LEADERSHIP AND MANAGEMENT

IN NURSING

CONCEPTS ANALYSIS

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ABSTRACT

This concept analysis explores the terms leadership and management and their application in the Clinical Nurse Manager position. Clinical Nurse Manager leadership and management preparation, understanding and application impacts on patient care delivery and outcomes (American Association of Colleges of Nursing, 2007; Herrin & Spears, 2007; Stanley, 2006). Interpretation and understanding of the concepts of leadership and management are inconsistent, and the terms are used interchangeably within verbal dialogue and literature. In addition, leadership and management are often specific to the context in which they are used. However, consistency in leadership and management application is an important factor in optimising patient care and outcomes in health care. This work hopes to further contribute to academic knowledge surrounding the concepts of leadership and management within the nursing context and the Clinical Nurse Manager position.

CONTENTS

INTRODUCTION

Leadership and management in nursing directly influence the quality of healthcare provided to patients and therefore directly impacts upon patient outcomes (American Association of Colleges of Nursing, [AACN] 2007; Herrin & Spears, 2007; Stanley, 2006). Inspiring leadership and reliable management are required at all levels of an organisation to provide employee alignment, learning and professional development, which can assist in optimising positive patient outcomes (Donner & Wheeler, 2004; Kennedy, 2008). If an organisation has strong management without leadership, bureaucracy can be stifling. In contrast, if an organisation has strong leadership without management, meaningless and mindless change can be rife. In addition, Northouse (2007) says both leadership and management are essential for organisations to prosper. In health care prospering can lead to optimal patient outcomes through organisational preparation of its employees, who then accomplish the vision and mission set by the organisation. In this particular instance, the vision and mission set out by the Bay of Plenty District Health Board (2006) states "Healthy thriving communities" and "Enabling communities to achieve good health and independence and ensure access to high quality services" (pg. 3), respectively. Bradley, Maddox and Spears (2008) identified that having the right people in the right positions with the right preparation allowed for greater achievement of the organisation vision and mission, than ever imagined. For the purpose of this work the concepts of leadership and management were selected because of their critical importance in Clinical Nurse Manager (CNM) preparation, nursing care delivery and patient outcomes.

CNMs directly affect the care given to patients through their position of leading and managing (Herrin & Spears, 2007; Schmidt, 1999; Stanley, 2006). The AACN (2007) report stated that between 44,000 and 98,000 American people die each year as a direct result of medical errors. In addition, the AACN maintained that the nursing profession must produce graduates prepared in clinical leadership, management and quality improvement strategies to assist in managing this epidemic. Therefore, CNMs must have a workable understanding of the concepts of leadership and management in order to carry out the role. Comprehensive understanding, or lack of, the concepts of leadership and management within nursing are eventually observed in patient outcomes. Confirming this, AACN (2007) say the CNM assumes accountability for patient

outcomes. Coordinating, delegating and supervising healthcare is the role of the CNM. This is underpinned by achieving core competencies, of which leadership and management are the main focus. Thus, the CNM understanding of leadership and management is conducive to best patient outcomes.

Nurses progressing to management positions remain largely uneducated, unsupported and with no or very little orientation or succession planning pertaining to management skills and knowledge (Heller, Drenkard, Esposito-Herr, Romano, Tom & Valentine, 2004). Tensions between leadership and management discourse and being unprepared for the CNM position can lead to unconscious incompetence (Hancock, 2008). Hancock (2008) draws on the work of Abraham Maslow and states unconscious incompetence is the first of four learning states. Put very simply, unconscious incompetence is when you don't know what you don't know. Unconscious incompetence can result in disenfranchising nursing professional and clinical growth, recruitment and retention issues, compromising patient outcomes and substandard care delivery (Gould, Kelly, Goldstone & Maidwell, 2001; Judkins 2007; Mrayyan, 2004; Schmidt, 1999). Additionally, often the most senior nurse on the ward may have developed skills in leadership. It is these informal leadership skills that are relied upon to fulfil the management role (Boulding, 2004). Heller, et al (2004) agrees there is an educational gap between nurses moving from acute care delivery to the manager position. Furthermore, providing leadership whilst being part of the nursing team, compared to functioning effectively as the front-line manager, leaves nurses unprepared for the complex requirements of the job.

Having lived the experience of being a leader and a manager, my innate interest in understanding the concepts of leadership and management similarities, differences and tensions have partly driven the need to complete this work. Furthermore, there appears to be a dearth of academic knowledge associated with leadership and management skills and application in nursing. Fairholm (2004) says building leadership and management capacity is now more focused and is trending towards developing practical and theoretical strength within healthcare. Kleinman (2003) suggests healthcare has entered the new millennium and concerns regarding effectiveness, cost containment, quality and consumer satisfaction, require astute and sophisticated business knowledge

and skills from the CNM. On position appointment the CNM is expected to have relevant knowledge and application of managing and reporting budgets, leading evidenced based clinical care, staff professional development, rostering, completing business cases, responding to patient complaints, and meeting the demands of acute health care. Kleinman (2003) supports this and describes how nurse managers are responsible for the operation of business units. Additionally, they often come less well prepared to manage the business activities than the clinical activities. Without the CNM having specific academic preparation in leadership and management the care received by the patient can be compromised, as can the ongoing motivation, energy and positioning of the CNM.

The concepts of leadership and management have been selected, as their meanings are ambiguous and associated with work undertaken by CNMs each day. The demarcation lines between leadership and management are vague, thus to the untrained eye, it can be difficult to make a distinction. Being able to distinguish them will enable an understanding of the tensions, resulting in an educated CNM that fulfils the role of optimising patient outcomes. Northouse (2007) describes the concepts of leadership and management have presented challenges to writers and researchers worldwide. They are equally as valued as they are complex. Whilst the writer appreciates individuals' interpretations based on previous knowledge, experiences and beliefs, this work will provide specific meanings drawn from literature, about the concepts of leadership and management, CNM knowledge and application and the impact on patient outcomes.

An introduction of the importance of leadership and management within healthcare, CNM preparation, knowledge and application and patient outcomes has been articulated. This work will offer an analysis of the concepts of leadership and management using Walker and Avant's (1995) concept analysis framework. The concept analysis methodology will now be presented and discussed.

METHODOLOGY

To enable understanding of the concepts of leadership and management, Walker and Avant's (1995) concept analysis framework will be used to structure the work. Axley (2008), Bell and Duffy (2008) and Walker and Avant (1995) describe a concept as a derived intellectual idea or label to construct elements of human experience. Alternatively, a concept is what we think it is, based on culturally acceptable values and word associations that conjure up images in our mind. Furthermore, concept formation assists us to organise and categorise our environmental perceptions or notions (Walker & Avant, 1995).

Concepts are context bound, can change over time and culture, subsequently are never fixed or provide truly obvious realities as there are pertinent changing dynamics such as knowledge, people and time involved (Bell & Duffy, 2008; Brocklehurst & Laurenson, 2008; Walker & Avant, 1995). However, word associations, behaviours and defining attributes link concepts together. Walker and Avant (1995) describe concept analysis as a strategy that groups sets of words, which offer defining attributes of specific concepts. The process incorporates separating specific defining attributes and irrelevant attributes. For example, one defining attribute of a cup maybe that it has a handle. Unless other defining attributes are grouped together, such as it is closed at one end, holds fluid and is made of porcelain, the reader may think I am referring to a door or a window latch. Ultimately concept analysis is examining and describing the use of a word (Walker & Avant, 1995). Rodgers and Knafl (2000) explain how concepts have 'family resemblances', but not necessarily have the defining attributes associated with the actual concept. The concept analysis process extracts actual meanings of concepts that are accepted within a particular culture or society.

Walker and Avant (1995) have adapted Wilson's (1963) eleven-step concept analysis framework to provide an eight-step concept analysis process. They suggest the steps occur simultaneously and proclaim how simple their concept analysis framework is to follow. Moreover, Walker and Avant assert how the framework easily refines concepts as it enables the writer a structure to extract meanings. Axley (2008) concurs and says when exploring specific concepts the use of Walker and Avant's (1995) concept analysis framework serves to clarify meaning and application in nursing. Alternatively, Bell and

Duffy (2008) propose Rodgers (1989) six-step evolutionary concept analysis framework is worth pursuing as it provides opportunity to explore both distinct and discrete meanings of complex concepts. Rodgers and Knafl (2000) claim the six-step evolutionary method has subtle differences to that of other concept analysis frameworks. For example, they suggest concepts should be examined apart from their context or any other relationship. So, if the cup was being analysed it would be imperative the writer had not used or seen one before. Rodgers and Knafl (2000) say there can be profound effects on the focus of enquiry resulting in altering the interpretations if the concept is examined in its context. In addition, they suggest there are differences between frameworks, although this is not necessarily disadvantaging the process, just observing the differing characteristics.

Beckwith, Dickinson and Kendall (2008) advise there is little evidence that concept analysis frameworks provide the necessary strength or reliability to enable development of nursing theory. Furthermore, they raised concerns regarding the unjustified adaptation to the concept analysis framework, suggesting a naive knowledge of the frameworks. In addition, Beckwith, Dickinson and Kendall propose the development of nursing theory constructed through concept analysis, which the frameworks underpin, have been left shallow and without significant rigour. However, theory development is not the purpose of this work. The purpose of this work is to identify defining attributes of leadership and management because of their critical importance in CNM preparation, nursing care delivery and patient outcomes. However, for specific concept analysis the structured flow enables the work to develop defining attributes.

Walker and Avant's (1995) concept analysis framework is appropriate for this work, which seeks to clarify leadership and management defining attributes to reduce tension, thus, application may be less fraught. Rodgers and Knafl (2000) draw on Wilson's (1963) work and describe how the emphasis of concept analysis is a technique that aids the user in clear thinking and communication. Walker and Avant (1995) argue concept analysis is appropriate as a method of enquiry when a concept "has always bothered the user" (pg, 40). The concepts leadership and management have bothered the author as ongoing tutelage to

staff development and optimal patient outcomes contrive internal tensions, resulting in frustration and dissatisfaction with the CNM position.

The concept analysis methodology has been described and examined. The framework will provide structure and elicit defining attributes to determine what leadership and management are in relation to CNM preparation and patient outcomes. The data collection method will be outlined next.

DATA COLLECTION METHOD

The concepts of leadership and management are analysed according to Walker and Avant (1995) concept analysis methodology. To begin this process the terms leadership, management and nursing were explored using electronic search engines. Google, Google Scholar, CINAHL, PsychINFO, Proquest, Science Direct and MEDLINE databases were searched using the keywords. Further keywords included nurse, nursing, leader, leadership, manage, management and concept analysis. Combinations of the key words were also used. A multitude of literature was found and reviewed, contributing to the analysis of the concepts and defining attributes.

In reflecting on the concepts identified within the initial search I have accessed significant references from within my own reading and practice to support and challenge ideas. Combinations of soft and hard cover publications; anecdotal experiences and conversations with other health professionals have been used, in order to strengthen the concept analysis process. Analysis of the similarities and differences in existing knowledge assertions has been undertaken by evaluating the multiple sources of data.

After determining the uses of the concepts leadership and management through a literature review the defining attributes will be presented. The defining attributes and model and contrary case studies will be presented and discussed. This enables the reader an opportunity to further understand the concepts under review. The antecedents and consequences of leadership and management will follow this. Finally the empirical referents of each of the concepts, conclusion and clinical practice implications will be presented to further elucidate the importance of leadership and management within healthcare, CNM preparation, knowledge and application and patient outcomes. Each step is further explained as it is addressed.

LITERATURE REVIEW - USES OF THE CONCEPTS

Concept analysis should begin with a comprehensive review of the literature so familiarity with the terminology to describe the concept is clear (Rodgers & Knafl, 2000; Walker & Avant, 1995). It is also imperative to keep in mind the chosen concepts are not just words but ideas, notions or characteristics connected with the words. Rogers (1989) suggests that random literature selection can make up a percentage of the literature review. Penrod and Hupcey (2005) propose random literature selection can omit seminal literature whilst Walker & Avant (1995) suggest that limiting the search may bias the researchers understanding of the true nature of the concept. Remembering to include both implicit and explicit uses of the concepts broadens the researchers view allowing valid defining attributes of the concepts. For this very reason literature pertaining to leadership and management from both nursing and non-nursing has been explored to inform the work.

The terms, and the relationship between leadership and management are ambiguous. The literature continues to prompt debate, often using them interchangeably. Repeatedly the meanings are intertwined, although the literature clearly describes the need for both leaders and managers in nursing (Bednar, 2007; Casida & Pinto-Zipp, 2008; Donaher, Russell, Scoble & Chen, 2007; Duffield & Franks, 2001; Freed & Dawson, 2006; Marquis & Huston, 1992; Marquis & Huston, 2009; Moran, Duffield, Beutel, et al, 2002). Marquis and Huston (1994), Marquis and Huston (2009) and Northouse (2007) define the differences of leadership and management whilst recognising one part of the management function is to lead, or provide leadership to others. Explanations are provided specific to the activities of each concept.

Kotter (2001) disputes that leadership and management are interchangeable functions, although agrees that one cannot function without the other; regardless that management is a formally appointed position with appointed authority. Kotter says combining strong leadership and strong management is the real challenge. Leaders and managers should be able to communicate the organisations vision with a planned and balanced view, whilst organising specific people to carry out specific plans. According to Northouse (2007) the overlapping leadership and management functions are centred on how they both involve influencing a group, in one way or another, in order to achieve

specific goals. In addition, Kotter (2001) suggests managers promote stability and cope with complexity whilst leaders press for change. Organisations that observe the contradictions of leadership and management equally prosper (Northouse, 2007), which can lead to attaining optimal patient outcomes. AACN (2007) claims that the performance of the CNM can be directly measured by the extent the CNM succeeds in improving patient and cost outcomes. Examples include reducing patient pressure areas, length of stay and increasing outpatient appointment attendance, for example.

Stanley (2006) suggests leaders and managers experience role conflict. The challenge of role conflict creates a tension within the person and the position. Fairholm (2004) says leadership and management has not had enough scholarly attention to observe and name this tension, and argues that too many functions or behaviours are described by the interchangeably used terms. Thus, developing understanding and application through academic preparation of the leadership and management concepts may go some way to resolving the tension by understanding the conflict. The AACN (2007) claim that CNM education surrounding leadership and management can enable them to realise the clinical need of individual patients whilst appreciating and insisting on fiscal management. Additionally, the AACN articulate that without specific education in leadership and management CNMs can struggle with this persistent tussle.

CNM decision making regarding staff education and development and delegating responsibilities to increase accountability and independence can be influenced by financial constraints, nursing numbers, patient acuity and the long term organisational plan, dictated by the executive and business managers. Northouse (2007) states that leaders facilitate change and growth in their personnel. Change and growth are synonymous with development and learning. Hence, if learning opportunities cannot be taken due to the aforementioned constraints, this can be a source of personal and positional conflict, resulting in disengagement and dissatisfaction within the position.

A general overview of the concepts of leadership and management have been discussed and debated. Leadership and management will now be explored separately in order to provide clarity, structure and flow to the work. The

concept of leadership will firstly be discussed, followed by the concept of management.

LEADERSHIP

Leadership has been studied extensively in various contexts including differing cultures, decades, theoretical beliefs and in fact has been discussed since the time of Plato (Goffee & Jones, 2000). The literature provides various definitions of the term leadership and what it means to individuals, based on previous knowledge, skills, personalities, situations and environmental impacts. Reviews of leadership theories, such as Follet's (1926) law of the situation leadership theory, or Lewin (1951) and White and Lippitt's (1960) authoritarian, democratic and laissez-faire theory, or transactional leadership have produced different schools of thought, in an attempt to explain where great leadership came from. Innate internal qualities, situational and environmental factors, behaviours and individual's backgrounds and situational circumstances were all thought to contribute to great leadership (Goffee & Jones, 2000; Horner, 1997; Marquis & Huston, 2009). Dearlove and Crainer (2005) suggest much of the traditional leadership theory can be grouped into three broad categories, character and personality traits, behaviour of the leader and leadership specific to the situational context. All three categories can be extremely complex and whilst individuals may have tendencies toward one trait, others can emerge dependent on the situation.

Fairholm (2004) and Marquis and Huston (2009) describe a number of notions linked with leadership, such as intelligence, knowledge, creativity, diplomacy, personal integrity, innovation and inspiration. Stanley (2006) proposes that leadership is about aligning people. Purpose and vision can assist in aligning people as this gives them a common goal to focus on (Scholtes, 1998). Aligning people is often the responsibility of the line manager, hence this is the appointed CNM. In addition, setting a direction, motivating and inspiring people, being credible and visionary, and anticipating and coping with change are also characteristics associated with leadership. These ideas, notions and characteristics conjure up a mental image. Through these images the concept of leadership emerges. The CNM, as the appointed leader, has the

responsibility of knowing and applying these terms in developing an environment conducive to delivering optimal patient care.

Marquis and Huston (2009) draw on Burns (1978) work and suggest that leaders and followers have an ability to raise each other's levels of motivation and have named the concept as transformational leadership. Transformational leadership searches for ways to help motivate followers by satisfying higher-order needs through: influencing attitudes by setting goals; communicating a vision; identifying specific individual attributes; being creative; role modelling; and examining effects (Dearlove & Crainer, 2005). Hence, employees are more fully engaged in the process of the work and productivity. Transformational leaders are able to initiate and cope with change and they have the ability to create something new out of the old. In this way, these leaders personally evolve while also helping their followers and organisations evolve (Northouse, 2007).

Marquis and Huston (2009) suggest leaders do not often have delegated authority, and generally have a wider variety of roles than that of a manager. In addition, Stanley (2006) declares anyone and everyone can have and use qualities associated with leadership, because leadership is about the heart and spirit, not the head and mind. Often leaders are not part of the formal organisation and are not often expected at strategic planning or business meetings (Marquis & Huston, 2009). Leaders focus on team process, information gathering and distribution, feedback, coaching, guiding and empowering others (Fairholm, 2004; Goffee & Jones, 2000; Marquis & Huston, 1992; Marquis & Huston, 1994).

Fairholm (2004) and Scholtes (1998) suggest leadership is the relationship created between the leader and the followers; it is the presence and spirit of the individual who leads the team. Leaders are not seen as individuals in charge of followers or hailed as heroic individuals. Good leader behaviour accounts for personal skills and capabilities, adapts to the future needs of the organisation, ensures professional communication, challenges thinking, encourages innovation and creativity and walks the talk (Dearlove & Crainer, 2005). On the contrary, Conley, Branowicki and Hanley (2007) suggest that leaders create standards of excellence and should then set an example for

others to follow. Scholtes (1998) describes leadership as a network of relationships and can be an inner journey for the formally or informally appointed leader. Additionally, the art of leadership encompasses negotiation, team member recognition, open and honest communication and visionary transactions, in a timely fashion (Scholtes, 1998).

Leadership is a dynamic and complex concept. Moreover leadership is an essential component of nursing practice. Nursing leadership can be measured through patient outcomes in that any patient nurse relationship is framed and grounded in expectations, goals, vision and energy (Northouse, 2007). Everyday meanings of leadership take account of circumstances and suggest that understanding of the meaning of leadership is context bound (Bell & Duffy, 2008; Horner, 1997; Walker & Avant, 1995). Fairholm (2004) says different perspectives on leadership exist and shape behaviours of individuals in specific ways according to their mindsets. Dearlove and Crainer (2005), and Horner (1997), offer an integrative perspective on leadership and suggests the traditional paradigm of leadership requires reshaping in that one person doing something to other people or for other people is irresponsible leadership. Additionally, Horner proposes the most appropriate leader is one who can lead others to lead themselves. With this view, it is suggested leadership exists within individuals and is not limited to formally appointed leaders. Horner (1997) and Fairholm (2004) suggest that, for leaders to be successful, they need to facilitate individuals in the process of leading themselves, dismissing the notion of one heroic individual.

Leaders are required to think and act differently, using innovation and personal values to help guide their actions, instead of following textbook solutions (Fairholm, 2004; Horner, 1997). Boulding (2007) says leadership is a process by which a person influences others to accomplish an objective, and directs the organisation in a way that makes it more cohesive and coherent. Leaders carry out this process by applying their leadership attributes, such as beliefs, values, ethics, character, knowledge, and skills. The basis of good leadership is honourable character and selfless service to the employer (Boulding, 2007). Additionally, Bennis (1993) suggests how leaders align resources, create a culture that fosters free expression of ideas and empowers others to contribute. Berragan (1998) agrees and suggests ethical and moral knowledge

can be influenced by how we live and may influence nursing practice delivery. Boulding (2007) suggests leadership is everything you do that effects the organisations objectives and employees well being. Fairholm (2004) claims that the ability to build successful relationships is a major factor in a leaders success. Practical and intellectual understanding of what leadership is offers a chance to improve skills, knowledge and application. Leadership involves influencing peoples souls rather than controlling their actions (Fairholm, 1997). Leaders need to connect with people and care for the whole person, including their spirituality.

Goleman (1995) has introduced the notion of emotional intelligence. Emotional intelligence is the interplay between the affective and cognitive domains. Essentially emotional intelligence is being self aware, building social skills, becoming more empathetic towards others, and becoming more understanding of self (Cohen, 2008). Parthasarathy (2009) says it is insufficient to be only intellectually capable as a leader or manager. Successful leaders must be emotionally intelligent as well. Additionally, emotional intelligence has been described as the link between emotional and social abilities and is central to productive leadership. Cohen (2008) suggests decision-making and relationships are both effected by emotional intelligence and understanding this notion underpins good leadership.

Heightened emotional awareness assists in self-recognition and how emotion impacts on decision-making (Cohen, 2008; Marquis & Huston, 2009; Parthasarathy, 2009). Recognition of emotion and application of these emotions in an intelligent way greatly increases job commitment, satisfaction, inspiration, innovation and hence staff and self performance (Goleman, 1995). Emotionally intelligent behaviour allows the leader to listen and authenticate the staff member's ideas, feeling's and thinking. The leader then motivates staff members to use their talents to the fullest extent (Conley, Branowicki & Hanley, 2007; Parthasarathy, 2009).

To enable the full use of emotional intelligence the leader must know themselves, strengths and weakness, knowledge and skills. Leaders must be self-aware regarding their impact on situations (Parthasarathy, 2009). CNM self-awareness must extend to the their power. CNM positional power can and

does impact on situations. La Monica Rigolosi (2005) discusses position power and personal power. Position power influences a group or changes an outcome simply through the delegated position. However, personal power flows upward from followers, earned through respect by being fair and using knowledge and experience to accomplish goals (La Monica Rigolosi, 2005). In addition, La Monica Rigolosi believes it is best to have both, but remain vigilant about the balance so staff's ideas are validated as their own. Self-awareness in particular is vital, as it facilitates the development of abilities to recognise, monitor, and adjust thought processes, behaviours, and impact on situations. Moreover, motivation, empathy, making sound and timely decisions, setting the example, knowing the people and looking out for their well-being are all leader responsibilities (Boulding, 2007; Parthasarathy, 2009).

Emotion as a barometer can provide a gauge for the leader to know when to become involved in a situation and when to let it run its course. Covey (2004) expresses that 'the when and how to do questions' usually tap into the emotional intelligence as the person reads the environmental, cultural and political temperature of the situation. Goffee and Jones (2000) support this and say inspirational leaders share four qualities. They selectively show their weaknesses and talk about values, rely on intuition to gauge appropriate timing and course of action, they empathise passionately, yet realistically and they capitalise on what is unique about themselves. Interplay between the four qualities is essential and a lack of emotional intelligence may contribute to a lack of clarity in utilising the qualities effectively. This lack of emotional intelligence can impact a leader's career, maybe negatively, especially in this diverse and complex world of healthcare (Parthasarathy, 2009).

However there is debate surrounding the actual impact that emotional intelligence has on personal and social interludes, and success in school, home and work (Northouse, 2007). Time constraints, immediacy demands on task completion, and pressured healthcare environments can challenge emotional intelligence and leadership values. Northouse (2007) acknowledges emotional intelligence appears to be an important feature of the leader. People who are more sensitive to their own emotion can provide more effective leadership. However, he does acknowledge further research is required to better understand the concept of emotional intelligence.

MANAGEMENT

The development of management theory began during the early twentieth century during the industrial revolution, to offer a sense of control, with Frederick Taylor (1911) developing the four principals of scientific management (Robbins & Coulter, 1999; Marquis & Huston, 1992; Marquis & Huston, 2009). Time in motion studies were utilised to promote greatest efficiency of time and energy, technical competence and ability. The sharing of common goals and organisational mission were communicated, as were rewards for high production. Taylor also postulated the management worker relationship theory. This theory brought high productivity and efficiency; however, staff were viewed primarily as economic animals, in that all they were after was financial gain. Around 1922, Max Weber studied large organisations to identify why some workers were more efficient than others. Weber found that rules, regulations and structure increased efficiency and introduced bureaucracy as part of management (Marquis & Huston, 2009).

During a similar time Henri Fayol (1925) first identified the seven management functions. These consisted of planning, organising, staffing, directing, coordinating, reporting and budgeting (Marquis & Huston, 2009; Northouse, 2007). Robbins and Coulter (1999) support this view by describing the aforementioned terms, although often modified, as a management process. Further defining theories of management throughout the twentieth century included activities of management, participative management, and employee participation.

Elton Mayo first discovered the Hawthorne effect between 1927 and 1932 (McCarney, Warner, Iliffe, van Haselen, Griffin & Fisher, 2007; Marquis & Huston, 2009). According to Leonard and Masatu (2006) this phenomenon is where employees changed their behaviours and increased their productivity due to the result of personal attention, such as being studied. The Hawthorne effect is characterised by a measurable positive and temporary behaviour change, which is distinctive in that individuals think they may be penalised or rewarded. Individuals eventually return to their pre-observation level of activity, even when they remain under supervision (Leonard & Masatu, 2006). Although first reported in industrial research the Hawthorne effect has implications for clinical research (McCarney et al, 2007). Nurse researcher

Groenkjaer (2002) found clinical decision-making might have been influenced just because of her presence whilst conducting an ethnographic study. McCarney et al (2007) states that if there is some demonstrable benefit from participating in clinical research, for whatever reason, then this has implications for good clinical practice and for improving care. The Groenkjaer (2002) trial contradicts this as she felt an important factor was to combat the Hawthorne effect, hence passive observation was undertaken followed by an interactive approach.

Marquis and Huston (2009) draw on Douglas McGregor's (1960) work that coined the names Theory X and Theory Y managers. Those of Theory X viewed their employees as lazy and requiring constant supervision whilst Theory Y managers believed their employees enjoy their job, want to work hard and are self-motivated (Marquis & Huston, 2009). Ouchi, a Japanese theorist went on to introduce Theory Z (1981), an extension of McGregor's work (Marquis & Huston, 2009). Characteristics consistent with Theory Z surrounded the interaction between the managers and employees. The emphasis was on employees 'fitting' their job, job security, establishment of strong bonds between managers and employee's and holistic concern for employees. However, American managers found this Japanese style of management hard to incorporate into their culture, so the theory lost favour (Marquis & Huston, 2009). Whilst theories continue to be produced and introduced it is recognised that any one theory does not come without its challenges.

The management process incorporates organising, which pertains to determining what needs to be done, how it will be done and who will do it (Marquis & Huston, 2009; Robbins & Coulter, 1999). Stanley (2006) proposes some qualities often associated with managers. They are: stable; risk minimises and rule keepers, system and process people, and this can contribute to achieving the 'organising' component. Robbins and Coulter (1999) define the concept of manager as a person who ensures the working environment is coordinated through manipulation, delegation and direction, to achieve organisational goals. Furthermore, management is described as one person working with and through others by organising specific activities to accomplish particular tasks. Scholtes (1998) suggests planning consists of identifying goals, tasks and priorities and also specifying methods and activities necessary to

successfully meet planned objectives. Stanley (2006) concurs and suggests transactional management is based on an exchange between the manager and follower. Transactional management is meeting the organisations focus through organising. The key is to lead people to distinguish what the required function is in order to reach the desired outcome. Hence, part of management is leadership (Marquis & Huston, 2009; Robbins & Coulter, 1999).

A manager engaging in leadership can produce an internal tension, a division, a sense there is a barrier. Flexibility in balancing the manager eye on the financial bottom line and the leader eye on the horizon is the key to success (Latham, 2008). This view is supported through Stanley's (2006) study where participants indicated how difficult it is to provide both leadership and management. Malcolm and Stewart (2008) say CNM visibility on wards, and escalating demands of managerial responsibilities increasingly diminishes clinical input and leadership. Overall, Stanley (2006) found that taking on managerial responsibilities was possibly detrimental to the ability to lead and guide the patient's care. Patient care can be compromised through a lack of leadership and clinical expertise, resulting in protocols not being adhered to and shortcuts in care delivery being taken. From anecdotal experience, as managerial duties overtake leadership opportunities the CNM is distracted in the office, rather than out working alongside staff attending to patient requirements. Leadership is about providing vision, spirit, heart and motivation, exploring new roads and change, whilst managing is about constancy, strength and control (Stanley, 2006). CNM understanding and application of leadership and management will enable a reduction in the tensions resulting in reducing frustration, increasing position fulfilment leading to optimal patient care delivery and best patient outcomes.

Controlling people does not necessarily assist in producing the best outcome. Covey (2004) draws on Bennis' (1994) work and suggests managers are the people responsible for getting others to do what needs to be done. Generally managers command and push for achievement whilst on the contrary, leaders communicate vision, and pull by the power of suggestion. Covey (2004) suggests remaining custodial can disempower individuals, resulting in the work place becoming a conflicted environment, and obstructing the development of trust. An imbalance in leadership and management knowledge, understanding,

and application may result in not achieving the organisations vision and mission (Kotter, 2001). However key components of the manager role is solidarity, cohesion and political astuteness. Solidarity provides a team with unity and shared aims, cohesion enables consistency, and political astuteness provides an informed good judgement to enable the team constant focus to work towards (Marquis & Huston, 2009). These very notions are required to assist in meeting the vision and mission.

Scholtes (1998) and Marquis and Huston (2009) suggest managers are always assigned a specific position within the organisation and have a legitimate source of power through the appointment, with delegated authority and control. Although as Boulding (2007) points out the position as manager or supervisor gives specific authority to accomplish certain tasks and objectives in the organisation. This power does not necessarily make that person a leader; it simply makes that person the boss. Kouzes and Posner (2003) describe how researchers have shown that when people believe they have an influence within the organisation the greater the effectiveness and performance. Additionally, they assert how leadership is a team effort whereas management is not.

However, the manager is expected to carry out specific managerial functions, as previously described. There is also an emphasis on control - personnel, budget and resource, decision-making, decision analysis and results. These include organisational achievements, knowledge of legislative requirements, advancing technology, finances and an understanding of the mission and vision of the organisation (Marquis & Huston, 2009). Yoder-Wise (1999) suggests managers must be resilient. A resilient person is someone who is hardy, focused, positive, organised and proactive. Additionally, resilience promotes adaptation, which assists in establishing priorities for problem solving. A combination of decision-making, critical thinking and creativity also contributes to the process of problem solving, which managers are required to institute as a core skill (Yoder-Wise, 1999). Robbins and Coulter (1999) concur and say problem solving is being aware of a discrepancy, feeling the pressure to act and finding or manipulating sufficient resources to rectify the problem.

A comprehensive review of the literature has been presented in order to articulate the meanings of leadership and management. Leadership and management terms are used interchangeably within the literature, which can result in concept confusion, leading to a poor understanding, resulting in an unnamed tension. In order to provide clearer understanding of the concepts of leadership and management the defining attributes are illustrated next.

DEFINING ATTRIBUTES

Concept analysis offers an opportunity to identify the defining attributes of the chosen concept (Bell & Duffy, 2009). Walker and Avant (1995) consider concepts to be context bound and suggest attributes are not immutable. Concepts can change with time, meaning, and situation. In order to capture meaning, grouping similar defining attributes which appear frequently in association with the concept, offer insights into the concept. This allows the concept's defining attributes to be differentiated from any other concept. Chinn and Kramer (1995) articulate the difficulty in defining abstract concepts, such as leadership and management as being due to an intangible definition. Additionally, a mental image can be difficult to conjure up when a concept requires a specific definition. From the literature the defining attributes of leadership and management will be presented, in summary form, as word labels (Rodgers & Knafl, 2000).

LEADERSHIP

Good leaders passionately believe they can make a difference, as they envision and communicate the future. Boulding (2007), Goffee and Jones (2000), Marquis and Huston (2009) and Northouse (2007) impress that leader attributes are: authenticity; vision; inspiration; energy; ethics; and morals. Additionally, leaders search for opportunities to challenge status quo and look for innovative and creative ways to improve or change organisations through the members of the team, ultimately relying on developing individual positive attributes. Leaders become most powerful when they give the power away, by turning the people into leaders themselves (Kouzes & Posner, 2003). Scholtes (1998) agrees and purports that leaders strive to create an atmosphere of trust and dignity; they strengthen others making each person feel capable, powerful and like a champion by building on their character.

Good leaders experiment and take risks. Knowing risks can fail, they accept the inevitable disappointments and consequences as learning opportunities (Dearlove & Crainer, 2005). Leadership involves power by influence, through use of communication and relationship building (Marquis & Huston, 2009). Influence is a major factor in successful and effective leadership. Through role modelling the leader can foster collaboration and build spirited teams by

actively involving others and incorporating dignity, respect and individual spirituality (DuBrin, 2007). Fairholm (2004) suggests leaders are whatever they do, based on situation; behaviours; values and qualities; and this translates through to others. Parthasarathy (2009) asserts that central to productive leadership is the display of emotionally intelligent behaviour. Leaders must be self aware, motivated and empathetic, search for self-improvement, seek responsibility challenge ideas with the intent to develop individuals, and take responsibility (Boulding, 2007; Parthasarathy, 2009). CNMs that understand and apply leadership defining attributes enable the potential of realising optimal patient outcomes through the staff they lead.

MANAGEMENT

Managers have a formally assigned position within organisations with a legitimate source of power, simply by holding a management position (Marquis & Huston, 2009). They are expected to carry out specific tasks such as planning, organising, directing, coordinating, reporting and budgeting. Other key attributes are resilience, manipulation, problem solving and creativity (Yoder-Wise, 1999; Robbins & Coulter, 1999). Creatively manipulating people, the environment, budgets, time and any other resource required to carry out a specific task in order to meet the organisations vision, is key part in optimising patient outcomes. There is formal responsibility attached to the management position (Robbins & Coulter, 1999). The manager is required to direct willing and unwilling employees to complete specific jobs (Marquis & Huston, 2009). Constancy, solidarity and cohesion feature as components of management. The manager is required to maintain a balanced view whilst the leader challenges and changes the status quo. Political astuteness and leadership abilities are key to successful management.

The defining attributes of leadership and management have been presented in order to provide an understanding of the ideas, notions and characteristics associated with the concepts. A model and contrary case will now be provided to further demonstrate the concept's use.

THE DEVELOPMENT OF CASES

The defining attributes of leadership and management have been presented. In order to further facilitate the reader to distinguish the uses of the concepts of leadership and management a model and contrary case will now be offered. The cases have been constructed to demonstrate the concept's use. Examples of differing types of cases such as model or contrary cases provides the reader an opportunity to construct an image, therefore enabling additional understanding of the concepts (Chinn & Kramer, 1995; Walker & Avant, 1995; Unsworth, 2000). A model case demonstrating leadership and management attributes will precede a contrary case devoid of leadership and management attributes. These will now be presented.

MODEL CASE

This model case has been constructed and used to demonstrate the use of leadership and management defining attributes. A model case is one that has clear examples of the defining attributes of the concepts being examined (Walker & Avant, 1995). Furthermore, model cases represent the writer's best understanding of the concepts at the time of writing and should be an obvious exemplary case (Chinn & Kramer, 1995; Rodgers & Knafl, 2000; Unsworth, 2000). Chinn and Kramer (1995) say abstract cases can be difficult to distinguish, however providing ideas, notions and characteristics can assist the reader in developing a mental image. The following is a model case constructed from the researchers observational experiences. Parts of the case have been disguised to provide confidentiality.

Recently a nurse moved from a large city hospital, away from family, in order to pursue a personal relationship and new job. On commencement of the position the CNM discussed the orientation programme, expected timeframes, preceptor supports and patient outcome expectations. The patient outcome expectations are driven from the organisational vision and mission and include specifics such as development of staff and patient professional relationships, patient education and advocacy, informed consent processes, staff procedural knowledge, product, protocol and procedural knowledge, clinical documentation, in order to provide a safe and effective service. This discussion was undertaken to provide the nurse an opportunity to discuss

pertinent issues, develop professional practice and knowledge in a clinically safe environment and to aid integration into the existing team. The CNM's intent for the conversation is essentially to begin capturing the nurse's inner journey and to develop the relationship. The nurse welcomed the support and opportunity. The nurse communicated a keenness to fulfil the new position, impressing with an enthusiasm for learning and development.

During the first 3 months the CNM observed the nurse struggling within the position and fitting into the team, suggested by labile affect, and passive aggressive communication evidenced by rolling of eyes, ignoring reasonable requests from team members, starting work late and leaving early, among other behaviours. Furthermore, team members have confided to the CNM that clinical documentation, patient education and attention to detail has been a contentious issue. The team reported that nearly all the care provided by the nurse has required additional input. For example the admission process or patient education, as these areas have not been fulfilled to the team's acceptable standard. Additionally the team reports they have attempted to show the nurse and role model acceptable standards such as patient care, admission and education. However, they met with verbal aggression. As part of further building of the relationship the CNM engaged in informal discussions with the nurse to identify and manage challenges. Discussion surrounding the nurses' feelings was encouraged. The nurse confirmed to the CNM that fitting in and realising the steep learning curve was challenging, yet confirmed her happiness to the CNM at each discussion. As planned, at 3 months, the CNM formally met with the nurse to discuss opportunities for growth and development within the position.

The nurse was invited to describe her development within the position so far. The nurse confided discomfort in the new environment and team. Growing confidence with the positions technicalities are confirmed, which was reassuring and a building block for both the CNM and nurse. However, the initial orientation work was incomplete, potentially resulting in the nurse being unsafe in clinical practice, possibly leading to compromised patient safety. As the trust developed the nurse communicated social and emotional challenges at home and general disillusionment related to the relocation and

downsizing of the organisation she is now employed in. To compound these feelings the nurse revealed a troubled teenager and financial challenges.

The CNM disclosed the rationale behind employing the nurse. The nurse was reminded of the interview, of the scenarios articulated and the drive and enthusiasm expressed to provide optimal care to patients. The positive personal and professional attributes of energy, enthusiasm, principle driven, legislative knowledge, duty to care, vision and values were also discussed. The CNM communicated the benefits of having the nurse in the area, to the team, patient welfare, and the facilities positive growth, due to the employment of the nurse. The CNM reiterated the vision of the facility and the service, which are based on the vision and mission of the organisation. The strengths the nurse brought to the position were aligned with the organisational vision by acknowledging attributes and communicating potential development opportunities such as learning, development of professional relationships and adding value to the service.

The CNM examined with the nurse potential solutions for the challenges currently faced, whilst acknowledging feelings and emotion. The trusting relationship had developed. Furthermore, the CNM communicated the importance of the nurse developing solutions; the CNM was keen to assist the exploration process of questioning. They agreed that working together to reinvigorate the nurse's home life and career was imperative. Using innovation, creativity and contextual listening the CNM documented a number of potential solutions discussed by the nurse, regardless of their achievability; so all possibilities are discovered, in an attempt to develop a plan of action. Of the achievable solutions, barriers are discovered and removed and goals for learning and team integration are established. A documented plan for action was achieved and further times to meet were arranged.

DISCUSSION

This model case illustrates the leadership and management concept attributes. Including various circumstances, behaviours, attitudes and feelings provides a picture to draw experiences around (Chinn & Kramer, 1995). Relating the discussion back to care of the patients and the organisational vision and mission

the CNM provides a plan for an organised introduction into the organisation and coordinates and facilitates support mechanisms through discussing the position orientation requirements, timeframes and preceptor support. The CNM and nurse have this discussion to enable the nurse an opportunity to align the nurse's vision with that of the organisation. Marquis and Huston (2009) say organising, coordinating, facilitating supports and discussing expectations is combining leadership and management skills. Furthermore, this is an example of demonstrating professional, moral and ethical responsibility of leadership and management (Stanley, 2006).

Covey (2004) suggests that in discussing specific organisational vision and values; passion, vision, inspiration and energy are observed. These attributes are linked with leadership abilities (Marquis & Huston, 2009). There is evidence the CNM desires to make a difference to how patients travel through the healthcare experience by communicating opportunities in an authentic way through aligning the nurse's previous experiences and knowledge with the development of the new position. Challenging the status quo by mobilising innovation to improve or change the service through the nurse's experiences, whilst developing individual positive attributes also demonstrates leadership attributes (Fairholm, 2004; Horner, 1997). This aligns to why we are here; patients are the cause and effect of the position, service and organisation.

The developed trust contributed to the nurse's dignity; hence strengthening the nurse's character and enabling potential solutions to be developed. Experimenting and taking risks by being genuine, empowering by influence, and building the relationship influenced the nurse to discover potential solutions (Cohen, 2008). These are key leadership traits (Covey, 2008). The CNM was keen to build a spirited team by actively involving the nurse through discussion, questioning, role modelling and engagement, thus leading to alignment. Individual emotion and spirituality was encouraged and included throughout the discussion, demonstrating further leadership abilities (Cohen, 2008).

Throughout this process, a documented plan was identified and initiated, in order to move the nurse forward, demonstrating management knowledge and abilities. The CNM is able to coordinate this innovation with the nurse, so the nurse has discovered her own solutions. Leading the nurse to lead herself is

responsible leadership, as only the nurse understands her own limitations, life experiences and knowledge. The nurse has engaged in the plan, as she contributed to its development. Additionally, at the CNM request, they agree to meet again. This portrays resilience and allows them both an opportunity to evaluate and further develop the plan. Evaluation is part of demonstrating management ability (Marquis & Huston, 2009). The CNM has demonstrated leadership and management defining attributes. Having presented a model case and explored it, a contrary case will now be offered.

CONTRARY CASE

This contrary case has been constructed and used to demonstrate the dearth of leadership and management defining attributes. A contrary case is one that has no or limited defining attributes of the concept being examined (Chinn & Kramer, 1995; Walker & Avant, 1995). Contrary cases represent the writer's best understanding of the concept at the time of writing. Contrary cases may have similarities to model cases, yet the lack of specific defining attributes should be sufficient for the reader to distinguish it is a contrary case (Chinn & Kramer, 1995). Rodgers and Knafl (2000) suggest a contrary case should be an obvious erroneous case. Following is a contrary case constructed from observed experiences. Parts of the case have been disguised to provide confidentiality.

The CNM walked with intent through the ward to find the nurse who admitted the patient inadequately. The inadequate admission had resulted in an incomplete holistic admission assessment and no baseline vital observations. By not completing a comprehensive assessment the patient was compromised. The patient's physical and cognitive capabilities, preexisting medical conditions, allergies, education, understanding of the admission, and anxiety remained unknown. Furthermore, this compromised the ability of the team to ensure the patient's needs were met during the health care experience.

In front of patients and nurse colleagues the CNM openly discussed the incomplete admission. The CNM described the nurse as incompetent and proceeded to ask about the level of commitment to the patient and organisation and stated there were sufficient staff to manage the workload. Everyone in the vicinity was looking uncomfortable and embarrassed. Patients

and staff tried to minimise the impact by looking the other way, and if able, move from the area as the CNM talked incessantly to the nurse. Patients were unable to move away. The CNM again defended the staffing levels, and proceeded to challenge and blame the nurse for the incident. The nurse was not given an opportunity to respond. The CNM instructed the nurse to complete the admission assessment and returned to the office. Patients were left questioning the confidence, competence and professionalism of both the staff and CNM. Their own personal safety also became a priority. Anxiety rose and nurses dealing with the event tried to play down the occurrence and sooth questioning nervous patients.

The nurse reported to the CNM before the shift ended to try and explain why the admission assessment was incomplete. The CNM interrupted the nurse and reiterated there was no good reason to leave a patient with an incomplete assessment and that sort of attitude and inattention would not be tolerated.

DISCUSSION

This contrary case illustrates a dearth in leadership and management concept attributes. Communication was aggressive, negatively geared and one sided. This is demonstrated through use of challenging, blaming and belittling language such as *incompetent* and the public forum the CNM chooses to use. Additionally, the public questioning about the nurses commitment can be viewed as disrespectful, unprofessional and unethical. This situation impedes the nurse's ability to clarify the situation and defend her professional position or decisions surrounding the patient admission assessment. Prohibiting the nurse to respond and being subject to verbal abuse disenfranchises patients, and staff alike. McKenna, Smith, Poole and Coverdale (2003) and Kerfoot (2008) say CNMs play a key role in influencing the climate of the working environment. There is a risk that patients observing and hearing the reprimand are unsettled and embarrassed. This coupled with vulnerability and likely illness can lead to increased anxiety. Swindale (2006) conveys that hospitalisation alone, regardless of disease provokes patient anxiety. However, as much as the CNM behaviour gives rise to the patient having a less than optimal health care experience, so too does an incomplete assessment, thus further reducing the opportunity for the best possible outcome. The American Nurses Association

(1985) code for nurses states that nurses are to safeguard patients from incompetence and unethical practice.

A deficiency in leadership attributes exists in this instance as the CNM fails to communicate the organisations vision and mission, which in turn fails to align the nurse. In addition, a dearth in management attributes also exists as a balanced view and political astuteness does not exist. Whilst the CNM is noticing the nurse's poor performance and calling the nurse to account for what is perceived to be incompetent, unsafe, and unethical practice the CNM is contributing to those very things. An example of this is discussing the situation in a public forum and disallowing the nurse a rebuttal. The CNM may think the best interest of the patient is at the forefront of practice, yet the feelings evoked as a result of the public humiliation will impact on the patient's outcome and experience. New Zealand Nurses Organisation (2001) conveys that professional relationships and interactions should be shrouded by respect. Moreover, caring as the moral foundation of nursing and well-being of another must be at the forefront of practice. However, the CNM is focusing on managing the resource, rather than leading the team and optimising patient outcomes. The focus may well be on attaining quality yet the spotlight is on clinical documentation and blame, rather than concentrating on supporting staff, staff learning and development, patient outcomes, and experience.

Whilst the staffing for the duty has been planned and organised the CNM has not enquired why or how the situation has occurred. Planning and organising are key management attributes (Marquis & Huston, 2009). However, key attributes of management such as coordinating, monitoring and leading staff are not apparent. The CNM has not evaluated how the staff are working as a team, or the patient acuity. Trust and relationship engagement have not been initiated or achieved with the nurse, other staff or patients. The CNM is preoccupied in the office and engaging with the nurses does not seem to be a priority. Stanley (2006) says clinical leaders and managers with day-to-day managerial responsibilities find it difficult to extract themselves from administrative duties. Scholtes (1998) articulates how leaders should strive to create an atmosphere of trust and dignity. Additionally, effective leader attributes evolve and impress vision, inspiration, and energy and are ethical and moral (Boulding, 2007; Goffee & Jones, 2000; Marquis & Huston, 2009;

Northouse, 2007). Leadership is about making staff feel capable and building on their natural character. Knowing the people, building relationships, engaging in conversations, walking the talk and focusing on patient optimal outcomes are attributes required by CNM's.

Respect can be lessened when confrontational situations develop. DuBrin (2007) describes how setting high standards can assist in making an inspiring, motivating and energising appeal to employees, to work towards achieving the organisational vision. The leader or manager who performs poorly, consistently increases the chances of others role modelling their behaviour. Management functions are something that must be exercised within organisations. However, leadership – the relationship between the leader and the followers must be underpinned by vision, values, respect and ethics (Stanley, 2006). Having presented a contrary case and discussed it, the leadership and management antecedents and consequences will now be offered.

ANTECEDENTS & CONSEQUENCES

Antecedents and consequences assist in refining the social contexts in which the concepts are used. Antecedents are events that occur prior to the occasion of the concept (Rodgers, 1989; Walker & Avant 1995). For example, an antecedent of leadership in nursing is vision. In order to obtain optimal patient outcomes, vision and mission must be communicated to provide alignment, to enable staff a common goal.

Consequences, on the other hand, transpire as a result of the occurrence of the concept (Rodgers, 1989). Walker and Avant (1995) suggest consequences can be useful in determining neglected ideas and variables. For example, as a result of leadership, a direction should be set and continually strived towards. Individual staff members should be leading themselves. Furthermore, antecedents and consequences are useful theoretically and can be positive or negative, concrete or abstract (Walker & Avant, 1995). Leadership antecedents and consequences will precede management antecedents and consequences.

LEADERSHIP ANTECEDENTS

As previously described throughout the work leadership is a complex concept and is affected by features such as time, context and people. Being informed by literature and developing the model and contrary cases have guided the leadership antecedents for this work.

Several antecedents to leadership were identified during the development of this work. Leadership activity appears to commence with self-awareness and follower-ship. Improved care delivery and optimal patient outcomes will result when the CNM communicates organisational vision and mission, and values and ethics to the followers. Through the CNM being enthusiastic and authentic, and applying emotional intelligence attaining optimal patient outcomes will be achieved. In order to offer this, knowledge development of the defining attributes and associated tensions of the CNM role is required. This can be achieved through academic preparation in leadership knowledge, skills, and articulation.

LEADERSHIP CONSEQUENCES

The consequence of CNM leadership is, fundamentally, people realising potentials that they had not previously foreseen (Horner, 1997). CNM responsibility essentially surrounds sound accepted ethics, morals, courage, communication and behaviour. When these are coupled with striving to achieve optimal patient outcomes such as comprehensive clinical assessment, education and informed consent, patients receive best treatment, care and results. Berragan (1998) agrees and suggests ethical and moral knowledge can be influenced by how we live. Past experiences and may influence our nursing practice, hence have an impact on patient outcome. Northouse (2007) concurs and says moral and ethical behaviour are central to good leadership.

As a consequence of leadership a reduction in the tension between the leadership role and management functions can be achieved. Being prepared for a leadership position can lead to unconscious competence (Hancock, 2008). Fairholm (2004) suggests that with scholarly attention the CNM can develop leadership understanding and application which may go some way to resolving the inherent conflict due to understanding and appreciating the tension.

As power is often associated with leadership, and leadership involves influence, CNMs have responsibilities for how others are affected by their leadership. Hence, there is a need to be self-aware and realise the impact the CNM can have on a situation. Northouse (2007) suggests leaders often set the ethical and moral climate of organisations, thus it is imperative followers are treated with respect and dignity. Furthermore, leadership consequence is associated with followers contributing to meeting the organisational vision and mission. In tangible terms, communicating the organisational vision and mission, and breathing life into employees through the CNM walking the talk, can energise and engage employees. CNMs communicating the long-term organisational plan can offer employees insight into future service developments and individual development opportunities, thus offering prospects that excite people (Dearlove & Crainer, 2005).

MANAGEMENT ANTECEDENTS

As previously described throughout this work management is more prescriptive than leadership and offers its own set of complexities. Being informed by literature and developing the model and contrary cases have guided the management antecedents for this work.

Management antecedents such as management knowledge, resourcing, and courage to understand self and the associated tensions the CNM position will bring, will combat workplace chaos, staff, and position dissatisfaction. CNM knowledge development through academic preparation in management theory and process application will contribute to attaining optimal patient outcomes. A defined: clinical area and budget; position purpose and appointment; legitimate line of direct reports; clinical leadership; service management capability; strategic quality improvement ability, are further CNM management antecedents.

MANAGEMENT CONSEQUENCES

The consequences associated with management are an efficiently run business with a level of bureaucracy that enforces the organisational vision and mission, thus benefiting the patients requiring the service, and the employees. Organisational strength relies upon sturdy management to make certain senseless change does not occur (Northouse, 2007). Marquis and Huston (2009) explain how regulations, structure and process development, which is associated with bureaucracy, is a result of management. CNM's understanding and application of the points relating to management consequences are imperative to the delivery of care and positive patient outcomes. Robbins and Coulter (1999) suggest that coordinating the working environment to accomplish goals can minimise risk to patient outcomes and provide solidarity and stability to the team and processes.

Antecedents and consequences pertaining to leadership and management have been developed as a result of the literature review, defining attributes, presentation of the model and contrary cases and discussion. They have been presented in order to provide a further opportunity to understanding the

refined uses of the concepts. Leadership and management empirical referents will now be explored.

EMPIRICAL REFERENTS

Empirical referents are useful as they can provide clear, observable phenomena by which to pinpoint the concept in action or demonstrate the existence of the concept itself (Montes-Sandoval, 1999; Walker & Avant, 1995). Empirical referents can be directly related back to the defining attributes and in some cases may be the same, but can be measured (Unsworth, 2000). Presentation of leadership empirical referents will precede management empirical referents.

LEADERSHIP EMPIRICAL REFERENTS

The leadership empirical referents of the CNM role are team and individual open and honest discussion; mutual respect; and relaying vision resulting in tangible changes to move a service forward. CNM understanding and application of leadership could be assessed by: concept defining attributes knowledge and academic development; team developed evidenced based service protocols to guide clinical practice resulting in optimal patient outcomes; employee satisfaction survey; employee engagement in their own performance development planning; admission and discharge timeliness; clinical documentation; patient compliment and complaints process.

MANAGEMENT EMPIRICAL REFERENTS

The management empirical referents of the CNM role are similar to that of leadership but also providing structure and processes, boundaries, and doing what is right. CNM understanding and application of management could be assessed by: concept defining attributes knowledge and academic development; auditing the service, including financial budgets, rostering practises (to assess development in planning, organising), staff performance development planning and, financial reporting; surveying the patient population surrounding their health care journey through the service; reviewing and evaluating reportable events.

Both leadership and management empirical referents have been presented. These empirical referents provide opportunities to collate tangible evidence to evaluate CNM leadership and management knowledge, understanding and

application development, resulting in optimal patient care delivery and best patient outcomes.

CLINICAL PRACTICE OPPORTUNITIES & IMPLICATIONS

This work raises awareness of the complexities and tensions of the concepts leadership and management, and the impact the CNM has on shaping the environment and patient outcomes. The purpose of this concept analysis was to explore leadership and management interpretations, their importance in the CNM preparation, nursing care delivery, and patient outcomes. Further research to determine what successful leadership and management is in nursing and how the CNM can be prepared for future positions is required. Sullivan, Bretschneider & McCausland (2003) suggest participants in their study identified the need for a structured orientation with dedicated formal mentoring, particularly in leadership and management, in order to competently undertake the managerial responsibilities.

This work offers an opportunity to review the CNM preparation and values the impact that the position has on achieving optimal patient outcomes. Communicating organisational vision and mission assists in aligning CNMs and will go some way to developing an organisational culture of scholarship. If one is to achieve the vision and mission through understanding their position and the impact their position has on others, academic preparation is imperative. The result will be team stability, service growth, and optimal patient health care experiences and outcomes.

It may be timely to develop combination leader manager CNM positions. Marquis and Huston (2009) discuss how leader managers keep the team informed by communicating vision; ensuring tasks are understood through questioning, supervising and accomplishing alongside the team, and utilising the full capabilities of the organisations resources, resulting in optimising patient outcomes. Leader managers tend to be futuristic, evidenced by thinking long term; they see how the team impacts on others and as a result work more broadly which enables the patient journey to be smooth between departments. Influencing others beyond their own group holds importance and leader managers put emphasis on organisational vision, values, and motivation. There is a manner of political astuteness about them and they think in terms of controlled change, resulting in assessing and responding to change in an organised methodical fashion. This is accomplished by challenging the status quo and ensuring renewal and improvements in quality whilst maintaining

solidarity and cohesion. Fairholm (2004) discusses the term leader manager. Leader managers are emotionally intelligent and identify situations that require timely intervention (Fairholm, 2004; Marquis & Huston, 2009).

In order to get the best out of employees, inspiration is the key in the relationship (Fairholm, 2004). Directing and coordinating is apparent but not overt (Marquis & Huston, 2009). Team decisions are made in order to move forward. Whilst this is time consuming and uses energy, time frames are outlined and constructive feedback is given. Leader managers break down bureaucratic barriers so employees are sheltered and their energy is not wasted. A good leader manager is not simply the boss by means of the position, but by means of the follower-ship they have (Boulding, 2007). Not everyone can be a leader manager and not all people who get to the top are leaders (Goffee & Jones, 2000; Kotter, 2001).

CONCLUSION

Leadership and management have been analysed as an essential concept in nursing and optimising patient outcomes. The lack of clear understanding of the terms leadership and management, development of CNMs and the impact this has on patient outcomes has been explored. There is a critical importance in developing future CNM's knowledge and concept development, articulation and application of leadership and management concepts through academic preparation, due to the direct impact they have on the delivery of nursing care and patient outcomes.

The concepts of leadership and management have been analysed using Walker and Avant's (1995) concept analysis framework. Through the use of this theoretical framework specific defining attributes have been exposed thus providing an opportunity to offer specific knowledge, such as the tension associated with the CNM position, to assist in the development of leadership and management knowledge. The tension between leadership and management has been named; nonetheless they are intertwined regardless of the appointed position. Developing knowledge and understanding surrounding the relationship of leadership and management prior and during the CNM position appointment is key to ensuring patient care is delivered in a way that is beneficial with optimal outcomes.

The literature review provides word labels to describe the concepts of leadership and management. Conceptual clarity pertaining to leadership and management is the key to delivering professional practice (Montes-Sandoval, 1999). Nursing has a moral responsibility and an ethical obligation to understand the fundamentals of the concepts of leadership and management, regardless of the contextual elements. Furthermore, having the right people in the right position with the right preparation will allow for less role confusion and ultimately assist in organisational vision and values to be realised (Bradley, Maddox & Spears, 2008). The defining attributes, antecedents, and empirical referents identified in this work will provide a framework for future CNM development.

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