

2013

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John Hurley  
*Southern Cross University*

Marie Hutchinson  
*Southern Cross University*

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## Publication details

Postprint of: Hurley, J & Hutchinson, M 2013, 'Setting a course: A critical review of the literature on nurse leadership in Australia', *Contemporary Nurse*, vol. 43, no. 2, pp. 178-182.

Published version available from:

<http://dx.doi.org/10.5172/conu.2013.43.2.178>

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## Setting a course: A critical review of the literature on nurse leadership in Australia

JOHN HURLEY AND MARIE HUTCHINSON

School of Health and Human Sciences, Southern Cross University, Coffs Harbour, NSW, Australia

**Abstract:** *Nurse leadership capability that is constructed, nurtured and supported from pre-registration level into the mature career stages intuitively appears to offer benefit for all health stakeholders. Literature suggests such effective nurse leadership impacts positively on not only the quality of clinical care, but also the working environment in which nursing is conducted. Yet a coordinated strategic impetus to develop this leadership capability throughout the nursing profession in Australia remains elusive to quantify. Australia produces many outstanding nurse leaders despite this apparent lack of strategic direction, and yet perhaps due to this lack of cohesive direction nursing leadership is arguably not embedded within and across the culture of the profession; or within health organizations generally. This paper seeks to critically explore the recent literature on nursing leadership in Australia, and to highlight the necessity to strengthen leadership capability across the stratified layers of the nursing workforce.*

**Keywords:** leadership, nursing, Australia

As the nursing profession pushes back the boundaries of the professional roles it undertakes there is an equally pressing need for nurses to be more capable of leading themselves, other professional staff and in leading on care delivery packages. An excellent example of this is the growth of nurse practitioners who as well as being capable of initiating and delivering complex health care, are simultaneously expected to be dynamic role models for others to emulate (Watson, 2008). However the very concept of what leadership is, how to assess leadership capability, or how to empirically quantify leadership has arguably resulted in a minor explosion of leadership models and approaches (Stanley, 2008). Diversified understandings of what leadership is, and what it is not, will impact upon how leadership is taught within universities and how leadership will be role modeled or mentored within practice settings. A dissonance between taught nurse leadership theory and the applied workplace leadership may also result. These dilemmas within nursing in identifying what leadership is are further highlighted by Stanley (2006) who found that clinical nurses identified leaders as being people who gave committed high quality nursing care, rather than the transformational leadership characteristics promoted within policy and education (Northouse, 2004). Given the connection between effective high quality

nursing care provision and effective leadership (Stanley, 2011), the imperatives for achieving a cohesive and effective approach to develop nurse leadership in Australia are clear.

Leadership theory within nursing contexts will generally acknowledge that leadership is a part of and yet is distinguishable from managing (Daly, Speedy, & Jackson, 2003; Stanley, 2006).

Leadership might be found throughout an organization structure, while management will tend to be embedded within middle to upper hierarchical echelons. Nursing has historically fused management and leadership, with only more recent times suggesting an increased interest in exploring leadership as being a distinct entity (O'Grady & Malloch, 2010). The historical beginnings of nursing to religious and military contexts, each grounded in structured hierarchical leadership can also be forwarded as having a lasting impact on the professions' attitudes and approaches to managing and leading (Stanley & Sherratt, 2010).

A literature search was undertaken to examine the question of 'what are the recent trends in Australian nursing leadership?' EBSCOhost MegaFILE Complete was searched with the terms of 'leadership + nursing + Australia 2001–2011'. One hundred and twenty-three hits were hand searched for papers examining general trends of leadership rather than focus papers on particular clinical interventions, to exclude brief opinion

papers, and to exclude papers not relevant to Australian nursing leadership. Sought were papers reporting on Australian nurse leadership or papers forwarding models of leadership to be applied into Australian contexts.

## OVERVIEW OF NURSING LEADERSHIP IN AUSTRALIA

Within an Australian context, nursing leadership offers a complex picture in terms of understanding its impact on the nursing profession, or identifying current and future trends. Halcomb, Davidson, and

Patterson (2008) highlight governmental priorities toward developing nursing leadership that stem back a decade to include the need for the workplace to act as a fostering environment to grow nurse leaders. These health care workplaces are far from simple environments with multi-disciplinary influences, discontinuous change and multiple priorities ranging from governance to care provision. Multi-disciplinary factors in particular have been noted as a barrier to nurses achieving consistent clinical leadership within Australian acute health care settings (Sorensen, Iedema, & Severinsson, 2008).

However, nursing culture and historical practices can also be identified as being problematic. Paterson, Henderson, and Trivella (2010) highlight that nursing rarely establishes and develops a leadership culture for beginning career staff, and nurses will often later do so only in response to the needs of the organization. Paterson et al. (2010) additionally identify the need for supportive clinical learning environments linked to structured leadership programs to successfully develop leadership capability.

Jarvis (2007) reports that clinical arenas remain influenced by medical model hierarchical structures that nullify nursing leadership, and importantly proposes that strategic nursing responses are required to build healthier workplace environments. The nursing work environment and leadership characteristics of nurse unit managers have been identified as statistically significant predictors of job satisfaction for Australian nurses (Duffield et al., 2009). Further, exploring the relationships between the social work environment of nurses, Roche and Duffield (2010) established connections between the quality of the nursing workplace environment and patient

clinical outcomes, workforce retention and staff feeling satisfied.

Arguably, nursing and health service studies exploring leadership largely ignore the clinical arena to focus instead on those holding senior organizational positions, a focus reflective of the manager/leader fusion long attributable to the nursing profession (Stanley & Sherratt, 2010). The impact of this merging of roles is significant given that it coexists with long standing health care reform policy that arguably drives the separation of nurse managers from their professional roots (Newman & Lawler, 2009). Nurse managers can in effect be managers who may occasionally (or perhaps never), nurse and who given the mounting demands being placed upon them by increasing economic rationalization of nursing, are often unable to provide leadership to staff experiencing stress and/or distress or clinical leadership for patients (Newman & Lawler, 2009). Additionally, there appears to be limited overt agreement within the nursing profession as to who are, and who are not leaders. Hierarchical traditional structures co-exist with new nursing roles such as nurse practitioners, who with expertise and a remit to influence health care can be easily identified as being leaders who build care teams and generate professional respect (Gardner, Carryer, Gardner, & Dunn, 2006). Simultaneously, the same nurse practitioner may not be actively engaged in wider organizational leadership roles such as work force retention or overarching care quality provision (Jeon, Glasgow, Merlyn, & Sansoni, 2010).

Despite such challenges the opportunities for nurses to assume leadership for service delivery and practice enhancement have also been acknowledged (Davidson, Elliot, & Daly, 2006). McCloughen, O'Brien, and Jackson (2009) offer findings that forward mentoring as a critically effective mechanism to foster future nurse leaders. This study pivotally emphasized the mentoring relationship as being altruistically based on advanced inter-personal capabilities and embedded values such as honesty, integrity and respect. Similarly Williams, Parker, Milson-Hawke, Cairney, and Peek (2009) report on a successful leadership preparation program. Within a well resourced and structured hospital education unit, mentors and leadership competency standards

were used to develop leaders who also held managing roles. Duffield (2005) also offers inter-personal and intra-personal capability development as being an important feature of nurse leadership development for nurse unit managers.

Daly et al. (2003) offer an expansive view toward the purpose of nursing leadership in Australia noting strategic, individual and social levels of impact, as well as leader attributes inclusive of inspirational dynamism and confidence. Contrasting these aspirations for nursing in Australia against the means to develop nurse leaders potentially offers partial explanation to the arguably fragmented and hesitant pace of expanding nursing leadership. As highlighted by Jeon et al. (2010) in their narrative synthesis, there is no single national institute for nursing leadership and leadership is often immersed within other aspects of university nurse education, rather than being distinctive and prominent. This theme of diffused approaches to nurse leadership preparation is evident in the literature on leadership models for nurse in Australia.

In terms of leadership approaches the Australian literature offers a range of preferred models. The leadership preparation described by Williams et al. (2009) and Duffield (2005) appears to have focused upon managerial understandings of nurse leadership that combine managing capabilities and clinical leadership development. However, Stanley (2008) contends that existing leadership models fail to reflect the realities of clinical leadership due their connection to managing roles and attributes. He also put forward that while transformational leadership theory remains the preferred leadership model from nurse academic perspectives that clinical nurses struggle to identify meaningful links between transformational leadership and their clinical leadership needs. Rather Stanley (2006, 2008) promotes congruent leadership which is driven by the leaders' values and beliefs toward nursing, hence inspiring others. Congruent leaders are clinical leaders whose advanced inter-personal capabilities and clinical expertise differentiates them from other leaders within the nursing profession (Stanley & Sherratt, 2010). In contrast Jackson (2008) promotes servant leadership as a model for nurse leadership,

particularly as a means of developing nurse led research. Not unlike congruent leadership, servant leadership has strong similarities to transformational leadership, but differs through the servant leadership being focused toward the needs of the individual rather than the wider organization.

### **Does policy resonate with literature?**

Leadership capabilities do not stand out within the National Competency Standards for the Registered Nurse (Australian Nursing Midwifery Council, 2006) with nurses leading and coordinating care being the sole leadership item. However, the Australian Nursing Midwifery Council (ANMC) standards for nurse practitioners are far more exacting, suggestive in contrast to Paterson et al. (2010), that leadership within nursing contexts is an advanced rather than a base capability or role (Australian Nursing Midwifery Council, 2006). Standard 3 of the ANMC standards for nurse practitioners powerfully connects nurse leadership to influencing systems of delivery, research and teaching as well as assuming responsibility and being multi-dimensional. Such divergences are possibly symptomatic of a lack of a cohesive body to drive leadership agendas within Australian nursing contexts.

An interesting comparison exists when contrasting the emphasis being placed upon nurses as leaders across the countries in the UK and in Australia. Pre-registration standards from the Nursing Midwifery Council (NMC) seek that the graduate nurse can not only lead themselves as well as others, but also that the graduate nurse influences services and develops their leadership capabilities over time (Nursing Midwifery Council, 2010). Additionally, distinctive educational programs and a raft of policies directly address leadership within nursing contexts (NHS Scotland, 2009; Royal College of Nursing, 2008, 2009).

### **FUTURE DIRECTIONS**

Generic Australian health policy initiatives appear to be focusing upon enhancing clinical leadership as a means to improve the health systems in Australia (Buchan, Currie, Lourey, & Duggan, 2010; National Health and Hospitals Commission, 2009). Such initiatives offer both opportunity and

risk to the nursing profession as it grapples to embed leadership capability across the layers of its workforce. Clearly, opportunity exists within current initiatives for enhanced nursing leadership and ability to assume meaningful clinical accountability. However, these initiatives, as all policy is, are contextualized within issues of politics and power where medical and managerial influences have long dominated. One may argue that nursing has at least two tasks to undertake in this instance, the first to determine its own cohesive direction and priorities toward leadership, and the second to be a part of and yet influential toward the multi-disciplinary approaches and strategies.

Another important question is where does nursing leadership in Australia sit between the 'base' expectations for a graduate nurse (Australian Nursing Midwifery Council, 2006) and the 'advanced' clinical roles and capabilities of nurse practitioners? The challenges for developing 'middle ground' nurse leadership are heightened further by both the increasingly high expectations of leaders (Blouin, McDonagh, Neistadt, & Helfand, 2006; Zilembo & Monterosso, 2008) and that the idea of leadership, particularly within nursing contexts, remains enmeshed within perceptions of management, rather than being part of and yet distinctive from it. While such distinctions may well be unambiguous within leadership literature, the nuances between a leader's future vision and a manager's current vision or a leader's innovation and a manager's efficiency protocol remain beyond the concern of many nurses (Graham & Jack, 2008; Hartley & Hinksman, 2003). Additionally, the potential disconnect between nurse academic leadership models and clinical leadership perspectives and the array of similar and yet simultaneously differing nurse leadership models may act as a disincentive for clinically focused nursing staff.

## CONCLUSIONS

The partially subjective and politically influenced development of health leadership creates an environment whereby preparation for enhancing nurse leadership capability across all nursing levels is made challenging. However, studies in this review have showed that where such preparation is nurse driven, well mentored and underpinned by

inter-personal capabilities, values and clear competency frameworks, that these challenges can be overcome. Developing and embedding a coordinated national nursing strategy for such programs appears to be the next priority. However, such a strategy will need to be a 'clinician centric' approach commencing from early nursing career stages to gradually build a culture of leadership within the profession.

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