS

Eight of 11 (73%) hospitals responded to the survey (Table 2). The majority ($n = 5$; 63%) of responses were from model three hospitals.

5.1 | Nursing vacancies

In order to understand the context in which the Health Care Group organised and managed its Nursing and Midwifery workforce, the participant hospitals were requested to provide the pre-COVID-19 staffing configuration as identified in Table 3. Participants were also requested to identify pre-COVID nursing vacancies using the same configuration. There were a total of 83 nursing vacancies in participating hospitals prior to COVID-19.

5.2 | Corporate planning

When questioned whether or not their organisation had a documented contingency plan to escalate intensive care units (ICU) in the event of a pandemic half ($n = 4$; 50%) of all the hospitals reported that they had this prior to March 2020. Seventy-five percent ($n = 6$) of organisations reported adopting a collaborative decision-making approach to decide on the reconfiguration of clinical areas (Figure 1). The majority ($n = 6$; 75%) of organisations indicated that both ward design, and clinical skills of the nurses working in the ward areas, informed decisions related to the reconfiguration of clinical areas as opposed to a surge in activity.

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TABLE 3 The pre-COVID staffing configuration across hospitals were as follows

Pre-COVID number whole time equivalent (WTE)	Hospital model 2 M (n)	3 M (n)	4 M (n)	Maternity services M (n)	Total M (n)
RGN/RM	116 (116)	239 (1196)	625 (625)	251 (251)	273 (2187)
CNM/CMM 1	11 (11)	17 (84)	55 (55)	44 (44)	24 (195)
CNM/CMM 2	15 (15)	29 (145)	82 (82)	62	38 (305)
CNM/CMM 3	0 (0)	5 (24)	8	8	5 (40)
CNS/CMS	7 (7)	13 (66)	63	10	18 (144)
cANP/RANP or cAMP/RAMP	4 (4)	6 (30)	21 (21)	6 (6)	8 (61)
ADON/ADOM	5 (5)	6 (32)	11 (11)	9 (9)	7 (57)
Other	2 (2)	4 (18)	1 (1)	1 (1)	4 (36)
Nurses (all grades) in ICU or equivalent	10 (9)	19 (77)	105 (105)	17 (17)	30 (209)
Nurses (all grades) in ED	14 (14)	28 (140)	90 (90)	17 (17)	33 (260)

Abbreviations: ADON/ADOM, assistant director of nursing/assistant director of midwifery (ADOM); cAMP/RAMP, candidate advanced midwife practitioner/registered advanced midwife practitioner; cANP/RANP, candidate advanced nurse practitioner/registered advanced nurse practitioner; CNM/CMM, clinical nurse manager/clinical midwife manager; CNS/CMS, clinical nurse specialist/clinical midwife specialist; ED, emergency department; ICU, intensive care unit; RGN/RM, registered general nurse/registered midwife.

TABLE 4 Immediate nursing mobilization to target areas from 1 March to 15 March 2020

Immediate staffing redeployment to increase capacity in departments	Hospital model 2 M (n)	3 M (n)	4 M (n)	Maternity services M (n)	Total M (n)
Emergency department	0 (0)	2 (10)	30 (30)	0 (0)	6 (40)
ICU/HDU	0 (0)	7 (36)	10 (10)	0 (0)	6 (46)
Other clinical areas	0 (0)	23 (116)	81 (81)	4 (4)	29 (201)

Abbreviations: HDU, high dependency unit; ICU, intensive care unit (ICU).

5.3 | Redeployment/mobilization of nurses

Participants were requested to list the areas where staff were mobilized from. Responses indicated that hospitals mobilized staff from within their own organisation to critical areas including emergency departments, critical care and newly designated COVID-19 areas (Table 4). Responses identified that staff were redeployed from a variety of clinical areas that were closed including outpatient departments, operating theatres, endoscopy services and nurse education and practice development departments. Clinical Nurse Specialists (CNS) were also redeployed from specialist services that were closed for outpatient visits. Two hospitals employed a number of agency nurses to increase the numbers of nurses working in critical areas.

The total number of nurses/midwives working across the eight hospitals in the study was reported as 3019, with 83 vacancies. Within the first 2 weeks of the pandemic, 287 (9%) members of the nursing/midwifery workforce were redeployed to alternative working areas. Overall, 11% ($n = 343$) of the nursing/midwifery workforce were redeployed across the eight hospitals (Table 5).

As part of the survey, the hospitals were asked to identify three education priorities for nursing staff at the onset of the pandemic. The first priority identified by all organisations was related to infection prevention control, including procedures for "don and doff" of personal protective equipment. This second education priority was the provision of instruction to enhance nursing staff in critical care skills including care of the patient receiving invasive and non-invasive ventilation. The third priority was to upskill Registered Nurses who were redeployed from other clinical areas, who were recent appointments to the hospital, many from the non-acute care sector, particularly from nursing homes.

Participants were requested to identify the education resources in place for redeployed staff and explain the mode of delivery of the education available. Responses indicated that the education was provided by Centres for Nurse Education, Nurse Practice Development from both local and regional areas, and higher education institutions. Two hospitals identified the use of online educational resources to support upskilling of staff.

5.4 | Feedback from participants

The results of the survey were presented to the group of participants at a scheduled meeting. There were two key discussion topics raised by the group, namely redeployment and education.

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TABLE 5 Total number of nurses mobilized in hospitals between 1 March and 1 June 2020

Total staffing redeployment to increase capacity in departments	Hospital model				
	2 M (n)	3 M (n)	4 M (n)	Maternity services M (n)	Total M (n)
All clinical areas	33 (33)	32 (162)	130 (130)	018 (18)	43 (343)

Note: Total number of staff that were redeployed from 1 March to 1 June 2020.

5.4.1 | Redeployment

The participant group ($n = 8$) expressed surprise at what they referred to as the small percentage of staff redeployed.

> I cannot believe it's only 9–11%, we phoned every available CNS (DOM 3)

They had anticipated that this number would be approximately 25% of staff. The rationale for anticipating a higher percentage was explained by the recollection of identifying and calling every possible CNS, they however noted that this group comprised 5% of all nurses/midwives.

A number of participants ($n = 6$) discussed that perhaps the survey did not capture what was described as "hidden redeployment." This was described as situations where out-patient based nurses/midwives were redeployed to ward areas to enable ward-based nurses to be redeployed to other wards with a higher patient acuity such as non-invasive ventilation. As one participant stated:

> I think it misses the double redeployment element where we put CNS into stable wards to move the ward staff to the more complex wards, there was a hidden element to redeployment if you like. (DON 6)

One participant stated, "it wasn't all about critical care." This comment was met with a lot of agreement. When nurses were moved between wards, this was not identified as redeployment in the survey; however, upon reflection, it was described as "double redeployment."

One participant reflected that there were a number of discussions prior to the pandemic where concerns were raised about critical care staff shortages. The same participant noted that despite the concerns, the group were able to mobilize staff to critical care during a crisis. The group agreed with this commentary.

5.4.2 | Education and training

The need for education resources was highlighted among the group, particularly in clinical educator roles where the availability of expertise to provide hands on skills training was needed. It was discussed that practical "hands-on" focused skills training was the primary requirement across the organisations.

A consensus among the group was related to the importance of the Clinical Facilitator roles and availability. This was particularly expressed amongst DON in model three hospitals as these were the education resources needed locally to prepare staff.

> Not having clinical facilitators was a real problem for us, we struggled to find someone to teach clinical skills (DON 4)

It was agreed that there is a lack of funding for these positions and the group expressed the need for permanent positions to be actioned.

6 | DISCUSSION

This study explored the nurses and midwives experience of mobilization in the first wave (1 March 2020 to 1 August 2020) of a global coronavirus pandemic in a large hospital group in the Republic of Ireland. Three key deliverables were required to occur almost simultaneously to enable mobilization of the nursing and midwifery workforce. They were Reconfiguration, Redeployment and Re-skilling. The clinical areas required reconfiguration from their previous specialist derogation to dedicated COVID-19 suitable clinical environments. Overall, during the COVID-19 pandemic, nurses and midwives' managers reported the urgent need to mobilize staff from other areas within their hospitals to their intensive care departments/units to meet the huge demand for intensive care nursing. In addition, they reported a crucial need to re-skill nurses and midwives in specific infection control skills including donning and doffing of personal protective equipment (PPE), educating and re-skilling nurses/midwives for critical care areas and new documentation.

6.1 | Reconfiguration

This research identified that a collaborative decision-making approach was applied to reconfigure clinical wards to accommodate a predictive surge in critical care and emergency departments as the COVID-19 virus increased in the community. The factors influencing ward reconfiguration was the ward design and the clinical skills of nurses. Hospital resource planning is complex at the best of times, but in the midst of a disaster has the potential to increase the loss of lives due to unavailability of specific resources and or skills (Aghapour et al., 2019). Arabi et al. (2021) argue that the best approach to management of critical care surges is to prevent them by implementing a centralized approach to management of admission to critical care. In

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contrast, Hattke and Martin (2020) argue whether a centralized or a decentralized approach is most appropriate is a matter of much debate. It is known that some form of coordination, collaboration or cooperation is necessary during a crisis (Kapucu et al., 2010; Martin et al., 2016) but the degree to which these occurred to bring about collective action within one hospital group is currently unknown. The literature would therefore attest to the centralized collaborative approach applied by the hospitals in the reconfiguration of clinical areas.

The ongoing shortage of nursing and midwives has attracted the attention of the Organisation for Economic Co-operation and Development (OECD), which projects a significant worldwide nursing shortage by 2030, with Ireland, having a projected nurse and midwife shortage of 9.1% (Scheffler & Arnold, 2019). The existing shortage of nurses had already provided a massive strategic risk to the effective functioning of the healthcare system, with many hospitals already facing a staffing crisis, when the COVID-19 pandemic hit (Jilani, 2019). However, the results of this study highlight that within one hospital group prior to COVID-19, there were only 83 (2%) whole time equivalent (WTE) nursing positions vacant prior to the pandemic.

6.2 | Redeployment

This is the first study to quantify the level of mobilization of nurses and midwives during the pandemic. The redeployment of employees was one of the core elements of the response to COVID-19 and reflects the leadership of the nursing executive teams in participating organisations. The findings identified that 9% of the workforce were mobilized within the first 2 weeks. The nursing and midwifery staff were mobilized internally to designated COVID-19 specialist areas. This process resonates with Minissian et al. (2020) whereby redeployment efforts took centre stage for optimizing staffing needs and the surge planning and redeployment efforts led by senior leaders were imperative to ensure crucial staffing needs were achieved.

At a national level, non-essential services (e.g., outpatient clinics and elective surgery) were cancelled or postponed. Arabi et al. (2021) recommend this systematic centralized approach to enable the health system "flex" to accommodate increased demand for hospitalized care. This was reflected in the results of this research where participants indicated that mobilization to COVID-19 designated areas was accommodated through internal redeployment of nurses and midwives whose positions were curtailed or temporarily suspended. The literature has reported consistent findings related to the nursing workforce mobilization. Retzlaff (2020) also noted the need to redeploy perioperative team members to other units and remarked that a common thread at health care facilities across the country was the willingness of staff members to pitch in and do what was necessary to help their communities respond to the COVID-19 pandemic, whether it was temporarily transitioning to a different unit, helping their colleagues with patient positioning, and donning or doffing PPE. To increase the number of nursing staff, nursing interns and retired nurses were used to fill vacancies (Propper et al., 2020). This was not consistent with the experience reported from participants in this research who identified that mobilization was accommodated through internal redeployment.

In the current study, the impact of nurse staffing levels on patient outcomes is unknown in the hospital group, given the scale, speed and age profile most affected during the first wave of the pandemic. Of note, there were 8582 deaths registered in Ireland during this period (Quarter 2, 2020) and of these 1227 deaths were assigned an Underlying Cause of Death (UCOD) of COVID-19, an increase of 14.1% (or 1063 deaths) from Quarter 2 2019 was also reported (Central Statistics Office, 2020).

6.3 | Re-skilling

The need to address related training and education in this study were infection control, intensive care nursing and orientation for nurses redeployed or nurses returning to professional practice relates to the challenges in providing support to reduce the gaps in critical knowledge by Chen et al. (2020). Danielis et al. (2021) described the experience of Italian nurses' redeployment who felt unsupported due to the absence of education and training in skills and documentation required to work in their new clinical area. This research supports the literature identifying that training and up-skilling of nurses was a feature of the measures taken by the profession during the pandemic. This research identified three key skill enhancement areas prioritized, infection and prevention and control, critical care skill enhancement and documentation updates.

The virus, COVID-19, was identified as a highly Infectious disease (WHO, 2020). While most nurses and midwives are familiar with a variety of infectious disease PPE related procedures, COVID-19 was highly contagious, therefore, required focused skills related to donning and doffing full PPE.

This research adds to the existing literature by identifying the specific requirement for "hands-on" skills training in lower acuity organisations. The participating nurse leaders expressed explicitly that skills requirements were not all critical care focused. In contrast, Jackson et al. (2020) identified that it was crucial to have adequate learning resources available to support staff who were redeployed to new areas in particular intensive care. Patient safety no matter what the circumstances are is paramount.

Participants in this study expressed a preference for hands-on skills training to re-skill redeployed staff. Only two organisations availed of the on online education made available. Almomani et al. (2021) reported that the upskilling of non-critical care nurses was conducted using simulation-based education and consisted of completing a mandatory online critical care awareness module. Similarly, Danielis et al. (2021) reported that nurses were required to gain competence individually as the only resource available was distance education. The findings in this research identified that education and skills acquisition was supported by clinical educators and academic partners. Participants highlighted a need for investment in specific clinical teaching roles to enable essential upskilling of staff.

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6.4 | Limitations

The findings emerging from this study need to be viewed within the context of its limitations, namely that this study reports on one period of time at the start of the COVID-19 pandemic and during what is now considered the first wave of the pandemic. In Ireland there have been two other substantial waves of COVID-19 which have impacted greatly on the provision of health care within the IEHG. Furthermore, the data presented in the paper represents eight of the 11 hospitals in one group, and the data gathered relating to one of the maternity care services was limited to protect anonymity. Future research will need to consider Nursing and Midwifery services for all Hospital Groups in the Republic of Ireland during the past 12 months and examine the experiences of the Nurses and Midwives who were redeployed during the pandemic to gain a greater understanding for future service development.

7 | CONCLUSIONS

Nurses are the backbone of healthcare delivery and demonstrated willingness and flexibility in adapting to new ways of working during the first wave of COVID-19 pandemic. This study revealed that workforce readiness during the first wave of a global pandemic was influenced by many factors, for example, a documented contingency plan, collaborative decision making, ward design, and the upskilling of nurses' clinical skill set. On reflection many of the Directors of Nursing were surprised at the low number of nurses redeployed to different departments but it was suggested that there may be some hidden redeployment as some nurses adopted different roles within their usual work environments. Educators, more importantly hands-on clinical educators were identified as essential to the successful mobilization of nursing staff across the organisation. Nursing and midwifery staff readiness to cooperate in this crisis is testament to their commitment to assist patients, families and colleagues to respond to COVID-19 tsunami that gripped the nation at the time.

7.1 | Implications for nursing management

This research identified three key factors for consideration by nursing management to mobilize the nursing workforce in response to a pandemic. Reconfiguration of clinical areas to respond to a surge in hospital capacity is a collaborative approach at management level. Closure of non-emergency services in the organisation results in availability of staff for redeployment. Hands-on skills training and refreshment of updated documentation is essential to support staff being redeployed to clinical areas. Organisational measures at macro and micro levels need to be considered if nursing and midwifery are to be adequately prepared for future surges or pandemics.

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CONFLICT OF INTEREST

The authors wish to declare that there are no conflicts of interest.

ETHICAL APPROVAL

A declaration from full ethical review was accepted by the Office of Research Ethics at the Higher Education Institution, reference LS-E-20-84-Ryder.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ORCID

Mary Ryder https://orcid.org/0000-0003-0988-4941
Barbara Coughlan https://orcid.org/0000-0002-6922-8308
Phil Halligan https://orcid.org/0000-0002-5276-477X
Suzanne Guerin https://orcid.org/0000-0002-6744-7590
Michael Connolly https://orcid.org/0000-0002-6602-1803

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Experiences of frontline nurse managers during the COVID-19: A qualitative study

Mónica Vázquez-Calatayud RN, MD, PhD, Nurse Director, Area of Nursing Professional Development[1,2,3,4] | Elena Regaira-Martínez RN, MD, Responsible, Area of Nursing Professional Development[1] | Carmen Rumeu-Casares RN, MD, Chief Nursing Officer[1,3] | Beatriz Paloma-Mora RN, MD, Nurse Director, Clinical Area[1,3] | Ainhoa Esain RN, MD, Nurse Director, Clinical Area[1] | Cristina Oroviogoicoechea RN, MD, PhD, Nurse Director, Area of Nursing Research and Innovation[1,3,4]

[1]Clínica Universidad de Navarra, Pamplona, Spain

[2]School of Nursing, Campus Universitario, Universidad de Navarra, Pamplona, Spain

[3]Innovation for a Person-Centred Care Research Group (ICCP-UNAV), University of Navarra, Pamplona, Spain

[4]Navarra's Health Research Institute (IdiSNA), Pamplona, Spain

Correspondence
Elena Regaira-Martínez, RN, MD, Responsible, Area of Nursing Professional Development, Clínica Universidad de Navarra, Pamplona, Spain.
Email: eregaira@unav.es

Abstract

Aim: To explore experiences of frontline nurse managers during COVID-19.

Background: The COVID-19 pandemic has complicated care provision and healthcare management around the world. Nurse managers have had to face the challenge of managing a crisis with precarious resources. Little research has been published about the experiences of nurse managers during the COVID-19 pandemic.

Methods: A qualitative descriptive study of 10 frontline nurse managers at a highly specialized university hospital in Spain was carried out. Semi-structured interviews were conducted between June and September 2020. The Consolidated Criteria for Reporting Qualitative Research checklist was used for reporting.

Results: Six themes emerged: constant adaptation to change, participation in decision-making, management of uncertainty, prioritization of the biopsychosocial well-being of the staff, preservation of humanized care and 'one for all'.

Conclusions: This study provides evidence for the experiences of nurse managers during the COVID-19 pandemic. In addition, analysing these experiences has helped identify some of the key competencies that these nurses must have to respond to a crisis and in their dual role as patient and nurse mediators.

Implications for Nursing Management: Knowing about the experiences of frontline nurse managers during the pandemic can facilitate planning and preparing nurse managers for future health disasters, including subsequent waves of COVID-19.

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KEYWORDS
COVID-19, experience, nurse manager, nursing, qualitative research

1 | INTRODUCTION

The COVID-19 pandemic has complicated the provision of care and the management of healthcare worldwide (Tort-Nasarre et al., 2021), placing nurses at the forefront of the response to the demands of the crisis (James & Bennett, 2020). Despite this, a lack of available nurses to respond to the urgent need to care for COVID-19 patients and their families has been observed worldwide (Al Thobaity & Alshammari, 2020). Nurse managers have had to face the challenge and threat of managing the crisis with precarious health supplies and resources, a changing workforce and exhausted staff who must cope with fear, uncertainty and the helplessness of not being able to assure humanized care for patients with COVID-19 and their families (Hofmeyer & Taylor, 2021; Xiang et al., 2020). This contributes to the need to design new protocols and continuously reorganize services based on the changing information about SARS-CoV-2, which has led to many frontline nurse managers being overwhelmed (Bookey-Bassett et al., 2020).

Despite the relevant role of nurse managers during the pandemic, little is known about their experiences (White, 2021). This qualitative study contributes to the knowledge on the unique experiences of frontline nurse managers during the pandemic, which can help plan and prepare nurse managers for future health disasters, including subsequent waves of COVID-19.

2 | BACKGROUND

The COVID-19 pandemic has caused a worldwide health and social crisis that has directly impacted the healthcare system (World Health Organization [WHO], 2021). In our country, the first case was confirmed on 31 January 2020. Since then, the virus has spread rapidly, and the country has been severely affected. The government enacted a national lockdown on 14 March 2020, which is gradually becoming the 'new normal' (Ministerio de Sanidad, Gobierno de España, 2021).

During this time, the role of nurse managers facing the pandemic has been briefly discussed in the grey literature. Published editorials have provided recommendations for effective leadership during the pandemic and suggest the requirement for courageous leaders with sound knowledge (Rosser et al., 2020; Shingler-Nace, 2020). Only one study published on nurse managers' experiences during the pandemic with a qualitative approach has been identified to date, although the study did not focus only on frontline nurse managers and was carried out in another context (White, 2021). According to this phenomenological study, the new role of nurse managers during the pandemic focuses on the emotional well-being of their staff and continual communication (White, 2021). However, little research regarding the experiences of nurse managers during the COVID-19 pandemic has been published. Notably, future studies in hospital contexts should be developed (Bookey-Bassett et al., 2020; Lake, 2020; White, 2021). Furthermore, health organizations call for training programmes that prepare nurse managers to respond effectively in such situations (Cariaso-Sugay et al., 2021; Hodge et al., 2017).

Understanding the experiences of frontline nurse managers during the COVID-19 pandemic is key to designing training programmes and organizational strategies that facilitate better management of future situations with similar epidemiological and clinical characteristics (Rosser et al., 2020).

3 | METHODS

3.1 | Aim

The aim of this study was to explore the experiences of frontline nurse managers during the COVID-19 pandemic.

3.2 | Design

A qualitative descriptive study was carried out. This design allows the study of people's experiences around a phenomenon (Polit & Beck, 2017).

3.3 | Participants

Ten nurse managers were selected by purposeful sampling, thus ensuring a notable degree of experience with the investigated phenomenon (Polit & Beck, 2017). The inclusion criteria were front-line nurse managers from different units/services of a highly specialized university hospital in Spain who voluntarily participated and signed the consent form. No exclusion criteria were applied. The sample size was considered sufficient when the addition of new subjects did not reveal novel aspects of the studied phenomenon, and sufficient material was available to offer deep descriptions and interpretations (Polit & Beck, 2017). The characteristics of the sample are presented in Table 1.

3.4 | Data collection

Semi-structured interviews were conducted between June and September 2020. The interviews were audio-recorded for later transcription, and each interview lasted approximately 40 min. The interviews began with an open question and then addressed the areas of

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TABLE 1 Sociodemographic data of the participants ($N = 10$)

	Mean ± SD (years)	Range (years)
Age	47.5 ± 7.33	36–57
Professional experience		
As a nurse	25.3 ± 8.3	9–36
As a nurse manager	5.4 ± 4.86	1–14
	n (%)	
Gender		
Female	100%	
Male	0%	
Education level		
Bachelor's degree	20%	
Master's degree	80%	

TABLE 2 Thematic guide

Tell me about your experience as a supervisor during this period.
What have been the main challenges you have faced during the COVID-19 pandemic in your unit/service? Why?
How have you faced these challenges? What has been your role as a supervisor in facing these challenges? What have been your priorities regarding staff? Regarding the team? Regarding patient care?
What barriers have you encountered in responding to the needs of your unit/service during this period? What facilitators have you encountered?
What strategies have you used to manage the crisis with the staff? With the team? With patients?
What has everything you have experienced meant to you? What are the main lessons you have learned during this period?
From your experience in these months, what are the key aspects in the management of a crisis like this one?
Before ending the interview, would you like to tell me anything else that I did not ask you about that is important to you?

interest: change and unit management, influencing factors and suggestions for improvement (Table 2). Aspects that complemented the data obtained through the interview, such as tone of voice, gestures and body posture, were recorded in the field notes to better understand and contextualize the experience of each nurse manager.

3.5 | Data analysis

A systematic analysis of the transcripts was conducted by applying the methods proposed by Burnard (1996). The initial phases of the analysis included comprehensive readings of the data and the development of a system of categories to describe the units of meaning identified in relation to the phenomenon studied. This system of categories was revised and refined based on the identification of common patterns. Accordingly, categories were ordered and regrouped into broader topics to explain the experiences of frontline nurse managers during the COVID-19 pandemic.

TABLE 3 Procedures used to enhance study rigour

Criteria	Procedures
Confirmability Logical and impartial interpretation of data	• Detailed descriptions of the characteristics of the participants and the criteria for the inclusion and selection of participants • Detailed and explicit descriptions of the research methods and procedures
Credibility Veracity of the results	• Use of textual quotes from the transcripts to support the arguments • Searches of the text for textual evidence to support the findings
Transferability Applicability of the results to similar contexts	• Each individual's perceptions are unique; the meanings behind them are common
Trust Stability and consistency of the data	• The interpretative results (narratives) have been confirmed by some of the participants

Source: Riege, 2003, pp. 78–79.

3.6 | Rigour

The procedures used to ensure the rigour of the study were selected based on the criteria proposed by Riege (2003) (see Table 3). In addition, the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used for reporting (Tong et al., 2007). The researchers considered their own reflexivity, being aware and reflexively self-critical of how their possible assumptions and biases could influence the process and the results (Riege, 2003). The research team consisted of female nurses in senior positions with PhD (MVC and CO) and master's degree qualifications (the rest), broad and diverse healthcare experience, experience in academia (MVC and CO) and experience with qualitative research methods (MVC, CO and ERM). Specifically, face-to-face interviews were conducted by two of the researchers (CO and ERM) who did not have a direct relationship with the interviewees. MVC, CO and ERM, who had experience in qualitative research, carried out the analysis and interpretation of the data. All research team members were involved in drafting the manuscript and revising it critically for important intellectual content.

3.7 | Ethical consideration

The participants were contacted via electronic mail and received verbal and written information emphasizing their free participation, confidentiality, data anonymity and the use of their data for scientific purposes. The first author encoded the identities of the participants as 'NM', with the number assigned to the interviewed nurse manager, and no other members of the team had access to identifying nurse

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TABLE 4 Themes and subthemes extracted from the qualitative data and examples

Themes	Subthemes	Examples of coded phrases
1. Constant adaptation to change	1.1 Urgent and constant reorganization of the service	I have to organize protocols and procedures from one day to the next, even within hours. It was a constant change *We were quickly looking for alternatives to many resources that were not available* *It was very changeable; it changed every day. We even changed the protocol every hour, everything had to be reorganized*
	1.2 Complexity of staff management in a changing situation	The staff changed every so often, so it was difficult to manage them *Another major challenge was managing the ever-changing staff*
	1.3 Communication problems in changing situations	I found changing the way I proceeded every day because there was so much contradictory information *We have sometimes lacked communication in changing circumstances* *Many times, in the most chaotic moments, different information has been received*
2. Participation in decision-making		It has been a time of important and quick decisions without consensus with many people *Some decisions are made without considering the repercussions*
3. Managing uncertainty		Convey calm; like there was calm inside the chaos or uncertainty and fear *We made a great effort to convey peace and tranquillity … in the midst of the uncertainty that existed* *You have to show that you feel secure, even though you have doubts inside you*
4. Prioritization of the biopsychosocial well-being of staff		My priority with the staff was to make sure that they did not lack anything *We have prioritized making staff feel supported and backed up* *To be there, to be present, morning and evening with the staff*
5. Preservation of humanized care		Do not forget about the person, being able to meet all the needs of the patient with care that is a little different from usual *I have been able to accompany people who were dying to their last breath, who were alone, and keeping their families informed*
6. 'One for all'	6.1. Teamwork	These moments have truly united the team. They have worked phenomenally as a team; they have laughed and cried together *As a team, we were going to direct, to organize as one, in sync, together*
	6.2. Collaboration	When you call, the doors open (…) the support is impressive *When I had needs or doubts … I always have a team that answered me at the moment and came and explained things to us*

manager information. Informed consent was collected from those who agreed to participate, and an interview was scheduled. This research was approved by the Research Ethics Committee of the University of Navarre (Code 2020.126) and by the hospital's management team and was performed in accordance with the criteria of the Declaration of Helsinki (World Medical Association, 2013).

4 | RESULTS

Six themes were identified as follows: (1) constant adaptation to change, (2) participation in decision-making, (3) management of uncertainty, (4) prioritization of the biopsychosocial well-being of staff, (5) preservation of humanized care and (6) 'one for all'.

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These themes and their respective subthemes from which they evolved appear in Table 4 with examples of supporting verbatim phrases.

4.1 | Constant adaptation to change

4.1.1 | Urgent and constant reorganization of the service

The pandemic situation abruptly brought on by COVID-19 required urgent and constant changes in the organization of services in terms of managing processes and staff, which required diligence and flexibility.

> When you are in the situation, you are so involved (…) in work, in organising (…). They called: 'Hey, you have to organise this', and there you are; it cannot wait for the next day, right? Things changed from one day to the next, even within hours, the protocols changed, and the procedures; so it was, well, a constant, constant, constant change (…). (NM1)

Faced with a new and unknown situation, the nurse managers indicated that they were forced to seek alternatives to the problems that arose and to provide prompt solutions. This proactive search for quick solutions helped them to face and overcome a situation for which they often lacked both organizational and patient care guidelines.

> (…) what were we going to do? If not, we were looking for alternatives to things: well, if there were no such thing … we would look for alternatives to many resources that were not available (…). We had to search for alternatives to the problems that came up and solve them quickly … because, well, you are never prepared; you always have things, you always have resources, alternatives. (NM6)

This proactive attitude of the nurse managers was present even before they had to face the pandemic. As the following quote illustrates, they began to plan and devise solutions for the organization of infrastructure and human and material resources after exploring and analysing situations in other regions.

> Before the worst of the pandemic arrived, we already began to work on things; we tried to organise (…) with all the experience we had of what was happening, of what we were hearing from Madrid (…); we got ahead of many things (…), most importantly, especially staff, patient organisation, organisation of medical teams, equipment, training …. (NM6)

4.1.2 | Complexity of staff management in a changing situation

The complexity of managing staff arose mainly because personnel requirements needed to be changed continuously to adapt to clinical activity and absenteeism due to COVID-19; the response in many cases involved incorporating staff from other services.

> What has happened to us is that the staff changed every so often, between some being infected and then having to replace them and then the number of patients increased, because we had to bring new people, so it was difficult to introduce new people (…). That has added more work, perhaps, for management because you did not have much time to teach a lot to another person …. (NM10)

On the other hand, activities required adjustment to the type of patients who were being treated in the units; therefore, management assumed the training of staff such that in a short time, nurses could learn to attend patients other than those for whom they were qualified to care.

> We were going to have to care for critical patients when the staff here (…) are not used to attending intubated patients; they do not know how to handle them, so they have helped us (…), people from the surgical area who were trained with ventilators (…), but that is an added fear (…) because patient care is the most important thing we have to provide. (NM3)

4.1.3 | Communication problems in changing situations

Nurse managers perceived difficulties with the flow of information that they received regarding the guidelines to be followed during the pandemic crisis, both vertically and horizontally.

At the vertical level, several nurse managers identified communication problems in their stories mainly for two reasons: (1) lack of impartial information at the right time and (2) diverse information that was contradictory or came from different sources. As illustrated in the quote below, both types of internal communication problems led nurse managers to continuously change their practices and to feel uncertainty and insecurity regarding their decisions.

> (…) I found myself changing the way I proceeded every day without knowing very well what I was basing myself on because there was so much contradictory information, and from very good sources in principle (…). It is that uncertainty and insecurity of 'Am I doing it right? Am I not doing it right? Will this be a good decision? Will it not be good…?' (NM7)

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On the other hand, regarding communication with their teams, nurse managers reflected on how the changing situation forced them to quickly convey different messages and devise strategies, such as the use of informal channels, to ensure that staff were informed. Nurse managers tried to transmit information that was clear, concise and truthful at all times and to convey it quickly to all staff members.

> Everything changed day by day, so we communicated by WhatsApp, which was the fastest …. People had not even assimilated one thing, when there were changes one after another (…). The information had to be given very concisely, very clearly. (NM6)

4.2 | Participation in decision-making

Decision-making at different levels was another relevant issue during the pandemic that nurse managers emphasized. On the one hand, at the operational level, they were able to participate in the decisions that were made.

> … our contributions have helped them, and they have listened to us (…); if we felt that something was not right, then we would go over it [occupational risks] again with them to change it … they did not make the protocols [for occupational risks] alone; they made them with us…. (NM2)

In this sense, one nurse manager stressed that after reflecting on what they did and how they did it, they were aware of the decisions that they had to make without consensus; due to the importance of these decisions, having a consensus would have been better.

> Now, afterwards, I realise how many things we did in a few days and that we organised without considering anyone's decisions (…). Therefore, you can see that it has been a time of making important and quick decisions without many people agreeing on them (…) and saying, 'My goodness, this is me; here I am deciding this, and I would have liked to have been able to agree with three or four others, right?' (NM1)

On the other hand, some nurse managers perceived not feeling involved in certain decisions that were made at a more strategic level and seemed not entirely correct and could have hindered operational management.

> Some decisions are made without considering …, without thinking about the repercussions they may have. I don't know, it's as if … if everyone can speak, everyone is involved, I think it would be better. (NM5)

This centralized decision-making also hindered operational aspects given the need to make decisions in a changing situation and without prior knowledge on which to base those decisions. Some nurse managers reported not being able to make correct decisions and not having autonomy due to a lack of updated information about which guidelines to follow because they felt that these guidelines were not quite viable in practice.

> You did not know what to rely on to reinforce these regulations. Everything was changing so fast that, in the end, you saw that you were not capable of making a correct decision because you did not really know what the real criterion was for making that decision (…). So, I lacked some autonomy because, in the end, you do many things according to your decision, but you still want to have slightly more general information …. (NM7)

4.3 | Managing uncertainty

The suddenness of COVID-19 generated many fears and considerable uncertainty among nursing professionals. Nurse managers became aware of the need to project a sense of calm, security, confidence and apparent control of the situation. They were aware of the importance of not expressing their doubts and uncertainties in their day-to-day work and not projecting their concerns and fears.

> You have to show you feel secure, even though you have doubts inside you, right? And this is so, but no matter how many times you try not to show your insecurity, in the end, you convey it. (NM9)

> Convey calm; they have been telling me that everyone had the sense of everything being organised, like there was calm inside the chaos or uncertainty and fear. (NM6)

Nurse managers also highlighted how, despite the uncertainty of the situation, the ability to anticipate events played an important role in the management of that uncertainty. The managers tried to look beyond the current problem and anticipate problems that could occur to avoid them or minimize their impact.

> Each day you came to work, it was something different (…). Therefore, for us, the most important thing was to get ahead of events, that is, that they never caught us unaware. (NM4)

4.4 | Prioritization of the biopsychosocial well-being of staff

One of the priorities that the nurse managers repeatedly expressed in the interviews was ensuring the biopsychosocial well-being of the

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staff in charge. They realized that their main objective was to ensure that nurses could work in the best possible physical conditions in terms of their rest and protection (material and training) to adequately care for patients with a minimal risk of contagion.

> That the staff were comfortable working within the circumstances in which they lived (…), they had shifts so that they were well-rested when they came to work (…), that they had material, that they did not lack anything. (NM2)

> Another important challenge was organising the groups of professionals. I made two groups in all the units so that they did not mix with each other and so that if there was a concern regarding infection in one, the other stayed, even though we worked with isolation protocols. (NM1)

Nurse managers also described how they formed teams such that they had a friendly work environment in which the professionals felt comfortable. At the same time, they tried to have staff with experience and knowledge to ensure the safety of care and a balance among the professionals themselves.

> When the shift groups were made, groups were not made randomly but with certain characteristics. Those groups were always the same. In addition, it was done with a thought towards like-minded people (…), and I think that was successful …. (NM6)

> Therefore, making those groups and then also bringing in the people who came, if they were an experienced person in X [service], I put them in a group that lacked that (…). That's how we went about figuring out groups. (NM3)

In addition, nurse managers were always receptive to responding to individual needs, sharing experiences and ensuring that the professionals could balance work and family life.

> My priority with the staff was to make sure they didn't lack anything; to listen to them in case someone didn't feel well enough to work; to talk to them to give them more days off if they needed it, or to replace them with other people, so that they would be well, calm, not overwhelmed; (…) we used to get together to share the good things, the bad things, their fears. They were calmer when they talked and said what they thought. (NM2)

> Changing people shifts, extending working hours (…), they said, 'It's that I have my parents, my children, but I work elsewhere'; what do we do? Of course, we are going to help you. We are going to do what we can together; we will arrange shifts. (NM6)

4.5 | Preservation of humanized care

This issue alludes to the double challenge that supervisors faced to ensure the protection of patients/families and professionals without losing sight of the person as the focus of care. This second challenge was difficult due to the impossibility of knowing the patients personally.

> I did not know the patients. I did not recognise their faces. I only knew them by name … Going through the unit and not being able to … and not having their families … that was really hard for me. (NM6)

In this sense, nurse managers highlighted their concern that the priority of nursing work should continue to be holistic care of the patient and to ensure that they could address all of the patient's needs and concerns and provide the support that they needed at all times during their hospitalization.

> Do not forget about the person. It has been very hard, the truth, because we have not been able to care as perhaps we would have liked to care, but that has been the greatest challenge: being able to meet all the needs of the patient with care that is a little different from usual. (NM10)

Similarly, an aspect of care that was highlighted was ensuring that the patient did not feel alone, trying to bring the family as close as possible and reinforcing behaviours that compensated the lack of closeness imposed by protective measures. Such measures included making calls or ensuring that the nurse had a greater presence in complicated situations.

> I have been able to accompany people who were dying to their last breath, who were alone, and I felt good because I was able to do that for them (…). There was also the challenge of keeping their families informed so that they would not be lost, not knowing where the relatives were or how they were admitted. (NM2)

> We asked them if they had been able to speak with their family; we would facilitate a call or make it ourselves and give the patient the phone. (NM10)

4.6 | 'One for all'

The crisis caused by COVID-19 became an opportunity for teamwork and collaboration among all the services that are part of patient care at the hospital.

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4.6.1 | Teamwork

Nurse managers reflected in their testimonies how during the first weeks of the health crisis, nursing teams were more united than ever, resulting in teamwork playing an important role not only in ensuring the quality of patient care and preserving the patients' safety but also in providing mutual support among nurses.

> These moments have really united the team. They have worked phenomenally as a team; they have laughed, they cried together …. (NM2)

This team spirit revealed the willingness of nursing professionals to become involved and offer their help with whatever was needed.

> It has been very easy to manage all the changes that have been generated in staff members, shifts, rotations; that is, they have helped a lot; they have made it much easier to be able to make the protocols and change them continuously. (NM10)

Support and unity were reflected not only among the nurses who performed their work at the bedside but also among the first-line nurse manager team.

> The support (…), the team of three was very helpful because you feel supported, the decisions, the consultations … I think it is a priority that as a team, we were going to direct, to organise as one, in synch, together, to get by, because there were many difficult moments. (NM6)

On the other hand, nurse managers reflected on how the relationship with the medical team was based on communication and trust. Meetings were held daily to address each patient condition; aspects of improvement were identified, and action plans were discussed and agreed upon. The crisis allowed the establishment of relationships and practices that were not usually carried out during patient care, which facilitated the provision of care and highlighted the focus on the patient.

> We have worked a lot as a team with the COVID team, which included infectious disease physicians, pneumologists … we met every day and talked patient by patient about how we saw it and how we could improve. (NM2)

4.6.2 | Collaboration

Collaboration among all the teams involved in patient care allowed the nurse managers to feel supported and ensured that decisions were made in a more agile and effective manner.

> We work at an institution where when you call, the doors open (…) but [it] also supports you with accompaniment (…). The support is impressive. (NM9)

> And then, I can tell you that other services have had (…) a very good attitude (…). They have made everything easier. (NM10)

Similarly, nurse managers valued the interdependence among the multiple departments of the hospital. They identified that their collaboration ensured that the needs of different services were covered quickly and diligently in a way that allowed formal channels to be skipped to expedite decision-making.

> When I had needs or doubts … I have always had a team that answered me at the moment and came and explained things to us. (NM2)

> There are many things for which, at certain times, the response is, 'Send me an email; write it down'. Well, no; now it is enough to call to get an answer, which I think has made things easier. In general, we have been open to not requiring written notification of authorisation to do something …. We have also been able to skip the usual regulatory channels to respond. (NM7)

5 | DISCUSSION

This study generated knowledge about nurse managers' experiences in the face of the COVID-19 pandemic in a hospital in Spain. Specifically, the findings provide explanations of these experiences as constant adaptation to change, participation in organizational decision-making at different levels, management of the uncertainty of the situation, prioritization of the biopsychosocial well-being of staff and preservation of humanized care, as well as an opportunity for teamwork and multi- and interprofessional collaboration. Additionally, the analysis of these experiences helped identify some of the competencies that nurse managers consider key from their experience to respond to a crisis, their dual role as patient and nurse mediators and strategies that may be useful in future pandemics.

In this study, adaptation to change was identified as a key experience that allows nurse managers to respond to the pandemic, with the peculiarity that during crises, adaptation must be developed continuously and diligently. Nurse managers identified this experience as a competency that they had to develop 'live' and required knowledge, attitudes and skills in reorganizing the processes and staff of the units, seeking quick solutions, making complex operational decisions and devising communication strategies with the team (e.g. using mobile apps) to obtain and convey new information quickly. These latter skills had previously been identified as essential for improving crisis leadership in the health context (Bookey-Bassett et al., 2020; Deitchman, 2013; Veenema et al., 2017). However, the literature indicates that organizations lack training programmes that prepare nurse managers to respond to a crisis (Baack & Alfred, 2013; Cariaso-Sugay et al., 2021; Hodge et al., 2017). Some of the findings of this study suggest the importance of nurse managers' attitude; specifically, they

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suggest that nurse managers must nurture a proactive and visionary attitude that allows them to anticipate events, analyse problems that may arise and think about how to avoid or minimize such problems. In this sense, integrating methodologies such as simulations, role-playing and case studies (Deitchman, 2013) into training may be interesting, which may allow nurse managers to improve their responses to future pandemic outbreaks of the same nature.

Another essential experience they have had to deal with and for which they must be trained in the face of COVID-19 is managing uncertainty. Nurse managers should project a sense of calm, confidence and authority among the staff in charge. These findings are consistent with the principles defined by the American Organization for Nursing Leadership for crisis management by nursing leaders and partially coincide with the results found in recent publications of the same nature (Bookey-Bassett et al., 2020; Shingler-Nace, 2020). The present study highlights the positive impact that leaders have on staff; by example, leaders encourage staff members to remain calm and modulate their attitudes and behaviours. These findings have interesting implications for teaching the management of uncertainty in a crisis situation and support the importance of training in emotional self-management for nurse managers.

In addition, the study allowed an examination of the protective role of nurse managers during the pandemic. Their dual mediating role has been linked to the so-called compassionate leadership in times of crisis, defined as 'the combination of supportive leadership approaches and the four components of compassion: attending, understanding, empathising and helping' (James & Bennett, 2020; Vogel & Flint, 2021). In this study, the characteristics of compassionate leadership have been reflected in the way in which a nurse manager relates to both patients and personnel during a pandemic. On the one hand, nurse managers have been the voice of patients during the crisis, prioritizing their needs at all times (Aquila et al., 2020). Recent studies corroborate this assertion (Bookey-Bassett et al., 2020; Hofmeyer & Taylor, 2021). Patient isolation and the absence of the relatives necessitated the development of strategies, such as telephone communication or a greater nurse presence, to alleviate the patients' loneliness and retain the essence of the patient–nurse relationship.

In line with the findings of other authors (Catania et al., 2020; Cathro & Blackmon, 2021; Hofmeyer & Taylor, 2021; White, 2021), the nurse managers in this study faced the challenge of protecting their staff members at the biopsychosocial level during the pandemic. Specifically, the findings of this study indicate that nurse managers in a crisis should ensure both the physical and mental protection of staff members, such as facilitating an adequate work environment, attending to psychological needs and/or providing emotional support. Among the strategies used to provide such support, being present both physically and emotionally through listening stands out (Bookey-Bassett et al., 2020). To this end, one practice that helps nurse managers to encourage and support their staff is, for instance, to create a space to frequently share fears and good and bad experiences, which results in feeling better and more confidently delivering care to patients. Hofmeyer and Taylor (2021) provide information, practice updates and resources to develop a personalized self-care plan to alleviate anxiety and support renewal and resilience. This strategic action of nurse managers can positively impact nurses' well-being and ability to provide safe and high-quality care for patients with COVID-19 (Hofmeyer & Taylor, 2021). Another interesting strategy used by nurse managers to support their staff, which was not found in the published literature, was the formation of related teams and the management of flexible shifts to ensure work–life balance. Because the balance between the two spheres is one of the priorities that nurses express for their professional development and proper performance under normal conditions (Vázquez-Calatayud et al., 2021), emphasizing this point in a situation as exceptional as a pandemic seems key. Through such actions, nurses will be able to count on the necessary support to maintain their well-being and reduce the possible harm caused by the crisis (Cathro & Blackmon, 2021).

Finally, the positive impact that working during the first wave of the pandemic had on the nurse managers of this study is notable; they felt support from superiors, peers and subordinates who worked 'one for all' in multi- and interprofessional collaboration with the common goal of providing the best patient care possible. This good relationship within and among teams can be attributed to the crucial moment that they experienced given that crises require professionals to assume interprofessional collaboration dynamics that are different from the usual dynamics (Reeves et al., 2010), which is a key element in times of crisis (Rosser et al., 2020).

5.1 | Limitations

As a limitation, this qualitative research gathers the experiences of nurse managers in a specific health context. Therefore, the findings pertain to the context in which the study took place and the perceptions of a limited number of participants. Although the sample can be considered small, it is sufficiently broad for a qualitative study because it ensured saturation of the data and redundancy in nurse managers' contributions. However, this study does not intend to generalize the findings but rather to provide in-depth knowledge about the reality perceived by the nurse managers included in the study. In this sense, developing similar research in other contexts would be desirable to improve the understanding of the phenomenon.

6 | CONCLUSIONS

This study provides evidence on the experiences of nurse managers during the COVID-19 pandemic. This knowledge can inform the design of educational and management strategies aimed at improving the management of the COVID-19 crisis and future pandemic outbreaks of a similar nature. A first step could be the development of training strategies for nurse managers to promote continuous and diligent adaptation to change and to help them manage uncertainty through training in emotional self-management and the promotion of a proactive and visionary attitude. Similarly, the importance of their

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dual role as patient–nursing staff mediators should be emphasized to provide an optimal response in a crisis. Lastly, these contributions must be further explored by carrying out new qualitative studies in other contexts.

7 | IMPLICATIONS FOR NURSING MANAGEMENT

Nurse managers can use these findings to improve organizational management policies during health catastrophes, including the impending waves of the COVID-19 pandemic, as well as future pandemic outbreaks of a similar nature. Similarly, the findings will serve as a basis for the design of educational strategies aiming to improve the key competencies that a nurse manager must learn to adequately respond to a crisis and ultimately improve the biopsychosocial well-being of staff and patient outcomes.

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

ETHICS STATEMENT

This research was approved by the Research Ethics Committee of the Navarre University (Code 2020.126) and by the hospital's management team and was performed in accordance with the criteria of the Declaration of Helsinki (2013).

DATA AVAILABILITY STATEMENT

Research data are not shared.

ORCID

Mónica Vázquez-Calatayud https://orcid.org/0000-0003-1073-4668

Elena Regaira-Martínez https://orcid.org/0000-0002-0892-5820

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REVIEW ARTICLE

WILEY

Exploring clinical leadership in long-term care: An integrative literature review

Parivash Enghiad MN, Nursing Instructor[1] | Lorraine Venturato PhD, Associate Professor[2] | Carol Ewashen PhD, Associate Professor Emeritas of Nursing[2]

[1]Faculty of Nursing, University of Calgary in Qatar, Doha, Qatar

[2]Faculty of Nursing, University of Calgary, Calgary, Alberta, Canada

Correspondence
Parivash Enghiad, Faculty of Nursing, University of Calgary in Qatar, Al-Rayyan Campus, P.O. Box 23133, Doha, Qatar.
Email: parivash.enghiad1@ucalgary.ca

Abstract

Aim: The aim of this study is to understand the concept of clinical leadership and clinical leadership development for nurses working with older adults in long-term care health care facilities.

Background: In Canada, clinical care within long-term care is undertaken by registered nurses and licenced practical nurses working with health care aides. Effective clinical leadership is essential for providing quality nursing care.

Evaluation: An integrative literature review using the framework of Whittemore and Knafl (2005). All selected articles were quality appraised using the Critical Appraisal Skills Program and the accuracy, authority, coverage, objectivity, date and significance checklist.

Key Issues: The analysis resulted in four themes: ambiguous definitions, practice-based and value-driven care, the impact of clinical leadership and clinical leadership development for Canadian nurses.

Conclusion: The findings suggest that ambiguity surrounds the concept of clinical leadership, with the term denoting both 'management' as a formal administrative role and 'leadership' in general. More recently, the clinical leadership focus has been on informal leadership by nurses at the bedside, where personal and professional values align with clinical action.

Implications for nursing management: Effective clinical leadership can have a positive impact on quality care and employee job satisfaction.

KEYWORDS
clinical leader, leader, leadership, licenced practical nurse, long-term care, nurse

1 | INTRODUCTION AND BACKGROUND

Canada has an aging population, and for the first time, the percentage of the population age 65 years and over exceeds those aged 15 years and under (Grenier, 2017). For many older adults, increasing age translates into increasing health problems and multiple co-morbidities. This means that, at some point, older adults may require health care in a residential care setting. These older adults' housing placements range from minimal support in independent living communities, which include housing for older adults with no major health issue and assisted living facilities that offer living space for older adults who may need help with their daily living activities, through to extensive

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support in residential or long-term care homes where supportive care is provided and memory care communities that are designed to provide care for residents with Alzheimer's disease and other forms of dementia (Kelly-Barton, 2015).

In Alberta, residential or long-term care may be provided in both assisted living and nursing home type settings depending on the amount and type of health care support required. In keeping with international conventions, the term 'long-term care' (LTC) will be used throughout this paper to describe both types of residential care settings. These settings are described as a union of health, personal care, accommodation and hospitality services that accommodate the well-being and independence of older adults who can no longer live independently without support (Alberta Health Services and Benefits, 2019).

In LTC, care is typically delivered by health care aides (HCAs) and licenced practical nurses (LPNs), often with a limited registered nurse (RN) presence. RNs in LTC often function in management roles, with most day-to-day clinical care being directed and provided by LPNs. Providing clinical care to older adults in these settings can be challenging because of a dual focus on quality of care and quality of life, while working within a highly regulated system with a diverse nursing workforce (McGilton et al., 2016). In LTC, care for older adults tends to be labour-intensive and challenging because of the wealth of complex health and social care needs present within a heterogeneous aging population (Faulk et al., 2008).

Currently, all nurses (RNs and LPNs) are expected to be clinical leaders and able to work within interprofessional collaborative teams in various health care settings to improve the health and care of patients (Cook & Leathard, 2004; Pepin et al., 2011). Importantly, clinical leadership is a way to improve quality of care (Stanley, 2006; Stanley et al., 2014). Therefore, effective clinical leadership could offer a solution to many of the challenges encountered with increased practice responsibilities, specifically among nurses working with older adults in long-term care in Canada. Because LPNs are the primary care providers in aged care (Corazzini et al., 2013), and effective CL can improve quality of care for the older-adult population and decrease healthcare costs through lowering staff turnover (Smith & Dabbs, 2007), clinical leadership development is essential for LPNs in LTC.

1.1 | Integrative literature review aim

The aim of this integrative literature review was to synthesize research studies and grey literature on the concept of clinical leadership and explore the relevance of clinical leadership for nurses working in long-term care. The integrative literature review was guided by the question: *How is clinical leadership conceptualized and developed for nurses in long-term care?*

2 | DESIGN

An integrative literature review approach is a systematic procedure for searching the literature and for analysing and synthesizing data to arrive at a comprehensive understanding of the selected topic (Whittemore & Knafl, 2005). An integrative review method allows for the review of findings of both qualitative and quantitative research.

2.1 | Search strategy

A literature search was completed using the following electronic databases: CINAHL plus, EMBASE (OVID), PubMed, Google Scholar and Medline. The key search terms were 'clinical leadership' OR 'nursing leadership' OR 'leadership' OR 'leader'; AND 'registered nurse' OR 'RN' OR 'licensed practical nurse' OR 'LPN' OR 'nurse' OR 'nursing' OR 'LVN'. The search included grey literature and snowballing from related literature.

The search inclusion criteria were peer-reviewed research articles and grey literature using the term 'clinical leadership' or 'leadership within nursing', specific to LPNs and RNs working in long-term care. The exclusion criteria were as follows: proceedings, dissertations or editorial articles; articles that related to acute care or hospital settings and articles not written in English.

The literature search resulted in 278 articles (see Figure 1). Fifteen duplicated articles were eliminated, and the remaining 263 articles were screened by abstract review, leading to 56 exclusions. The remaining 207 articles were assessed for eligibility, resulting in 16 articles that met all the study criteria (Table 1). The 16 selected articles used the term 'clinical leadership' or 'leadership within nursing', with most of the articles focused on nurse managers in a formal management or leadership role. Seven articles were broadly related to the concept of clinical leadership, one article focused on clinical leadership within LTC in Canada and four articles focused on clinical leadership within continuing care/LTC (Table 1).

2.2 | Quality appraisal

We employed three different appraisal tools to evaluate the 16 included articles (see Table 2 for a summary of these assessments). The Mixed Methods Appraisal Tool (MMAT, 2008) was used to assess the qualitative and quantitative research studies, which included five mixed-method studies. The MMAT explores key demensions of quality such as the clarity and appropriateness of the research questions, methodology and data collection, and coherence between the methodology, analysis and interpretation of data. This tool consisted of answering seven 'yes, no, or, can't tell' questions. Eleven articles were appraised as a 'yes' to all questions, whereas five articles received one 'cannot tell' to one of the questions. Overall, the quality of all the articles appraised with MMAT was good.

The Critical Appraisal Skills Program (CASP) was used to assess the quality of the two systematic literature reviews. The CASP evaluates literature review papers for the clarity of research questions, inclusion, relevences, quality of findings, applications, outcomes and

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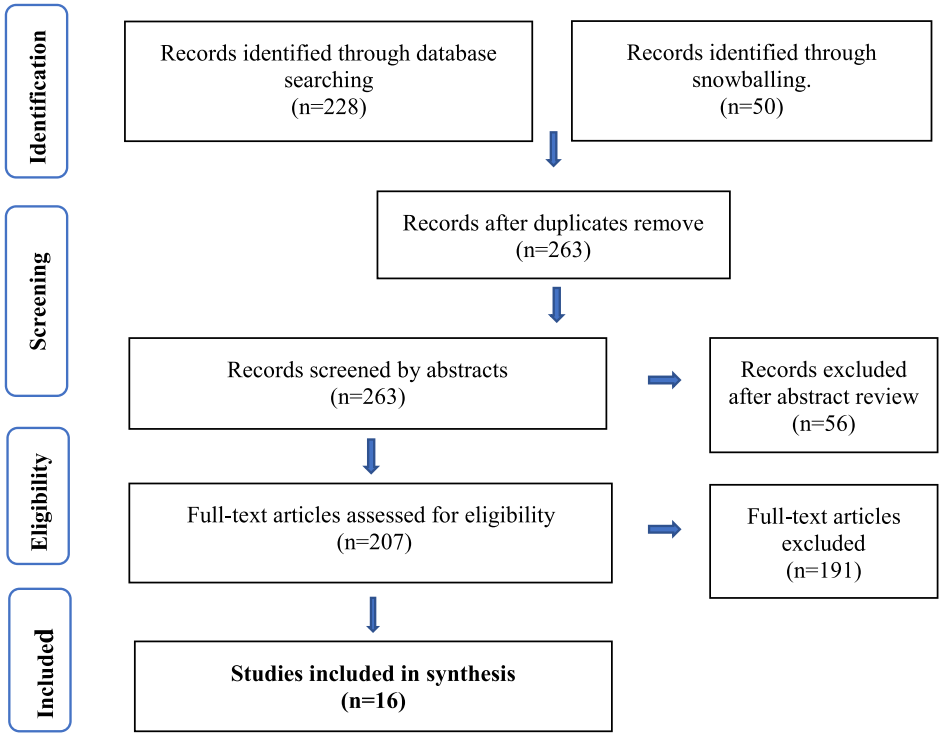

FIGURE 1 Flow diagram of search strategy

benefits with 32 'yes, no, and can't tell' questions. Both systematic reviews were assessed as good quality.

The AACODS (accuracy, authority, coverage, objectivity, date and significance) checklist was used to determine the quality of information in the three grey literature articles included in this review (see Table 2). Two of the included articles received a positive appraisal for all six AACODS categories, whereas one was assessed as unclear in accuracy but clear in all other categories.

3 | RESULTS

Summaries of each of the selected 16 articles, based on careful reading, are in Table 1. Study design or method of the 16 articles breaks down as follows: five mixed-method studies, four quantitative, one qualitative, three systematic literature reviews, one literature synthesis, one leadership development programme with self-assessment survey and one report on leadership education. Three of the studies were conducted in Canada, five in the USA, four in Australia, two in Ireland, one in the Philippines and one in Columbia, and papers were published between 2004 to 2018. The sample size for the four quantitative and six mixed-method studies ranged from 15 to 856, whereas the one qualitative study had 102 participants. Two studies included only LPNs or LPN students, four studies focused on RNs, and the rest focused on other health care workers. Clearly, the selected articles included a variety of methods, were international in scope and had a wide range of sample sizes.

3.1 | Thematic analysis

All articles were analysed thematically using Whittemore and Knafl's (2005) framework. This analysis involves a step-by-step process of noting patterns, and comparing and contrasting similarities and differences across all selected literature. Through this process, we identified four main themes related to the concept of clinical leadership: (1) ambiguous definitions; (2) practice-based, values-driven care; (3) the impact of clinical leadership and (4) clinical leadership development.

3.1.1 | Ambiguous definitions: Delineating clinical leadership, leadership and management

Although the concept of clinical leadership is garnering more attention in the literature (Jeon et al., 2010), a considerable lack of clarity persists. Although nurses and other healthcare professionals are reasonably familiar with the term and idea of 'leadership', *clinical leadership* is often a new term for them (Stanley & Stanley, 2018). Other leadership terms, such as nursing leadership or health care leadership, receive more attention and are more clearly defined in the health care and nursing literature (Stanley & Stanley, 2018), although these terms are often used interchangeably.

Two distinct meanings for the term 'clinical leadership' were found:

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TABLE 1 Summary of selected articles (total articles = 16)

	Author(s), year and title	Key findings	Study design or method	Origin	Setting	Participants
1	Curtis et al. (2011) Developing leadership in nursing: The impact of education and training	Leadership is an essential for nursing practice and has a positive impact on clinical outcome and employee satisfaction. Ongoing leadership training is important	Grey literature synthesis	Ireland	Health care	Nurse managers N = not specified
2	Faulk et al. (2008) Broadening the knowledge of the LPN long-term care provider: a pilot study	Gaps in LPN's leadership and management knowledge and skills were noted, and Showed improvent with a leadership education program.	Quantitative study; Pre/post questionnaire	USA	LTC	LPNs $N = 15$
3	Fiset et al. (2017) Clinical nursing leadership education in long-term care: intervention design and evaluation	There are demands for ongoing leadership training in LTC settings.	Mixed method study	Canada (Ontario)	LTC	RNs, registered PN, Nursing administrators $N = 29$
4	Gifford et al. (2013) Developing leadership capacity for guideline use: A pilot cluster randomized control trial	Leadership development requires developing vision, mission, and values. Using leadership guidelines can be useful with more work on tailoring the guidelines to the participants' special needs.	Mixed method study (sequential)	Canada (Ottawa)	Home health care	RN, RPN, Qualitative: $N = 26$ Quantitative chart audit: $N = 54$ (control), $N = 34$ (experimental)
5	Jeon et al. (2010) Policy options to improve leadership of middle managers in the Australian residential aged care setting: a Narrative synthesis	Despite differences, there is some overlapping characteristics between leadership and management elements such as communication, decision-making, integrity, Role modeling, negotiation, and setting standards.	Systematic literature synthesis	Australia	LTC	RN, LPN, nurse aid, director of nurse, advanced practice nurse, personal care assistant, Enrolled nurse, $N = 153$ (articles)
6	Jeon et al. (2015) Cluster randomized controlled trial of an aged care specific leadership and management programme to improve work environment, staff turnover, and care quality	Lack of definition of manager/leader characteristics within aged care.	Quantitative Delphi design study (double-blind, cluster, randomized controlled)	Australia	LTC	Staff, managers $N = 23$

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TABLE 1 (Continued)

	Author(s), year and title	Key findings	Study design or method	Origin	Setting	Participants
7	Lekan et al. (2011) Clinical leadership development in accelerated baccalaureate nursing students: An education innovation	Clinical leadership training has a positive impact on clinical care within a multidisciplinary team and a successful learning expeience.	Quantitative/qualitative; pre/post assessment; clinical leadership education	USA	LTC	Nursing students (RNs) $N = 40$ (pre-test); $N = 42$ (post-test)
8	Mbewe and Jones (2015) Does associate degree curricula adequately prepare nurses for leadership roles?	Lack of leadership preparational was identified in nursing curriculum. Leaders indicated lack of comfort in their role.	Mixed method	USA	Unknown (associate degree program)	Nursing students (RN) $N = 50$
9	McNamara et al. (2011) Boundary matters: Clinical leadership and the distinctive disciplinary contribution of nursing to multidisciplinary care	Clinical leadership development for nurses should be led by nurses themselves. Clinical leadership development should be stressed for all nurses as all nurses are clinical leaders	Mixed method	Ireland	National, regional & local tertiary centres.	Midwifes, Staff nurse Managers (RN) Directors $N = 144$
10	Moltio et al. (2015) Self-assessed clinical leadership competency of student nurses	In clinical leadership competency domains, personal qualities received the lowest mark while working with others, managing and improving services, and setting direction received highest marks from nursing participants. Sex was not a factor in establishment of clinical leadership competency.	Quantitative, descriptive study (self-questionnaire)	Philippines	University	Nursing student (bachelorette) $N = 74$
11	O'Rourke et al. (2004) Regional clinical nurse specialists in long-term care: With a focus on clinical, educational, research and leadership areas, clinical nurse specialists prove their worth in enhancing resident care in personal care homes	Developing mission, vision, and values are needed for building clinical teams and this requires both initiative and ongoing support.	Grey literature: Educational support for personal care home (PCH)	Canada (Manitoba)	LTC	All health care team of PCH
12	Scott-Cawiezell et al. (2004) Exploring nursing home staff's	Communication and leadership improvement can help develop a	Qualitative/quantitative; Cross-sectional	USA	LTC	RN, LPN, CNA $N = 856$, communication, $N = 845$, leadership,

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TABLE 1 (Continued)

	Author(s), year and title	Key findings	Study design or method	Origin	Setting	Participants
	perceptions of communication and leadership to facilitate quality improvement	quality improvement environment. LPNs reported lack of clarity in their leadership expectations and were the least satisfied group among the participants. LPNs had less openness in communication.				
13	Stanley and Stanley (2018) Clinical leadership and nursing explored: A literature Search	Clinical leadership frameworks and guidelines were required for middle managers in aged care. Literature recognizes clinical leaders values are parallel with their actions.	Systematic literature review (concept analysis)	Australia	All settings	ALL health care staffs (nation-wide literatures) $N = 27$
14	Venturato and Drew (2010) Beyond "doing": Supporting clinical leadership and nursing practice in aged care through innovative models of care	Communication, team work, clinical leadership, and clear articulating and modelling are key to success of health care models.	Qualitative, exploratory	Australia	LTC	RN, PCW, CNA, administration, $N = 19$
15	Vogelsmeier et al. (2010) Evaluation of a leadership development academy for RNs in long-term care	Preparing nurses to be effective leaders required structured leadership programme, consistent application, and reflection on practice.	Grey leadership: Development programme (self-assessment instrument)	Columbia	LTC	RN $N = 56$
16	Wittenberg-Lyles et al. (2013) The practical nurse: A case for COMFORT communication training	There is a lack of communication skills in nursing curriculum.	Pre-test/post-test design study	USA	LTC, home care settings	LPN students $N = 32$

Abbreviations: CAN, Certified Nursing Assistance; PCW, patient care worker; RPN, Registered Practical Nurse.

1. Clinical leadership associated with clinical care—which refers to nurses in a clinical role who demonstrate informal leadership associated with clinical care and clinical management, but without a formal leadership role title (Stanley & Stanley, 2018).
2. Clinical leadership associated with a formal management role—which refers to nurse leaders with a clinical background who carry formal authority, such as an administrative position (Gifford et al., 2013). Studies often refer to nursing leadership without any clear reference to the definition or type of leadership being studied, such as in O'Rourke et al. (2004).

Even pulling forward these two definitions of clinical leadership, developing clinical leadership theory and practice remains challenging, given that the research literature lacks clarity and distinction with respect to which type of leadership is under study. This ambiguity is further complicated by the fact that some behaviors and characteristics are common across all meanings of leadership, management and clinical leadership L. Table 3 summarizes both the distinct and the shared leadership features of management, leadership and clinical leadership that the review reveals. Some studies, such as Stanley and Stanley (2018), Venturato and Drew (2010) and

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TABLE 2 Quality appraisal

	Author(s) & year	Article Appraisal
1	Curtis et al. (2011)	***AACODS checklist*** Accuracy Y; Authority Y; Coverage Y; Objectivity Y; Date Y; Significant Y
2	Faulk et al. (2008)	***MMAT*** **Phase 1:** S1. Are there clear research questions? Y S2. Do the collected data allow to address the research questions? Y **Phase 2:** 1.1. Is the qualitative approach appropriate to answer the research question? Y 1.2. Are the qualitative data collection methods adequate to address the research question? Y 1.3. Are the findings adequately derived from the data? Y 1.4. Is the interpretation of results sufficiently substantiated by data? 1.5. Is there coherence between qualitative data sources, collection, analysis, and interpretation? Y
3	Fiset et al. (2017)	***MMAT,*** **Phase 1:** S1. Are there clear research questions? Y S2. Do the collected data allow to address the research questions? Y **Phase 2:** 5.1. Is there an adequate rationale for using a mixed method design to address the research question? Y 5.2. Are the different components of the study effectively integrated to answer the research question? Y 5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? CT 5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? Y 5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? Y
4	Gifford et al. (2013)	***MMAT*** **Phase 1:** S1. Are there clear research questions? Y S2. Do the collected data allow to address the research questions? Y **Phase 2:** 5.1. Is there an adequate rationale for using a mixed method design to address the research question? Y 5.2. Are the different components of the study effectively integrated to answer the research question? Y 5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? CT 5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? Y 5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? Y
5	Jeon et al. (2010)	***CASP*** 1. Did the review address a clearly focused question? Y 2. Did the authors look for the right type of papers? Y 3. Do you think all the important, relevant studies were included? Y 4. Did the review's authors do enough to assess quality of the included studies? Y 5. If the results of the review have been combined, was it reasonable to do so? Y 6. What are the overall results of the review? **Result very clear** 7. How precise are the results? Very precise 8. Can the results be applied to the local population? Y 9. Were all important outcomes considered? Y 10. Are the benefits worth the harms and costs? No harm
6	Jeon et al. (2015)	***MMAT*** **Phase 1:** S1. Are there clear research questions? Y S2. Do the collected data allow to address the research questions? Y **Phase 2:** 2.1. Is randomization appropriately performed? Y 2.2. Are the groups comparable at baseline? Y

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TABLE 2 (Continued)

	Author(s) & year	Article Appraisal
		2.3. Are there complete outcome data? Y 2.4. Are outcome assessors blinded to the intervention provided? Y 2.5 Did the participants adhere to the assigned intervention? Y
7	Lekan et al. (2011)	***MMAT*** **Phase 1:** S1. Are there clear research questions? Y S2. Do the collected data allow to address the research questions? Y **Phase 2:** 5.1. Is there an adequate rationale for using a mixed method design to address the research question? Y 5.2. Are the different components of the study effectively integrated to answer the research question? Y 5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? Y 5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? Y 5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? Y
8	Mbewe and Jones (2015)	***MMAT*** **Phase 1:** S1. Are there clear research questions? Y S2. Do the collected data allow to address the research questions? Y **Phase 2:** 5.1. Is there an adequate rationale for using a mixed method design to address the research question? Y 5.2. Are the different components of the study effectively integrated to answer the research question? Y 5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? Y 5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? Y 5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? CT
9	McNamara et al. (2011)	***MMAT*** **Phase 1:** S1. Are there clear research questions? Y S2. Do the collected data allow to address the research questions? Y **Phase 2:** 5.1. Is there an adequate rationale for using a mixed method design to address the research question? Y 5.2. Are the different components of the study effectively integrated to answer the research question? Y 5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? Y 5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? Y 5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? Y
10	Moltio et al. (2015)	***MMAT*** **Phase 1:** S1. Are there clear research questions? Y S2. Do the collected data allow to address the research questions? Y **Phase 2:** 4.1. Is the sampling strategy relevant to address the research question? Y 4.2. Is the sample representative of the target population? Y 4.3. Are the measurements appropriate? Y 4.4. Is the risk of nonresponse bias low? Y 4.5. Is the statistical analysis appropriate to answer the research question? Y
11	O'Rourke et al. (2004)	***AACODS checklist*** Accuracy Clear aim, CT about method; Authority Y; Coverage Y; Objectivity Y Date Y; Significant Y

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TABLE 2 (Continued)

	Author(s) & year	Article Appraisal
12	Scott-Cawiezell et al. (2004)	***MMAT*** **Phase 1:** S1. Are there clear research questions? Y S2. Do the collected data allow to address the research questions? Y **Phase 2:** 5.1. Is there an adequate rationale for using a mixed method design to address the research question? Y 5.2. Are the different components of the study effectively integrated to answer the research question? Y 5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted? Y 5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? Y 5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved? Y
13	Stanley and Stanley (2018)	***CASP*** 1. Did the review address a clearly focused question? Y 2. Did the authors look for the right type of papers? Y 3. Do you think all the important, relevant studies were included? Y 4. Did the review's authors do enough to assess quality of the included studies? Y 5. If the results of the review have been combined, was it reasonable to do so? Y 6. What are the overall results of the review? Very clear result 7. How precise are the results? Y 8. Can the results be applied to the local population? Y 9. Were all important outcomes considered? Y 10. Are the benefits worth the harms and costs? No harm
14	Vogelsmeier et al. (2010)	***AACODS checklist*** Accuracy Y; Authority Y; Coverage Y; Objectivity Y; Date Y; Significant Y
15	Venturato and Drew (2010)	***MMAT*** **Phase 1:** S1. Are there clear research questions? Y S2. Do the collected data allow to address the research questions? Y **Phase 2:** 1.1. Is the qualitative approach appropriate to answer the research question? Y 1.2. Are the qualitative data collection methods adequate to address the research question? Y 1.3. Are the findings adequately derived from the data? Y 1.4. Is the interpretation of results sufficiently substantiated by data? Y 1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation? Y
16	Wittenberg-Lyles et al. (2013)	***MMAT*** **Phase 1:** S1. Are there clear research questions? Y S2. Do the collected data allow to address the research questions? Y **Phase 2:** 3.1. Are the participants representative of the target population? Y 3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)? Y 3.3. Are there complete outcome data? Y 3.4. Are the confounders accounted for in the design and analysis? CT 3.5. During the study period, is the intervention administered (or exposure occurred) as intended? Y

Abbreviations: CT, cannot tell; Y, yes.

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TABLE 3 Distinct and shared leadership features

Management	Leadership	CL	Shared features
• Tied to a formal role & has positional authority • Often features a move away from the bedside, e.g., nurse unit manager • Team-building, inspiring a shared vision • Initiating/driving change • Influencing conflict management • Reinforcing vision • Delegating responsibilities	• May or may not be a formal role, with or without formal authority • May be a clinical lead position e.g., nurse educator or a clinical nurse specialist • Advanced/specialist clinical knowledge	• Clinical role with informal authority • Located at the bedside/in direct patient care. e.g., RN, LPN (clinical) • Teamwork • Clinically competent • Values- and beliefs- focused	• Communication • Decision-making • Empowering others • Role model

Moltio et al. (2015), focused on common, shared features like effective communication, being a decision-maker and empowering others. The overlapping and common characteristics among clinical leadership and leadership (management) (Table 3) also contributes to vague clinical leadership boundaries within the literature. Furthermore, much of the literature is focused on RNs, and the literature on clinical leadership in LTC and long-term care is limited.

Some studies align clinical leadership or leadership within formal managerial roles (Gifford et al., 2013; Jeon et al., 2010, 2015). These studies examined clinical leadership among nurse managers, midwives and directors. Clinical leaders were identified as having several responsibilities: delegation, planning, evaluation and supervision; sharing ambitions and organizational vision and improving relationship and organizational dynamics. Jeon et al. (2015) linked long-term care clinical leaders (in aged care), to 'middle managers' in Australia, whereas Stanley and Stanley (2018) explained that managers tend to be removed from 'the floor' or bedside to deal with staffing and resources issues. This shift then leads to less time and attention to direct client care. As well, Stanley and Stanley distinguish clinical leadership from titled leadership.

Some scholars, like Faulk et al. (2008) and Lekan et al. (2011), used the term clinical leadership in a more general sense. Clinical leaders were defined as having both formal and informal authority, with general leadership characteristics and behaviors, such as influencing others, managing conflicts, reinforcing the vision of the organization, achieving organizational goals and delegating tasks and responsibilities. These studies primarily focused on RNs and noted that leaders may or may not have a managerial or administrative role.

Stanley and Stanley (2018) define clinical leaders as those who are clinically competent, open and approachable and knowledgeable in their area of practice. Clinical leaders tend to have influence rather than authority and are often identified as informal leaders on the floor or at the bedside. They also identify a skill set for clinical leaders, which includes effective communication and decision-making, and having the ability to empower and motivate colleagues in the care team; they are also good role models and are visible in practice. They further identify clinical leaders as nurses who support team members in their clinical scope of practice. Clinical leaders are also embedded in the provision of clinical care and the hands-on, day-to-day clinical work (Jeon et al., 2015).

3.1.2 | Practice-based and values-driven care

Clinical leaders' beliefs and values are their motivations for providing high-quality care to patients and clients (O'Rourke et al., 2004; Stanley & Stanley, 2018; Venturato & Drew, 2010). Clinical leaders stand by their nursing values when a conflict occurs, and when they face critical problems and practice challenges, their values and beliefs align with their actions. As mentioned previously, Stanley and Stanley (2018) found that clinical leaders adhere to the same values in clinical practice that motivated them to pursue nursing in the first place, such as respect for others and concern for the well-being of others. They also emphasize the impact of clinical leaders' individual values such as being caring on their motivation to work (O'Rourke et al., 2004). Clinical leaders get recognized because of their orientation to providing care and their passion for providing high quality of care for their patients/client (Moltio et al., 2015; Stanley & Stanley, 2018). Other team members recognize clinical leaders because their practice is based on, and guided by, the same beliefs and values that the team members uphold. As a result, nurses follow clinical leaders whose values are comparable to their own (Stanley & Stanley, 2018).

3.1.3 | Impact of clinical leadership

The literature has repeatedly reported the impact of nursing leadership on patient outcomes and employee satisfaction (Curtis et al., 2011; Jeon et al., 2010; Vogelsmeier et al., 2010; Venturato & Drew, 2010; McNamara et al., 2011; Wittenberg-Lyles et al., 2013). Clinical leadership was identified as a factor in nurses' job satisfaction and retention. This is important, because job satisfaction improves retention of nurses and can enhance the quality of patient care (Curtis et al., 2011; Faulk et al., 2008; Venturato & Drew, 2010; Wittenberg-Lyles et al., 2013). Further, high nurse turnover can result in poor patient outcomes within LTC settings and can lead to increases in rates of infection, pressure ulcers and behavioural issues (Venturato & Drew, 2010). Researchers have also noted that the presence of skilled clinical leaders ensures patients receive high-quality care (Curtis et al., 2011; Venturato & Drew, 2010; Wittenberg-Lyles et al., 2013).

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3.1.4 | Clinical leadership development for Canadian/Alberta nurses

In this literature review, we found a limited number of studies on clinical leadership in Canada, and particularly in relation to long-term care. Among the six studies conducted in Canada, only one study and one article were related to long-term care. The literature review results suggest that very few countries offer a systematic comprehensive clinical leadership development programme (CLDP). The Royal College of Nursing in the UK is one of the programmes that offers a CLDP to improve staff nurses' clinical leadership skills in acute care and community health care settings. An American leadership education programme, learn, empower, achieve, produce (LEAP), is a clinical leadership programme designed specifically for aged-care settings to enable staff empowerment and job satisfaction (Jeon et al., 2010).

The need for clinical leadership training has been highlighted in many studies (Fiset et al., 2017; Gifford et al., 2013), and the literature on clinical leadership development mirrors the approach taken in defining clinical leadership, in that it focuses on behaviours and skills particularly in relation to clinical leadership characteristics, such as communication, teamwork and role-modelling (Table 3). Most of these studies were conducted on undergraduate and graduate RNs in relation to clinical leadership; they reached the same conclusion, which is that leadership training for nurses is a necessity (Mbewe & Jones, 2015; Moltio et al., 2015). Mbewe and Jones (2015) identified that there are existing concerns among new RN graduates about their lack of adequate leadership training. Their concerns were specific to teamwork, collaboration and professional identity. Moltio et al. (2015) highlighted the need for leadership training to be incorporated early in undergraduate RN education. Faulk et al. (2008) explain that some skills, such as quality improvement, delegation, conflict resolution and team-building, are essential for delivering care of a high quality. They also identified the need for further research to develop various characteristics of clinical leadership skills for LPNs in LTC settings.

Some studies noted some limits to LPN leadership education and skills, acknowledging the need for specific leadership and focused clinical leadership training. For instance, Faulk et al. (2008) discussed LPNs' limited exposure to quality improvement, delegation, conflict management and team-building, whereas Scott-Cawiezell et al. (2004) showed that LPNs had less exposure to, or education in, leadership like teambuilding, conflict management, delegation and communication. Fiset et al. (2017) emphasized clinical leadership learning requirements, such as communication and conflict management skills, for LPNs in LTC settings. Similarly, Wittenberg-Lyles et al.'s (2013) study captured the importance of improvement in communication skills. Scott-Cawiezell et al. (2004), Fiset et al. (2017) and Faulk et al. (2008) agreed on the need for further research to address the limited leadership learning resources, along with the need for improvement in clinical leadership skills for those who are working in residential aged-care contexts.

4 | DISCUSSION

Clinical leadership has been defined in various ways in the literature, which has directed researchers down different paths. Even with the ambiguous and varied definitions in the literature (Brown et al., 2016), most scholars define clinical leadership according to a set of desired behaviours or skills. Notably, some of the described characteristics for a clinical leader across these various definitions have been consistent: being an expert and experienced nurse, someone with effective communication skills and being willing to help team members. Harper (1995) and Stanley (2008) identify clinical leaders as nurses who support team members in their clinical scope of practice. The majority of definitions identify clinical leaders as experts and experienced clinical nurses in their specialty (Dierckx de Casterlé et al., 2008; Harper, 1995; McNamara et al., 2011; Stanley et al., 2012).

A few researchers have expressed other characteristics of clinical leaders—nursing values, integrity, trust, autonomy, privacy, humanity, hope, security and personhood—that drive nurses in their practice, shape them (Fagermoen,1997) and motivate them as clinical leaders (Stanley, 2016). Among the various theories of clinical leadership, congruent clinical leadership theory is one that is relevant for nursing. This theory defines clinical leaders as 'valuers'. This theory is well suited to nurses, because their shared values are what bring them to this profession (Stanley, 2016). Moreover, despite other theories that have been *adopted* by nurses, congruent clinical leadership theory was developed based on studies that *focused on* health care professionals, especially nurses. Congruent clinical leadership theory offers nurses a framework to advance their leadership, which is matched with their values, beliefs and actions, can apply to 'anyone' and is not limited to titled older adunurses or managers. Congruent clinical leadership defines clinical leaders as those who are clinically competent, knowledgeable, effective communicators, decision-makers and empowered motivators. They are also open and approachable, role models for others on their team, visible in practice and act on their values. Team members follow a clinical leader who inspires them with their shared values (Stanley, 2016). Therefore, given these compelling reasons, congruent clinical leadership theory is higly relevant for a nurse clinical leader.

Other literature has described the influence of nursing leadership on patient outcomes and employee satisfaction. Pepin et al. (2011) emphasize the importance of clinical leadership as one of the key factors in enhancing the quality and safety of care across acute care settings, whereas McGilton et al. (2016) highlight the influence of nursing leadership on nursing aids' job satisfaction and quality of care for residents in LTC. Clinical leaders' knowledge, skills and experiences empower them daily to make clinical decisions that translate into a higher quality of care for patients (Dierckx de Casterlé et al., 2008). Although the studies show significant benefits of effective CL on older-adult quality of life, job satisfaction and health care cost reduction, limited research exists on clinical leadership training and development (Smith & Dabbs, 2007).

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TABLE 4 Example of LPN programmes in Canada

Province	Program	Example training provider	Length
Newfoundland and Labrador	LPN diploma	Centre for Nursing studies	16 months
British Colombia	LPN diploma	Vancouver community College	16 months
Alberta	LPN diploma	Bow Valley College	20 months
Nova Scotia	LPN diploma	Nova Scotia community College	2 years
New Brunswick	LPN diploma	New Brunswick community College	2 years
Manitoba	LPN diploma	Assiniboine community College	2 years
Saskatchewan	LPN diploma	Saskatchewan polytechnic	2 years
Nunavut	LPN diploma	Nunavut Arctic College	2 years
Quebec	Nursing intensive programme diploma	John Abbott College	2 years
Yukon	LPN diploma	Yukon College	2 years
Prince Edward Island	LPN diploma	Holland College	2 years
Ontario	LPN diploma	Georgian College	30 months

This review revealed a focus in the literature on the impact of clinical leadership on the quality of RN practice, but few studies look at clinical leadership development for LPNs. This gap matters because RNs, LPNs, enrolled nurses (ENs) and registered practical nurse (RPN) have distinct education, training and practice experience in clinical judgement, critical thinking and leadership (Unruh, 2003). The length and content of LPN programmes vary in various countries and even among Canadian provinces (Table 4). For instance, whereas Vancouver Community College (2018) in British Columbia has a programme of 16 months, Bow Valley College (2018) in Alberta, Canada, offers a longer 20-month LPN programme, and Georgian College (2018) in Ontario offers a more extended 30 months programme. In the United States, current LPN programmes can be as short as 12 months (Faulk et al., 2008). This variation in programme length is a result of the LPN programmes being modified to serve jurisdictional expectations (Butcher & Mackinnon, 2015).

5 | CONCLUSIONS

Despite these variable training and jurisdictional requirements, LPNs provide more than 70% of aged care across North America (Corazzini et al., 2013). Because LPNs are now responsible for increasingly complex activities, including supervising care aides, building and leading teams, making critical decisions, resolving conflict, dealing with families and collaborating with other healthcare disciplines (Tarnowski et al., 2017), clinical leadership training for nurses, especially LPNs, is crucial.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

Despite considerable research on clinical leadership, a lack of clarity in the clinical leadership concept remains. Some studies associated clinical leadership with clinical care, whereas others associated it with a formal management role. Nurse managers would have to clearly communicate how clinical leadership is understood as well as the respective clinical leadership responsibilities. To date, published literature identifies clinical leadership responsibilities as follows: delegation, planning, evaluation and supervision; sharing ambitions and organizational vision and improving relationship and organizational dynamics. More importantly for managers, clinical leaders are valuable in acknowledging and validating those who provide frontline day-to-day clinical work and in exemplifying professional beliefs and values to team members.

The results of this integrative literature review suggest a potential positive impact of clinical leadership training for staff with improved job satisfaction and improved retention of nurses. Although clinical leaders may not formally have a managerial position, clinical leaders motivate their clinical colleagues, are value-driven and have expertise in hands-on clinical work. Nurses with effective clinical leadership skills could work with managers to create a positive work culture and effective, efficient clinical teams. Training in clinical leadership could promote best nursing practice and improve patient and programme quality of care and safety.

Ultimately, literature review supports the need for clinical leadership training for nurses in particular new RN graduates and LPNs. This concern has been more specific to teamwork, collaboration and professional identity.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICS STATEMENT

Ethical approval was not required for this manuscript because this was an integrative literature review.

DATA AVAILABILITY STATEMENT

The data that support the findings of this integrative literature review are openly available and listed in Table 1 and references.

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ORCID

Parivash Enghiad https://orcid.org/0000-0003-4065-1951

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