What Model of Clinical Nursing Leadership Has the Most Impact on the Quality of Care at the Unit Level and How Would It Be Best to Implement a New Clinical Nursing Leadership System? – A Literature Review

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ABSTRACT

Background

As the healthcare sector seems to change constantly due to economic downturns, chaotic work settings, retirements of clinical leaders and resources shortages; the implementation of effective leadership approaches has become necessary to ensure better delivery of healthcare and patient satisfaction. Although there is a wide body of knowledge regarding the positive influence of clinical leadership models in practice, some gaps still exist in the approaches of implementing such leadership models at the clinical unit level.

Aim

The aim of this dissertation is to analyse the effectiveness of clinical leadership models and the influence that these models have on the quality of care at the unit level. The dissertation also aims to recommend how a new clinical nursing leadership system could be implemented in healthcare units.

Methods

This dissertation is a literature review, assessing and analysing relevant primary research from medical databases and journals collected from the period of 2006 to present. Thematic analysis was used to analyse the search results.

Results

A total of eight studies satisfied the eligibility criteria and were included. Current evidence suggests associations between positive clinical leadership, increased openness in communication, higher patient satisfaction, and lower medical errors.

Conclusions

There is a positive association between clinical nursing leadership and a variety of patient outcomes. However, future testing of various clinical leadership models is warranted to test the best mechanisms to implement clinical leadership in nursing practice.

Chapter One - Background

1.1 Introduction

This chapter gives an overview surrounding the research focus of this literature review, and also highlights its main aim and objectives. The main research focus of this dissertation is the impact leadership has in the field of nursing, in terms of their impact on quality of care, and also on nurse satisfaction. The sustenance of care quality is being tested in the modern age given the workforce shortages, economic downturn, and the work environments being increasingly stressful; thus any improvements in improving patient care is still considered a major challenge. The right leadership model, however, may be critical for change- and may retain and attract high-performing nurses as followers, allowing for a bettered quality of care.

1.2 Background

The achievement of effective professional and high-quality care within the healthcare system nowadays depend on the performance of health providers- which is mainly assessed by improvements of patient outcomes (Wong and Cummings, 2009). In recent years, clinical leadership has become an increasingly important factor for ensuring the effective delivery of healthcare (Cummings *et* al., 2010). In their 2013 paper, Storey and Holti stated clinical nursing leadership to be the development of specific interpersonal and characteristic skills. Although some personal characteristics, such as a sense of leadership and influence on change, remain essential parts of clinical leadership- there are other factors that play a major role in effective clinical nursing leadership allowing for the delivery of high quality care. Cook (2001) stated the presence of four clinical leadership styles in nursing: transactional, connective, renaissance, and transformational. Varied clinical leadership styles have been adopted worldwide in recent years due to their increasing evidence of positive effects on quality of care. This evidence however varies according to leadership style; transformational leadership has been long viewed to be ideal in healthcare (Carryer *et al*., 2007). Healthcare management focusses on the development of care work, ensuring the best possible conditions are met to maximise the quality of patient care- the care and the quality of care provided to patients remain top

priority for such management forms (Wong and Cummings, 2009). Effective management, however, is much relied on teamwork within a healthcare unit. Collegial support, both in terms of social and technical support, have been linked with being positively associated with the overall job satisfaction of healthcare providers (Laschinger *et al*., 2009) According to Özpehlivan and Acar (2015), support from managers was associated with increased job satisfaction and improved quality of work in healthcare providers. Both managerial support and leadership- although distinct with separate systems of action- tend to be complementary (Kotter, 2013).

Management involves a set of processes, such as planning, budgeting and job structuring, to allow for the basic purpose of an organisation to be carried out. On the other hand, leadership allows for improvements in certain sectors of an organisation, with focus on empowering followers or allowing for change in activities. Due to them being situation dependent, leadership styles may require to be adapted based on the needs of the followers, the team, and the unit as a whole (Kotter, 2013). With the advances in modern day medicine, a global improvement in the quality of treatment had been attained, along with improved life spans- however, the human factor still remains a major constant, with the key to a successful harmony among healthcare providers and patients being dependent on leadership (Wong *et al*., 2013). Effective nurse leaders tend to work at both unit and organisational level; while unit level focusses on decisions that are directly linked to treatment and patient care; organisational level decisions contribute to policy making, interventions, changes in treatment modes, etc. Unit level leadership focusses on achieving optimal patient outcomes using safe care treatment/ procedures- these leaders engage nurses in decision making to improve overall care delivery. On the other hand, at an organisational level, these leaders participate at senior level decision making by contributing to strategic directions. Nevertheless, effective leadership traits at both levels are equally important to ensure improved care outcomes. This research focus of this dissertation is on clinical nursing leadership's impact on the nursing setting and quality of care. This dissertation will collect and analyse evidence about the relationship between clinical nursing leadership and the quality of care. This may also aid in leading future interventions and policy making in the author's place of work and influence the roles of nurses.

1.3 Research question

The research question that this dissertation focuses on is stated as follows: 'What model of clinical nursing leadership has the most impact on the quality of care at the unit level, and how would it be best to implement a new clinical nursing leadership system?'

1.4 Aim and objectives

The purpose of this study is to analyse existing literature on the effectiveness of clinical leadership models and the influence that these models may have on the quality of care at the unit level. The study aims to recommend how a new clinical nursing leadership system could be implemented with three specific objectives:

1- To summarise related published articles that consider whether or not clinical leadership in nursing is effective. This will help to identify current gaps that may cause compromised care in the healthcare sector.

2- To examine literature on clinical leadership models and its effectiveness on competencies of nurse leaders, including the quality of care at the unit level.

3- To recommend the most effective clinical leadership model and how this could be implemented at unit level.

1.5 Structure of the dissertation

The dissertation starts with giving the background of clinical leadership and its significance. It then highlights the importance of investing more in research to assess the different types of clinical leadership and their influence on the quality of care. The literature review is set as the focus of the second chapter. Chapter three explores the different styles of research methodologies, methods of research, and then describes literature review as the selected method to address the dissertation's question. Chapter four describes the eligibility criteria, the search strategy, databases, keywords used, data collection methods, and thematic analysis as the selected method for collecting and analysing data. Chapter five describes the search results. Lastly, chapter six summarises the findings of the dissertation; this chapter further gives recommendations for further research and is followed by a list of references.

1.6 Conclusion

This chapter has outlined the background to the dissertation's focus. It has given a summary of leadership in nursing as a promising approach in healthcare settings. It also listed the overall aim and the specific objectives of the dissertation.

Chapter Two – Literature Review

2.1 Introduction

Although the literature on clinical nursing leadership (CNL) covers a wide variety of subjects, this chapter focuses on reviewing what is known about the impact implementing clinical leadership models; with particular focus on the impact on the quality of nursing care- both in terms of nurses' skills and satisfaction, and quality of patient care received. Further, this chapter also focuses on addressing the gaps in nursing research regarding clinical leadership while providing an overview of potential effective models. It begins with introducing and defining clinical leadership, after which it focuses on what researchers have investigated in this subject so far. The chapter goes on to examine the different models of clinical nursing leadership; how it functions and whether it may be effective in a clinical setting.

2.2 Background – Clinical nursing leadership

Healthcare systems worldwide are looking for effective ways to decrease the burden of healthcare costs and to improve health outcomes (Leonard *et al*., 2004). Researchers have also been focussed on obtaining a balance in the relationship between policy, leadership, and health (Bevan, 2010). The importance of effective leadership in healthcare has been emphasised as they represent amongst the main disciplines of healthcare; nursing leadership is pivotal to this (Roussel *et al*., 2009). In their 1999 study, Antrobus and Kitson reported that as compared to leadership within other domains (academic, management and political), clinical practice leadership has a rather poor status and offers a limited career structure. This finding was similarly observed over the years- in their 2004 study, Heller *et al* suggested the inadequate preparation of the nurses at an academic level to be amongst the main reasons for this lowered status of clinical practice leadership. According to this study, at the educational level, nurses aren't taught of the importance of leadership or as to how they may be able to develop their leadership skills. As clinical settings often follow various leadership styles, new nurses may find it difficult to work under such leaders- possibly contributing to increased work stress and burnout. Due to this rather strenuous transition into a clinical setting, several new nurses may not be able to meet clinical demands; further, as these nurses gain

expertise, they may rely solely on experience in their future leadership roles which may be ineffective depending on situation. New nurses are faced with several new challenges as compared to earlier times (these include cultural diversity, financial constraints, new technologies and new roles); according to Curtis *et al* (2011) leadership within nursing should not be viewed as being optional- and must be integrated into nurses' education programmes. Further, apart from leadership qualities, the importance of teamwork and communication have been largely absent in formal training; according to Leonard *et al* (2004), inadvertent patient harm is mostly caused due to communication failures.

According to Stanley (2006), several variations exist on the standard and definition of clinical nursing leadership. In their 2013 study, Bender *et al* also reported the differences on assumed clinical leadership standards. Leadership tends to involve a host of factors including power, influence, goals and followership; it conjures several thoughts, images and reflections. Several definitions to leadership exist given that various dimensions of it had been evidenced; a common theme that had been observed in several of these definitions is that "'leadership involves influencing the attitudes, beliefs, behaviours and feelings of other people" (Spector, 2006 as referred to in Curtis *et al*., 2011; p. 306). In this dissertation, clinical nursing leadership is defined as delivering care at the bedside by professional nurses who have sufficient clinical knowledge and improved clinical and organisational skills to perform multi-approach thinking. The following definition of clinical leadership in nursing will be used: *''A professional competency demonstrated in clinical care which improves the behaviour and skills of nurses to encourage others in the work environment to promote healthcare and patients' outcomes''* (adapted from Cook and Leathard, 2004). According to several studies (Cook, 2001; Duffield *et al,* 2001; Firth, 2002), skilled nursing leaders can have a key role in informing the whole nursing profession to be more sensible and responsive to the complex nature of healthcare systems. For example, the Canadian Nurses Association (2009) said that nursing leaders can be, and not limited to, senior managers, chief executives, policy-makers, and administrators. It also added that having nursing leaders facilitate advocacy for quality healthcare, collaboration, communication, and evaluation within the health system.

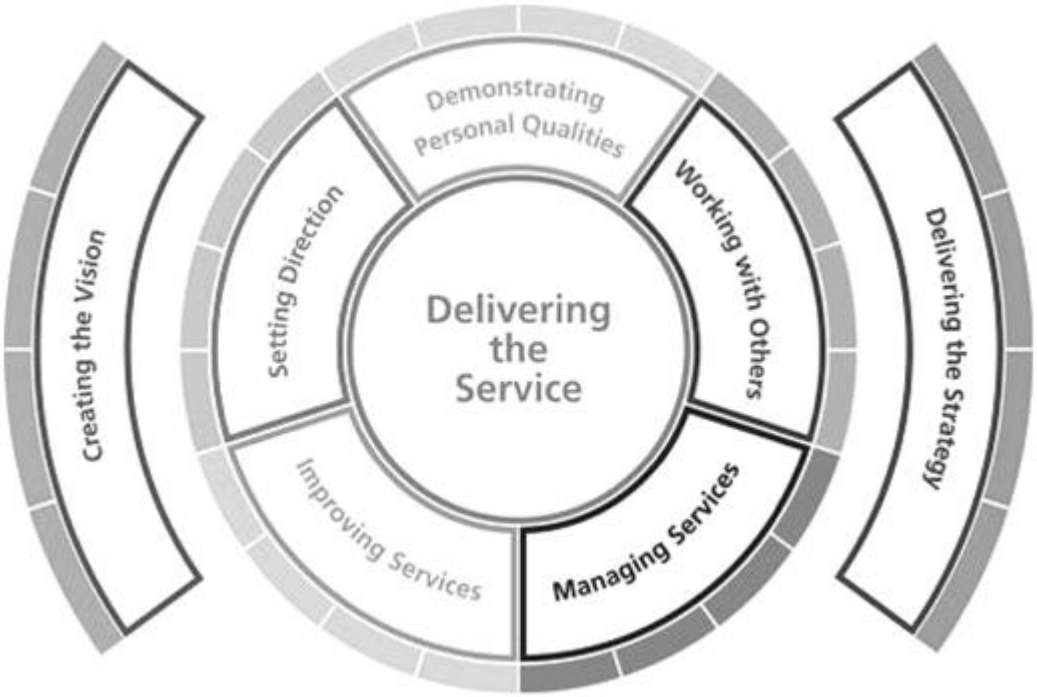

Fig 1.1) Nursing leadership framework (adapted from Moltio *et al*., 2015)

The delivery of high quality service to the clients is considered the primary aim of clinical leadership in healthcare services (NHS, 2012). According to Moltio *et al* (2015), "it is vital to be competent in the 5 core domains of leadership framework namely: (1) demonstrating personal qualities, (2) working with others, (3) managing services, (4) improving services and (5) setting direction" (Moltio *et al*., 2015; p77) (Figure 1.1). However, over the years, researchers had observed the rather interchangeable use of the terms clinical nursing leadership and leadership at the administrative or managerial level (Cook, 2001; Connelly et al, 2003). While a few researchers believe leadership to be far more complex than management skills, several researchers also believe leadership to be amongst the primary functions of a good manager. In nursing, leadership is largely dependent on nursing knowledge derived from their nursing practice- these leaders tend to influence and improve practice environment making them largely different from general leadership (Curtis *et al*., 2011). This knowledgebase of their work/ profession also allows them to translate the same into policies, thereby influencing the context in which they operate (Antrobus and Kitson, 1999). The poor development of nursing leadership, owing to the poor academic foundation of the same, may be detrimental to nursing knowledge and also affect their partnership with other leadership domains (academic, management, and political), limiting their role to perform. However,

nursing leadership is still challenging for nurses themselves. According to Cook (2001), the nursing environments had been limited by several issues- mostly surrounding funding and staffing problems. Wong and Laschinger (2012) report these issues to be far more prominent in the current age especially due to the workforce shortages, stressful work environments and declining economy. Nevertheless, the right leadership model may allow for leaders to guide followers despite these issues, and obtain the highest possible quality of patient care.

2.2.1 Clinical nursing leadership in literature

Clinical nursing leadership has been rather widely studied in across the globe (Connelly *et al*, 2003; Stanley, 2006). Whilst reading available literature on clinical leadership in nursing practice, it was noticed that there were significant variations in the definition of clinical leadership. Several researchers believe that although research investigates the nature of authority and impact of clinical leadership in nursing, it did not offer a clear definition of it (Salanova *et al*., 2011; Wong and Laschinger, 2012). Most researchers, using qualitative or quantitative methods, had examined role definition and its effectiveness in clinical nursing leadership within healthcare systems. In their 2007 study, Carryer *et al* claimed three practice domains to characterise the core role of nurses; dynamic practice, professional efficacy and clinical leadership. This study observed that although nurses increase the range of service contexts by incorporating a range of tasks and procedures, the lack of international standardisation in relation to advanced practice nursing roles tend to lower output and leadership efficacy. Further, a few studies suggested professional development for nursing leaders in healthcare. This is in line with studies that obtained the lack of sufficient academic guidance in calling for the preparation of nurse leaders. When it came to nurse leaders, several studies had also made some attempts to specify their roles as clinical nursing leaders in their health systems (Goudreau *et al,* 2014).

In his study, Cook (2001) had collected evidence on the growth of clinical nursing leadership across the UK, the U.S.A and Australia from 1992 to 1997. This study obtained its research data by interviewing clinical nurse leaders. Cook observed that within clinical settings, the leadership themes revolved around four major styles, or the combination of them; he identified these styles as 1) transactional, 2) transformational, 3)

connective, and 4) renaissance leadership styles. This study critically reviewed these leadership styles and assessed how it could be used to influence change. Transactional leadership uses an exchange or transaction between workers, leaders and colleagues in order to accomplish work; this had been referred to as the autocratic leadership form in the past. Transformational leadership is an example of “rationally focussed leadership” which uses motivation as key- to allow followers to believe they could exceed their own expectations (Cummings *et al*., 2010). Apart from motivation, transformational leaders also use individualised consideration and intellectual stimulation to achieve results; it is also related to democratic styles of leadership which involves leaders and employees to be engaged in a common objective of encouraging positive change and innovation (Burns, 2001). The connective leadership form had been suggested to be an improvement over transformational style, being more affiliative- transformational styles had been suggested to have more emphasis on conflict and competition (Cummings *et al*., 2010). The connective leadership style aims to empower the workforce by building collaborative work and communication channels that support change; this theme has similarities to both transformational and renaissance themes (Ewens, 2002). Renaissance leadership requires the effective use of power and the ability to communicate on different levels to make stakeholders favour changes; this theme was previously called a ‘charismatic’ theme (Cook, 2001). Despite the various leadership styles, most follow common goals for the empowerment of the group or organisation. Fig 1.2 sets out a few of such key roles which may be used interchangeably across leadership styles.

- Teaching
- Inspiring confidence
- Empowering
- Improving performance – supporting reflection/clinical supervision
- Rewarding and recognizing individual contributions
- Recognizing the needs of the service from clinically based environment
- Leading and developing services – implementing change
- Supporting the organization and, when necessary, providing a bridge between senior management and team members/employees in informing, supporting and developing national agreed initiatives/government initiatives

Fig 1.2) Leadership roles in healthcare (Oliver, 2006)

In their 2011 study, Bender *et al* stressed on the importance of an ideal leader being able to carry out both organisational and systemic tasks. While organisational determinants revolve around resource allocation, management structures and leadership; systemic determinants include direct relations with practitioners and patients, as well as their social and cultural norms. The combination of both clinical and administrative tasks may be easier to handle for nurses as compared to other professions- as mentioned earlier, nursing leadership traits are highly determined by the nursing knowledge. The nurses can thus use the knowledge gained form experiences in the unit to frame policies and recommendations that may aid in the better working environments of their colleagues/ followers (Curtis *et al*., 2011). However, despite this, several research groups had investigated the roles of nurse managers and obtained that several nurse managers' report problems in balancing administrative and clinical practice of their jobs (Rice *et al*., 2010; Tilden, 2011). According to Doherty (2003), *"At the beginning of the 21st century ward sisters and charge nurses are viewed as having a pivotal role in health care, perhaps with little clarity about what this means in practice"* (Doherty, 2003, p. 35). However, the importance of management roles in addition to clinical roles is well understood today. Only nurses with clinical experience may be able to correctly guide policies and recommendations in the healthcare sector. These, in turn, may allow for the betterment of their colleagues/ followers whilst paving way for better care quality.

2.3 The impact of clinical leadership in nursing

Patient safety is a science that is subject to constant changes; given the increased burden of disease over recent years, there remain several unknown factors (Curtis *et al*., 2011). Determining the exact results of unsafe care thus remains a rather tedious task. This section looks into the attributes of leadership in clinical nursing; whether the right leadership model would in fact be advantageous to the healthcare system. In his 2001 study, Loke claimed that effective clinical leadership led to improved interpersonal and organisational skills within healthcare workers. This study was conducted in Singapore and conducted interviews on 100 nurses; the improved skills that resulted with effective leadership also allowed for an increase in competence. The nurses reported clinical leaders to be able to recognise individual success, thus acting as role models. The support that these nurses receive from their leaders in turn allow for their own skill acquisition. For example, Connelly et al (2003) grouped several advantages of clinical

nurse leaders into four main categories; 1) technical, 2) critical analysis, 3) organisational skills, and 4) personal skills. Therefore, an ideal leader may contribute to educating their followers on such skills; which woud further uplift quality of patient care. Further, according to Connelly et al, an efficient clinical leader would be one who has experience and knowledge in each one of the categories.

According to Laschinger and Leiter (2006), an ideal nurse leader has various roles- including that of increasing support among co-workers, building professional relationships, deciding on staffing levels and being involved in policy-related decision making. The study concluded that the conditions for work engagement and patient safety were ultimately determined by nursing leadership. The conditions for work engagement tend to be supported by other researchers as well; for example, Bender et al (2011) reported the strong link between employee work satisfaction and burnout with leadership qualities. An efficient leader would keep employees satisfied with their jobs, which in turn allow them to thrive harder at their work roles- thus perhaps improving patient care. A few studies (Vogus and Sutcliffe, 2007; Wong and Cummings, 2007) have also looked into the direct outcomes on patient care due to leadership. For example, Vogus and Sutcliffe (2007) conducted interviews among staff in 10 hospitals; this study obtained fewer medication errors that resulted in hospital units as a result of trusted leadership combined with high levels of safety organising. Similarly, in their 2007 review, Wong and Cummings obtained a significant increase in patient satisfaction as well as a lowered prevalence of adverse events that resulted from positive leadership practices. This study reported relationship-oriented leadership to be most effective as, similar to reports from other studies, co-workers and followers tend to look up to the leaders as role models, further paving way to their participations in decision making and communication openness. This flexibility in communication to nursing staff has been reported in other studies as well, including the 2004 research by Stanley. Stanley conducted a pilot study in a clinic for paediatrics in the UK and showed that apart from communication, nurse leader characteristics included the capability to cope with crisis, clinical knowledge and experience, consideration of staff and supportive attitude.

The advantages reported by Stanley were similar to those reported by Cook; that of supporting and influencing roles, however, tend to be dependent on the leader-worker relationship. In his 2001 study, Cook, in addition to describing different leadership themes, provided five advantages of the presence of clinical nurse leaders in the health

system: 1) highlighting, 2) respecting, 3) influencing, 4) creativity and 5) supporting. Each of these advantages pointed towards the easing of workflow among followers/ colleagues while paving way for the self-development of these nurses as well. Cummings *et al* (2008) reported that leaders who had less contact with care-givers resulted in a significant decrease in leader effectiveness within a healthcare setting. At the same time, leaders with higher contact with their followers, patients and caregivers tend to provide greater opportunities for the practice; the nurses that follow such leaders tend to have higher perceived self-efficacy and increased competence. The study concluded that any leadership model would only be successful if it gives emphasis on relationship skills; this element must be the core of leadership training programmes, which, according to this dissertation, would be effective for bringing about both short term and long term change. To conclude, research has addressed the advantages of a clinical nurse leader from the perspective of their associations and links with their health systems, as well as with describing other characteristics such as managing workload and clinical experience. Not only has the definition of clinical nursing leadership been investigated to assess the skills and advantages of it, but some research has been published to establish the value their role has in the delivery of high quality healthcare and in improving patients' outcomes.

2.4 Historical context on the vital nature of the clinical nurse leader throughout the years

Leadership had been long viewed as being instrumental within an organisation. In 2000, the United States American Association of Colleges of Nursing (AACN) reported the need to improve patient outcomes with improvements in nursing education and using changes in practice environments. The findings of the report also suggested the enhancement of nursing as a career choice by making fundamental changes to education, practice and licensure. This then led to the creation of a new nursing role, the Clinical Nurse Leader (CNL) (AACN, 2009). The AACN as well as the Institute of Medicine (IOM) guided the development of CNL. Central to this development was also the commitment to identify various nursing competencies; this included planning care delivery changes, addressing the complexities of healthcare while providing feedback on how to best evolve such roles. Since its establishment in role and education, CNL has been observed to improve outcomes through coordination and facilitation of care (Tornabeni, 2006). While CNL programmes tend to focus on aiding patient groups with

lower financial/ social resources, or those with complex problems such as multiple chronic diseases, it does not focus on specific patient groups, such as cardiovascular patients (Baernholdt and Cottingham, 2011).

However, as CNL courses are rather newly implemented, its impact on nursing leaders and on followers/ co-workers are yet to be correctly determined. Similarly, the exact role and expectations of CNL tend to vary significantly according to the clinical unit, location, and other factors (Baernholdt and Cottingham, 2011). Table 1.1 lists a few of these expectations of CNL. Several researchers aimed to understand how nurses feel about transitioning to roles with leadership requirements. For example, Wilmot (1998) aimed to understand the transitioning from general nurses to ward managers among UK nurses. At the time this study was conducted, nurses believed CNL to hold the key to a secure future, hence opting for them. Wilmot interviewed the nurses to understand what they felt about the transition; the nurses reported the change to be rather stressful and challengeable- although the new role allowed for improvements in clinical practice. Apart from personal and clinical changes, a few studies (Gould *et al*., 2001; Kan, 2001) also reported on the organisational difficulties that leaders may experience. In their 2001 study, Gould et al used an interview cum survey method to collect data from clinical nurse leaders. According to this study, clinical nurse leaders had self-confidence but did not have certainty in their capability to deal with budget and human resource allocations. Kan (2002) assessed how clinical nurse leaders work when supervising their nurses at the unit level in New Zealand. This research showed that clinical nurse leaders had the ability to make positive changes within the healthcare organisation; this may be due to internal and external factors. Other studies had also obtained it to be important for health organisations to recognise the complexity of nursing, and to encourage and prepare new nurses for performing tasks whilst improving the overall performance of the health system (Williams, 2004).

Table 1.1) CNL role components and expectancies (Tornabeni and Miller, 2008)

Curriculum elements	*CNL role functions*	*CNL role expectations*	*End of programme competencies*
Nursing leadership	Advocate	• Keeps clients well informed • Includes clients in care planning • Advocates for the profession • Works with interdisciplinary team • Strives to achieve social justice within the microsystem	Effects change through advocacy for the profession, interdisciplinary health care team and the client. Communicates effectively to achieve quality client outcomes and lateral integration of care for a cohort of clients.
	Member of a profession	• Effects change in health care practice • Effects change in health outcomes • Effects change in the profession	Actively pursues new knowledge and skills as the CNL role, needs of clients, and the health care system evolve.
Care environment management	Team manager	• Properly delegates and manages • Uses team resources effectively • Serves as leader/partner on interdisciplinary team	Properly delegates and utilizes the nursing team resources (human and fiscal) and serves as a leader and partner in the interdisciplinary health care team. Identifies clinical and cost outcomes that improve safety, effectiveness, timeliness, efficiency, quality, and the degree to which they are client centered.
	Information manager	• Uses information systems/technologies • Improves health care outcomes	Uses information systems and technology at the point of care to improve health care outcomes
	Systems analyst/ risk anticipator	• Participates in system reviews •Evaluates/ anticipates client risks to improve patient safety	Participates in systems review to critically evaluate and anticipate risks to client safety to improve quality of client care delivery.
Clinical outcomes management	Clinician	•Design/coordinates/evaluates care • Delivers care in a timely, cost-effective manner • Emphasizes health promotion/risk reduction	Assumes accountability for health care outcomes for a specific group of clients within a unit or setting recognizing the influence of the meso- and macrosystems on the microsystem. Assimilates and applies research-based information to design, implement and evaluate client plans of care.
	Outcomes manager	• Uses data to change practice and improve outcomes • Achieves optimal client outcomes	Synthesizes data, information and knowledge to evaluate and achieve optimal client and care environment outcomes
	Educator	• Uses teaching/learning principles/ strategies • Uses current information, materials and techniques • Facilitates clients' learning, anticipating their health trajectory needs • Facilitates client care using evidence-based resources • Facilitates group and other health professions' learning and professional development	Uses appropriate teaching/learning principles and strategies as well as current information, materials and technologies to facilitate the learning of clients, groups and other health care professionals

While CNL is believed to improve certain key areas of healthcare, it highly depends on the knowledge and skills of the individual, as well as their ability to coordinate and evaluate patient groups in complex health systems (Baernholdt and Cottingham, 2011). According to Rosseter (2009), outcomes may improve when CNLs are incorporated into staffing mix. In their 2003 study, Marquis and Huston emphasised on the need for clinical nurse leaders to become trainers, evaluators or mentor. They aimed to describe extensively what kinds of managing and leadership should be developed; according to this study, clinical supervision can be implemented to improve preliminary knowledge of nurses helping them to function more effectively, whilst covering the needs of their organisations. As described earlier, ideal leaders require a skillset combination to tackle both technical and organisational skills. Allowing for nurses to function effectively may also require changes to various organisational policies and guidelines- these, in the long

run, are aimed for the betterment of patient care. John (2003) noted that the clinical supervision model have small influence on the improvement of leadership skills but did help to improve negotiations skills to solve problems. Despite this, a common issue within modern day healthcare is the wide range of issues surrounding interdisciplinary collaborative processes. The inefficiency of such processes result in fragmented patient care that had been associated with several preventable adverse outcomes. CNL is also believed to aid at an organisational level by providing competency skill-base and necessary leadership skills, allowing for the flourishment of interdisciplinary collaborations (Bender *et al.,* 2013). In their 2015 study, Bender *et a*l aimed to test this hypothesis and observed collaborative environments to be enhanced with the implementation of CNL.

In their qualitative study in the management of senior nurses, Sullivan *et al* (2003) recommended that leadership interventions must be developed using evidence to improve the outcomes of clinical nursing leadership. This view had been reported by several other studies as well (Richardson and Storr, 2010; Bender *et al.,* 2013). In 2003, Thorpe and Loo investigated the professional development needed for the role of 'first-line nurse leaders'. These are nurses that provide healthcare at the bedside. Using quantitative interviews, they concluded that these first-line nurse leaders should be supported with training and development modules as well as a supportive environment, and any future intervention must be based on needs assessment of nurses. The 2000 report by AACN also obtained similar findings were they recommended an increase need for training of specialised nurses at the bedside. Williams (2004), in contrast, argued that professional development should be delivered through formal and structured education on leadership management, finance and quality management within nursing schools. Cook and Leathard (2004) mentioned that current implementation for clinical nursing leadership is still incomplete. According to this study, there are still no descriptors of clinical nurse leaders within the health system; they added that clinical nurse leaders are only getting voluntary training modules that are informal and unprofessional, and that these modules do not represent wider organisational development policies.

2.5 Models of Clinical Nursing Leadership

2.5.1 Transformational leadership

The four major models mentioned previously (as per Cook, 2001) (transactional, connective, renaissance, and transformational) had been since applied to all kinds of organisations, including that of the healthcare system. The most recent theme (or model) seems to use or promote concepts of transformational leadership (Akerjordet and Severinsson, 2010). There was a limited number of studies (Dunham-Taylor, 2000; Leach, 2005) that had assessed the utilisation and impact of transformational leadership among nurses. Dunham-Taylor (2000) recruited about 400 hospital nurse executives in his study and noticed that scores of transformational leadership were positively associated with staff satisfaction and team-work efficiency. In 2005, Leach also assessed the link between nurse executive leaders and nurse manager leaders; they investigated the association between nurse executive leaders and organisational commitment among nurses. This study concluded that there was a positive association between nurse executive leadership and nurse management leadership. Nurse executives who were also transformational leaders were more likely to improve their work environment through high standard skills, performance, and commitment. These were in line to previous studies that reported nurse managers to be highly transformational- in which they use motivation, inspiration and encouragement to strengthen the ability and performance of staff (Ohman, 2000). Indeed, a rather limited number of papers have followed theoretical models other than transformational leadership (Akerjordet and Severinsson, 2010; Katrinli *et al,* 2008; Wong and Giallonardo, 2013). A transformational leadership model can be therefore considered as the most applied and tested model in nursing research (Wong *et al*., 2013).

Fig 1.3) transformational leadership (Northouse, 2011)

A transformational leader tends to have closer professional relationships with their followers/ subordinates, providing individualised consideration of both needs and capabilities of fellow workers (Salanova *et al*., 2011). Figure 1.3 depicts the transformational leadership model wherein the personal qualities of a leader form the backbone of their leadership qualities; the other qualities, including engaging of the employees and organisation revolve around this central factor. This holds true despite the 'power' that these leaders hold over their subordinates. In nursing, CNLs act as role models and allow subordinates to learn from their experiences, paving way to improvements in nurses' self-efficacy. What allows transformational leadership to stand out is its human factor- the amount of openness and mutual trust that this leadership style holds is far more than other leadership styles. Several research groups (Mok and Au-Yeung, 2002, Nielsen and Munir, 2009) had reported improved self-efficacy measures among employees as a direct result of transformational leadership. This improved self-efficacy also aids in bridging the relationship between the well-being of employees and transformational leadership. In their 2007 study, Gilmartin and D'Aunno also studied the effects of transformational and transactional leadership by reviewing and analysing healthcare leadership research from 1989 to 2005. They reported that healthcare

research significantly supports the implementation of transformational leadership model because of its positive association with patient satisfaction, staff performance, and staff turnover. Further, they also added that the positive effects of transformational leadership are more obvious and stronger when applied among providers with less experience. In addition to this, several other researchers (Munir *et al,* 2012; Apekey *et al,* 2011; Cummings *et al,* 2008; McFadden *et al,* 2009; Kvist *et al,* 2013; Wong *et al,* 2013) mentioned various positive impacts of transformational leadership in healthcare such as improved work-life balance, patient safety, patient confidentiality, openness about malpractice and errors.

2.5.2 Authentic leadership

Authentic leadership is another theory/ model that was investigated in the UK as an alternative nine-factor model for healthcare. In their 2001 study, Metcalf and Metcalf concluded that authentic leadership model was studied in a limited number for healthcare research. Authentic leadership comprises the importance of leader legitimacy through trust-worthy relationships with employees on different levels by appreciating their efforts and behaving morally and transparently. This kind of trust will then lead to effective engagement and enhanced performance among staff which will further pave way to improved patient outcomes and satisfaction among employees and patients. An authentic leader aims to result in genuine, sustained performance by fostering their own and their follower's development and authenticity. These leaders tend to request adequate input and perspectives from followers prior to making important decisions. According to Wong *et al* (2010), nurse leaders who had high levels of authentic leadership in their work environment had a higher level of trust and engagement with others. Wong and Giallonardo (2013) also reported positive associations between authentic leadership and trustworthiness, perceptions of healthcare, and patient satisfaction. Moreover, authentic leaders were able to empower their employees to perform better, leading to effective work environments among nurses. The active engagement of employees in various activities results in higher performance and productivity from the employees, thus supporting 'self-determination' (Avolio *et al*., 2005). To sum up, there is clear evidence suggesting the importance of both transformational and authentic leadership models as indicators of nursing practice; this may indirectly allow improving health outcomes within health facilities.

2.5.3 Other leadership models

There is significant need to develop an effective approach to clinical nursing leadership that is unique and distinct for both healthcare workers and patients within the healthcare system. In their 2005 study, Millward and Bryan suggested the need for a practical use of the concept of clinical nursing leadership that involves links between healthcare providers, work environment, and users. In their review, Cummings *et al* (2008) summarised available evidence on clinical leadership in nursing and concluded that all of their reviewed studies (24 included) examined four areas in leadership: 1) behaviours and attitudes of nurse leaders, 2) characteristics and skills of leaders, 3) impact of context and practice settings, and 4) leader involvement in educational programmes. Cummings *et al* (2008) also noticed that studies included in their review followed weak methods and that there is a need to develop robust theory and research methodology on the development of models of clinical nursing leadership as required in the future. Another review (Jennings *et al,* 2007) summarised papers that addressed nursing leadership and management from the perspective of competencies. This review concluded that there was a little understanding of the distinction between nurse managers and nurse leaders. Cook (2001) was among the few researchers who studied clinical nursing leadership in different countries including the UK, the USA and Australia. In his study, Cook reported the lack of a clear definition for clinical nursing leadership, with several studies interchangeably using the terms clinical nursing leadership and nursing management.

There is an increasing number of leadership models that have come into spotlight over recent years, mainly in nursing practice- as mentioned in the above sections, the transformational leadership model seem to be the most investigated in the healthcare field. The use of authentic and cognitive leadership models are fairly new in comparison to the four main models set out by Cook (2001). In her 2004 study, Jooste suggested an ''Arch of Leadership'' Model which has four main categories: 1) Clarity: Are nurses clear of their job description and duties? 2) Commitment: What do staff or users need from their nurse leader? 3 Self-esteem: Do followers know their own abilities, what they can and cannot accomplish? 4) Cost: what is the cost they give or get for attitudes among users?. Although Jooste explored challenges in clinical nursing leadership, the role of authority, and potential future intervention- her model seemed to be adapted from other

traditional leadership models, mostly from the transactional theme. Another interesting proposed model is the ‘’nursing leadership knowing’’ which was adapted from ‘patterns of knowing’ in nursing (Jackson *et al*., 2009). Adapting from previous authors on theories of knowing for nursing (Heath, 1997; Munhall, 2007; White, 1995), Jackson *et al* (2009) described listed well-known theories of knowing for nursing as methods of leadership knowing: empiric, aesthetic, personal, socio-political, ethical and unknowing; for which they provided descriptions and qualities, as well as examples. Their model can be reasonably relevant to clinical nursing; its utilisation in practice however needs to be further investigated.

2.6 Limitations to Clinical Leadership

Existing literature has documented several barriers to the adoption of clinical nursing leadership in healthcare. These limitations tend to be rather diverse in nature; for example, Oxtoby (2013) argued that males had dominated the field of medicine for several years where females faced many obstacles and barriers to be promoted in health organisations. This study observed that these drawbacks may be overcome provided female healthcare providers believe in their working potentials. However, several other barriers exist and are rather tedious to be eliminated. In the sections that follow, some of these barriers are explored:

1- **<u>Bureaucratic approaches in clinical units in Hospitals</u>**

In 2000, Bate conducted an empirical study to assess the organisational and official procedures within an NHS hospital. In his study, he aimed to set up a link to a wider scope of work on the importance of integrating clinical leadership in hospitals. According to this research study, consultants in the assessed hospital refused the legitimacy of management within the hospital and they also weakened and underestimated the managerial value. Bate reported that the hospital developed its structure into sub-sections which work in isolation from each-other. This caused major leadership problems in the hospital that led to increase work tensions between the hospital’s departments and their associated programs (Batalden *et al*, 2003). As mentioned earlier, the efficacy of leadership is largely dependent on the social interactions that follow between the leader and co-workers/ followers. Complete isolation, such as this case, would eventually lead

to lightened relationships between the leader and their followers. Such relationships and mutual trust are necessary in most of the leadership models that had been discussed in the preceding sections. Another major limitation that had been observed was the lack of time according to hospital policy; in their 2015 study, Adriaenssens *et al* reported nurses to feel frustrated at lowered decision authorities when it came to time-related choices. That is, time taken per patient, or time taken per rounds. Several nurses reported the strict time guidelines they were required to follow- this higher time pressure was linked with job dissatisfaction and fatigue- also compromising the quality of care provided to the patient.

2- Legitimacy of non- clinician workers

Healthcare providers and managers can be seen as dominators in clinical settings; where the managers should have had levels of freedom to take actions and make changes. In healthcare practice, however, it seems that healthcare providers, mainly clinicians, are people who have the authority to make changes; while the managers, on the other hand, were fearful to challenge such changes as they might face a vote of 'no confidence' because of the way health facilities function (Batalden *et* al., 2003). Bate (2000) argued that this problem cannot be solved with dealing exclusively with hospitals, but instead a national network should be designed to change the behaviour of clinicians who underestimate and undermine the organisational structure, and do not accept to be controlled in a hierarchical system. The expenditures of non-participation would exceed the costs of them being involved. In underlying the importance of working in community networks rather than hierarchies, and the linkage between doctors and managers in a compressive system, Ferlie and Shortell (2001) argued that that single dependence on one individual as a source of leadership is wrong, especially in multiple-managerial-based organisations including hospitals and clinics where different levels of staff have different management roles. Instead, they suggested integration of collective and team leadership styles within clinical leadership.

3- Group Leadership

The examination of current research points towards a poorly developed critical analysis of the theory and practice of nursing leadership. Rather than having external focus, or

being influenced by external factors, nursing leadership has been long viewed as being an internal professional concern (Antrobus and Kitson, 1999). Nursing leadership can be viewed as a set of processes with the purpose of influencing and shaping both health policy and nursing practice. Several research groups had obtained the presence of a political vacuum around the field of nursing (Robinson, 1991); rather than having inputs from nurses, several health policies across the globe are often formulated by group of individuals who have little or no clinical experience. Nevertheless, several research groups have studied the effects of organisational influence on nursing leadership. Degeling *et al* (1998) and Degeling e*t al* (2003) investigated the importance of collective leadership within hospital reforms in Australia and the UK respectively. They concluded that lay managers were more willing to accept the concepts of change and were more ready to encourage implementation of change in their health organisations. However, the researchers noticed slight variations between the answers of both doctors and nurse managers. Although doctors and nurse managers were able to recognise the structure of health authority, they did not want to encourage change because they themselves were considered essential for maintaining the normative orientations of their participation in patient care. Thus clinicians had enough power and authority to resist change or accept it as they see appropriate to them. The studies concluded that the implementation of leadership models at the very top level of hospitals were not effective because clinicians are imperative in deciding reforms through indirect influence and processes.

Degeling *et al* (1998) acknowledged that leadership should not be seen as an outcome of official authority or position of hierarchy; but instead leadership is linked to the capability of staff to achieve their task in an effective manner, which, in a manner, predicts the effectiveness to the sub-culture of health context. Further, leadership and followership models support the idea that leaders are not simply leaders because of their job position, but because of their capability and potential to support change of behaviours among others. Although Degeling *et al* (2003) mentioned that engaging clinicians, especially doctors, in leadership on an individual basis is necessary; they obtained that clinical leadership is an insufficient condition for change. Firth-Cozens and Mowbray (2001) noted that senior managers and policy makers also have an essential role in structuring the scope of leadership and management in middle and lower levels in health organisations. They reported that medical leaders would be able to change their sub-cultures if their actions are accepted by the wider organisation system. Therefore, the authors believed that staff should be engaged in leadership at various levels so that any

managerial process does not limit their scope of work by the institutional system. However, despite playing a key role in innovation and facilitation that is necessary for the development of practice, clinical leadership tends to be poorly developed; this may not only limit the role of clinical leaders but also be detrimental to other leadership domains.

Fig 1.4) Interconnected leadership domains according to Antrobus and Kitson, 1999

Nursing leadership, unlike that of other professions, allow a much broader strategic view of nursing, given that the nursing leaders tend to interpret and translate between practice and policy. Clinical leadership cannot be considered as a pure individual concept which is affected by the characteristics of a person, but instead it constitutes of multi-level processes between various levels within the same organisation, society, sub-cultures and other accountabilities in healthcare settings. This is clearly a different aspect towards leadership as several other research groups identify leaders as persons who are solely leaders, occupying official positions of authority, and supporting their employees' skills and performance bias the demonstration of power and authority on them. Degeling *et al* (2003) mentioned that leadership should be studied and implemented as part of a social process in which leaders encourage followers to change through social approaches. One can say that leading change is dynamic but quite complex; many medical leaders can affect their followers and colleagues by focusing on specific aspects of culture, society, and identity. Baumeister e*t al* (2003) obtained that due to the significant professional concept underpinning most clinical identities, this approach of influence could be more successful if those who lead change were medical leaders themselves. However, it is assumed that such leadership process will be incomplete because successful leadership

constitutes of a constellation of leaders from different levels. These leaders in turn support change in many ways in their sub-cultures in which a top management exists to support their influence. In their 2000 study, Silversin and Kornacki said that in addition to top leaders, followers had a critical role in supporting change as well.

4- Weak Planning

Several research groups have observed that clinical leadership might be an important factor influencing the accomplishment and fulfilment of health system which is related to the poor leadership role of managers and policy makers (Mott, 2008; Busari, 2013). Mohapel and Dickson (2007) suggested assessing and reviewing staff and organisational performance in managed care to improve clinical leadership and management capacity of the clinicians in improving healthcare delivery. Health decision makers and other managers (from directors to the heads of programs) under the ministries of health, clinical units including non-governmental organisations, and other leaders need to be alerted on the benefits of adopting clinical leadership models in their institutions. In their paper, Castro and Dorgan (2008) questioned whether the adoption of clinical leadership is worthy when it is a complex and expensive process; especially that several competing tasks may affect healthcare providers' time. They also added that before the adoption of such processes, health organisations should seek evidence of the association between clinical leadership and staff skills, and performance both on the clinical and financial dimensions. Similarly, Busari (2013) added that evidence of a direct association between clinical leadership and quality will remain debatable and elusive due to the inherent complexity of health contexts whose performance is influenced by overlapping confounders of which clinical leadership might be only one.

To sum up, the evaluation of healthcare organisations have proved that most healthcare organisations have different aims and tasks that are not directly associated to planning and leadership (Woolnough and Faugier 2002). Besides this, Hewison and Griffiths (2004) asserted that healthcare systems should have regular plans and updates on human resources. Moreover, other papers indicated that lack of funding and inadequate allocation of resources is a common problem among health organisations, especially in low-income and middle-income countries (Adano, 2006; Asante and Hall, 2010).

2.7 Conclusion

This chapter had described clinical leadership in nursing in a historical context. The chapter also discussed definitions of clinical nursing leadership, its attributes, and its models and theories. It can be concluded that the future challenge for the implementation of clinical nursing leadership is to develop a robust foundation of evidence for best practices in clinical leadership in complex healthcare settings. Such leadership should improve nursing practice and also empower inter-professional communication within the larger healthcare system. Moreover, theories and models of clinical nursing leadership seem yet to be developed and empirically tested in practice to evaluate its impact on health organisations.

Chapter Three – Methodology

3.1 Introduction

This chapter describes the chosen research methodology for this dissertation. It starts with describing the difference between the two most common research approaches - qualitative and quantitative. Literature review was chosen to carry out this dissertation as they are useful for examining sample groups that can be have been researched through previously published papers. The chapter also overviews the stages of conducting a literature review; including critical analysis and ethical issues in research.

3.2 Research paradigms

Research can be briefly described as any sort of data/ fact collection on a particular subject area; this may be as a method of enrichment of knowledge or as an assessment, or investigation, towards evidence and interpretation of findings into practice (Shuttleworth, 2008). The application of theories in research could be due to the fact that the search process inevitably support change in the body of knowledge, which, among many influencers, tend to affect the investigator's expectations and intentions of how to seek and support change (Sobh and Perry, 2006). Researcher's tend to have their own opinions or understandings about their surroundings; every individual's thoughts are shaped in a unique way as per their beliefs or cultures- thus, the investigator's expectations or intentions are mostly based on what's known as the "researcher's paradigm". In their paper, Tashakkori and Teddlie call for the use of rhetorical neutrality that allows researchers to test or empirically justify stated hypotheses by remaining emotionally detached from their study (or objects of their study), thus eliminating any biases. Researchers following the quantitative methodology contend that the entities being observed are separated from the observer, thus leading to social observations themselves being treated as entities. On the other hand, qualitative purists believe the separation to not quite be effective as the observer is the only source of reality; these researchers believe research to be value-bound- and that context- and time- free generalisations aren't quite desirable (Johnson and Onwuegbuzie, 2004).

Clarifying the rationale behind some researchers' support as to why certain behaviours and decisions had been taken in research, Kuhn (1996) pointed out that humans should

be strongly engaged in changing the behaviours and practices in research; further, the involvement or researcher's own paradigm should be also seen and viewed as a journey that strengthens both the personal growth of a researcher and other individuals recruited in the research (Kuhn, 1996; as referred in Morgan, 2007). For researchers, it is necessary that they understand the different objectives of any research with alternative theoretical underpinnings, which helps them select an alternative research methodology. According to Morgan (2007), the researcher's paradigm is based on several factors; ontology, axiology, epistemology, methodology and reflexivity. Ontology relates to the nature of reality whereas axiology constitutes the morals and ethics that the researchers believe and follow (Morgan, 2007). Epistemology looks into the theory of knowledge to comprehend the nature and scope of knowledge as well as the reliability of its findings and the feasibility of conducting it (Willig, 2008). Richardson (1996) mentioned that reflexivity is the reflection of experience and perception of the individual over researchers. He also proposed that reflexivity should be used as an "extension of understanding" as it demonstrates an awareness of the method in which the researcher interprets the data throughout the research process. Willig (2008) obtained that reflexivity investigates the manners in which a researcher's participation in a certain study affects and informs such study. Further, in their Study, Willig also posed three questions to demonstrate all factors determining and affecting a researcher's paradigm: "1) What type of evidence/ knowledge does the methodology aim to provide?, 2) What types assumptions does the methodology make about the external environment?, and 3) How does the methodology conceive the role of the researcher throughout the research process" (Willig, 2008; p. 12-13).

3.3 Qualitative and Quantitative Research

Research methodology can be defined as the approach adopted during the research process to help answer the research question (Jackson, 2013). While methodology is a strategy that helps designing and organising the research process, and sometimes reflect the researcher's paradigm; research methods are the scientific tools that ''not necessarily depend on the paradigm/philosophy of researchers'', and are adopted to collect, interpret and analyse data, synthesise results to report findings and draw conclusions. Although research methodologies must originate from the research question and its objectives, research may sometimes be influenced by the researcher's beliefs and paradigms (McGregor *et al*., 2010). This might be due to the fact that researchers tend to collect and analyse information, making it difficult to separate themselves from their own thinking and views which could cause bias. This form of bias, often termed as confirmation bias, tends to deeply seated in the natural tendencies of individuals; researchers may also dismiss the evidence that doesn't support their hypothesis, only judging evidence to be reliable and relevant if it confirms their hypothesis (Rabin and Schrag, 1999). Culture bias also tends to affect several researchers where their influences and motivations may be viewed through cultural lens, hence causing bias. Although sometimes it may be unachievable or complicated, researchers should aim to choose the most appropriate methodology that only reflects the research question, and helps them achieve the research objectives. In this section, two leading methodologies in research are described; this would allow selecting a research methodology which best matches the research question of this dissertation

3.3.1 Quantitative methodology

Quantitative research adopts the strategy that, in order to address an issue, is important to quantify it; this involves conversion of data in terms of numbers, and the use of tools to collect numerical data and to analyse them. Gillis and Jackson (2002) believe that quantitative research is associated with positivist paradigm, which follows an objective way to decrease risk of bias and also attempts to find out scientific facts not perceptions. Nevertheless, the objectiveness of social science enquiries is stressed on by quantitative purists. According to Johnson and Onwuegbuzie, (2004), the major focus on quantitative research include those on "deduction, confirmation, theory/ hypothesis testing, explanation, prediction, standardized data collection, and statistical analysis" (Johnson

and Onwuegbuzie, 2004; p.18). The empiric-analytical paradigm recognises the quantitative approach as that with philosophical beliefs that include breaking down the research problem into parts in order to explain and predict how they work. Data quantification is followed to reflect the data that had been collected by this type of research, into numerical data.

The stages followed in quantitative research also depend on objective examination within a value free setting (Fossey *et* al., 2002). Cronin *et al* (2008) identified quantitative study as gathering numerical data and analyse them to examine scientific associations and synthesise results. Other researchers referred to quantitative research as both methodology and researcher's paradigm (Kuhn, 1996; cited in Morgan, 2007). Paradigms are essentially views or beliefs adopted by a researcher, which sometimes structure an overall strategy for the conducting of studies. As an example, Smith and Stewart (2001) obtained that quantitative methodology in research refers to an epistemological theoretical thinking where research is a process that is scientific, and the results should be reported in unbiased way. On the other hand, Aveyard (2014) believes that quantitative research follows positivism that uses objective stages to collect and analyse numbers; this linkage of quantitative research to positivism had been reported by other studies as well (Curtis and Drennan, 2013).

3.3.2 Qualitative methodology

"Qualitative research is a field of inquiry in its own right. It crosscuts disciplines, fields and subject matters. A complex interconnected family of terms, concept and assumptions surround the term qualitative research." (Denzin and Lincoln, 2005; p. 2). Qualitative methodology is linked with both descriptive and interpretive paradigms. Descriptive research usually examines the correct description of phenomena, while the interpretive paradigm studies supports that predictions cannot be made as reality is constructed by subjective perception. According to Pollard (2002), "To the interpretive researcher, the purpose of research is to describe and interpret the phenomena of the world in attempts to get shared meaning with others." (Pollard (2002); p. 38). Denzin and Lincoln (2005) asserted that although interpretive research is within qualitative designs, looking for an agreed definition of qualitative methodology is not particularly useful. They argued that the open-ended structure of the qualitative methodology forms perpetual resistance

against any attempt to impose one paradigm over the overall research. According to Aveyard (2014), qualitative methodology collects textual data relevant to the research question; this data is then coded and analysed to address the phenomena under study. Bowling (2009) added that there are many theories that base qualitative research; these philosophies include interpretivism and constructivism. Bryman and Bell (2015) defined interpretivism as studying people's understanding of experiences rather than studying the experience itself. Constructivism assesses people's experiences which are based on social construction rather than that of objective reality (Bryman and Bell, 2015). Nevertheless, both these terms tend to be used interchangeably in research (Merriam, 2014).

Quantitative methodology assesses individual experiences in an objectively real manner, where data collection is independent of the subjects (Bryman and Bell, 2015). Further, this methodology form may be useful to give a detailed critical analysis of what people experience in an open-ended structure in their free social context (Flick, 2009). According to Bowling (2009), researchers use qualitative methods when they intend to collect textual data from the study participants in a natural setting. Aveyard (2014) added that researchers who follow qualitative methodology normally aim to examine the structure of phenomena, in terms of how participants react to phenomena and how they build their world based on their experiences. However, Bryman and Bell (2015) asserted that researchers do not use numerical tools to collect data and analyse them in qualitative research. Instead, they use observational methods such as interviews and surveys to address phenomena under study. Researchers have examined studies that focus on leadership in nursing to have followed both quantitative and qualitative methodologies, and also mixed-methods. Following the research question and its objectives, this dissertation will carry out a literature review to assess what is known about clinical nursing leadership and to give more depth and insight to the results of available research; this will allow recommending the most effective clinical leadership model and as to how this could be implemented at unit level. In searching for potentially relevant studies, the hierarchy of evidence will be followed e.g. randomised control trials, grey literature, and surveys in order to address the dissertation's question based on robust and up-to-date evidence.

3.4 Literature review – chosen methodology for this dissertation

Literature reviews may be defined as *"a systematic, explicit and reproducible method for identifying, evaluating, and interpreting the existing body of recorded work produced by researchers, scholars, and practitioners"* (Fink, 1998, p. 3). Different types of literature reviews have been used in nursing research (Polit and Beck, 2010). For example, literature reviews may be conducted in a narrative manner by gathering data from a number of papers addressing similar questions. The main aim of narrative reviews are to summarise an existing body of knowledge in one research paper, and to highlight the importance of the subject being studied (Cronin *et al*., 2008). In contrast to narrative reviews, other types of reviews use a systematic well-organised methodology to critically review a set of studies, analyse them, and present unbiased findings to close gap or end contradictions over a certain subject and add to the existing body of knowledge- these are called systematic reviews (Chalmers, 2003; Singh, 2006). In systematic reviews, authors may follow qualitative, quantitative, or mixed methodologies. An example of quantitative data analysis method in systematic reviews is meta-analysis (Burns and Grove, 2009). Meta-analysis is a method of statistical analysis of numerical data of a set of papers which examine similar topics. In contrast, meta-ethnography and thematic analysis are qualitative method of analysing textual data (Britten *et al.,* 2002).

Thematic analysis consists of critical review of a group of relevant papers on a certain topic and does not use any statistical approaches to analyse data or synthesise results. Braun and Clarke (2006) mentioned that authors can use thematic analysis in most post-positivist and interpretivist studies. According to Boyatzis (1998), there are five main steps of conducting thematic analysis, these include: (1) looking for relevant papers, (2) finding out key text in papers, (3) analysing text, (4) quantifying textual data, and (5) generating themes and discussing them. Literature reviews can be seen as a non-invasive method of collecting data and as a means of summarising data and interrupting results from existing literature in a comprehensive way (Pope *et* al., 2007). However, these reviews rely heavily on studies and research papers that had been published- which may, at times, lead to limitations in the search strategy, thus affecting results. Further, literature reviews are useful for examining sample groups that can be sometimes difficult to-reach, but which could be examined indirectly through published papers. Thus, literature reviews avoid social desirability, and is helpful for studying people's opinions,

experiences, and beliefs (Fleischmann *et al.,* 2009). In this dissertation, a literature review of relevant research papers will be carried out to assess the research question.

3.5 Carrying out the literature review

Conducting a literature review consists of consequent stages starting by collecting data and comprehending them; critically reviewing and analysing data; and ends with reporting findings (Levy and Ellis, 2006). Other authors have mentioned similar stages for carrying out literature reviews (Aveyard, 2010; Burns and Grove, 2009; Machi and McEvoy, 2009). Burns and Grove's 7-stage process, however, is considered comprehensive and easy to follow. Therefore, based on the process of literature review mentioned in in their paper, this dissertation will conduct a literature review as per the following: (1) selecting a topic of interest, (2) structuring a research problem and objectives, (3) searching the literature, (4) comprehending the literature, (5) analysing and critically review the data, (6) synthesising the results, and (7) reporting findings.

<u>Selecting a topic of interest and structuring a research problem and objectives</u>

Once the topic of clinical leadership and its impact at the unit level had been chosen, it was necessary to conduct a preliminary literature review in order to generate a focused- but not too narrow- question for this dissertation. Aveyard (2010) mentioned that a research question should seek to cover unexplored areas of research and experiences that have not been studied before. This paper also added that there are some concepts that should be respected when structuring a research question; these concepts include that research questions should be clear, specific and realistic and that it can be addressed. Based on recommendations from Aveyard (2010), the research question for this dissertation was formed only after carrying out a preliminary literature review. Polit *et al* (2001) mentioned that there are some qualitative researchers that do not favour carrying out a preliminary literature review before the process of data collection- mainly because the literature review may affect the author's opinion and conceptualisation of the research. Morse and Field (1998) also addressed a similar opinion and argued that preliminary literature reviews may mislead the researcher's capability to make accurate decisions and report unbiased findings in research. Despite this, a preliminary literature review was necessary in this dissertation to provide guidance and support in

understanding the subject under study, and in identifying any bias in previous published research. Another objective of the literature review was to provide background information and to orientate the researcher on concepts such clinical leadership and models of leadership, as well as to put the current dissertation into the context of what is known and unknown about the subject area (Parahoo, 1997). It is worth mentioning that after the dissertation's results had been analysed and interpreted, the researcher reviewed the literature again and linked the findings to the existing body of knowledge.

Searching for potentially relevant studies

Searching databases and other sources to locate potentially relevant papers must only be conducted after determining what kind of papers the researcher aims to identify in order to address the research question (Aveyard, 2010; Burns and Grove, 2009). This is because literature should always be searched based on the eligibility criteria. Setting eligibility criteria may be particularly useful when there is too much literature available for a particular subject area; this would aid in narrowing down the literature to a manageable scope, also making it appropriate for a narrow research question (Vining *et al*., 2014). Such criteria set standards to include relevant studies and exclude all irrelevant studies and should be always set before searching the literature in order to enhance both the transparency and the credibility of the study (Aveyard, 2010). Randolph (2009) went a step further and obtained that eligibility criteria are often derived from the research question and its objectives.

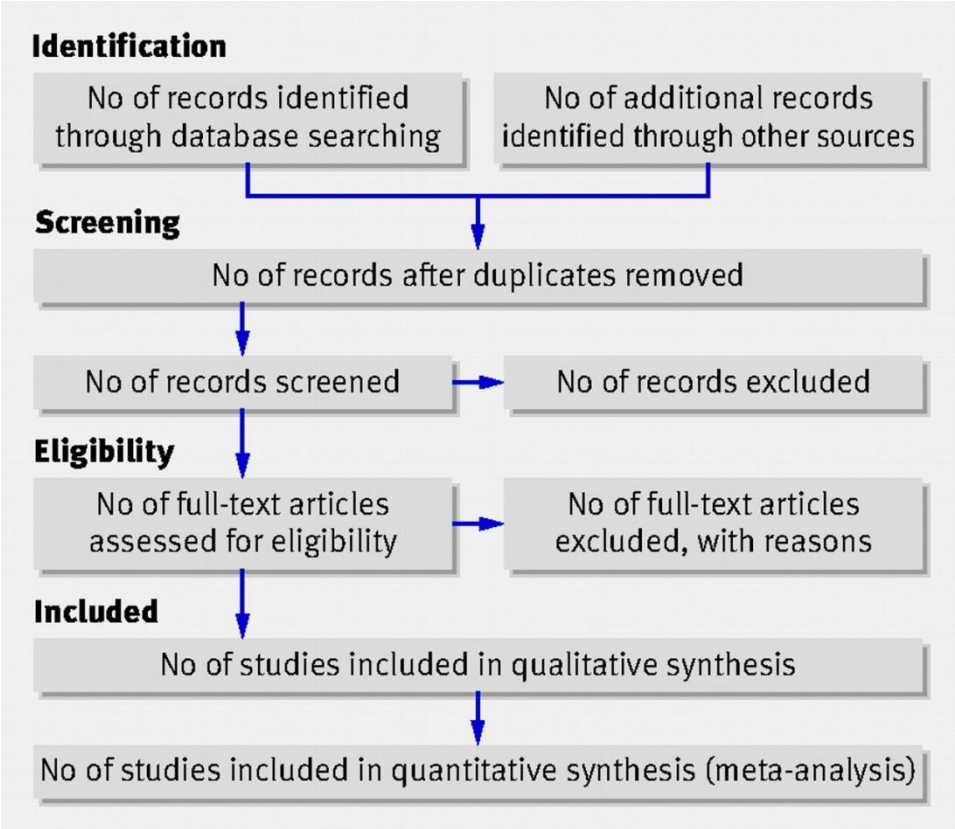

Fig 3.1) Flow of information through the different phases of a systematic review (Kleijnen and Moher, 2009)

After setting eligibility criteria, search keywords are identified from the research question or the literature review (Aveyard, 2010). Using keywords, the researcher may carry out searches in all relevant databases and journals. Rather than focussing on the published articles themselves, several studies recommend going through summaries and reference lists of such papers as they may help the researcher attain sufficient data (Randolph, 2009). Once the required papers have been attained, quality assurance and assessments play an important role in making sure that the research conducted is of best quality and in fact, unbiased. Quality assurance tends to inform on crucial decisions including information on what is published or disseminated or on how research is conducted. In defining terms, quality assurance basically ensures that the work produced had in fact passed a quality threshold- the assurance process ensures that the study had been carried out based on best available knowledge and techniques, and that the research had been properly conducted with results being accurately reported. As far as

academic research papers are concerned, several researchers believe peer reviewing to be the most effective system for assuring or assessing research quality (RIN, 2010).

Reviewing the literature and writing up the research

Critical review is the process of evaluating and comparing between paper and another to locate their strengths and weaknesses (Levy and Ellis, 2006). Aveyard (2014) and Booth *et al* (2012) mentioned that critical appraisal consists of: (1) evaluating whether the methods could be trusted to lead to accurate research and not to cause biased results, and (2) examining whether the research findings are published in an unbiased way. In this dissertation, the search results will be reviewed and assessed to understand gaps in research on clinical nursing leadership, and also to address the research question. The last two stages of carrying out a literature review is synthesising the results and then writing up the research. Synthesising the results include collecting relatable themes from a set of papers to address the research question (Aveyard, 2010). According to the kind of data gathered, the researcher should use an appropriate data analysis method such as meta-analysis, meta-ethnography, or thematic analysis to proceed. In this dissertation, qualitative data will be collected and therefore thematic analysis will be used to analyse the data.

3.6 Thematic analysis

According to Thomas and Harden (2008), there are three main stages in performing a thematic analysis; these include: (1) coding textual data from a number of studies that are linked to the subject being studied, (2) developing descriptive themes from codes, (3) reviewing and analysing these themes to report findings. Braun and Clarke (2006) described a more detailed process of the six stages to perform a thematic analysis. These stages are: 1) Reading and re-reading papers to comprehend them, 2) Highlighting interesting data, and coding all necessary data, 3) Generating sub-themes from coded data, 4) Developing themes from sub-themes and reviewing them, 5) Giving a name/title to each theme, and 6) Writing up the review in unbiased way.

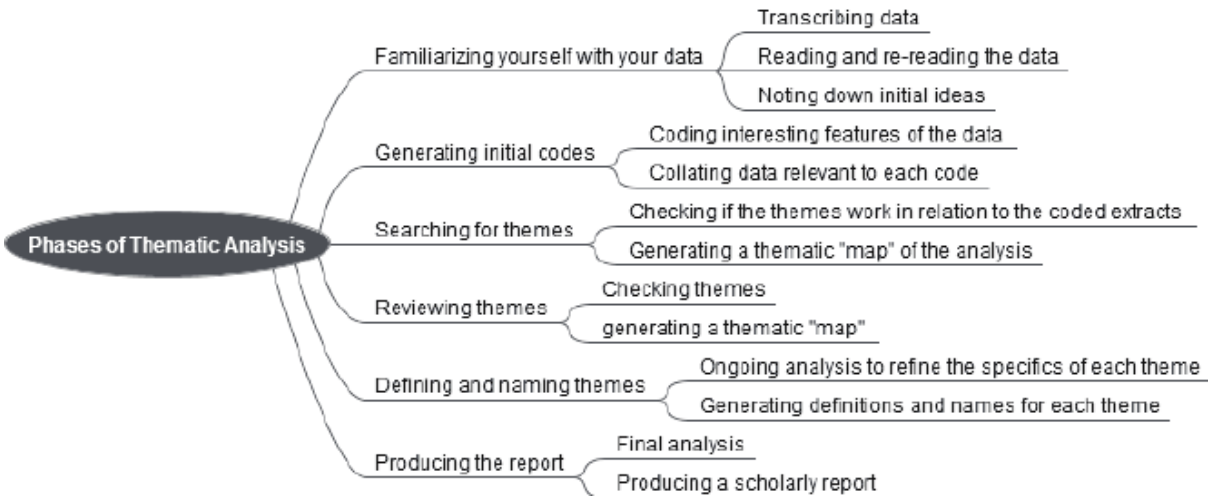

Fig 3.2) Phases of thematic analysis according to Braun and Clarke, 2006 (Fig from Echenique, 2014)

According to Clarke and Braun (2013), thematic analysis is easily comprehensive, easy to follow, and flexible. This dissertation will use thematic analysis to analyse qualitative data and to locate potential relationships between the different research methods used to address the impact of clinical nursing leadership's on the nursing setting and quality of care. It is worth noting that Dixon-Woods *et al* (2005) argued that this method of analysis is not transparent and inaccurate due to its lack of clear consistent and detailed stages. However, clarity is inherent in thematic analysis and helps enhance the credibility of the results. Thematic analysis also helps readers to understand how researchers came to their conclusions. In this dissertation, Braun's and Clarke's (2006) six stages of thematic analysis will be used to analyse data.

3.7 Ethics in research

Qualitative research is often undertaken in contexts involving the participation of people in their daily environments. Therefore, any research that includes person involvement should be aware of the ethical concerns that may be derived from such studies. Ethical issues in research include appropriateness of the research method and the behaviours in reporting findings. According to Alderson (2005) and Orb *et al* (2001), there are three main concepts reflecting ethics research; respecting the rights of people involved in research and preventing their abuse, providing best outcomes, and eliminating

unintended harmful effects. Orb *et al* (2001) added that ethical issues should not end by giving approval but it is a continuous process throughout the research duration. Moreover, non-maleficence, respecting and taking care of people, and keeping their information confidential is crucial in research studies (Beauchamp and Childress, 1994). Ethical concerns in research include following the most relevant research methodology and using unbiased behaviour in analysing the search results and writing up the research. According to Smith and Stewart (2001), researchers may aid future work by similar research groups if they publish the mistakes or errors encountered in their research. The institutional risk associated with this current study was no more than minimal; this dissertation does not involve human subjects. The benefits are potential administrative benefits related to the influence of clinical nursing leadership in clinical units. The results of this dissertation do not pose any employment risk to the individual clinical nurses recruited in the included studies in the dissertation.

This dissertation will use and report clear research methods, including the keywords and databases, eligibility criteria, data collection and analysis, and critical analysis. According to Weingarten *et al* (2004), the usage of consistent research methods enhances the strength, transparency and replicability of the research. Smith and Sewart (2001) believes that carrying out a literature review not only involves information on cost-effectiveness, benefit-harm association and quality of life, but also facilitates examining whether the results can be generalised to different populations. The search results in this dissertation will be also assessed against reliability and validity. While validity relates to a researcher's confidence that reported findings demonstrate and represent what they claim to pose in terms of their research question, reliability is related to the accuracy of the collection and data analysis used in research (Aveyard, 2014).

3.8 Conclusion

This chapter has described what a research methodology is, and it has also explained variations between quantitative and qualitative methodologies. The chapter then outlined the literature review (thematic analysis) as the selected methodology for this dissertation; the stages of undertaking literature review were also described. This chapter concluded that ethics will be respected in this dissertation.

Chapter 4 – Methods

4.1 Introduction

This chapter aims to describe the chosen research methodology that was used to investigate this dissertation's research question; it describes why literature review was chosen as being suitable for examining this research topic. Further, this chapter outlines the PICO approach that was used to formulate an answerable question; the criteria for inclusion and exclusion; the keywords that were used in the searches to obtain the research articles, as well as the journals and databases that were used for these searches. This section also aims to address the details of analysis that were carried out to obtain data.

4.2 The Research Question

This literature review was designed to help address the research question; how does implementing a model of clinical nursing leadership in a clinical unit affect quality outcomes and patient satisfaction, and to determine what model would have the most positive influence on the quality of healthcare. The formulation of the right research question determines the success of a research project; a question that can be researchable allows a thorough analysis and examination of literature/ data surrounding the topic- allowing the addition of useful information to address the uncertainty of a particular problem (Aslam and Emmanuel, 2010). Of the frameworks that are generally used for framing of research questions, the PICO strategy is rather well-known; mainly due to it dissecting the research question into parts that can be further examined. This approach was used in this dissertation to help the researcher generate a specific, but not too narrow, research question and to formulate a possible researchable and answerable question. Further, this approach made it feasible to achieve the objectives of this dissertation. The acronym PICO stands for Population, Intervention, Comparison, and Outcome (Aveyard, 2010). Wood and Ross-Kerr (2006) asserted that a researchable answerable question addresses the issues that may be faced with a specific topic; upon further research, it may lead to evidence-based answers to add information to the existing body of knowledge.

The various parts of the PICO format also allowed convenience in locating potentially relevant papers for this dissertation (Figure 4.1). Specifically, the four components that helped facilitate identification of relevant information in this study are as follows; (a) population- patients in clinical units were chosen as specific population that the research problem addresses to; (b) intervention- addition of clinical nursing leadership role was believed to be sufficient intervention for addressing the research problem; (c) comparison- patient outcomes without the implementation of clinical nursing leadership (in order to compare the efficacy of the new intervention with a control group) ; and (d) outcome- patient satisfaction and quality of health outcomes may help determine the effect of the proposed intervention (Aveyard, 2014). Although the addition of clinical leadership tends to focus on performance improvement strategies, both nurses and patients are involved in this research problem- in terms that the changes in nurses' knowledge and skills could also affect patient satisfaction and health outcomes. This jointly increased confounders of the evaluation of the impact of CNL on the quality of care.

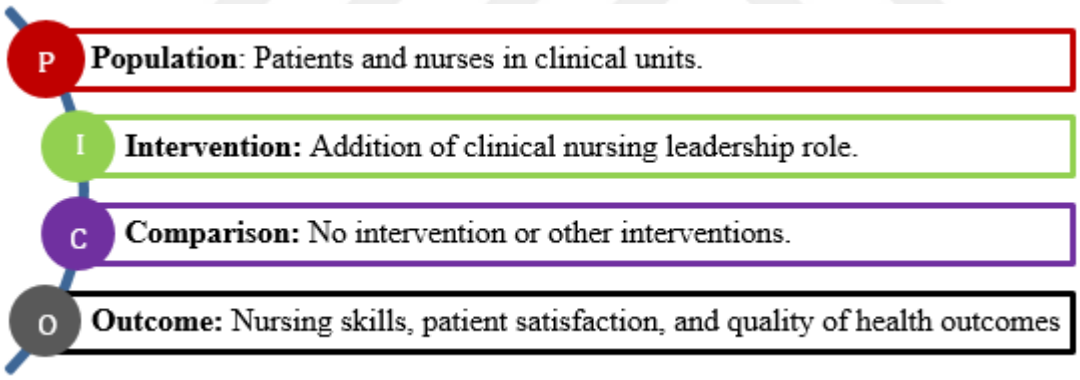

Figure 4.1- PICO Framework

4.3 Eligibility criteria

The inclusion and exclusion criteria were developed from the dissertation's research question and its specific aim and objectives.

4.3.1 Types of studies

This dissertation included consideration of studies that were based on qualitative, quantitative and mixed-research methodologies. This inclusion of various study types may allow for a deeper understanding of the research question, while also obtaining various perspectives to it. In quantitative research, both randomised controlled trials (RCTs) and non-randomised controlled trials were taken into consideration; the outcome measures of interrupted studies were obtained before determining whether they were suitable to be included. Nevertheless, RCTs were sought as they were necessary to assess the effectiveness of interventions in nursing research and were usually carried out to compare the effectiveness of health-related intervention between two or more randomised participant groups- i.e. control and intervention groups (Aveyard, 2010). Qualitative studies, on the other hand, allow getting more insight on perceptions, experiences and beliefs experienced by healthcare providers in health units (Flick, 2009). In short, primary research studies relating to impact of clinical leadership on nurses' skills as well as patient's health outcomes were included. To ensure reliability of information in this dissertation, the focus was primarily on only published studies in leading healthcare databases and journals. A few earlier studies had suggested that the publishing of research papers may not necessarily indicate them to be reliable or free of bias, however, we believe that it may reduce the likelihood that data and methods are not properly and fully reported (Boaz and Ashby, 2003).

Although the absolute exclusion of un-published articles may lead to a form of publication bias, it may help keep the task feasible and time-manageable. The articles that were narrowed down were further critically evaluated and assessed for their research quality. Given that this dissertation was an individual project, peer-reviewing had been suggested to greatly improve dissertation drafts (Pautasso, 2013). The reviewer may find inconsistencies and inaccuracies that I, the author, otherwise may not be able to find due to being engrossed in the typescript. To keep the search and analysis feasible and up-to-date, the search was limited to papers written and published since 2006, and presented

in English language. Apart from the above mentioned study types, several papers that were obtained as being relevant for this dissertation's research question were case studies. Only a few studies had been obtained in the initial searches to find studies investigating the effect of models of clinical nursing leadership in improving healthcare quality. Due to this reason, the search was extended to include studies addressing the role of CNL in patient's satisfaction and nurses' technical skills.

Table 4.1 Eligibility criteria

Inclusion criteria	Exclusion criteria
• Language: primary studies in English. • Date: since 2006. • Population: nurses, hospitalised patients, patients. • Intervention: use of CNL model. • Outcome/measurements: effect of CNL model on healthcare quality	• Based on population: - no nurses, no patients. - not focused on clinical leadership • Based on the intervention: - no use of CNL model - different system as a main intervention • Based on the subject: - studies non-related with the aim and objectives • Based on the study type - short articles – editorials, pictorials, brief items, comments

4.3.2 Keywords

A variety of keywords were used during the search. These keywords were derived from the dissertation's question. Searched keywords included: clinical nursing leadership, CNL, clinical nurse leader, patient outcomes, health outcomes, patient satisfaction, care coordination, nurse staffing and models of clinical leadership. Table 4.2 shows the search history that had been carried out for this dissertation along with the relevant number of papers that had been obtained against each. In addition to this, Boolean operators ''AND" and OR" were followed to organise the search process. For this purpose, the ''AND'' command searches for both terms and were used to first organise the search, and also to combine the keywords. ''OR" command searches were used for either term to broaden the search (Aveyard, 2010). Terms were combined to maximise finding relevant studies

that would address the question. For instance, CNL was combined with nurse staffing, or clinical leadership was combined with health outcomes to gather relevant data.

Table 4.2 History of the volume of searches for identified keywords

Sets	Search terms	Databases searched	Result
S1	Clinical nurse leader OR CNL OR clinical leadership OR nurse staffing	Medline Cinahl OVID Cochrane ScienceDirect	1330 152 1,753 93 4
S2	Patient outcome OR health outcomes or Patient satisfaction	Medline Cinahl OVID Cochrane ScienceDirect	113,708 14,266 268,693 4,482 5,378
S3	Care coordination OR health outcomes	Medline Cinahl OVID Cochrane ScienceDirect	63,948 10,668 115,690 3,755 991
S4	S1 AND S2 AND S3	Medline Cinahl OVID Cochrane ScienceDirect	65 8 173 1 13

4.4 The search strategy

After setting out the selection/ eligibility criteria, priority was given to extract relevant keywords from the research question and the literature review. This was followed by undertaking electronic searches of databases and journals, and looking for copies of potentially relevant references. The goal was to locate the highest levels of potentially relevant evidence that investigated the impact of the clinical nursing leadership on the quality of health outcomes. Moreover, literature that represented expert opinions related to healthcare reform and coordination of care was reviewed for writing up the background and literature review chapters.

4.4.1 Searching databases and journals

Given that the dissertation topic was to be viewed from a nursing point of view, databases used included CINAHL, Cochrane Library, Medline, Science Direct, OVID, Nursing and Allied Health Collection, the Joint Commission and the Institute of Medicine websites. The search time frame was set to those published between 2006 and 2016; and included papers published in English. It was important, at this stage, to look for evidence of high quality to better address the dissertation's question. Therefore, located papers were assessed based on Melnyk and Fineout-Overholt (2015) criteria of the hierarchy of evidence. Ridley (2008) mentioned that following the snowball technique would ensure better chances to refine and systemise the research focus.

4.4.2 Other search strategies

- Going through references of systematic/ literature reviews to locate potentially relevant primary papers.
- Hand searching of paperback medical journals.
- Contacting researchers- mainly to get access to research papers that were not available in full-text.

4.5 Data collection and analysis

4.5.1 Selection of papers

Papers were located and identified through the databases and journals as mentioned above. Identified studies were then assessed through the eligibility criteria. A record of reasons for inclusion and excluding papers was kept to increase the credibility of this dissertation and to decrease selection bias. The reference management software ‘’Endnote’’ was used to organise references retrieved from searches of electronic databases and style them in a Harvard referencing style (The Cochrane Public Health Group, 2011).

4.5.2 Methods of analysing data – thematic analysis

Thematic analysis was used to analyse qualitative data in this dissertation. The thematic analysis method focuses on identifying, analysing, and reporting patterns or themes within data (Aronson, 1995). This mode of analysis was selected as it allows the researcher to link text in any relevant research studies and compare them to answer the research question (Aveyard, 2010). The following data was extracted from the included studies: study method, population characteristics (job position, skills, and working places), intervention (model of clinical nursing leadership), findings and limitations of the research.

Braun’s and Clarke’s (2006) recursive thematic analysis of six phases of was followed. This six-phase process was chosen because it is systematic, organised, easy to follow, and could help address the dissertation’s question in unbiased manner (Thomas and Harden, 2008). The first phase of thematic analysis common to all forms of qualitative analysis is getting familiar with the data compiled from the included studies. It requires the researcher to carefully read and re-read each information and data item to thoroughly familiarise themselves with the dataset. The second phase of the analysis includes systematic coding of the data to generate initial codes. This helps in identifying any potentially meaningful data at the most minute level. In this phase, the entire dataset is coded and collated for further stages of analysis. The following phase in thematic

analysis entails searching for themes or patterns in the dataset that is being analysed. In this third phase the analysis expands to a broader focus on themes that are linked to the study's objectives. Patterns of meaning and potential themes are identified for data to be classified into. Phase four of thematic analysis comprises reviewing of the candidate or the final themes- themes are re-examined to refine, split, combine or discard, as necessary. These themes are reviewed against the dataset to confirm that the themes have clear and identifiable distinction in between them. It is then followed by phase five which consists of defining and naming of the themes. The researcher is required to produce detailed and informative definition and name of each theme to present the essence of what all the themes are about while to also to denote the relationship of one theme with the others. The final phase is writing up and producing the report (Clarke and Braun, 2014). Figure 4.2 lists the 6 stages of thematic analysis.

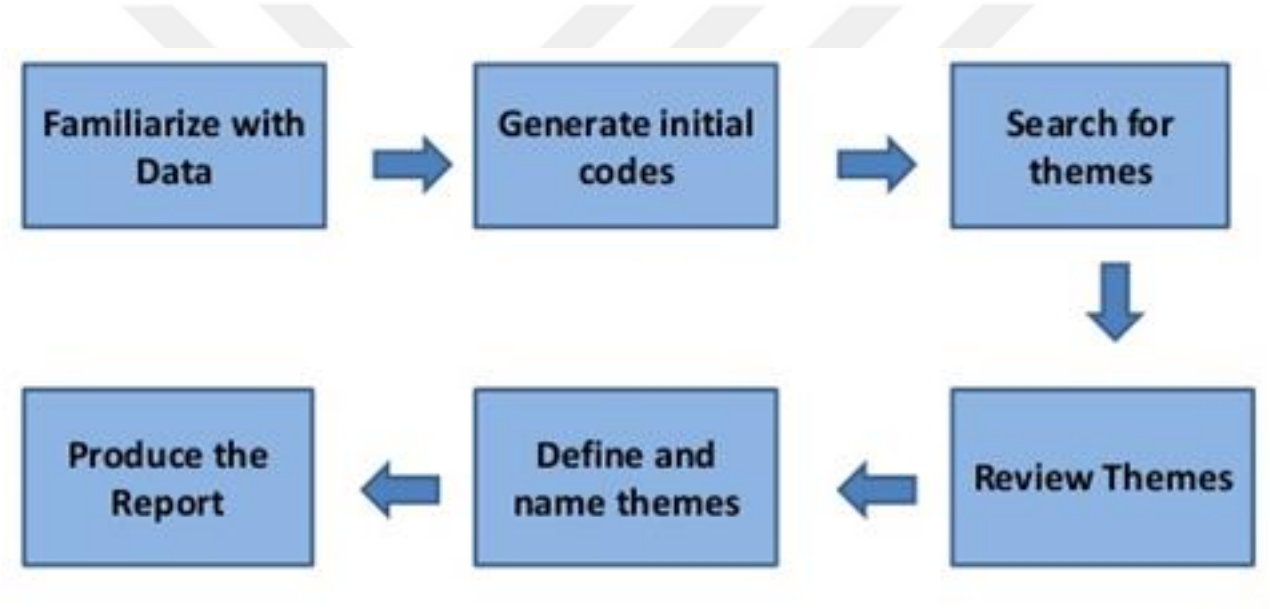

Figure 4.2) Phases of thematic analysis (Braun and Clarke, 2006)

4.6 Conclusion

This chapter described how the literature review was conducted, and how data was searched, collected, synthesised, and analysed. It had outlined the search strategy for this dissertation, the inclusion and exclusion criteria, and relevant databases to identify potential suitable papers. The chapter also gave information on how extracted information was organised. It then described how thematic analysis was used to analyse qualitative data in the included studies. The next chapter will present the search results and analyse them.

Chapter 5 – Results and Discussion

5.1 Introduction

This chapter presents the findings based on the various criteria listed in the previous chapter. According to Woods (2011), the initiation of preliminary analysis often begins with discovering the most crucial themes/ patterns from the findings. This chapter uses the application of Braun's and Clarke's (2006) six stages of thematic analysis to be able to identify such codes and sub-themes. Upon compilation of the required themes, it may allow for potential answers to the research question.

5.2 The search strategy

The search strategy that was carried out in accordance with the inclusion/ exclusion criteria was described in the previous chapter. During the search process, the priority was given to identify primary research that addressed the effectiveness of clinical nursing leadership models. However, these criteria allowed for a rather limited number of potentially relevant studies; to address this, the search strategy sought primary studies that addressed a similar topic on clinical leadership. Rather than being a limitation, this allowed the current search to compare the impact of clinical nursing leadership models, and to identify the most effective model. Obtaining other studies that focussed on a wider area helped gain a wider focus into the subject area- that wasn't restricted to the research question. This aided in improving my understanding of leadership qualities on a wider aspect. Apart from the focus on primary research articles, the search also allowed for scanning through systematic and literature reviews that were related to the subject area. The use of such reviews for obtaining primary research articles have been strongly suggested by various studies (Gill *et al*., 2008). Nevertheless, the scanning of such reviews for references had obtained a large number of research studies which were irrelevant or did not match the set criteria- several of these identified more general leadership models than clinical leadership models. The search strategy in this dissertation identified more than 200 papers through the various databases and journals mentioned in Chapter 4; several of these papers, however, were secondary research or had inaccessible full-texts and had to be excluded. Only 59 of full-text primary research papers were found relevant and accessible; these were assessed based on the eligibility

criteria- several of them were published before 2006. A total of 8 papers were eligible and had been chosen for this dissertation; the search process is described in Figure 5.1.

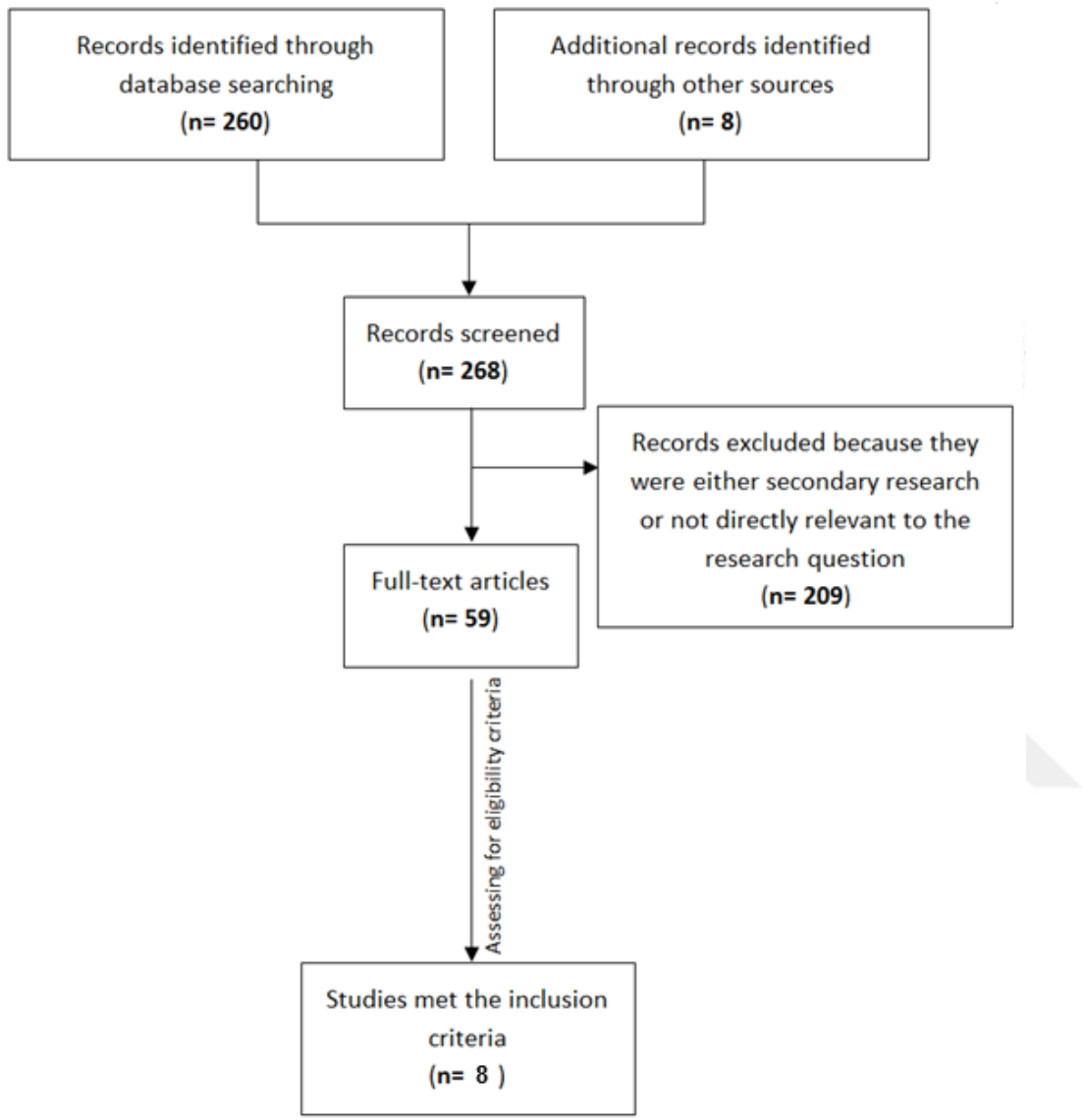

Figure 5.1) The search process

5.3 The search results

Table 5.1 lists the search results which included all eligible studies for this dissertation.

Table 5.1 – The search results

No.	Study	Research method	Objective	Findings
1	Wong and Cummings 2009- Authentic leadership: a new theory for nursing or back to basics?	Descriptive analysis	To assess authentic leadership model on nursing practice and to determine its relevance in terms of being a new model as is, or an amendment made to an earlier leadership model.	The authors assessed this leadership form to be able to influence organisational performance and work outcomes. Further, due to its bonds with authenticity and trust, a positive association linked authentic leadership and effective management and leadership performance among nurses. The study concluded that the leadership model may allow for healthier work environments and stressed on the importance of the positive psychological factor.
2	Havig *et al* 2011- Leadership, staffing and quality of care in nursing homes.	A cross-sectional survey	To assess the influence of nurse leaders' task- and relationship-oriented leadership models on three indicators of care quality.	This study was carried out at 40 nursing home wards in Norway; it utilised various sources to obtain data- including interviews, questionnaires and field observations. The task-oriented leadership style was obtained with significant positive relationships with two (of three) measures of quality of care. The positive measures were as assessed by relatives and staff, but not to quality as assessed by field observations. Relationship oriented

				leadership style, however, did not show positive relationship with any of the indexes.
3	Gardner *et al* 2007- The relationships between nurses' perceptions of the hemodialysis unit work environment and nurse turnover, patient satisfaction, and hospitalizations.	A descriptive correlational design	To examine the relationship between nurses' perceptions of the work environment and leadership, and their effects on patient outcomes.	The study included a descriptive, correlational design to obtain data from 199 registered nurses working in facilities of a national dialysis company. Nurses rated their work environments more favourably at an average; they agreed that it values the status of nurses. Further, the nurse manager was also generally agreed to be a good leader; however, nurses stressed on the importance of collegial collaboration among nurses, including those in different disciplines, to significantly attribute to professional practice environments.
4	Tourangeau *et al* 2007-Impact of hospital nursing care on 30- day mortality for acute medical patients.	Testing and assessment of clinical leadership model	To assess processes involved in hospital care (including leadership) influencing 30-day mortality for acute medical patients.	This study obtained and developed indicators using data from various surveys and databases (these included patient data, nurse data and staffing data in Ontario between 2002- 03). Lower mortality rates were obtained in hospitals with higher number of registered nurses, and those with higher use of care-maps and protocols. However, nurses rated manager support to be rather low. Further- nurses working in hospitals with lower mortality felt less

				support from their managers as compared to those with higher mortality rates.
5	Raup 2008- The impact of ED nurse manager leadership style on staff nurse turnover and patient satisfaction in academic health center hospitals.	Survey	To explore what types of leadership models were used by nurse managers emergency departments and assess their impact on staff nurse turnover and patient satisfaction.	This study involved obtaining surveys from 45 participants (15 nurse managers and 30 staff nurses). Lower staff nurse turnover was associated with transformational leadership model, compared to non-transformational leadership. However, transformational leadership model appear to have a significant influence on patient satisfaction.
6	Cummings *et al* 2010- The contribution of hospital nursing leadership styles to 30-day patient mortality.	Multilevel analysis	To assess the association between nursing leadership models and mortality after controlling confounders such as patient demographics, comorbidities, and hospital factors.	This study included 90 acute care hospitals in Canada; the leadership styles that were followed in these hospitals were divided into resonant, dissonant and mixed. 30-day mortality was 7.8% across 21,570 patients. High-resonant leadership styles were associated with the lowest mortality (5.2%). Nevertheless, both dissonant and resonant leadership styles were linked with lower mortality rates. Mixed leadership, on the other hand, was linked with the highest mortality rates (8.1%).

				Leadership nursing models explained 6.2% of variance in 30-day patient mortality.
7	Pepin et al 2011- A cognitive learning model of clinical nursing leadership.	Interpretative phenomenological study design	To develop a clinical leadership nursing model and assess its competency; specifically to aid the transition from student nursing to expertise.	This study gathered data in the form of interviews from 32 undergraduate nursing students and 21 nurses in Canada. Cognitive leadership model (CLM), according to this study, had significant associations with healthcare benefits that extended to organisational level and beyond. Data obtained from student interviews suggested the need for support in order to develop clinical leadership. Nevertheless, the first three stages of the CLM model re-examines both educational and clinical contexts for leadership development.
8	Kroposki and Alexander 2006- Correlation among client satisfaction,	Correlational descriptive study	To compare patient and organisational factors including clinical leadership.	Patient's satisfaction increased when nurses perceive meeting patients' psychosocial needs, when nurses and supervisors had a good working relationship, and when nurses used leadership models and guidelines to direct their practice.

	nursing perception of outcomes, and organizational variables.			

The following themes (Table 5.2) were merged after textural data was identified and analysed from the 8 studies. First, initial codes in Table 5.2 were produced from the textual data of papers. Then, how different codes could generate one useful theme was considered. Also, the relationship between codes and between different themes were analysed to address the research question. Final themes were reviewed and refined.

Table 5.2 Thematic map

Themes	**Sub-themes**	**Codes/ data**
Patient health/	Collaborative working	Quality of care of patients and their families Lower mortality rates were obtained in hospitals with higher number of registered nurses, and those with
	patient mortality	

clinical outcomes	Patient relationships	higher use of politeness, care-maps and protocols. Giving medical advice, helping patients, supporting the family.
Patient satisfaction	Standards of ethical	Patients' psychosocial needs, when nurses and supervisors had a good working relationship. Consent forms Health-related quality of life and healthcare utilisation in patients. visionary, coaching task- and relationship- oriented leadership models, giving direction, clarification of tasks and clear task expectations
	Moral conduct	
	Patient healthcare utilisation	
	Communication model	Maximum job satisfaction and satisfaction with supervision. Authentic leadership and effective
	Transformational model	

Models of clinical nursing leadership	Cognitive	management and leadership performance among nurses. Authenticity and trust. Improving perceptions, preferences, and needs captured by the capability to understand oneself.
	Ongoing Education model	
	Role Modelling	
	Authentic leadership model	

5.4 Discussion

An ideal leadership model in nursing may emphasise the importance of mentoring in their work environments- the leader would ideally understand the connections between mentoring and organisational cultures (Laschinger *et al*., 2014). Recent years have seen several leadership models that enhance mentoring and support positive leadership (Bally, 2007). Further, staff nurses have been pushed to adopt a visionary leadership style- one that may empower, motivate and inspire fellow colleagues and followers (Bally, 2007). However, given the vast literature that surrounds leadership models, it often becomes a task to select an appropriate model- especially in a healthcare setting. Healthcare settings may have varied organisational cultures in various hospitals; and may also differ according to region (Bally, 2007). Selecting the right leadership model whilst keeping such factors in mind may allow obtaining maximum effectiveness of the leadership model; such implementation may fail to work if there is no understanding of the organisational culture (Bally, 2007). Improper nursing leadership has also been linked to job dissatisfaction among nurses; this may be further aggravated due to trends in diminishing resources, unit downsizing, and cost containment. In their 2000 study, Bratt *et al* reported nursing leadership to be among the major factors determining job satisfaction in nurses. This study obtained that nurses had a higher job satisfaction who perceived their managers to have a participative style.

Several studies have linked the importance of nursing leadership and management in healthcare settings (Wong and Cummings, 2009; Kotter, 2013). The work environment is largely controlled by the characteristics of such leaders, and their relationships with nurses (Boyle *et al*., 1999). Apart from leader relations, collegial relationships have also linked with organisational work satisfaction (Lucas *et al*., 1993). Nevertheless, given the several leadership models that are currently present in modern day literature, it may be tedious to select the appropriate one- in terms of quality of care provided. This dissertation aimed to address that very research question; eight studies were obtained that linked leadership styles in healthcare to quality of care. Thematic analysis was used to analyse the papers that were selected; this method remains the most widely used qualitative approach (Folkestad, 2008). Figure 5.2 shows the final sub-themes and themes that were used in this dissertation. Obtaining of these themes allowed for links to the dissertation's

research question. This section is further divided into sub-sections, in accordance with these themes.

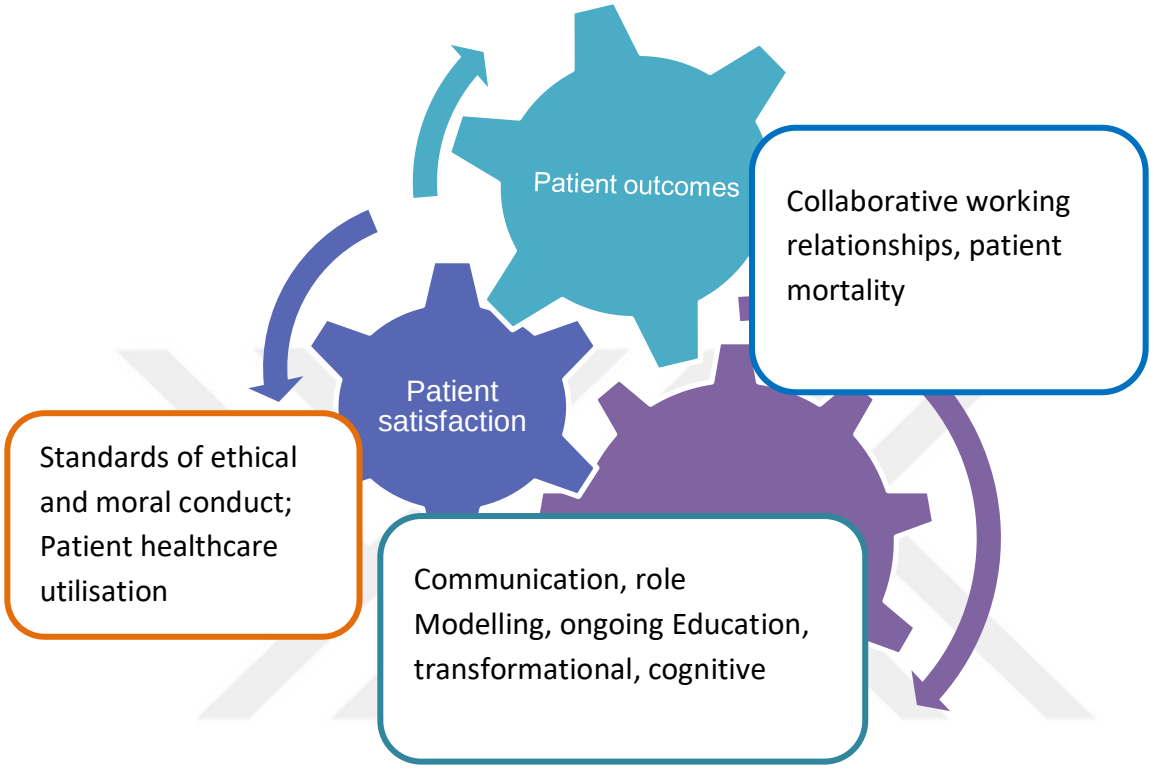

Figure 5.2) The developed sub-thematic and thematic map, showing the three final themes

5.4.1 Theme I - Patient health outcomes

Patient health outcomes are often appropriate measures in most health-related research, including that of clinical leadership. In the results that were obtained in this study, majority of papers agreed that the quality of patient care and health outcomes can be improved by providing organisational and clinical leadership for nursing practice. Among the eight included studies, four (Pepin *et al,* 2010; Tourangeau *et al,* 2007; Cummings *et al,* 2010; Wong and Cummings, 2009) explored the effect of clinical leadership on the relationships between nurse managers, nurse performance and patient outcomes including the quality of care of patients and their families. In these four studies, the authors argued that although employers can have an impact

on patient health outcomes, one cannot deny that individual nurses have more of a direct impact on the patients that are hospitalised and require looking after. They also mentioned that clinical nurse leaders can affect health outcomes by improving their organisational skills and transferring clinical leadership techniques and experience to other nurses in their work environment. A few authors (Tourangeau *et al,* 2007; Cummings *et al,* 2010) also observed that all nurses are leaders as they have the natural ability to guide patients toward better health outcomes while collaborating with health professionals in their work environment.

In two of the included studies, clinical leadership was significantly linked with survival of patients (Cummings *et al,* 2010; Tourangeau *et al*, 2007). These studies looked into whether the 30-day mortality rates in acute care settings may be improved with effective leadership models. Cummings *et al* gathered data from 90 acute care hospitals in Canada to assess the association between leadership models and mortality. This study obtained the resonant leadership model to be significantly associated with lower patient mortality; according to their results, both resonant and dissonant leadership models were linked with lower mortality, while mixed leadership models had high mortality rates. Resonant leadership styles in leaders allow them to personally connect with followers and have a higher degree of emotional intelligence; various leadership subtypes- such as visionary, coaching, and affiliate- have been identified to fall under the resonant leadership style (Goleman *et al*., 2013). On the other hand, dissonant leaders tend to be more on the authoritative side, having more of an emotional distance from followers. The leadership subtypes that form the resonant leadership style also include elements that promote transformational leadership (Tullai-McGuinness *et al*., 2011). Various other studies observed nurses to report that there were a few key leadership styles followed by majority of nurse leaders; nevertheless, the resonant leadership style allowed for maximum job satisfaction and satisfaction with supervision (Cummings *et al*., 2005).

Cummings *et al* (2010) concluded that hospital nursing leadership models help increase the quality of patient care and health outcomes through improved homogeneity of leadership models, clarity of communication channels between leaders and healthcare staff, and supportive work environment. The study mentioned that nurse managers with increased control on patient's outcomes, due to increased nursing ability, gave direct support to nursing staff and patients. Not only did this

study contribute knowledge to nursing leadership on patient mortality- which is a major deficit within health research- it also gave detailed information about data sets and methods used to gather and analyse them. On the contrary to this study, Tourangeau *et al* (2007) reported leadership styles to not link to improved survival rates in an acute care setting. Rather, this study obtained a lower mortality rate in hospitals where nurses reported less support from their managers. According to Tourangeau, this finding may have been due to these managers focussing on other hospital processes that'd indirectly help lowering patient mortality; therefore, rather than providing support to employees, Tourangeau and colleagues believed these managers to perhaps promote patient care initiatives or securing resources. However, due to the use of weak power for regression models, this study had several limitations.

Tourangeau *et al* (2007) also reported that clinical nurses with broader span of organisational and managerial scope have a lower ability to give direct clinical support to other nurses in their work environment. Nevertheless, other studies (Vesterinen *et al*., 2012) report that depending on situation, employees may have variable levels of competence; it is, however, up to the manager to reflect on their leadership skills, and adapt them accordingly. Moving to patient utilisation health outcomes, two studies (Cummings *et al,* 2010; Gardner *et al,* 2007) addressed patient healthcare utilisation indicators our results; mainly bed occupancy, hospitalisation rate, hospital readmissions and duration of hospital stay as indicators related to factors affecting clinical environment including. Gardner *et al* suggested that the number of hospitalised patients is a considerable factor for assessing the overall health situation of patients, especially those after surgeries or on dialysis. Patient utilisation outcomes assess what kind of health services and resources (both physical and human resources) are used in controlling and improving patients' health-related outcomes. Both of the above mentioned studies found a negative association between nursing leadership skills and hospitalisation, in which improved managerial and organisational skills of nurses could decrease the total number or patients hospitalised. Gardner *et al*'s study, however, had some limitations because nurses included in their study were from a dialysis healthcare organisation. Therefore, participants' responses may have been affected by an organisational structure that provides only dialysis and could have led to response biases. Another

limitation could be the potential for socially desirability bias as most nurse participants filled in the survey in the presence of a member of the research group.

5.4.2 Theme II - Patient satisfaction

The results obtained four studies that assessed the link of clinical leadership practices to patient satisfaction. These studies generally concluded that there is a positive association between clinical leadership and increased patient satisfaction. In their 2011 study, Havig *et al* used three indicators on care quality to assess leadership influence on care quality and patient satisfaction; this study aimed to compare task- and relationship- oriented leadership models. The task- oriented model was associated with positive care quality by two of three measures (that is, as assessed by relatives of the patient, and staff; field observation indicator did not obtain a significant positive relationship). This study gathered data on 40 ward managers and 13 nursing home directors- with perspectives from 444 employees, 378 relatives (telephonic interviews) and 900 hours of field observations. While task-oriented leadership models may be understandably associated as positive care by relatives, this result was surprising in terms of staff indicator. Task-oriented leaderships essentially follow a dissonant style; other studies had obtained staff to favour a resonant style better. Surprisingly, the results by Havig *et al* also indicated the relationship oriented leadership style to not show any significant changes in indexes. This study also asserted that clinical nurse leaders are able to improve patient care by giving direction, clarification of tasks and clear task expectations.

Raup (2008) also conducted surveys to obtain a comparison between transformational and non-transformational leadership forms; they reported transformational leadership to be associated with a lower staff nurse turnover, as well as in having significant influence on patient satisfaction. In their 2007 study, Gardner et al obtained data from 199 registered nurses working in facilities of a national dialysis company. Majority of nurses in this study strongly agreed to having a ‘good leader’ who was supportive of nurses’ roles. This study recorded patients to report a 48% satisfaction with overall care, and a 96% satisfaction with nursing care in the facilities. However, nurses reported collegial relationships to be far more important in determining patient care outcomes than leadership qualities. This

constant link between leadership and group cohesion had been obtained by other studies as well (Vesterinen *et al*., 2012). Perhaps, a leadership style that also understands the importance of collegial collaboration among employees, especially intra-discipline collaboration, may aid in improvements in the quality of care. Kroposki and Alexander (2006) obtained several factors that determine the level of patient satisfaction in healthcare; these factors include leadership, good professional relationships, and the nurses' skills in meeting the patients' psychosocial needs.

5.4.3 Theme III - Models of clinical nursing leadership

A common theme in all included studies was that the adoption of clinical leadership is a necessary factor in both theoretical and practical models to support healthcare in the clinical unit and to improve patient outcomes; however, there is still a major gap to cover the much stronger evidence on the different application and conceptualisations of clinical leadership models in nursing practice. Further, there was a gap in understanding the mechanisms of clinical leadership application models in the work environment. Most included studies did not have a clear definition of clinical nursing leadership and also did not identify possible approaches by which clinical nurse leaders affect patients and health outcomes. This made it rather difficult to decide on a particular model of clinical leadership which would have most impact on the quality of patient care. Relationally focussed leadership styles often result in higher productivity and greater work satisfaction by promoting employee engagement; this leadership model is linked with positive work environments (Uhl-Bien, 2006). Two studies (Cummings *et al*., 2010; Havig *et al*., 2011) that were included in the results focussed on resonant leadership styles; however, both of them had contrasting results. The 30-day mortality rates in acute care units were obtained to be lower in case of units following resonant leadership styles (Cummings *et al*., 2010); however, Havig *et al* (2011) reported relationship- oriented leadership models to be not significantly associated with positive patient care quality (on the basis on three indicators). According to Goleman et al (2002), the emotional intelligence framework is composed of four domains; "emotional self-awareness, self-management, socio-political awareness, and effective management of relationships with others" (Laschinger *et al*., 2014; p. 7). In a recent study, Squires et

al (2010) also mentioned improved work environments, lower turnover, higher job satisfaction and higher quality leader-nurse relationships as a result of resonant leadership.

Several of the included studies had a multi-analysis approach because they analysed the effect of leadership on individuals, work environment, and patients (Havig *et al* 2011; Tourangeau *et al* 2007; Pepin *et al* 2011). Although it is an essential concept, the definition and implantation of clinical leadership as manager support or capability, is, somehow, a narrow aspect of leadership, as opposed to wider and more complicated definitions of leadership that can affect behaviour and have an impact on strategies suggested in other clinical leadership nursing models such as transformational or resonant leadership. Among all included studies, transformational leadership theory was the most frequently mentioned and/or used leadership model in nursing literature. Gardner *et al* (2007), Kroposki and Alexander (2006), and Raup (2008) observed that transformational leadership can help nurse managers to increase their collaborative work with the nursing staff. Raup (2008) also observed transformational leadership to have a significant influence on patient satisfaction while also being associated with a lowered staff nurse turnover. According to Burns (1978), a transformational leader has a deep set of ideas and internal values that motivates followers by appealing to moral values and higher ideas; rather than focussing on individual interests, this leadership model motivates followers to sustain the greater good. The transformational leadership model tends to engage the followers in an intellectual and emotional level; satisfying the higher needs of the follower while also recognising the importance of rewards (Surakka, 2008). In their 2012 paper, Doody and Doody claimed four components of transformational leadership; “idealised influence; inspirational motivation; intellectual stimulation; and individual consideration”. Idealised influence provides followers with a sense of mission, building trust, confidence and admiration. Inspirational motivation allows employees to encourage their colleagues and other staff to achieve goals and aspirations of the organisation. A transformational leader also empowers staff so as to encourage approaching challenges or proposal of ideas by stimulating intellect. Lastly, transformational leaders also support and encourage employees to attain higher levels of achievement (Doody and Doody, 2012).

Attention to other clinical leadership models that could be directly linked to nursing practice and healthcare are worthy of further investigation. This may also allow for application of potential alleviating processes that they suggest between leadership and patient outcomes. For example, Wong and Cummins (2009) had studied the association between authentic leadership model and nursing practice. They found that there was a positive effect of authentic leadership model on nursing performance, behaviour, engagement, empowerment in work environment. This study defines authentic leadership as controlling one's personal experiences, by improving perceptions, preferences, and needs captured by the capability to understand oneself. They suggested that nurse leader behaviour could be improved and promoted by positive psychological capacities and a positive ethical environment to enhance self-awareness, transparency, and positive organisational development. They also said that such behaviour improves trust and professional work through an open environment for sharing information and expressions to reduce the displays of inappropriate and/or unintended actions in nursing practice. Citing a more recent research, Giallonardo (2013) also reported positive associations between authentic leadership and trustworthiness, perceptions of healthcare, and patient satisfaction (see Chapter Two). In their 2011 study, Pepin *et al* investigated the effect of cognitive model on nursing practice. According to this study, there are three stages of the model that could help improve nursing practice and positively influence patient's outcomes. These stages are: 1) understanding of clinical leadership in nursing; 2) integration of clinical leadership job tasks, and 3) implementation of active leadership and leadership competency. The findings of this study are similar to what was explored in the literature review in which cognitive learning models were found to help improve learning skills and monitoring and evaluation (Tardif, 2006).

In their study, Havig *et al* (2011) reported that there are different sub-types of clinical leadership such as task-oriented, relationship-oriented, transactional and transformational. Their study only focused on two models; task-oriented leadership and relationship-oriented leadership. Task-oriented model explains the attitudes and behaviours work activities such as (what to do, how to do it, when to do it). This model also clarifies the roles and responsibilities of each member in the work environment and involves communication plans and role expectations. Not only does task-oriented model monitor employees' performance, it also gathers data and

indicators to assess progress and contributions in the work environment. On the other hand relationship-oriented model comprises the behaviours of supporting, building and developing, and praising employees toward preferable performance and outcome. This study concluded that there was a positive association between the two leadership models they used and quality of care. However, they found that a stronger effect on quality care can be provided by implementing task-oriented leadership style because nurses should in particular focus on task-oriented environments such as organisation's structure, coordination, defined roles and responsibilities, and monitoring and evaluating. However, findings may be unrepresentative due to the small sample size recruited in this study as well as the quality of care was assessed by self-reported data only; which may have led to bias. None of the studies mentioned a comprehensive mechanism of clinical leadership integration in nursing practice. Only few studies (Havig *et al*., 2011; Raup, 2008; Cummings *et al*., 2010) had compared one or more models; questions still remain as to which model may be feasible and effective in practice.

5.5 Conclusion

This chapter had overviewed the search results. A total of eight studies were eligible and included in this dissertation. The results of the included studies were collected and analysed using thematic analysis. Three main themes were generated: patient outcomes, patient satisfaction, and models of clinical nursing leadership. The following chapter will summarise these results and provide recommendations.

Chapter Six – Summary and Recommendations

6.1 Introduction

This chapter summarises the dissertation's findings and provides answers to the dissertation's research question. It also provides some recommendations for the changes that can be made to leadership qualities in the healthcare sector, as well as recommendations for future research.

6.2 The dissertation's focus

To address the research question on "What model of clinical nursing leadership has the most impact on the quality of care at the unit level and how would it be best to implement a new clinical nursing leadership system?", this dissertation has searched health-related and specific-topic databases and journals to locate potentially relevant studies on the influence of clinical leadership on nursing practice. The search results were further assessed to see whether they meet the eligibility criteria that had been earlier set (Chapter 4). Eight studies were selected to be included for this literature review. The studies were examined to assess the effectiveness of clinical leadership models on competencies of nurse leaders including the quality of care at the unit level. Most of the included studies reported positive association between health outcomes and the integration of clinical nursing leadership into health organisations. One study (Tourangeau *et al.,* 2007), however, reported higher mortality rates with higher leadership support; this study aimed to assess processes involved in hospital care (including leadership) influencing 30-day mortality for acute medical patients. Nevertheless, the authors believed that the lower mortality rates (as reported by employees to have lower managerial support) were mainly due to these leaders being occupied in other tasks (perhaps administrative) - to ensure patient care and safety. However, several of the included studies had a small number of participants for their research; further, the models of clinical leadership were variable and inconsistent. Therefore, it was not feasible to compare between these models as they were applied in different sub-structures of health organisations and had different

target groups. Researchers assessed the impact of clinical leadership models on various indicators of health outcomes such as patient safety, patient satisfaction and outcomes, patient mortality, and nurses' skills and performance. Although the findings that were reported in chapter five confirmed what was studied in the literature review section, at this stage one cannot recommend the most effective clinical leadership model; further research is still needed to cover gaps in knowledge and assess the effectiveness of clinical leadership models using robust research methods before these guidelines may be implemented at unit levels. For example, a cohort study may aid assessing a prospective association between the effectiveness of clinical leadership on nursing practice and patient's outcomes, and also provide evidence-based interventions that work in practice.

6.3 Study strengths and limitations

The initial definition of clinical nursing leadership (as observed during data analysis- chapter two) helped in understanding what the terms professionalism and clinical leadership constitutes of. In this dissertation, clinical leadership was defined as ''A professional competency demonstrated in clinical care which improves the behaviour and skills of nurses to encourage others in the work environment to promote healthcare and patients' outcomes''. Professionalism, on the other hand, is expressed in the attitudes and behaviours of each individual nurse- it requires autonomy, body of knowledge, and core disciplinary values (Kelly *et al*., 2008) Thus, the above definition helps differentiate between professionalism and clinical leadership. However, in searching for relevant papers, it was understood that a better definition and classification for clinical leadership was necessary; researchers tend to use their studies as examples of clinical nursing leadership, which only strengthen the researcher's point of view

This dissertation did have several limitations. First, the wide variety of clinical leadership definitions, processes, study settings, and outcome measures limited the ability to categorise leadership into groups according to their style, study environment, or target group. Moreover the small sample size observed in several included studies and the sample's heterogeneity reduced the integration and strengths of findings. While it was attempted to locate unpublished research and

contact authors, unpublished research that was relevant to the research question and written after 2006 was not obtained; further, grey literature was not included in this dissertation. Therefore, this dissertation may not have reviewed all eligible and relevant studies on clinical leadership. In addition to this, the exclusion of published studies in other languages than English may have also limited the dissertation's findings and its generalisability. It is believed that the variations in the definition and outcome measurement of clinical leadership in healthcare across included papers may have also reduced the validity and reliability of findings. All of the papers included were descriptive, reducing interpretations of causality to the co-variation between the research variables and the theoretical associations. The theoretical underpinnings and paradigms were not reported by several studies that were included in this dissertation and this may have affected the synthesis of results and reporting the findings.

6.4 Summary of findings

The findings of this dissertation is in line with findings from other studies and reviews in which clinical leadership is associated with positive quality of care and improved patient's outcomes. In general, effective leadership was associated with more positive work environments, also improving self-efficacy and work commitment by nurses. These findings lean towards the integration of different approaches of organisational and clinical practices such as supervision, human resources, and leadership programmes within the health settings; support and motivation of nurses are also necessary to achieve better healthcare outcomes and satisfaction. Thereby, supporting healthcare providers, including nurses, to be leaders and get leader roles with the necessary competencies that boost clinical leadership models are critical to effective healthcare provisions at all levels of organisations. During data analysis for chapter two, it was observed that the leadership training programs are essential to be included during training of nurses- to ensure their professional development. However, several of these key factors have been largely absent in formal training- including the importance of communication and teamwork in nursing (Leonard *et al.,* 2004). Nurse leaders contribute to improved health practice engagement with their work environment by supporting and empowering staff, giving positive and

comprehensive feedback, and providing transparent communication with staff and patients. Therefore, creating channels for meaningful communication between decision makers and other stakeholders and clinical nurses is crucial to discuss patient issues that could influence patient satisfaction and safety.

Nevertheless, the unclear mechanisms of clinical leadership and heavy cross-cutting managerial roles may make the creation of such channels a challenging process; it does, however, remain a priority that should and promoted and studied. Further, the findings indicate that nurses should be given the opportunity and physical resources to assess and improve patients' outcomes and address their training needs regarding care, management of diseases and its risk factors, and other issues related to patients. Supportive clinical leadership in nursing is associated with positive patient safety and satisfaction, and this should encourage clinical unit leaders' to review patent processes and the role of nurses in improving health outcomes. All included studies had provided evidence that when nurses demonstrate higher leadership skills and positions, the staff within their units reported improved patient safety and satisfaction. As earlier mentioned, only one study (Tourangeau *et al.,* 2007) went against this finding; however, further research may be required to ensure the credibility of their findings as this study obtained patient data, nurse data and staffing data mostly from databases. The findings of this dissertation also indicate the ability of nurse leaders to empower a healthy workplace is influenced by their understanding of work environment, patient needs, and their capability to implement effective safety strategies. Additionally, the development of safety procedures through the implementation of clinical leadership models, which include leaders' walkabout safety rounds, were associated with better quality of care at the unit level.

6.5 How would it be best to implement a new clinical nursing leadership system?

This dissertation provided a theoretical understanding of clinical leadership in nursing practice to enhance quality of health outcomes. This dissertation also provided an understanding of different theories of clinical leadership that may be helpful in framing a leadership strategy that addresses dimensions of nursing

practice, and provided a review of what is already known on leadership as a preliminary roadmap of necessary actions for successful nursing leadership. Adequate preparation and understanding of the integration of leadership models in healthcare settings is still absent in healthcare literature and it is crucial to create a mechanism for leadership model that ensures consistency and efficiency. Towards the implementation of clinical leadership, the first step of a health care organisation should be to identify nurse leaders present and review their skills and competencies. The second should be to help these leaders improve and appreciate their leadership capacities. According to Stanley (2006), healthcare providers themselves seldom know and understand their leadership potential; this may be a major barrier to their leadership development and may prevail even if their organisations values their potential and are willing to nurture them and make them effective clinical leaders. Stanley (2006) added that innovation is not about a structure or a mechanism, although innovation may be complexion multi-level large chaotic organisations. Innovation, instead, is about nurses who are willing to positively influence on quality patient care and improve quality outcomes and care standards. It is suggested that effective leaderships cause innovation; innovation, in turn, can lead to change and that change may improve healthcare, service provision, and quality standards (Goudreau *et al,* 2014).

By reviewing available literature on clinical nursing leadership, this dissertation asserts that there has been great investment in clinical leadership shaping and understanding in health organisations worldwide over the recent years. However, a constructive understanding about what clinical leadership really means is still pending. Also, there is still a gap on how the healthcare providers will risk the potential for change in their work environments. Therefore, it is suggested that nurse leaders need to be recognised and assessed by their employers and by themselves, for genuine innovation of effective clinical leadership. The implementation of various mechanisms of clinical leadership in nursing units should then be carried out to compare between their effectiveness in practice and to guide future interventions. Based on the findings of this dissertation, the recommendations can be summarised into three elements of clinical leadership necessary for change and redesign in health settings:

1. Review what is already known in organisations about leadership to design future interventions with cross boundary service improvement.

2. To assess the capabilities and potential of nurses (and their top management) to make changes for integrating clinical leadership into their daily practice.

3. To identify barriers to the implementation of clinical leadership and as to how these barriers may be eliminated.

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Appendix – Student's supervision

1 July 2016 00:12

Dear Ms Karen Sheehy

I hope you are well.

My name is Sevilay Ergun, I was told that you are my new dissertation supervisor for my MSc. I would like to let you know that I am in Turkey for my wedding ceremony. You can see my dissertation topic in attachment. If it is Okay for you, I am interested in studying on this research, however, if you advise me on something new, we can discuss it.

If you like, we can communicate via Skype.

Best Regards

Sevilay Ergun

<sevilay first dissertation part.doc>

5 July 2016 16:51

Dear Sevilay,

Apologies for the delay. I have spoken to Marion Waite regarding her advice to you and the topic and you have been advised, the topic is not appropriate and is not a suitable topic to meet the learning outcomes of the MSc in Nursing (Clinical leadership in practice).. You need to choose something that is relevant to your

current practice and meets the outcomes for the title of the course. I am happy to discuss this with you further on Skype if you wish. Please note I am away on leave at the end of July and August.

Kind regards,

Karen

11 July 2016 12:23

Dear Karen,

Many thanks for your respond. Really apologies for the late e mail. I could not write e mail because of my wedding ceromony and I had no internet connection in the village.

I will search new dissertation topic and I will sent it to you via e mail. We can discuss this dissertation topic with together on skype next week, If you available. Sorry again and again, due to my situation I could not respond your e mail, but now everyting is ok and I am searching new dissertaion topic. I will let you know when I find new topic in a short time.

Kinds Regards

Sevilay

12 July 2016 14:18

Dear Servilay,

Thank you for getting back in touch. I hope you had a very good wedding. I look forward to hearing back from you regarding your topic and plans.

Kind regards,Karen

13 July 2016 13:27

Dear Karen,

Many thanks for your interest, my wedding was good, now I am studying for my dissertation, I am searching a new topic, when I find a few questions I will send them for you to discuss with together on Skype next week. Many thanks Karen.

Kind Regards

Sevilay

21 July 2016 14:18

Dear Karen,

I created a question after my search, If you think it is suitable topic for the dissertation I will start to write the primary literature review as a first part. I will send the question, aim and objectives in this word document. What is your recommends for me about this topic and question? Many thanks for everything and your interest Karen.

Kind Regards

Sevilay

<Question.docx>

21 July 2016 15:21

Dear Sevilay,

Could you tell me why you have chosen this topic? I am a bit concerned that it doesn't really address the course aims/outcomes as it is not directly related to your

practice and leadership-which is the course title-MSc in Nursing (Clinical leadership in practice). This is more about education. I think you are working in an operating theater environment, am I correct? You need a topic related to the area of work and nursing leadership in this area.

Kind regards,

Karen

21 July 2016 19:03

Dear Karen,

Many thanks for your respond, I have 5 years experiences about nursing. Yes, I worked as a surgical nurse in the last two years but in the first three years I did training nursing, infection control nursing and clinical nursing. So I created this question, because, it is related to general nursing education and training for the nursing students before in a real patient care environment also when I finish my MSc, I will be a lecture in a university to teach undergraduate students.

So, If this question suitable for the dissertation I can continue with this. Because, in Turkey, with the developing technology, the use of virtual simulation in nursing education has increased. This gives an opportunity for non-technical and technical skills in nursing education also simulation applications and tools have been used widely and it is one of the trusted training methods. In Turkey the use of simulation contributes positively to learning experience and professional skills of nursing students before in a real patient care environment. However, this question is not suitable for the dissertation I can continue with this question as an optional topic ‘’ What is the effectiveness of breathing and coughing exercises to reduce pain among children after abdomen surgery’’? What is your recommends Karen, really many thanks for your interest for me.

Kind Regards

Sevilay Ergun

22 July 2016 10:22

Morning Sevilay,

I know this is difficult but you have to pick up the MSc title in what you are proposing. I am not sure if either of these has anything to do with leadership? Is there an issue in your workplace around leadership that you could chose?

Regards,

Karen

22 July 2016 12:36

Dear Karen,

Really many thanks for your interest, Could we speak with together on Skype. Do you have any time today, tomorrow or next days. I want to tell my situation, why I could not choose a question about leadership and why I choosed a question about my previous experiences and general nursing topic. Thank you Karen.

Kind Regards

Sevilay

25 July 2016 12:46

Morning Sevilay

You have caught me as I am about to go away for the week so no chance to catch up with you till next week. I am in on Monday if that would be good to get hold of you? You have to meet the programme outcomes and as the award is around leadership your topic has to be aligned to this. I will pick up emails for the next day or so.

Kind regards,

Karen

25 July 2016 13:58

Dear Karen,

Many thanks for your e-mail, sorry disturb you, ok I will create a question about leadership and nurse leaders, I spoke my advisor from Turkey in the University, she allowed me to choose leadership topic for my dissertation. Now, there is no problem to choose this topic. Really many thanks Karen for your interest.

Kind Regards

Sevilay

1 August 2016 11:36

Dear Sevilay,

I am about this week - would you be able to send me some details about what you

intend to do for your lit review research please.

Thank you

Karen

1 August 2016 12:20

Dear Karen,

I am happy with your interest, thank you for your respond. I searched and I created these questions which are include clinical nurse leaders,

1- What is the effect of integration in to practice of clinical nurse leaders on clinical quality outcomes and patient satisfaction?

This topic is controversial among nurses in Turkey. When I was a nurse I noticed this problem between nurses. They arque that ‘’Should clinical nurse leaders integrate in to practice or not?’’ In some clinics, clinical nurses integrate in to practice but in some clinics clinical nurses don’t integrate in to practice, they just organise and manage the clinic and clinic staff. So I will search the effect of integration in to practice of clinical nurse leaders on clinical quality outcomes and patient satisfaction? If this question suitable to search for my literature review I can start to write my aim and objectives with my first primary literature review. Additionally, I created a few optional questions to search,

2- What is the effect of presence of clinical nurse leaders on hand washing behaviour and patient safety in hospital?

3- What is the effect of presence of clinical nurse leaders on nurses and patient satisfaction?

4- What is the effect of presence of clinical nurse leaders on clinical quality outcomes and patient satisfaction? I can choose one of these questions, If they are suitable for my dissertation topic. If they are not suitable I need your help and your suggestion. What is your idea and recommend about these questions? Really many thanks Karen.

Kind Regards, Sevilay

1 August 2016 14:22

Dear Sevilay,

Thank you -have you done a preliminary scope of the literature? to see what research papers there are for you to analyse as this will be important in choosing the specific question? Can you let me know what you have found.

Kind regards

Karen

1 August 2016 16:04

Dear Karen,

Thank you for your respond,These are a few articles which were scoped and downloaded also I will continue to find and read new articles.

Kind Regards

Sevilay

<untitled folder>

2 August 2016 13:34

Dear Sevilay,

Thank you for sending this through.

You want to try and narrow your question down. Looking at the preliminary literature, you sent me, there is relatively little robust research on the impact of clinical leadership and quality patient outcomes. A lot of the papers are descriptive or opinion papers and many are very old, and of course there are a lot of other reasons

why patient outcomes may have improved. One of the issues you will have is defining what a CL is - if you read the papers closely they do not seem to have the same definition or job role-indeed if they dont tell you what this is-and some do not-then it is difficult to compare them at all. The topic of impact of CL on quality outcomes would be a suitable topic area -but the area of hand washing is not a good choice.Try and make sure you have research papers only that have an explicit methodology -as you are going to have to discuss this in your writing up. Try and have papers only in the last 5 years or so. The other literature you can use as part of your analysis/discussion.

Could you try and send me a revised title and outline by Tuesday next week? hopefully you would have been able to search for more papers by then.

Kind regards,

Karen

2 August 2016 14:11

Dear Karen,

Many thanks for your recommends and interest, I will do my best to find new research papers and to write preliminary literature review. I will try to finish by Tuesday next week and I will send it via e-mail. I will choose this question ‘’ What is the effect of integration into practice of clinical nurse leaders on clinical quality outcomes and patient satisfaction?’’ Many thanks for everything Karen

Kind Regards

Sevilay

11 August 2016 8:12

Dear Karen,

Really apologise for the late e-mail. I know, I promised to send the outline on Tuesday but after my searching for the previous question, I could not find enough articles about the topic. So I decided to change the question again. I am thinking to

create a new question about clinical leadership and nurse leaders. In this time, firstly I will find some articles then I will create the new question. Could I send the question, outline, aims and objectives on Monday or Tuesday? Many thanks.

Kind Regards, Sevilay

11 August 2016 14:05

Dear Servilay,

Of course, however I am on leave until the 1st of September from next week but will look at your email. regards

Karen

11 August 2016 14:21

Dear Karen,

Really many many thanks for your respond and interest. Ok, when I complete I will send my work on your e-mail.

Kind Regards

Sevilay

19 August 2016 9:59

Dear Karen,

I know that you are in holiday until September, sorry disturb you, but I need your recommends about my study. I wrote an outline, aim and objectives. If it is ok I will continue to do extensively search to complete preliminary literature review. Many thanks.

Kind Regards

Sevilay

<first part.docx>

22 August 2016 12:38

Dear Servilay,

Thank you for your email. I will be able to look at this tomorrow .

Kind regards

Karen

22 August 2016 13:27

Dear Karen,

Ok, many thanks for your interest. Kind Regards

Sevilay

24 August 2016 13:25

Dear Sevilay,

I have annotated your document and refined the question. Is this acceptable to you? Please try to start with an overall history/background, definitions and put it into context of your own place of work and role. Good luck with it.

Kind regards,

Karen

24 August 2016 22:12

Dear Karen,

Really many thanks for your respond. Yes I am thinking to start with this question. Ok I will start with background and definition. I will develop my study better than this. When I complete and improve this study, I will sent it to you to have a feedback. Many thanks.

Kind Regards

Sevilay

12 September 2016 15:27

Good afternoon Servilay,

I hope your work is going well. I wonder if you could provide me with an update and send me the draft of your work so far please. I was expecting to review at least the first 2 chapters by now?

Kind regards,

Karen

14 September 2016 16:45

Good afternoon,

I think you are asking if you can get my feedback -I have just sent it to you? yes I am happy to keep giving you feedback as I do want to see the chosen papers and analysis and discussion chapters please. We do not recommend particular proof readers but I know that there are several online ones that do this service.No hard copy necessary and Sue Atkins will set up a box for extensions so please submit to the correct one.

I hope this is helpful,

Kind regards

Karen

14 September 2016 20:00

Dear Karen,

I am very apologise for the late response, I was in the village so I did not notice this e-mail because of internet connection. I will send my work about dissertation what I did until now. I will send it in this week because I need your idea about my dissertation. Thank you for your interest.

Kind Regards

Sevilay Ergun

20 September 13:18

Dear Servilay,

I look forward to seeing your work this week- I am making an exceptional case for you as by now supervisors would not be commenting on work. You only have a few days left before the submission and I do want to see the chapters as you do them before final submission please. I am concerned you haven't sent me anything yet. If your internet connection is so poor how are you managing to do the literature review?

Kind regards,

Karen

20 September 2016 13:30

Dear Karen,

I will send my work in a few days I will complete my background information and methodology. I have three weeks extension, the deadline for me is 21 October. I had poor internet connection just 4 days when I was in the village, other times I had enough internet connection. There is no problem for my work. Really thank you Karen for your interest, I am doing my best and I will send my first two parts in this week. Then I will complete all my work.

Kind Regards

Sevilay

20 September 2016 13:34

Dear Karen,

This is my e mail for the deadline.

Dear Sevilay

Yes, Helen Aveyard and I have also received a copy of the Mitigating Circumstances decision. I can therefore confirm that the submission date for your dissertation is now **Friday 21st October 2016 by 13.00.**

I can also confirm that your new dissertation supervisor is **Karen Sheehy**. Please email Karen as soon as possible in order to arrange your plan for supervision.

Thanks and best wishes

Sue

25 September 2016 16:36

Dear Karen,

I am sending to you the first two chapter, I almost complete them but I will go back to complete them exactly after your feedback. I need your comment about my study. Now, I am doing the methodology chapter. Many thanks for your interest.

<dissertation first part.docx>

26 September 2016 14:45

Dear Sevilay,

Thank you for sending this through. The main issue I have with it is that you seem to be describing the literature. it is not clear why you have the sub titles. If you look at my annotation it might make more sense. So for the background chapter you need to make it clear what the context and historical nature of nurse leadership is in your workplace - so that it leads the reader to your question. Your work here has tended to describe models, literature/studies etc rather than summarise them within a discussion.

Have you read Storey and Holti (2013) Towards New Models of Leadership in the NHS? and have you looked at the healthcare leadership models in the NHS (2013) and maybe the NHS Leadership Academy as there is a lot of work on the site that would make your study more up to date. I know the NHS is a different model to yours but the literature is significant. Interestingly maybe the culture in a particular organisation or country is very relevant to the model and nursing leadership style- which you could discuss?

Please can you keep the dissertation supervision documentation up to date as you will need to submit the record with your final assessment. All online feedback/contact is counted in the supervision - this has taken me nearly an hour.

I hope this helps and look forward to seeing more soon.

Kind regards

Karen

26 September 2016 19:32

Dear Karen,

Many thanks for your prompt reply and I will of course read what you recommended and modify the literature according to that. I will also keep a record of your supervision. My methodology chapter will be ready by tomorrow and please tell me If you want me something about the sending section I wrote so far. Really thank you for your interest.

Kind Regards

Sevilay

27 September 2016 09:37

Thank you Servilay. Please do send me the next chapter.

Kind regards

Karen

27 September 2016 19:53

Dear Karen,

Please find my methodology chapter attached to this e-mail. Also can you please go through the following links and see whether they are relevant to my dissertation because I want to include them in the result chapter. Many thanks for your interest.

Kind Regards

Sevilay

<Chapter Three – Methodology.docx>

30 September 2016 12:03

Dear Karen,

Sorry disturb you, I am thinking to complete my dissertation until 10 th October, is it ok to you for the feedback because after your feedback I will add something and I will send it to a prof-reader before my deadline (21 th October). I am looking for a prof-reader in the University. Do you know any prof-reader in the University to recommend for me?

I will upload my dissertation on the module page only online without hard copy is not it?

Really many thanks for everything

Kind Regards

Sevilay

30 September 2016 16:21

Dear Servilay,

Please find attached my comments on this chapter. My concern is that it is very descriptive and tends to lack application to your own area of practice/review. I have given you some pointers regarding discussing the ontology, philosophy etc more clearly as at the moment you do not really seem to have any depth of understanding demonstrated. Try and make sure the literature is up to date preferably within the last 5 years as you have some very old quotes and references in here.The articles you attached - The Clinical Nurse Leader and the Importance of CL are not research papers but maybe useful for background and discussion chapters. The Mannix paper is research so you could use this as one of the papers you will analyse. Have you found any other research papers, more up to date, as you need much more that need to be presented on a table and included in the dissertation. I would like to see the papers please.

Happy to keep reviewing your work

.Kind regards

Karen

30 September 2016 17:49

Good afternoon,

I think you are asking if you can get my feedback -I have just sent it to you? yes I am happy to keep giving you feedback as I do want to see the chosen papers and analysis and discussion chapters please. We do not recommend particular proof readers but I know that there are several online ones that do this service. No hard copy necessary and Sue Atkins will set up a box for extensions so please submit to the correct one.I hope this is helpful,

Kind regards

Karen

30 September 2016 17:49

Dear Servilay

I apologise I have just found out that students should only use the proof readers that are available thorough Oxford Brookes International (OBI). Otherwise they are in breach of university regulations. They run a dissertation checking service. If you go into your Brookes pages you will see the link. You need to organise this yourself. Once you have done this OBI will seek my approval as supervisor.

Hope this is helps

Karen

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14 October 2016 21:40

Dear Karen,

Sorry I am late for the method section, now I am writhing the result section. Please give me a feedback about this method section, I need your recommends. Really thank you for everything.

Kind Regards

Sevilay

<Chapter 4 – Methods.docx>

Dear Karen, 21 October 2016 23:54

Sorry for this e-mail and disturb you, this is my final dissertation, I did little changing on it to send it. I would appreciate your feedback. Really thank you.

Kind Regards

Sevilay

< FINAL Dissertation What Model of Clinical Nursing Leadership Has the Most Impact on the Quality of Care at the Unit Level and How Would It Be Best to Implement a New Clinical Nursing Leadership System.docx>

Dear Sevilay, 24 October 2016 19:12

Please find attached additional comments on the whole that was attached from your email, I have used tracking. Some of the comments I have made previously are still inserted here and your work does tend to be descriptive. I find, particularly after the method chapter, your work gets a little off track and confused and I'm not sure if you have answered the questions/objectives you set. Try and review each paper separately then have the discussion chapter as you have not really discussed the methodology of each, can you attach copies in the appendix? I did not receive the papers that you have chosen to comment on.

Did you have a chance to look at the NHS Leadership Academy website for more up to date papers? Your recommendations need to reflect the papers and I am not sure where some of these come from, so take care when making general recommendations. I think it better if you laid out the recommendations so that they are clearer -and have suggested how. I hope this helps.

Kind regards,

Karen

Karen Sheehy MA, PgCEA, PgCert Research, BA (Hons), SFHEA, RN, RSCPHN
Senior Lecturer ~Mentorship and Professional Education &
Health Education England Thames Valley Fellow-Mentorship
Faculty of Health and Life Sciences, Oxford Brookes University, OX3 0FL
Tel: 01865 485293

Dear Karen, 24 October 2016 20:19

Really many thanks for your all help and feedback. I will complete them.

Kind Regards

Sevilay

Dear Karen, 14 December 2016 14:04

I saw my result on PIP pages, What should I do now to do it better? What is your recommends for my dissertation? Please tell your recommends for me, I need your help. If I fail I will lose my job in Turkey. Thank you everything.

Kind Regards

Sevilay

Dear Sevilay 14 December 2016 14:14

You have considerable comments on Moodle both in the general comment section and inserted in text. Please go through the pages and review your work accordingly. I am happy to comment on anything that you revise.

One of the main concerns is that your work has a lot of copying from sources - either directly or very poor paraphrasing, whereby you have replaced the odd word but essentially the same structure from the original text is there.You need to read and

then write in your own words. Look at the structure carefully and overall make sure you have included all the parts from the advice on the dissertation layout on Moodle. Essential keep asking yourself if you have answered the question (s) you pose as there is little discussion regarding the best model for you to use in your practice area and subsequent recommendations based on the literature review.

I will try and advise you in anyway I can. Start now and work out a timeline for your chapter revisions.

Kind regards,

Karen

Dear Karen, 14 December 2016 14:32

Thank you for everything Karen, I thought that I did my best for this dissertation but I noticed some deficits. Immediately, I will start to do it better and I will sent it before deadline for the feedback.

Kind Regards

Sevilay

Dear Karen 12 January 2017 12:57

Sorry disturb you, I started to complete my deficits and I added some new information in my dissertation. I completed the first two chapters but I need your help and recommendations to continue about this dissertation. This is my last chance to pass otherwise I will lose my job. Thank you everything.

Kind Regards

Sevilay

Dear Sevilay, 13 January 2017 14:43

Thank you for sending me this. I'll get back to you on Tuesday with feedback. Please do carry on revising your methodology chapter as that is not reliant on the context so much.
Regards
Karen

Dear Karen 17 January 2017 13:27

Sorry disturb you, I completed the methodology part and I am sending it to you for the feedback with the first two parts. I added the methodology part in the previous work and I am sending them together. Really thank you for your interest and feedback.

Kind Regards

Sevilay

Dear Karen, 20 January 10:34

I really apologise to disturb you, I hope you are well.

I completed the half of the dissertation and I sent it to you on Tuesday for the feedback. Did you see the half of the dissertation?

Thank you for everything.

Kind Regards

Sevilay

Dear Servilay 20 January 2017 17:38

Apologies for not replying earlier -it had been a very busy week. I will have your feedback done over the weekend.

Kind regards

Karen

Dear Karen, 20 January 2017 18:06

Thank you for your e-mail.

Kind Regards

Sevilay

Dear Sevilay 27 January 2017 18:09

My apologies for taking so long to get this back to you but it has taken me an age to go through so many words and make comments.My concern is that you already have over 12,000 words here and still have a way to go with the actual review so you will need to make some drastic cuts to the word count.

Mainly the issue of you being descriptive remains. It is unclear if the content of this is in your own words and the work tends not to be about the literature review so comes across as very abstract. It is not always clear that you understand what you are

writing.Try not to assume the reader (me and another tutor) know anything about what you are writing. You need to read the papers/literature and summarise them in your won words. Sometimes many authors say the same thing so use more than one reference in the bracket. A lot of the references are very old.

Make it clear how each links to your work - for example you do not need to describe what qualitative and quantitative is but you are able to explain you understand it when you review your papers. For the purpose of the methodology chapter you mainly want to discuss the methodology of how you are going about your literature review.

I am happy to review your work again if it helps.

Kind regards

Karen

Dear Karen, 27 January 2017 19:05

Really thank you for your feedback, believe me please, I am doing my best for this dissertation, because this is my last chance to pass. If I fail I will lose my job and my education life. I am a scholarship student, I have a contract with government, they gave me last chance to pass so I am really under pressure and I have many health problem. I am not good in body and mind also I have financial problems due to this extension education. I apologise for my situation and my feelings.

Kind Regards

Sevilay

Dear Karen, 3 February 2017 12:09

Sorry for this e mail to you, I completed the Methods, Result and Discussion parts. I really followed your feedback on the module page and I did some changes. Could you give me a feedback again for these parts please?

In line with your feedback, now, I am reviewing the first half of the dissertation (Background, Literature Review and Methodology). After this review, I will complete chapter 6 (Summary and Recommendations).

I will submit all dissertation parts on 10 February is not it?

Really thank you for everything

Kind Regards

Sevilay

Dear Sevilay 6 February 2017 15:45

I will have this back to you tomorrow. Yes it is the 10th Feb -there is a re submission box set up on Moodle.

Kind regards

Karen

Dear Karen, 6 February 2017 16:37

Thank you for your e mail and interest. Ok, I will wait your feedback for these two

parts tomorrow.

Thank you for everything

Kind Regards

Sevilay

Dear Sevilay 7 February 2017 10:52

Please find attached the latest feedback. I am concerned regarding the content being your own thoughts and analysis as you are using 'we' 'our' and this tends to indicate that you may have copied from a source. There are gaps in your work regarding the description of the papers themselves in relation to the detail of their methodology and sample etc - if you are going to compare and assume an evidence base for your recommendations then you would need to make it clear that the research they are based on are robust etc and it is not coming across in your work that well. It seems to me that you may have read the discussion and conclusion of the papers rather than understood the methodology which is needed at this level of work.

Kind regards,

Karen

Dear Karen 7 February 2017 11:27

Really thank you for your feedback and help, I will review these parts again and I will do my best for this dissertation.

Kind Regards

Sevilay