

**Practice Environment Perceptions of First – Line Managers of Nursing**

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## ABSTRACT

As the health care system experienced a complex tapestry of transitions in the past decade, first-line managers (FLMs) strived to maintain a sense of stability for themselves and their staff in chaotic work environments. Individuals across the nation are striving to ensure health care team members have quality work environments. The paucity of literature examining the perceptions FLMs have of their work environment prompted this study.

This study provided FLMs employed in regional and provincial hospitals in Saskatchewan “a voice” to share their perceptions of their work environments with others. It is an adaptation of the descriptive survey design used by Remus, Smith, and Schissel (2000) in their study of staff nurses. The adaptation was based on the literature, making it applicable to FLMs, and incorporating the six Quality Worklife Indicators (QWI) of the Canadian Nurses Association’s (CNA’s) Quality Professional Practice Environments framework. The questionnaire also incorporated open-ended questions that enabled respondents to elaborate on their perceptions of their work environments.

The total population of 113 FLMs in regional (FLMRs) and provincial (FLMPs) hospitals in Saskatchewan was invited to participate in this study. Sixty-nine respondents (61.1%) chose to do so. FLMRs had a higher, although not significant, response rate, (67.6% n=23) than did FLMPs (58.2% n=46). The researcher attempted to make personal contact and correspond with each invited participant when distributing the questionnaires. In the open ended questions, participants in this study described intertwined multidimensional roles and responsibilities resulting in unmanageable workloads. They faced daily challenges involving relationships, putting out fires, balancing system/personnel relationships, staffing issues, resources, time, and salary. FLMs who successfully resolved their challenges felt a sense of accomplishment or

reward, increasing their self confidence in their ability to successfully fill their roles as a FLM. FLMs described that being a change agent, teamwork, recognition by others, relationships, working with patients, and control over practice as the most rewarding elements within in their practice environments. The Environment Perception Scale responses reflected positive perceptions of work environments on all subscales except control over workload. Overall, FLMPs had a slightly more positive perception of their work environments than did FLMRs, except on the control over workload subscale. However, there were no significant differences between the groups except on the innovation and creativity subscale, where FLMRs scored significantly lower.

Study results offer senior administrators, professional associations, government, educators, and others an opportunity to increase their understanding and awareness of the perceptions FLMs have of their practice environment. Awareness of these perceptions will facilitate supporting or strengthening the rewards FLM's perceive in their practice environments, resulting in a richer practice environment. Identification and awareness of the perceived challenges is the first step in addressing them. Educators will find these results useful in better preparing future leaders of nursing for formal management roles.

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## CHAPTER 1

### Introduction

As changes in the health care system continue, first-line managers (FLMs) must strive to maintain a sense of stability in work environments that are often chaotic and unhealthy (Dixon, 1999). FLMs are employed in first level management positions and are accountable to senior management, including general managers (GMs), directors, or vice presidents (VPs), depending on the organizational structure of the agency (Parsons & Stonestreet, 2003; Saskatoon District Health, 1998). Senior managers do not necessarily have a nursing background. For the purposes of this study, FLMs are registered nurses (RNs) or registered psychiatric nurses (RPNs) practicing out of scope and responsible for a particular team or group that delivers nursing service in an acute care agency.

As restructuring and change occur in the health system, nursing departments or wards may be amalgamated, management layers thinned, reporting relations altered, and managerial roles changed to become more complex (Anthony et al., 2005; Care & Udod, 2003, Porter-O'Grady, 2003a, Saskatchewan Health, 2005). As FLMs attempt to provide quality practice environments for themselves and their staff, they are faced with many challenges. They may find themselves fulfilling potentially conflicting roles such as facilitating patient care, managing human resources, and accounting for operational/functional budgeting of the unit/units. They may be employed in agencies with limited resources and unmanageable workloads. They may be required to make decisions independently, often with minimal support from senior leadership and health team members (Alexander, 1998; Care & Udod, 2003; Chan, 2001; Dixon, 1999; Goddard & Spence Laschinger, 1997; Gould, Kelly, Goldstone, & Maidwell, 2001a; Gould,

Kelly, & Maidwell, 2001b; Spence Laschinger, Almost, Purdy, & Kim, 2004; Martin, 2005; Saskatchewan Health 2005).

### *1.1 Statement of the Problem*

Researchers, especially in the last decade when health care changes were occurring almost continuously, often grouped FLMs with either administrators or nurses as a whole. In Saskatchewan, there are no published reports on the work environments of FLMs. This is of concern as FLMs are a unique group and a vital link in the health care chain.

### *1.2 Purpose of the Study*

This study identified the perceptions that FLMs employed in regional and provincial hospitals in Saskatchewan have of their practice environments.

### *1.3 Significance of the Study*

Individuals across the nation are striving to ensure health care team members have quality work environments. This study provided FLMs in Saskatchewan “a voice” to share their perceptions of their work environments with others, offering senior administrators, professional associations, government, educators, and others an opportunity to increase their understanding and awareness of the perceptions FLMs have of their practice environment. Awareness of these perceptions will facilitate supporting or strengthening the rewards FLM’s perceive in their practice environments, resulting in a richer practice environment. Identification and awareness of the perceived challenges is the first step in addressing them. Educators will find these results useful in better preparing future leaders of nursing. This is the first study of this nature done in Saskatchewan.

### *1.4 Definition of Terms*

The following definitions were used in this study:

#### *1.4.1 First - line Manager (FLM)*

A registered nurse or a registered psychiatric nurse practicing out of scope and responsible for a particular team or group that delivers nursing service in an acute care organization. An FLM is employed in a first level management position and is accountable to a General Manager, Director or Vice President, depending on the organizational structure of the agency (Parsons & Stonestreet, 2003; Saskatoon District Health, 1998).

#### *1.4.2 Nurse*

A registered nurse (RN) or a registered psychiatric nurse (RPN). While it is recognized that licensed practical nurses (LPNs) make important contributions to the health of individuals, for the purposes of this study they will not be included in the definition of nurse.

#### *1.4.3 Provincial Hospital*

One of five hospitals designated as a provincial hospital by Saskatchewan Health. These hospitals provide individuals with specialized services such as cancer treatment, heart surgery, and intensive care for infants and diagnostic tests such as MRI scans, in addition to services offered at regional hospitals (Saskatchewan Health, 2001).

#### *1.4.4 Quality Professional Practice Environment*

A work environment that meets the needs and goals of individual nurses as they assist patients or clients to reach their personal health goals (O'Brien-Pallas, Baumann, & Villeneuve, 1994).

#### *1.4.5 Regional Hospital*

One of six hospitals designated as a regional hospital by Saskatchewan Health. These hospitals provide minimal to specialty services that include, "internal medicine, general surgery,

obstetrics and gynecology. These hospitals will also offer intensive care services”  
(Saskatchewan Health, 2001, p. 38).

### *1.5 Research Question*

This study answers the following question:

How do FLMs employed in regional and provincial hospitals in Saskatchewan perceive their practice environments?

## CHAPTER 2

### Background

Changes in the health care system, decreased funding, and fewer nurses have resulted in heavy workloads and unhealthy work environments for nurses. Health care changes were occurring almost continuously in the last decade, but published reports on the work environments of FLM's as a unique group are missing in the literature. This chapter provides an overview of the literature and the conceptual framework used for this study.

#### *2.1 Literature Overview*

In 2011, Canada will be faced with a shortage of 113,000 nurses (Canadian Nurses Association [CNA], 2001a). Meanwhile, fewer nurses, decreased funding, and changes in the health care system have left nurses at all levels with unmanageable workloads and unhealthy practice environments (Health Canada, 2002). As a group, nurses have raised many concerns about their own practice environments but the distinct voice of FLMs is missing. Baumann et al. (2001a) state that, "Canada's nursing shortage is at least in part due to a work environment that burns out the experienced and discourages new recruits" (p.1). Currently, there is an enormous amount of literature discussing the nursing shortage and related working conditions of RNs in Saskatchewan and elsewhere. There have been many studies in the area of recruitment and retention of RNs in an attempt to better understand and address the nursing shortage and funding cutbacks (Backman, 2000; Baumann et al., 2001b; Brown, Weir, Rideout, & Ingram, 1995; Buchan, 1997, 1999; CNA, 1998; Ferrante, 1993; Health Canada, 2001; LeMoal, 1999a; Parsons, & Stonestreet, 2003; Remus, Smith & Schissel, 2000; Shamian & Thomson, 1999; Skelton-Green, 1996; Tovey & Adams, 1999).

In the early 1980's, nursing research focused on the role of FLMs in the promotion of standards of care, education of FLMs, and support received by FLMs in their workplaces. Studies were small and used a variety of methodologies making cross study comparisons difficult (Gould et al., 2001a; 2001b). However, common themes did appear. FLMs were identified as having a pivotal and complex role as they ensured quality patient care. Education was viewed as essential to provide nurses with the preparation required to competently fill FLM positions. The likelihood of role conflicts related to role expectations, stress and job satisfaction was identified (Gould et al., 2001a; 2001b; McGillis Hall & Donner, 1997).

In the 1990's, research explored the measurement of patient-care outcomes and the relationship of these outcomes to patient care delivery models (Adams, Bond, & Arber, 1995). Little research focused on the FLMs themselves, yet their role was becoming more complex. As expectations of FLMs increased over the years, lack of current research relating to the FLM group created a gap (Gould et al., 2001a; 2001b).

In the United States in the early 1980's, there were hospitals that, despite national shortages, were able to successfully recruit and retain nurses at all levels. These hospitals had the reputation of being good places to work. They had high productivity, quality work environments for their employees, and nurses reported experiencing overall job satisfaction. They were given the label "Magnet Hospitals" (Kramer, & Schmalenberg, 1988a; 1988b).

In Canada there are currently attempts to promote incorporation of magnetism into the work environments of Canadian nurses. Canadian terminology of "Quality Work Environments" (Muzio, 2004), "Quality Professional Practice Environments" (CNA, 2001b), and "Healthy Work Environments" (Baumann et al., 2001a), parallel the American phrase "Magnet Environments". Research specifically exploring the practice environments of FLMs is limited.

## *2.2 Conceptual Framework*

As stakeholders across Canada began to address the retention and recruitment of nurses, it became clear that “no issue was more significant in its impact on the satisfaction, recruitment and retention of nurses than the health of nurses and the places they work” (Health Canada, 2001, p. 3). Although this statement refers to nurses in general, it may be especially true of FLMs as they are responsible for providing leadership within their organizations. It is essential that they have quality work environments to allow them to effectively lead and support their staff.

There are many initiatives across Canada attempting to improve the work environments of RN's. In 2001, the Saskatchewan Registered Nurses Association (SRNA) began its consultation program, the Quality Workplace Program (SRNA, 2001a; 2001b; 2001c). Lowe (2002) reported that in April 2002, the CNA held a national workshop at which participants developed a comprehensive framework to foster high quality workplaces. This became the CNA's Quality Professional Practice Environments framework with six quality of work life indicators (QWIs). The national workshop recommended that the indicators become part of the Canadian Council on Health Services Accreditation's (CCHSA's) 2004 Achieving Improved Measurement (AIM) Accreditation Program. The AIM Accreditation Program is used to accredit health care organizations in Canada (Lowe, 2002). The CNA's Quality Professional Practice Environments framework is the conceptual framework for this study. The QWIs are: control over workload; nursing leadership; control over practice; support and recognition; professional development; innovation and creativity.

### 2.2.1 Control Over Workload

Restructuring and changes in the system affect the role of the leader (Alexander, 1998; Kerfoot & Wantz, 2003; Kleinman, 2003; Porter-O'Grady, 2003a, 2003b; Spence Laschinger, et al.). As the roles and responsibilities of the FLM expand, FLMs are forced to address increasingly complex issues with a greater span of responsibility in an environment where communication is often complex (Walker, 2001). “Additional demands coming from supervisors and staff nurses result in role overload and role conflict being added to role ambiguity” (Thorpe & Loo, 2003, p. 323). It is apparent that FLMs experience “multiple and competing demands that they must balance in defining, prioritizing, and implementing their role responsibilities to meet the goals of the organization as well as those of their profession” (Anthony et al., 2005, p. 146).

The impact of changes on the roles of FLMs is just beginning to be identified. According to Thorpe and Loo, (2003) “the role of the F-LNMs [*sic*] has received little attention in the research literature, particularly relevant to their role change resulting from regionalization” (p. 322). The objectives Thorpe and Loo’s study were to:

Explore and describe emerging new roles of First – Line Nurse Managers (F-LNM [*sic*] i.e. individuals who oversee the daily operations of nursing units, regardless of their titles) in one Canadian province, identifying their requisite knowledge, skills, competencies, and determine the training and development needs of these managers. (p. 321)

The findings of Thorpe and Loo (2003) regarding the roles of the FLM suggest “that the

role of the F-LNM [*sic*] continues to evolve, consistent with the changing health care system” (p. 321). Research in this area is limited yet very much needed (McGillis Hall & Donner, 1997; Spence Laschinger et al., 2004).

Research involving either only staff nurses or all levels of nurses as a group reveals that RNs are concerned about their workloads (Adams, 2001; Aiken, Sochalski, & Lake, 1997; Alexander, 1998; Backman, 2000; Baumann, et al., 2001a; Kramer & Schmalenberg, 2003; LeMoal, 1999b; McGirr & Bakker, 2000; Remus et al., 2000). Although FLMs experience many workload challenges similar to those of first line staff nurses, they also tend to spend many hours on budget and paper work, limiting time spent on other elements of their role. FLMs may sense that the “hands-on, supervisor-employee, coaching, mentoring, supporting role was all but lost in many cases - and lost at great cost to the quality of patient care and team functioning” (Health Canada, 2002, p. 19). Research is vital at the level of FLMs as they have a valuable leadership role in the health care system.

### *2.2.2 Nursing Leadership*

The literature describes high expectations and many roles of nursing leaders as they strive to achieve quality work environments. For FLMs to fulfill their roles, it is imperative that they become nursing leaders. Nursing leaders have the responsibility to create, instill, and clarify the value system in the organization (Dixon, 1999; Scott, Sochalski, & Aiken, 1999; Trofino, 1995; Ward, 2002). Nurse leaders should strive to be visible, supportive, and responsive to the staff (Dixon, 1999; Scott et al., 1999). It is important that they attempt to become actively involved in provincial and national organizations (Scott et al., 1999). They should be knowledgeable and value education and professional development of all nurses in the organization. Ideally, they are energetic and enthusiastic, maintaining high expectations of themselves and their staff as they

ensure that excellence is the only standard of care given to the public. To facilitate movement toward achievement of goals of the agency, it is critical that communication between leaders and staff remains open and free flowing, particularly regarding reasons for change, intended outcomes and timely feedback (Alexander, 1998; Dixon, 1999; Fisher, 1993; Fullam, Lando, Johansen, Reyes, & Szaloczy, 1998; Kerfoot, 1998; Leveck & Jones, 1996; Lynch, 1994; Scott et al., 1999). As FLMs involve staff in decision-making processes, the work environment created has a high level of unit cohesiveness, efficient work teams, job satisfaction, increased quality of care and lower job stress (Alexander, 1998; Dixon, 1999; Green & Jordan, 2004; Havens, 1998; Havens & Vasey, 2003; Ingersoll, Schultz, Hoffart, & Ryan, 1996; Kerfoot, 1998; Leveck & Jones, 1996; Morrison, Jones, & Fuller, 1997; Mrayyan, 2003; Scott et al., 1999). Each FLM perceives the challenges in her/his work place differently. FLMs who identify obstacles as being small and easy to rise above will be confident in their ability to successfully fulfill their managerial role. Managers who view challenges as being huge and difficult to conquer will be less confident in their own abilities to fulfill their FLM role.

Research exploring Saskatchewan's FLMs' perceptions of their work environment is lacking. Such research is essential, as it will begin to unveil FLMs' perceptions of the leadership they receive from their leaders, and the effect this leadership has on their practice. It will also reveal the extent to which they are able to achieve some of these qualities of leadership themselves.

### *2.2.3 Control Over Practice*

According to Kramer and Schmalenberg, (2004) control over nursing practice (CNP) is defined in the literature in various ways. They define CNP as:

a participatory process enabled by a visible, organized, viable structure through which nurses have input and engage in decision making about practice policies, and issues, as well as personnel issues affecting nurses. The effectiveness of the structure is apparent in outcomes achieved and recognition of nursing's CNP by others. (p. 46)

As changes within the healthcare system have occurred, the number of FLM positions has decreased while their span of control has increased, resulting in FLMs experiencing challenges when fulfilling their roles and responsibilities (Morash, Brintnell, & Rodger, 2005). Employers should examine and benchmark their FLM's span of control to ensure that they are able to successfully accomplish their assigned functions, as they strive to meet the needs of their staff and patients (Health Canada, 2002).

As work environments enable FLMs to make changes and participate in organizational decisions, their sense of autonomy increases (Scott et al., 1999). It is imperative that the work environments of FLMs support their professional practice.

Research done in the late 1980s and early 1990s (Kramer, 1990; Kramer & Schmalenberg, 1988a; 1988b) contributed to understanding of the positive results that occur when sound organizational practices in relation to nursing are implemented in hospitals. Research reinforced previous findings that autonomy of nurses, control by nurses over their practice environments, and positive collaboration between nurses and physicians contributes to greater job satisfaction for nurses (Laschinger & Havens, 1996; Rafferty, Ball, & Aiken, 2001).

#### *2.2.4 Support and Recognition*

Environments that provide FLMs with sufficient support from health team members, colleagues and employers allow FLMs to better fulfill their multiple roles and responsibilities (Gould et al., 2001a; Health Canada, 2002; Lowe, 2002). Significant input and participation into

health care and policy making decisions by FLMs should be encouraged and valued. Work environments should enhance a culture of appreciation towards individuals and groups for their performance, achievements, and should acknowledge their contributions to the agency's mission. These recognitions or rewards should occur on a daily basis and may include formal and informal programs. Formal programs may include compensation, benefits, financial incentives and opportunities for advancement. Informal ways of expressing organizational appreciation may include saying thank you, giving time off, flexibility in schedule and many non monetary items (McManis & Monslave Associates, 2004; Office of Personnel Management [OPM], 2006). There is limited research related to the degree of support provided to nurses fulfilling FLM positions (Spence Laschinger, Shamian, & Thomson, 2001).

In addition, nurses with administrative support feel more valued (Aiken, Smith, & Lake, 1994; McGirr & Baker, 2000). If nurses experience job satisfaction, hospitals have less staff turnover, lower nursing vacancy rates and improved employee loyalties (Aiken et al., 1997; Bumgarner & Beard, 2003; Duffield, Aiken, O'Brien-Pallas & Wise, 2004; Erickson, Holm & Chelminiak, 2004). A limitation of the research reviewed is that it groups all nurses together. Research focusing specifically on FLMs is lacking.

### *2.2.5 Professional Development*

Environments that foster high personal-regard, self-awareness, and self-esteem in FLMs enable them to more effectively provide their staff with positive reinforcement and encouragement, thereby promoting staff learning and growth (Davidhizar, 1993). Care and Udod (2003) note that, "there exists limited empirical data on the competencies needed of first-line managers within the Canadian health care context" (p. 2). Therefore, they conducted a descriptive, exploratory study of FLMs in a Western Canadian province to assist in the

understanding of the FLMs' perceptions of their role competencies in the competency categories of technical, human, conceptual, leadership, and financial management. They found that the nurse managers had varied perceptions of their abilities surrounding each of the managerial competencies and wanted more professional development opportunities that would enable them to successfully achieve their professional goals. Although the relevance of findings to Saskatchewan is not known, they are of interest because this is one of the few Canadian studies reported in the literature. Further research is needed to explore the perceived rewards and challenges FLMs experience as they attempt to meet the expected competencies to successfully fulfill the role of FLMs.

Jarman (1992) conducted a predominately descriptive study that surveyed top level administrators employed in both acute and long-term facilities in rural and urban communities in Saskatchewan. Although her study did not include FLMs, the results are of interest as the study took place in Saskatchewan. Jarman found that the majority of these top-level administrators had a diploma in nursing as their highest level of preparation. They acquired their administrative positions because of their seniority and clinical expertise because, as Jarman says, "a good clinical nurse is automatically expected to become a good nursing administrator via osmosis" (p. 68). Neither diploma nor baccalaureate prepared managers in her study believed that their basic nursing education adequately prepared them to fulfill their administrative roles. Those who were diploma prepared were unsure as to the level of education needed to fulfill these administrative positions whereas those with baccalaureate and master's preparation identified master's preparation as being required. All identified the need for continuing education focusing on nursing administration topics and standards.

A study by Gould et al. (2001a) focused on clinical nurse managers employed at four acute care hospitals in the United Kingdom. The researchers found that nurse managers who perceived themselves as receiving minimal to poor educational preparation in areas related to their job expectations reported less job satisfaction. They also explored the managers' perceptions of their continuing professional development needs and made recommendations for future educational programs to meet the expressed needs. Research exploring Canadian FLMs' perceptions of their continuing professional development needs is lacking.

In Ontario, Rush, Bajnok, Grinspun, Matthews, and McCutcheon (2005) found that FLMs require comprehensive knowledge and unique skills based on the fundamentals of leadership. "In order to support, promote and sustain the role of the nurse manager (NM), it is essential that educational resources and opportunities be responsive, relevant, accessible and affordable" (p. 2). The purpose of their study was threefold: to explore which aspects of the NM role are particularly demanding and may require further education; to formally scan the educational offerings specific to the NM role; and to identify gaps in needs verses available education as a base for strategic educational programming for nurse leaders (Rush et al., 2005). Similar research would be beneficial in Saskatchewan as Rush et al. (2005) state that results of their study will "...serve as a base for defining current role demands, educational need, learning styles, preference and barriers. The gap analysis will facilitate the preparation of a slate of strategic initiatives to support the NM role..." (p. 2).

### *2.2.6 Innovation and Creativity*

Gilmartin (1999) notes that as FLMs face the immense challenges in today's health care environments, creativity and innovation are essential for the evolution of professional practice, improvement in care delivery and organizational performance, and success in meeting the needs

of health care service. Professional nurses have the expertise, knowledge and ability to meet complex consumer needs but innovation, change and creativity are challenges facing FLMs as they often function in environments with high expectations, large workloads, stress, and limited resources. FLMs and their staff require environments that provide them with time, resources and support to be creative and innovative in their daily activities.

Sullivan, Baumgardner, Henninger, and Jones (1994) examined how nurse managers at Johns Hopkins Hospital spent their time. On the basis of their findings, Sullivan et al. developed an orientation/education program for nurse managers to strengthen their ability to perform in their role. This orientation/education program “linked learning opportunities for new and existing nurse managers to the strategic objectives of the organization and the development of nursing” (Sullivan et al., 1994, p.34). A one-year program evaluation was completed by 52 of the participating nurse managers who reported that participating in the orientation/education program enabled them to achieve a higher degree of independence in meeting their new performance standards and that unit culture had changed to include characteristics of innovation (Henninger, Jones, Baumgardner, & Sullivan, 1994).

Gould et al. (2001b) examined nurse managers’ perceptions of factors affecting role performance by interviewing fifteen clinical nurse managers in four trusts in the United Kingdom. The results revealed that the managers tended to dislike the financial and human resource aspects of their role as they felt they lacked knowledge in these areas. In addition, the managers expressed concern about the lack of support they received for increasing their knowledge of technology, with some commenting that they were responsible for familiarizing themselves with the computer system on their own time and at their own expense. On the other

hand, these managers derived satisfaction from providing quality environments for their patients and staff, and making decisions and changes that had a positive impact on service delivery.

### *2.3 Summary*

An overview of the literature and conceptual framework used for this study has been discussed. It is evident that FLM roles are multiple and complex. FLMs are caught between constraints in financial and human resources as they lead their staff towards providing quality patient care in healthy work environments. Further research at the level of the FLM is essential. Sharing their perceptions of their work environments with others can lead to strategies to support the FLMs and improve their work environments.

## CHAPTER 3

### Methodology

This chapter describes the procedure used for this study of the perceptions FLMs in Saskatchewan have of their practice environment. The design, setting, sample, ethical considerations, instrument, and procedures are discussed.

#### *3.1 Design*

This study examined Saskatchewan's FLMs' perceptions of their work environments, adapting the descriptive survey design used by Remus et al. (2000) in their study of staff nurses. A structured questionnaire incorporating both open and closed questions was used (refer to Appendix A for questionnaire). According to Burns and Grove (2005), descriptive research "is used to generate new knowledge about concepts or topics about which limited research has been conducted" (p. 44). A descriptive design was appropriate for this study because there are few published reports on the work environments of FLMs.

#### *3.2 Setting*

According to Saskatchewan Health (2001), most hospitals in Saskatchewan are in smaller communities. These hospitals "fill an important role for the local residents, providing basic medical and emergency services, a place to recover after surgery or a bed for observation" (p. 33). Smaller cities have mid-sized hospitals responsible for providing residents with a wide variety of basic medical services and commonly needed surgeries and diagnostic tests. The two largest cities have the largest hospitals providing an extensive range of specialized care. "They have the necessary volume of patients and the critical mass of doctors and other health care providers needed to deliver quality, high specialized programs" (p. 33). Saskatchewan Health (2001) describes six hospitals in communities between 15,000 and 40,000 individuals as regional

hospitals. Regional hospitals provide services that include “24 – hour emergency services; general medical services for adults and children; low complexity surgeries; and low-risk deliveries of babies” (p. 36). There are five provincial hospitals in the two major cities providing the services of those of regional hospitals plus many specialized services, that “include tests such as MRI scans and a wide range of surgeries and specialized medical services such as cancer treatment, heart surgery or intensive care for infants” (Saskatchewan Health, 2001, p. 39).

### *3.3 Sample*

The total population of 113 FLMPs in regional (FLMRs) and provincial (FLMPs) hospitals in Saskatchewan was invited to participate in this study. Nurse managers in other health care institutions were not included in this study as their roles are not necessarily similar to FLMRs or FLMPs. All FLMPs and FLMRs in Saskatchewan are English-speaking RNs or RPNs. They practice out of scope and are responsible for a particular team or group that delivers nursing services. They hold first level management positions, and are accountable to a General Manager, Director or Vice President. See result section for response rate (4.2) and demographics (4.3) of participants.

### *3.4 Ethical Considerations*

A cover letter (Appendix B) outlining the study and noting that there were no foreseeable risks to the participants was provided to the FLMPs. The letter explained that completion and return of the questionnaire implied consent. Potential participants were made aware that their participation was strictly voluntary, and that confidentiality and anonymity would be maintained. No names appeared on any data collected. To ensure confidentiality as the research was being conducted, all data were stored in a locked box in a secure area at the researcher’s home. Following the completion of this study, all data will be safeguarded and securely stored for five

years by Professor Barbara Smith, Thesis Chairperson and Professor at the College of Nursing, University of Saskatchewan.

This study received ethical approval from the University of Saskatchewan Behavioral Research Ethics Board in September 2004 (Appendix C). In addition, approval for the implementation of this study was obtained from each Health Authority, in accordance with their specified policies. A cover letter (Appendix D) and questionnaire (Appendix A) were sent to the Chief Executive Officer (CEO) in each affected Health Authority, to obtain consent to conduct this research at the named hospitals in their Health Authority. All health authorities granted permission to conduct this research within the requested facilities.

### *3.5 Instrument*

Remus et al. (2000) developed a questionnaire that was “based on the literature and input from the Saskatchewan Registered Nurses Association (SRNA) and the Saskatchewan Union of Nurses (SUN)” (p. 1). The questionnaire of Remus et al. was adapted, based on the literature, so that it was applicable to FLNs and reflected the six QWI of the CNA’s Quality Professional Practice Environments framework. The questionnaire contained a likert – type scale and also incorporated open-ended questions that enabled respondents to elaborate on their perceptions of their work environments (Appendix A). Responses to the open-ended questions were transcribed, examined for categories, and themes were identified and reported to further elaborate on the quantitative data (Streubert & Carpenter, 1999).

Remus et al. (2000) established content validity of the original instrument by pretesting it with a group of staff nurses. Because that study focused on staff nurses, literature related to FLNs was reviewed to modify the questionnaire by adding, deleting and rewording some of the questions to make it appropriate for FLNs. The literature review contributed to content validity.

In addition, the modified questionnaire was pilot-tested to reestablish face and content validity and to detect construction defects (Converse & Presser, 1986; Dillman, 2000; Peterson, 2000; Polit & Beck, 2004). In the pilot-test, the modified questionnaire was completed by five FLMs employed at a long-term care (LTC) facility. These FLMs had similar roles to FLMs in provincial and regional hospitals but worked in a LTC facility and were therefore not eligible for inclusion in the study. The LTC managers provided feedback to the researcher on the content, clarity, and appropriateness of questions and the time it took to answer the questionnaire. Subsequently the only change made was to the cover letter (Appendix B), extending the time to complete the questionnaire to approximately 30 to 40 minutes.

### *3.5.1 Methods of Measurement*

The questionnaire (Appendix A) was divided into three sections. The first section, open-ended in nature, asked participants to describe their roles, responsibilities, rewards, and challenges in their practice environments. The second section contained a Likert type scale and focused on the FLMs' perception of their practice environment. The six QWI categories as identified in the CNA's Quality Professional Practice Environments framework were used in the analysis to sort the items into six subscales: control over workload; nursing leadership; control over practice; support and recognition; professional development; innovation and creativity. This became the Environment Perception Scale (EPS). As Polit and Hungler (1999) suggest, there were an equal number of positively and negatively worded statements that were scored so the high scores consistently reflected the positives (Appendix E). Each statement was rated on a 4-point Likert scale. Positive statements were assigned the following scores: 0 = not applicable; 1 = disagree; 2 = disagree somewhat; 3 = agree somewhat; 4 = agree. Negative statements were assigned the following scores: 0 = not applicable; 1 = agree; 2 = agree somewhat; 3 = disagree

somewhat; 4 = disagree. A weighted average response was calculated by adding up the assigned points, “which ...are scored according to the direction of favorability expressed” (Polit & Hungler, 1999, p. 358) for all the respondents in the group answering the question and dividing by the number of respondents. The score for each question was thus between 0 and 4. Group and sub group (total FLM group and FLMP and FLMR subgroups) scores were compared. The mean values on the subscales were also compared. Respondents were invited to make additional comments at the end of the EPS to clarify, expand, or add any information.

The third section of the questionnaire focused on demographic data, including education, employment history, and years until retirement.

### *3.6 Procedure*

To maximize survey response, Dillman (2000) suggests that the researcher include: “(1) a respondent-friendly questionnaire, (2) up to five contacts with the questionnaire recipient, (3) inclusion of stamped return envelopes, (4) personalized correspondence, and (5) a token financial incentive that is sent with the survey request” (p. 150). In keeping with Dillman’s (2000) suggestions, the following procedure was designed to promote as high response rate as possible.

The researcher planned to make initial telephone contact with the senior manager in each identified hospital, in order to obtain a list identifying the FLMS in the hospitals in which the study was proposed. An overview of the study, as described in the cover letter (Appendix B) would be discussed and, if requested to do so, the researcher would meet with the senior manager or provide a copy of the cover letter and questionnaire.

To personalize the study as recommended by Dillman (2000), the researcher planned to first contact each FLM by telephone at work and invite him/her to participate in the study and then to meet with the researcher who would explain the study, answer questions and encourage

participation. Ideally, the meetings in a particular hospital would occur in a group. Rather than offering a financial incentive as suggested by Dillman (2000), it was planned to provide beverages and muffins at the group meetings. During the meeting, the researcher would provide an overview of the study as described in the cover letter and personally provide each FLM with an envelope containing a cover letter (Appendix B), questionnaire (Appendix A), a postage paid, addressed return envelope for the questionnaire, and a postage paid, addressed postcard (Appendix F), to be sent separately to the researcher if the FLM wanted a summary of the results of the study. The postcard would be mailed separately from the questionnaire to maintain anonymity of respondents. If an FLM was unable to attend the meeting, the researcher would deliver materials to his/her mailbox on their unit, make an appointment to talk with him/her by phone, and arrange an individual meeting if necessary.

Completed questionnaires were to be sent to the home of the researcher. Following the delivery of the survey packages to the participants, three yellow follow up postcards (Appendix G) would be mailed to each FLM at his/her place of employment, two to three weeks apart, thanking the FLM for participating and reminding those who had not responded, to do so.

Upon receipt of an envelope containing a questionnaire, the researcher would remove the questionnaire and immediately shred the envelope and put the questionnaire into a locked box. The locked box would be kept in a secure place in the researcher's home. There would be no way to identify the individuals who had responded. The only identification would be color coding of the questionnaire to identify participants as either provincial or regional employees. Data collection was to start in September 2004 and be completed in November 2004.

In response to situations beyond the control of the researcher, modifications to the planned data collection process were necessary. Every senior manager or their assistant

requested information to be either faxed or hand delivered to them. Therefore, a senior manager information package was put together and included a cover letter requesting permission from the Chief Executive Officer (CEO) and their Health Authority to conduct this research at their hospital/hospitals (Appendix D) and both the application sent to the University of Saskatchewan Behavioral Research Ethics Board (this included the questionnaire, Appendix A) and the letter of approval (Appendix C) received from them. The senior manager or their assistant indicated they would then discuss and share the information package with their CEO.

To ensure confidentiality and anonymity of the participants, a broad overview of the data collection procedure implemented for each hospital will be described. The six regional hospitals are designated as hospitals R1-R6 and the provincial hospitals as P1-P5.

### *3.6.1 Regional Hospitals*

In September 2004, the researcher spoke on the telephone with either the senior manager or their administrative assistant and provided them an overview of the study. The senior manager information package was faxed as per request. In November, the researcher had received permission from three senior managers that the research could be conducted in their hospital (R1-R3). The list of names and telephone numbers of the FLMs were provided to the researcher by either email or telephone. The three senior managers responsible for R4-R6 indicated that their FLMs were presently unable to participate in this study as their workloads were heavy and they were pressed for time.

*3.6.1.1 Hospitals R1-R3.* The researcher either contacted each FLM in R1-R3 directly by phone or left a voice message introducing the researcher, providing an overview of the study, and extending an invitation to meet the researcher. The meetings proceeded as outlined and

survey packages were distributed. Those FLMs who met the researcher took the survey packages to the other FLMs who were unable to attend. Reminder cards were mailed as planned.

*3.6.1.2 Hospitals R4-R6.* In January 2005 the researcher had received permission from the senior managers from R4 and R5 that the research could be conducted in their hospitals. In April, the senior manager from R6 granted permission. The senior managers from R4-R6 provided the researcher with the names of the FLMs, while R4's lists also included the FLMs telephone numbers and R5's list identified the FLMs email addresses. The lists provided by R4 and R5 enabled the researcher to contact each FLM either by telephone, voice message or email so that the researcher could introduce herself, provide an overview of the study, and extend an invitation to meet the researcher. The senior manager of R6 coordinated the meeting between the researcher and the FLMs so no personal contact was made between the researcher and the FLMs prior to the meeting.

The meetings with the FLMs were planned to occur in the hospital and in a group setting. However, this was not always possible and in some instances meetings occurred elsewhere, resulting in some FLMs having to stay at the hospital and work rather attend the meeting. At one facility, the FLMs forgot about the meeting and only two FLMs were in the facility and able to meet with the researcher. In another facility the researcher arrived and discovered that the only FLM at work in the facility that day was presently working as a staff nurse in the unit as they were short of nurses. The meeting with this FLM was short on the unit.

If an FLM was unable to attend the meeting, the researcher had planned to deliver materials to his/her mailbox on their unit, make an appointment to talk with him/her by phone, and arrange an individual meeting if necessary. Instead, the FLMs from each facility who met

with the researcher took the survey packages for their colleagues who were unable to attend the meeting.

### 3.6.2 *Provincial Hospitals*

The five provincial hospitals are located in two different health regions. The researcher was required to obtain separate approval from each health region (Region A and B) prior to conducting the study.

3.6.2.1 *Region A*. In September 2004, the researcher spoke with two senior managers from Region A and was advised to contact the VP of Nursing for permission to implement the study in the region hospitals (P1, P2, P3). The researcher spoke on the telephone with an administrative assistant in the corporate office for the health region and was asked to provide the senior manager information package along with the region's completed application for approval to conduct a research project in the health region. In October, the CEO's administrative assistant forwarded the application package to a senior manager. In November, the administrative assistant sent the researcher an email stating that the senior manager had approved the study (Appendix H). An appointment was made through the administrative assistant for the senior manager to telephone the researcher to discuss the study. In December, the researcher and the senior manager spoke on the telephone. The researcher was informed that the senior manager had forwarded the application package with her signature of approval, to the region's research unit. Later in December, the manager of the research unit telephoned the researcher indicating that the researcher needed to revise the previously submitted application for approval to conduct the research by obtaining a signature from the researcher's supervisor (not previously requested) and updating the start date and time lines because the application form was in system longer than expected. Changes were made as required and in January 2005, the health region provided

approval for the research. Following a telephone conversation with the administrative assistant, the researcher obtained the list of the names and work telephone numbers of the FLMs employed in Region A hospitals.

In January 2005, the researcher spoke on the telephone with one of the FLMs from each of the provincial hospitals in the region providing overview of the study and arranging a meeting date and time at each facility. Prior to the meeting at P1 the researcher telephoned and left voice messages with half of the FLMs and spoke directly with the others, informing them about the prearranged meeting between the researcher and the FLMs to discuss the study. The initial FLMs contacted from P2 and P3 requested that the researcher not telephone their colleagues prior to the meeting.

The researcher met with the FLMs at P1 and P2 in March and the meetings proceeded as outlined and the survey packages were provided. All FLMs at P1 attended the meeting. The FLMs from P2 who did not attend the meeting had their survey packages hand delivered to their mailboxes. In addition, the researcher was able to informally meet or leave telephone messages each with them. Each FLM from P1 and P2 was provided an overview of the study and encouraged to participate. Reminder cards were mailed as planned except for those who had put their name and return address on the envelope of the returned surveys. They did not receive reminder cards when they were mailed out.

On the date of the meeting with the FLMs of P3 the researcher was ill. Subsequently, the researcher hand delivered the survey packages to the units of the FLMs at P3 and the researcher either spoke with each FLM in person or left a telephone message introducing herself, providing an overview of the study and encouraging participation. Reminder cards were mailed as planned.

3.6.2.2 *Region B*. In September 2004, the researcher spoke on the telephone with an administrative assistant in the corporate office for Region B. The researcher faxed the senior manager the information package and a completed application for approval to conduct research in the health region. In October, the researcher received a letter from the VP indicating that March would be a better time for data collection in their hospitals and to request permission later. In December, the researcher reapplied, suggesting data collection begin in March. In January 2005 the researcher received a certificate of approval from the health region (Appendix I) to proceed with the study. In February 2005, the researcher received a list of the names and work telephone numbers of the FLMS in the hospitals (P4 and P5).

In March 2005, the researcher spoke by telephone with one of the FLMS from Region B, introduced herself and provided an overview of the study. Arrangements were made for the researcher to attend the April FLM meeting at each provincial facility in the region. The FLM requested that the researcher not telephone the other FLMS prior to the meeting.

April 2005, the researcher met FLMS from P4 and P5. The meeting proceeded as outlined and survey packages were distributed. At the meeting, it was identified that one of the FLMS attending the meeting was not on the researcher's list of FLMS. The FLMS then provided the names and mailing addresses of other FLMS whose names were not on the list. The next day the researcher mailed the survey packages the FLMS. The FLMS who did not attend the meeting and were on the researcher's list had their survey packages hand delivered to them by other FLMS.

### 3.6.3 *Miscellaneous Modifications*

The data collection process was from October 2004 to May 2005 rather than September to November 2004. Modifications to data handling occurred. It was initially planned that upon

receipt of an envelope containing a questionnaire, the researcher would remove the questionnaire and immediately shred the envelope and put the questionnaire into a locked box. Occasionally the researcher was able to identify the hospital from which the survey was returned. Because the sample population was small (113), and the researcher has had, or continues to have, relationships with some of the participants; to ensure anonymity, the researcher put all of the unopened, returned questionnaires into a locked box until completion of the data collection process. On May 27<sup>th</sup>, all returned surveys were opened and the envelopes shredded. No further questionnaires were received after May 27<sup>th</sup>.

Initially, the surveys were to be color coded to facilitate separation of responses from regional and provincial hospitals. Ultimately, however, to remove any differences between the surveys, they were coded on the right upper corner. The code 01 was used to represent participants from regional hospitals and 02 participants from provincial hospitals. Questionnaires were separated into FLMR and FLMP piles and then the pages were separated into piles by page.

### *3.7 Summary*

FLMs employed in regional and provincials hospitals in Saskatchewan were surveyed to examine their work environment, using a descriptive survey design. Adaptations to planned methodology were required to meet organizational diversity. To maximize survey response a variety of strategies were implemented. Data collection began in October 2004 and was completed in May 2005.

## CHAPTER 4

### Results

This chapter describes the analysis procedure and results for this study of the perceptions FLMs in Saskatchewan have of their practice environment. Demographic information and FLMs' perceptions of their roles and responsibilities, rewards and challenges, and practice environments are included.

#### *4.1 Description of Data Analysis*

Descriptive statistics were used to describe the total group of respondents and the two subgroups, FLMPs and FMLRs. The Statistical Package for Social Sciences (SPSS) Version 10.0 was used to analyze the quantitative data, with statistical significance set at 0.05 and a confidence interval of 95%. The mean and standard deviation were determined for the overall EPS and for each of the subscales. Two-tailed t-tests were used to make comparisons between the FLMPs and FLMPs because there was no prior hypothesis. Narrative responses were transcribed, examined for categories, and themes identified to provide further elaboration of the quantitative data (Streubert & Carpenter, 1999).

#### 4.2 Response Rate

The overall response rate was 61.1% (n=69). The FLMPs had a higher response rate than did FMLRs. A two-sided Pearson chi-square revealed no significant difference between groups (see Table 4.1).

**Table 4.1 Response Rate**

	FLMP	FMLR	Total
Distributed	79	34	113
Returned	46	23	69
Rate (%)	58.2	67.6	61.1

\*Significance level < .05

FLMP = Front - line manager employed in provincial hospital

FMLR = Front - line managers employed in regional hospital

### 4.3 Demographics

#### 4.3.1 Nursing Education

4.3.1.1 *Basic nursing education.* FLMPs were asked to identify their initial RN/RPN program. The vast majority (85.5%) reported diploma preparation and 14.5 % a nursing degree as shown in Table 4.2.

**Table 4.2 Basic Nursing Education**

	FLMR (n=23) n (%)	FLMP (n= 46) n (%)	Total (n=69) n (%)	Significance (two-tailed)
Diploma in Nursing	20 (87.0)	39 (85.0)	59 (85.5)	.971
Bachelor's Degree in Nursing	3 (13.0)	7 (15.0)	10 (14.5)	

\*Significance level < .05

FLMP = Front - line manager employed in provincial hospital

FLMR = Front - line employed in regional hospital

A two-sided Pearson chi-square revealed no significant difference in the distribution between the groups.

4.3.1.2 *Formal education after basic education.* FLMPs were asked to identify their formal education over and above basic entry level. Certificates such as Advanced Cardiac Life Support, Intermediate Life Support, Basic Life Support and other education mandated by the employer were excluded. Of the 69 FLMPs, most had at least one other qualification. Other qualifications included certificates in areas such as geriatrics, health care administration, nursing administration and various CNA certifications and an assortment of other courses. Pearsons Chi-Square revealed no significant differences between the groups.

FLMs were asked to identify if they had completed a bachelors degree in nursing or in another field after their initial nursing program (i.e. post diploma program). Of the 69 respondents, 27.5 % (n= 19) had completed a post diploma Bachelor of Science in Nursing (BSN), 13 % (n = 3) of FLMRs, and 34.8 % (n=16) of FLMPs. While the percentage of FLMPs with post diploma nursing degrees is considerably higher, a two-sided Pearson chi-square revealed no significant difference between groups. Of the 69 FLMs, 4 had a bachelor's degree in another field. One was an FLMR and 3 were FLMPs. Numbers were too small for analysis.

FLMs were asked if they had completed a masters degree in nursing or in another field. Five FLMs (7.2 %) had a master's degree in nursing. All were employed in provincial hospitals. Five had a master's degree in a field other than nursing. One was an FLMR and 4 were an FLMPs. Numbers were too small for analysis. There are no FLMs with a doctoral degrees in nursing or in another field.

Of the 69 FLMs, 46% (n=32) presently have a BSN through either an initial or post diploma program, nine (28%) FLMRs, and 23 (72%) FLMPs. While the percentage of FLMPs with nursing degrees is considerably higher, a two-sided Pearson chi-square revealed no significant difference between the groups.

#### 4.3.2 *Hours of Work*

FLMs were asked first how many hours they were expected to work per week (see Table 4.3), and then how many they actually worked (Table 4.4).

Only one FLM, an FLMR, is expected to work nineteen hours or less per week. Three quarters are expected to work twenty to thirty nine hours per week, and the remainder forty or more hours per week. There were no significant differences between groups (see Table 4.3)

**Table 4.3 Hours Expected**

Hours per week	FLMR (n=23) n (%)	FLMP (n= 44**) n (%)	Total (n=67) n (%)	Significance (two-tailed)
≤ 19	1 (4.3)	0 (0)	1 (1.5)	.349
20 – 39	16 (69.6)	34 (77.3 %)	50 (74.6)	
≥ 40	6 (26.1)	10 (22.7 %)	16 (23.9)	

\*Significance level < .05

\*\*Two FLMPs did not answer this question

FLMP = Front - line manager employed in provincial hospital

FLMR = Front - line manager employed in regional hospital

One FLM, an FLMR, actually works fewer than 20 hours per week. The vast majority (88.2 % [n=60]) actually work forty to fifty nine hours per week with 4, all FLMPs, reporting working sixty or more hours. No significant differences were found between groups (see Table 4.4).

**Table 4.4 Actual Hours**

Hours per week	FLMR (n=23) n (%)	FLMP (n=45**) n (%)	Total (n=68) n (%)	Significance (two-tailed)
≤ 19	1 (4.3)	0 (0)	1 (1.5)	.190
20 - 39	3 (13.0)	0 (0)	3 (4.4)	
40 – 59	19 (82.6)	41 (91.1)	60 (88.2)	
≥ 60	0 (0)	4 (8.9)	4 (5.9)	

\*Significance level < .05

\*\* One FLMP did not answer this question

FLMP = Front - line manager employed in provincial hospital

FLMR = Front - line manager employed in regional hospital

FLMs were asked to identify their usual hours of work. Most (89.6 %, n=60) work eight hour shifts. There were no significant differences between groups. In addition to their scheduled hours of work, 52.2% (n=12) of FLMRs and 47.8 % (n=22) of FLMPs are required to be on call. No significant differences were found between groups. The FLMs who take call indicated that they had to manage a variety of situations when on call including clinical and patient issues and trouble shooting regarding hospital policy. Frequency of call varied greatly, from one week three

times a year to whenever the FLM is not at work (except for holidays). There were no significant differences between groups.

#### *4.3.3 Years in Current Position*

More than half of the FLMs (52.9% n=36) have been in their current position five years or less, 19.1% (n=13) six to ten years, 23.5% (n=16) eleven to twenty years, and 4.4 % (n=3) twenty one to thirty years. There were no significant differences between groups.

#### *4.3.4 Years as a FLM*

Of the total group, 34.8% (n=24) have been FLMs five years or less, 23.2% (n=16) six to ten years, 26.1% (n=18) eleven to twenty years, 14.5% (n= 10) twenty one to thirty years, and 1.4% (n=1) thirty one to forty years. There were no significant differences between groups.

#### *4.3.5 Years Employed by Health Region*

In the total group, 8.7% (n=6) had been employed by their health region five years or less, 8.7% (n=6) six to ten years, 23.1 % (n=18), eleven to twenty years, 39.1% (n= 27) twenty one to thirty years, and 17.4% (n= 12) thirty one to forty years. No significant differences were found between groups.

#### *4.3.6 Changed Agencies*

FLMs were asked if they changed agencies within the last five years either voluntarily or on request of their employer. No one was required to change, but 20.3% (n=14) chose to do so. There was no significant difference between groups.

#### *4.3.7 Years Practicing as an RN/RPN*

The vast majority of FLMs had been practicing for more than twenty years, with only one of 69 practicing ten years or less. There was no significant difference between groups (see Table 4.5).

**Table 4.5 Years Practicing**

Years	FMLR (n=23) n (%)	FLMP (n= 46) n (%)	Total (n=69) n (%)	Significance (two-tailed)
≤ 10	0 (0)	1 (2.2)	1 (1.4)	.487
11 - 20	6 (26.1)	8 (17.4)	14 (20.3)	
21 - 30	12 (52.2)	20 (43.5)	32 (36.4)	
31 – 40	5 (21.7)	17 (37)	22 (31.9)	

\*Significance level < .05

FLMP = Front - line manager employed in provincial hospital

FLMR = Front - line manager employed in regional hospital

#### 4.3.8 Years to Retirement

Over 40% of FLMs (44.8% n=30) plan to retire in five years or less and another 29.9% (n=20) in six to ten years. Only three (4.5%) plan to be practicing in more than 15 years. No significant difference was found between the two groups (see Table 4.6).

**Table 4.6 Years to Retirement**

Years	FLMR (n=22**) n (%)	FLMP (n=45**) n (%)	Total (n=67) n (%)	Significance (two-tailed)
≤ 5	7 (31.8)	23 (51.1)	30 (44.8)	.312
6 - 10	10 (45.5)	10 (22.2)	20 (29.9)	
11 - 15	4 (18.2)	10 (22.2)	14 (20.9)	
16 - 20	1 (4.5)	1 (2.2)	2 (3.0)	
21 - 25	0 (0)	1 (2.2)	1 (1.5)	

\*Significance level < .05

\*\* Not all FLM respondents employed in regional & provincial hospitals answered this question

FLMP = Front - line manager employed in provincial hospital

FLMR = Front - line manager employed in regional hospital

#### 4.4 Environment Perception Scale

Section two of the survey was the EPS, a Likert type scale consisting of 30 questions comprised of six subscales: control over workload; nursing leadership; control over practice; support and recognition; professional development; innovation and creativity (Appendix E). During analysis of the EPS, the positively and negatively worded statements were scored so that high scores consistently reflected the positives. Mean scores were calculated for each question, subscale and total scale for the total group and the two subgroups. When the mean scores of the

30 individual items were compared for the groups using t-tests, there were no significant differences.

The maximum mean score on each subscale was 20 (see Table 4.8). The EPS responses reflected positive perceptions (mean  $\geq 13.48$  [over 67%]) of the work environment on all subscales except control over workload (mean = 9.35 [below 50%]). Of the subscales scored positively, nursing leadership scored highest with a mean of 16.65 (83%). The other four positive means were 13.48 – 13.95 (67% - 70%). FLMPs had a slightly higher positive perception score on all scales than did FLMRs, except for the control over workload subscale (see Table 4.7).

**Table 4.7 Environment Perception Scale Scores**

QWI	FLMR			FLMP			Total		Significance (two-tailed)	
	n	Mean	SD	n	Mean	SD	n	Mean		SD
Nursing Leadership	23	16.65	1.72	44**	16.68	2.30	67**	16.67	2.10	.96
Control Over Practice	23	13.83	2.79	46	14.22	2.90	69	14.09	2.85	.59
Support and Recognition	22**	13.95	2.23	45**	14.55	2.53	67**	14.36	2.43	.35
Professional Development	23	13.87	3.11	45**	14.33	2.32	68**	14.18	2.60	.49
Innovation and Creativity	23	13.48	2.95	46	15.22	2.43	69	14.64	2.72	.01*
Control Over Workload	23	9.35	2.74	46	8.59	2.50	69	8.84	2.59	.25

\* Significant difference  $p < .05$

\*\* Not all respondents answered each question

QWI = Quality work life indicators

FMLR = Front - line manager employed in regional hospitals

FLMP = Front - line manager employed in provincial hospitals

Independent sample t-test revealed no significant difference between the groups except on the innovation and creativity subscale.

**Table 4.8 Subscale comparison of FLMRs and FLMPs**

	df	t	Significance (two-tailed)
Nursing Leadership	65	-.05	.96
Control Over Practice	67	-.53	.59
Support and Recognition	65	-.95	.35
Professional Development	66	-.69	.49
Innovation and Creativity	67	-2.61	.01*
Control Over Workload	67	1.15	.25

\* Significant difference  $p < .05$

Note: Equal Variance Assumed

QWI = Quality work life indicators

FMLR = Front - line manager employed in regional hospitals

FLMP = Front - line manager employed in provincial hospitals

Following the EPS, space was provided for respondents to write comments. Thirteen of the 69 respondents (18.84%), six FLMRs and 7 FLMPs provided additional information. Comments revealed that FLMs perceive themselves as having heavy workloads with minimal time, resources, support and financial rewards.

#### *4.5 Open Ended Questions*

FLMs were asked to describe their perceived roles and responsibilities, rewards and challenges in their work environments. Responses were examined for categories and themes were identified.

##### *4.5.1 Perceived Roles*

The themes that emerged from FLMs' perceived roles in the practice environment were management, administration, education, and leadership. FLMs strive to fulfill these perceived roles on their own unit/units and when covering other units when their colleagues are away.

*4.5.1.1 Management.* FLMs identified management, including supervision, and resource and personnel management as one of their roles. Fulfilling the role of a supervisor involves providing direction, leadership, performance management and support for staff. FLMs described their role as resource manager as including good stewardship, keeping staff informed, utilizing available personnel, developing business plans for new incentives, staffing, capital submissions and equipment purchasing. Managing personnel involves recruiting and hiring staff and ensuring collective agreement guidelines are followed. It also includes addressing "workload/staffing issues by performing duties such as contacting appropriate staff, and/or scheduling, approving overtime, vacation and leave of absences." (FLMR)

*4.5.1.2 Administration.* FLMs are involved with various administrative functions, a range of assigned projects and covering for senior managers in their absence. FLMs participate in accreditation, development, monitoring and amending of quality monitoring and risk management programs, and service monitoring such as quality and safety.

*4.5.1.3 Education.* FLMs act as resource persons for various individuals. As they collaborate with other health team members they are directly or indirectly involved with education. Descriptions of the FLMs educational role included:

- “Promote, support, and bring education programs to the staff.” (FLMR)
- “active involvement in staff education, teaching or facilitating required training, advocating for educational opportunities and needs for staff in region and provincially (conferences etc.)”. (FLMP)

*4.5.1.4 Leadership.* FLMs described providing leadership through role modeling as they abide by the organization’s policies, procedures, vision, mission, and philosophies in their daily activities. They are responsible for creating/maintaining a positive, productive work environment that enhances staff morale, fosters respect, builds trust and encourages open communication. Comments relating to the leadership role included:

- “Take a lead role in analysis of current and future requirements of the area, initiating the development of specific goals and objectives and setting priorities for planning and implementing strategies.” (FLMR)
- “Be a change agent – includes introducing ideas about how to improve on current practices by altering current methodologies, introducing and facilitating changes that have been developed by the facility and/or the region.” (FLMP)

#### 4.5.2 Perceived Responsibilities

FLM's perceived responsibilities fell into the themes of policy, advocacy, evaluation, coordination, accountability, staffing, and continuing education.

*4.5.2.1 Policy.* FLMS noted that they are responsible for the development, implementation and monitoring of policies, procedures and care pathways as health team members strive towards quality patient care. They reported the following:

- Establishing nursing standards, evidence based practice, facility policies and procedures to set standards of nursing care.” (FLMR)
- “Development, implementation and monitoring of resources, procedures, and standards for the region.” (FLMP)

*4.5.2.2 Advocacy.* FLMS describe advocacy for clients, staff and employers as one of their responsibilities, despite budgetary constraints, increases in workloads and operational limitations. They noted the following:

- “Patient advocate - acting on behalf of the client to ensure the provision of safe and informed care.” (FLMP)
- “Ward - advocacy.” (FLMR)

*4.5.2.3 Evaluation.* FLMS identified responsibility for evaluation in several areas as follows:

- “Monitor departmental performances by creating and reviewing statistical records, indicators and provide regular reports.” (FLMR)
- “Evaluation of new resources.” (FLMP)

- “Monitor and create quality control checks as it pertains to patient care and equipment used on patients.” (FLMR)

4.5.2.4 *Coordination*. FLMs recognized coordination as one of their responsibilities.

They described arranging staff meetings, ambulance transfers and circulation of operating room slates to appropriate departments. They also coordinate other activities including:

- “Coordination and supervision of case delivery.” (FMLR)
- “Coordinates on-going patient care.” (FMLR)
- “Facilitate/coordinates nursing research activities – regional.” (FLMP)
- “Coordinate booking of surgical cases with in patient/day surgery beds and staffing.” (FLMP)
- “Participate in planning/coordination and/or presenting at professional conferences.” (FLMP)

4.5.2.5 *Accountability*. There were many circumstances in which FLMs identify themselves as being accountable to others. They are accountable for the daily activities of the unit/units, ensuring quality patient care through integration of multidisciplinary teams, adequate/appropriate staffing and utilization of resources, and the evaluation of nursing care. They reported the following:

- “Ensuring standard patient care, policies and procedures are followed to provide quality patient care.” (FLMP)
- “Accountability for care of clients and evaluating nursing care.” (FLMR)
- “I am responsible for the day to day activities of the ward.”(FLMR)
- “Accountable for integration of clinical care delivery and multidisciplinary professional practice.” (FLMP)

*4.5.2.6 Staffing.* FLMs are responsible for the daily staffing on the unit/units. An FLMP summarized the many comments made by FLMs describing their staffing responsibilities.

- Human resource management – hiring, performance reviews, and issues (formal and informal), setting up orientation, mentoring and supporting staff (professional and non professional) – in work and family issues, discipline, union partnership, occupational health and safety, scheduling, staffing, vacation, sick time management. (FLMP)

*4.5.2.7 Continuing education.* FLMs described being a resource person as one of their responsibilities. Some FLMRs did not have an individual in a formal staff educator position resulting in their being involved in orientation and other education activities. FLMs reported the following:

- “Teaching and recertifying staff in various transfer of function.” (FLMR)
- “I am called upon to be a resource person by my staff and by my peers.” (FLMP)

### *4.5.3 Perceived Rewards*

The themes that emerged when FLMs described what was most rewarding in their practice environments included change agent, teamwork, recognition by others, relationships, working with patients, and control over practice.

*4.5.3.1 Change agent.* FLMs are involved in the change process as it affects individuals and events. They described a sense of satisfaction when they participate, influence, and witness the benefits of positive change. They described the following as rewarding:

- “Implementing change that is identified as positive by staff and improves patient care.” (FLMR)
- “Change management in a unit – when you have time to plan, involve staff,

be there to support and celebrate success from start to finish.” (FLMP)

FLMs may experience a sense of gratification when they feel as though they have had a positive influence on others. Comments FLMs made included:

- “Realizing at the end of day, you have made a difference to some one of staff/family/patient/co – workers.” (FLMP)
- “Although I feel quite overwhelmed at times, I do have a feeling of accomplishment when I am able to complete some project that improves patient care and helps the staff.” (FLMR)

FLMs expressed a sense of pleasure as they effectively empowered individuals, encouraged continuing education, and facilitated growth and development of their staff. They enjoyed observing seasoned staff mentoring students and new staff. FLMs describe how observing staff growth has been a positive experience for them.

- “Development of broad scope of strategies to work with, mentor and bring out the best in those I work with.” (FLMP)
- “The fact that I have empowered them to actually be team leaders and create positive change within their work place and how they do business.” (FLMR)

*4.5.3.2 Team work.* FLMs described being part of a team, developing teams and promoting teamwork as being positive. They received gratification participating on teams where there was mutual respect and trust and where physicians, service aides, unit clerks, RN’s and Licensed Practical Nurses are treated as being equally important to the team.

- “Being part of a team – is a good feeling.” (FLMP)
- “The trust and team work I have been able to develop amongst the staff (nursing and physicians) in my department.” (FLMR).

4.5.3.3 *Recognition by others.* FLMs suggested that they experienced a sense of reward when they or their staff received recognition from others:

- “It is also very rewarding when a patient or their family come to you and tell you what a good job the staff are doing and what good nursing care they give.”

(FMLR)

or when their opinions were sought and listened to.

- “It is also rewarding to plan and strategize and have those opinions valued by senior management and supported.” (FLMP)

4.5.3.4 *Relationships.* FLMs described their ability to maintain relationships with staff, supervisors, peers, patients’ families and health team members as a positive experience. They placed a high value on relationships. For example, one FLMP said:

- “The only thing that I find rewarding in my job is the fostering of a great working environment. As a unit we have a great respect for one another and I am proud to be a part of that.”

Other comments included:

- “I have many visitors in my office throughout the day to chat – touch base. My open door policy is very rewarding. I could go on and on . . .” (FLMP)
- “Having interaction with the patients and families, is the most rewarding part of my job.” (FLMR)
- “Relationships – especially with managers and colleagues but also very much with staff members.” (FLMP)
- “Camaraderie of the other nurse unit managers. Used this forum for moral support and problem solving in difficult situations.” (FLMR)

4.5.3.5 *Working with patients.* Opportunities to provide direct patient care are limited for FLMs. They identified assisting in direct patient care as very rewarding.

They reported the following:

- “Opportunities (rare) to assist in direct patient care are very rewarding.” (FLMP)
- “Working with the patients” (FLMR)

4.5.3.6 *Control over practice.* FLMs described making decisions, working independently, and having a sense of autonomy and flexibility in their practice environments as rewarding.

- “Autonomy and latitude in decision making.” (FLMR)
- “Can function without micromanagement from middle or upper administration. Can do my job without having to report details to my supervisor.” (FLMR)
- “The flexibility of the job – to be able to set my own pace, develops my own priorities.” (FLMP)
- “I like being able to function independently.” (FLMP)

FLMs appreciate the flexibility their position allows them. If they do not take call, work nights or weekends this is viewed positive.

- “Hours of work fit well with my family life. No nights, no weekends.” (FLMR)
- “The fact that we are no longer on call. We were forced to do this at one time.” (FLMR)
- “Independence – able to flex hours (taking time back at my convenience, for meeting attended etc).” (FLMP)
- “Able to take holidays with minimal restrictions (as long as I arrange coverage of my unit with another manager)” (FLMP)

#### 4.5.4 Perceived Challenges

FLMs faced a variety of daily challenges. Comments FLMs made included:

- “The challenge – I would hate to be in a job where there is no problems to fix, problems to solve.” (FLMP)
- “I love a challenge and most days it is very challenging trying to juggle my schedule to get things done.” (FLMR)
- “Variety in my day. It is a busy job with challenges but it is not boring and predictable.” (FLMR)

The themes that emerged from FLM’s perceived challenges included personnel issues, putting out fires, relationships, lack of control, lack of support and recognition.

*4.5.4.1 Personnel issues.* FLMs perceived a variety of personnel issues as challenges. A number referred to difficulties presented by collective agreements.

- “Union issues. Differences in interpretation of contract.” (FLMR)
- “Most challenging is staffing, staff development etc. within the confines of a collective agreement. Having to chose employees in seniority driven system-not always able to get more suitable vs. most senior.” (FLMR)

Daily interactions with various personalities was at times a challenge as FLMs described:

- “Dealing with sick time/family leaves: the legitimate use of sick and family time give me no concern. However, the abuse of the above is not acceptable. Finding methods to appropriately deal with staff is a challenge.” (FLMP)

- “Confrontation of difficult or inappropriate behavior of staff is certainly challenging and taxing. Sometimes getting staff members to recognize and own their behavior is a huge challenge.” (FLMP)

One FLMR noted that she found it stressful to refuse staff members time off such as vacation when she did not have the casual staff to replace them.

*4.5.4.2 Putting out fires.* Identifying problems or potential problems in the practice environment and attempting to minimize or solve them fall into the category “putting out fires.” Some FLMs described spending much of their time as putting out fires. Frequent interruptions to put out fires resulted in frustration, mental exhaustion and fragmentation of their ability to complete daily work.

- “Frequently the day is spent reacting to issues and problem solving. At the end of the day one often feels like nothing much has been accomplished.” (FLMP)
- “Have many interruptions in this job where you drop whatever you are doing to deal with something else.” (FLMR)

*4.5.4.3 Relationships.* Relationships can be challenging in the FLMs’ practice environment. Some of their comments included:

- “Dealing with a variety of staff members, physicians, support staff, etc. and utilizing diplomacy when you have little time. Sometimes it is tempting to be more direct!” (FLMR)
- “Families are very challenging. They can zap every bit of time and energy out of you.” (FLMR)
- “Director and senior management often have a confrontational working relationship which I feel is a detriment.” (FLMP)

*4.5.4.4 Lack of control.* It is challenging when FLMs experience feelings of not having control within their work environment. Many described experiencing feelings of lack of control when their work environment did not support their professional practice, increased their sense of autonomy, encouraged/support change or enable them to participate in organizational decisions. FLMs constantly deal with staffing issues and the challenges associated with budgeting and accessing and restricting use of often minimal resources. Maintaining a balance within the system was a challenge. Some comments reflecting lack of control included:

- “I also find that physicians seem to have more powers than nurses when it comes to senior management and this create difficulties when patient care issues arise.” (FLMR)
- “Middle management [sic] is a position sandwiched between front line staff levels and administration. Frequently it is very difficult to find the balance between the two layers.” (FLMP)

FLMs perceived budgeting as a great challenge in their practice environment. They said:

- “Maintaining a balance between fiscal responsibilities and a high standard of care for patient and staff is my greatest challenge.” (FLMR)
- The continued balancing of maintaining quality standards of care with depleted funds, aged equipment, exhausted staff. Government restriction of finances while attempting to promote a healthy work environment.” (FLMR)
- “Limited financial resources often force the staff to work with equipment that is very old technology or the equipment has frequent break downs. Replacement is very difficult.” (FLMP)

- “Not much control over financial expenditure. Physician’s practices – determine drug costs. Type of patients on the unit – determine supply costs. Unions and patient satisfaction – determine staffing cost.” (FLMP)

There were FLMPs who perceived themselves as not always participating in the organizational decisions. Some of their comments included:

- “When senior leadership does not ask or listen to ideas/suggestions from this level.” (FLMP)
- “The health region is huge – the structure complex – it’s hard to know who makes the decision - sometimes wonder if anyone even makes a decision anymore.” (FLMP)
- “Change is often a secret and we are ultimately asked to explain and implement even though we may not have been part of the decision making process.” (FLMP)
- “Trying to get approval for change to take place as necessary (trying to get concerns addressed by senior management and CEO).” (FLMR)
- “Finding a voice with senior management is challenging without a nurse representative in that category.” (FLMR)

*4.5.4.5 Lack of time.* Many FLMPs perceived that they did not have enough hours in the day to complete their work. Some of their comments included:

- “No time for quality improvements or visioning with staff.” (FLMP)
- “Not enough time to complete my duties”. (FLMR)
- “No time to communicate with staff related to operational goals, visions or supportive practice.” (FLMP)

- “Finding the time to complete all my duties in a timely fashion. With so many duties I find that sometimes things take so long to work through all levels that they get lost.” (FLMR)
- “I never feel like I am caught up in my work.” (FLMP)

*4.5.4.6 Lack of support and recognition.* Some FLMs were challenged as they perceived themselves as receiving minimal to no support and recognition. Some of their comments included:

- “Lack of support for specific duties i.e. budget, discipline.” (FLMR)
- “Although there is ‘lip service’ given to the statement --- feeling valued, it is rare to feel valued in this position.” (FLMP)
- “Physicians still think they are right no matter what and they give little respect to our roles as nurse managers.” (FLMR)
- “Lack of respect and recognition – no perks in this position.” (FLMP)

In some situations, perception of inequitable monetary rewards led FLMs to experience feelings of lack of recognition. Comments included:

- “Salary! I make less than a majority of my staff – all are experienced employees with up to 42 years of service.” (FLMP)
- “In this region they have frozen the salaries of the out of scope manager although the CEO took a raise.” (FLMR)
- “Inequities from one manager position to another. Salaries are definitely not fair.” (FLMP)
- “Inequities – similar areas have such different levels of support (staff, education funding). Manager benefits not equal, wages not equal, standards for hire varies -

degree is a requirement but not followed. Managers without a degree making same wage I am (but should be less). Creates no incentive for me to advance/take classes as I feel there is minimal recognition.” (FLMP)

- “Expectation to put in extra time without compensation.” (FLMP)

#### *4.6 Summary*

The EPS and narrative responses provided an overview of the multiple roles and responsibilities, rewards and challenges perceived by FLMPs. FLMPs had positive perceptions of their work environment on all EPS subscales except control over workload. The independent sample t-test for equality of means revealed no significant difference between the groups except on the innovation and creativity subscale. Narrative comments revealed many areas of dissatisfaction.

## CHAPTER 5

### Discussion

Healthcare is constantly changing. Saskatchewan has experienced a shortage of nurses, regionalization, shifting managerial structures, increasing technology, organizational reform, and strengthening of the multidisciplinary nature of healthcare. Across the nation attempts are being made to ensure health care team members have quality work environments. Change affects FLMs. The paucity of literature examining the perceptions FLMs have of their work environment prompted this study.

This study provided FLMRs and FLMPs in Saskatchewan an opportunity to share their perceptions of their work environments. In this chapter, the CNA's Quality Professional Practice Environments framework is used for discussion of the study results. As the nursing community within Saskatchewan is relatively small, and the researcher has had or continues to have relationships with some of the FLMs, minor alterations in the planned data collection process and analysis and reporting of aggregate versus individual hospital responses occurred to ensure anonymity and confidentiality.

#### *5.1 Discussion of Findings*

##### *5.1.1 Response Rate*

The total population of 113 FLMs in regional and provincial hospitals in Saskatchewan was invited to participate. Over 60% chose to do so. FLMRs had a higher, although not significant, response rate than did FLMPs, perhaps because the researcher was able to personally contact more FLMRs than FLMPs.

This study's response rate is higher than Remus et al. (2000) whose response rate was 47%. The higher response rate may be a result of the increased personal contact the researcher

had with the invited participants and the token of food and beverage that was provided as an incentive to participate in the study.

The researcher's original intent was to make initial telephone contact with each senior manager responsible for the FLMS. In some health regions the researcher encountered difficulties identifying the appropriate senior manager. In some instances, all communication between the researcher and senior manager was done through the senior manager's assistant, making communication difficult and drawn out. Response rates might have been higher if the researcher had been able to speak directly with each senior manager to foster administration's support for the study.

The process and time involved in receiving approval to conduct research in the health authorities varied. Once approval was obtained, the researcher followed procedures as outlined by senior managers to obtain the list of FLMS. The procedure was inconsistent from setting to setting. Two of the lists were incomplete and although the researcher made efforts to include all of the FLMS at the designated hospitals, the number of FLMS invited might have been lower than the actual number of FLMS.

Dillman (2000) suggests that multiple attempts should be made to contact invited participants. The number of contacts made with each FLM varied. Sometimes the researcher was asked not to contact the FLMS prior to the meetings. In other facilities, FLMS were contacted either through telephone or email. Response rates might have been higher if all eligible participants were contacted prior to the meetings. Face to face meetings with the FLMS helped to personalize the study and may have increased the response rate, as Dillman (2000) suggests. Making personal contact with each FLM is a challenge in today's health care practice environments as FLMS may lack time to personally meet with researchers or even complete a

survey. Usually FLMs at the meetings took packages to those not there. The researcher assumes that the packages were distributed as agreed but there was no way to know for certain.

During the meetings, the FLMs were provided an explanation of the study, anonymity and confidentiality were reinforced, and questions, although minor and few in number, were addressed. Emphasizing that anonymity and confidentiality would be maintained was important to maximize the response rate and promote accuracy and honesty of responses. The researcher was aware that FLMs might be suspicious of their work environment, as they have experienced a variety of changes, challenges and issues, often resulting in poorer quality working environments and making it difficult for them to trust. Reinforcement of confidentiality was also important since the researcher had been nursing in the province over twenty years and with a relatively small nursing community and numerous opportunities to network, the researcher personally knew many of the FLMs. The researcher provided participants with a postage paid, addressed postcard for each FLM to send to the researcher to request a summary of the results of the study. Fifty eight returned the postcard indicating high interest in the study results.

It was initially planned that upon receipt of an envelope containing a questionnaire the researcher would remove the questionnaire and immediately shred the envelope and put the questionnaire into a locked box. The data collection process was from October 2004 to April 2005 rather than September to November 2004 as planned. On occasion, because the study period was so protracted, the researcher was sometimes able to identify the hospital from which the survey was returned. If the researcher had opened envelopes and read the responses it would not have been difficult to identify the respondents as they described their roles and responsibilities in a particular hospital. Anonymity was ensured by the researcher putting all of the unopened returned questionnaires into a locked box until completion of the data collection

process. Following completion of data collection all returned surveys were opened and the envelopes shredded. Questionnaires were separated into FLMR and FLMP piles and then the pages were separated into piles by page.

### *5.1.2 Demographics*

*5.1.2.1 Education.* This study with 81.2% of FLMs reporting a diploma as their basic preparation is consistent with Remus et al's. (2000) findings where 80% of staff nurse respondents received a diploma from their basic nursing program. According to the Canadian Institute for Health Information [CIHI] (2002), since the 1990's Canada has seen a substantial increase in the number of RNs entering practice with a bachelors degree in nursing as the diploma programs across Canada have been eliminated. This trend is not apparent in this study because so many FLMs have been in practice for many years. FLMs were asked to identify completion of formal education programs, following the FLMs initial basic entry level RN/RPN education program. According to CIHI (2002), there is a larger number of RNs from urban centers in comparison to rural (defined as outside populations of 10,000 or more) who are upgrading their academic nursing qualifications. Regional hospitals were in smaller centers and had a population between 15,000 and 40,000 individuals. However, results from this study show a trend similar to that identified by CIHI as a higher percentage, although not significantly so, of FLMPs had completed a post basic BSN than had FLMRs. Several FLMs had completed an Advanced Nurse Specialist (ANS)/Nurse Practitioner (NP) diploma program. FLMs might benefit more from completing education in areas of leadership because an ANS/NP promotes clinical rather than administrative expertise.

Just under half of the FLMs presently have a BSN (either as their basic or post basic nursing education), 28% of FLMRs, and 50% of FLMPs. Although the percentage of FLMPs

with nursing degrees is considerably higher, there was no significant difference between the groups. This is higher than the CIHI (2005) finding that in 2004, 29.8% of RN's employed in nursing in Canada and 27.9% in Saskatchewan have a BSN. The much higher percentage found in this study is a positive finding because BSN programs are designed to provide a broad educational base and to develop leadership skills.

Several factors affect individuals pursuing a post basic BSN in nursing, including their age, the number of years left until retirement, incentives, desire, and accessibility of programs. FLMPs may have a greater percentage of individuals with a post basic BSN as they live in urban communities where access to post secondary education is relatively easy. However, increasing opportunities for distance education may minimize these differences. In addition, as of 2000, the minimal educational qualification for entry into nursing practice in Saskatchewan is a BSN, resulting in an overall increase in RNs with a BSN. Although those without a BSN may feel pressure, three quarters of the participants in this study have been practicing more than twenty years, decreasing the likelihood of their pursuing a BSN if they did not already have one.

Jarman's (1992) study of top-level administrators found the majority had a diploma in nursing as their highest level of preparation with only 19.3% of top-level administrators having a BSN and 1.8% a Masters in Nursing and 3.5% a masters in something other than nursing. The results of the current study are very positive as it revealed that a higher percentage of FLMPs have baccalaureate or masters education than did top level administrators in 1990. This bodes well for the future.

*5.1.2.2 Hours of work.* According to A. Fornwald, Manager of Labour Relations at the Saskatoon Health Region (SHR) (personal communication, April 25, 2006) FLMPs are expected to work 37.5 hours per week. FLMPs in SHR receive 12 paid days off per year (one per month) in

addition to regular holidays to make up for extra hours worked over the 37.5 hours per week.

This is an SHR policy. Each health region has its own policy. Development and implementation of a cross regional policy would help ensure equity among FLMs. The vast majority of FLMs (88.2%) work forty to fifty nine hours per week, with 6% working sixty hours or more hours per week.

Over 90% of FLMs were working more than forty hours per week, likely related to heavy workloads. Many FLMs revealed that they felt as though they were never caught up. Inability to complete job expectations or to do the job in a reasonable number of hours may lead to an imbalance in personal and professional lives, decreased job satisfaction, and burnout. As Canada is facing a nursing shortage, it is imperative that nurses be retained. Although workloads are heavy, FLMs still find rewards, such as some flexibility when it comes to taking time owing and holidays. Such flexibility is a key retention strategy as it provides a sense of control, and fosters a balance between professional and personal lives (Thorpe & Loo, 2003; Upenieks, 2003). Nonetheless, it was clear FLMs' workloads must be made more manageable.

In addition to their scheduled hours of work, slightly over one third of FLMs were required to be on call. The frequency of call varied greatly, as did situations they have to manage while on call. While on call, FLMs did a great deal of trouble shooting and dealing with crises. Being on call was perceived as difficult, particularly because of already extremely heavy workloads. FLMs often worked over 40 hours a week and were then on call without any additional compensation. This may lead to further emotional and physical exhaustion, decreased job satisfaction, and burnout. To recruit and retain FLMs, organizations must provide realistic workloads, compensation, and quality work environments.

*5.1.2.3 Anticipated retirement.* More than three quarters of FLMs had been practicing nursing for more than 20 years. Not surprisingly, an almost equal number plan to retire within 10 years. This would be expected, comparing a management nurse group to a staff nurse group. These results were higher than Remus et al. (2000) whose respondents identified that 45% worked over 20 years with 37% planning to retire in less than five years. Attempting to predict the exact number of retirees was difficult as “to date relatively little research has been undertaken examining RNs’ retirement age or whether the average age of retirement has changed over time” (Canadian Federation of Nurses Union [CFNU], 2006, p. 12). Baumann and O’Brien-Pallis (2001) conducted a study that identified 55-58 years as being the average age of retirement of Ontario nurses. Nurses’ ability to retire is associated with a variety of factors, such as financial resources, personal health, and ability to perform job requirements. Most FLMs have many years of nursing experience. With their experience comes a wealth of knowledge and expertise that will be a challenge to replace, especially as there is a nursing shortage. It is imperative that staff nurses be recruited and mentored into FLM positions and that FLMs be recruited and retained. This means that there must be quality work environments with a mixture of senior and junior nurses.

### *5.1.3 Quality Professional Practice Environment*

*5.1.3.1 Control over workload.* It was evident that FLMs were striving to fulfill a variety of intertwined and multidimensional roles and responsibilities. This was expected as the literature identifies a wide and enlarging variety of FLM roles and responsibilities (Anthony, et al., 2005; Kleinman, 2003; Kramer, Schmalenberg & Maguire, 2004; Lageson, 2004; Parsons, & Stonestreet, 2003; Persson, & Thylefors, 1999; Rogers, 2005; Spence Laschinger et al., 2004; Thorpe, & Loo, 2003; Wieck, 2005). FLMs play a vital role in the management of transitions.

Whiley (2001) states that “the role of the nurse manager of an acute or critical care unit is the most difficult role in health care” (p. 356).

FLMs are attempting to fulfill expanding roles and responsibilities, and to address increasingly complex issues (Thorpe & Loo, 2003; Walker, 2001). These expanding roles and responsibilities affect the workload of FLMs. The lowest score on the EPS was on the control over workload subscale. Comments made by FLMs indicated their perceived roles to include administration, education, leadership, and management of staff, resources and personnel. Their perceived responsibilities were policy, advocacy, evaluation, coordination, accountability, staffing and continuing education. In addition, the majority of FLMs spend considerable time orientating and educating their staff. Provincial hospitals have individuals in educator positions responsible for orientation and education of staff. This was not necessarily the case in regional hospitals. Having an educator would decrease the workload for the manager in the area of staff education. The EPS subscale, control over workload, revealed that the majority of FLMs were expected to cover additional areas/units if another FLM were away, are were not able to take their meal/coffee breaks, often felt pressured to complete all their paper work, often felt pressured because they didn't have time to do all that they wanted to do, and were dissatisfied with the number of hours they worked. One FLM noted that there were “many interruptions in this job where you drop whatever you are doing to deal with something else.” Further research on the impact changing roles and responsibilities have on FLMs in relation to their control over workload is required, followed by changes to give FLMs more control over their workloads. The results of the current study are similar to Thorpe and Loo's (2003) study. Their findings were that FLMs are experiencing changes involving expansion of their jobs with an emphasis on efficiency, and that their roles are continuing to evolve.

The results of this study were similar to Remus et al. (2000) as the front-line nurses identified that they function in environments with heavy workloads, often working short staffed as a result of inability to replace nurses. They expressed concern with their ability to provide quality patient care as they function in an environment that provides them with limited time to carry out this expectation. Front-line nurses experienced frustration in that they feel as though they did not to a good job. The frustration of front–line nurses must be dealt with by FLMs, further adding to their workloads.

As FLMs attempt to meet high expectations of themselves, senior management, staff and the public, they face many challenges, including limited resources and heavy workloads. There are FLMs who enjoy the variety and challenges in their positions. However, many find it difficult to fulfill all the demands and expectations. Caution must be taken when adding new roles and functions without deleting old ones as chaos and overwork will occur (Kramer et al., 2004). As McGillis Hall and Donner (1997) and Spence Laschinger, et al., (2004) suggest, research in this area is needed to determine appropriate roles, responsibilities, and workloads for FLMs.

*5.1.3.2 Nursing leadership.* FLMs identified leadership as one of their roles. Results of the EPS indicated FLMs perceived nursing leadership positively within their work environment. On the nursing leadership subscale, the majority of FLMs indicated they were well informed on matters in their workplace, there was high productivity on the unit/units they managed, there were strong feelings of belongingness on the unit/units they managed, and they were involved in professional activities. To maximize the recruitment and retention of FLMs, further research on nursing leadership within the work environment is required as strengths must be recognized and reinforced.

The perceptions of FLMs in the current study were similar to those found in the literature (Dixon, 1999; Scott et al., 1999; Trofino, 1995; Ward, 2002) as they described striving to achieve quality work environments for themselves and their staff. They perceived themselves as being knowledgeable and valuing education and professional development of all nurses in the organization. They were responsible for creating, instilling, and clarifying the value system of the organization and attempted to be visible, supportive, and responsive to the staff as described in the literature (Dixon, 1999; Scott et al., 1999). Finding the time to fulfill these expectations was a challenge.

Kramer et al. (2004) described the majority of nurse managers as having begun their nursing careers in an era where nursing leadership was not an expected role of the nurse manager. This was true of the FLMs in the current study, resulting in the need for leadership behaviors to be learned. The majority of managers of nursing employed in magnet hospitals are master's prepared and presumably have learned leadership theory and skills in their graduate programs. Of the FLMs in this study, only 5.5% (n=5) had a Master's Degree in Nursing. All were from provincial hospitals. Five (one FMLR and four FLMP's) had a Masters Degree in a field other than nursing. Because leadership is now an expected role for nurses and is included in BSN programs, and BSN is the minimum educational qualification for entry into nursing practice, new graduates should have increased knowledge in relation to leadership and will be prepared for graduate studies. As more graduate programs become available at both masters and doctoral levels and become available by distance, nurses will have increased opportunities to pursue graduate level education. FLMs will require support, including financial assistance and leaves from work, to assist them in furthering their education.

FLMs perceived themselves as leaders who assist staff to move towards the vision, mission, and goals of the agency. To achieve this, it is critical that communication between leaders and staff remains open and free flowing, particularly regarding reasons for change, intended outcomes, and timely feedback (Alexander, 1998; Dixon, 1999; Fisher, 1993; Fullam et al., 1998; Kerfoot, 1998; Leveck & Jones, 1996; Lynch, 1994; Scott et al., 1999). Contrary to the EPS results, FLMs commented on open communication being a challenge at times. They did not always participate in organizational decisions and was not well informed by senior management resulting in a practice environment that lacks trust. The disparity between the results of the EPS and narrative comments may be explained by the low reliability of the EPS.

Comments in this study were similar to results in Remus et al.'s (2000) study of front-line nurses where the majority felt as though they had little opportunity to influence policy and procedures. They felt their ability to participate in the decision making process was minimal. The situation must improve for FLMs before it can improve for front line nurses.

*5.1.3.3 Control over practice.* FLMs perceived control over practice positively within their work environment according to the score on the EPS. When examining each item in the subscale, the majority indicated they were satisfied with the amount of responsibility they had, felt comfortable making administrative decisions, and perceived that in their job they can practice independently within their scope of practice. However, they also identified dissatisfaction with the amount of control they had over their working conditions and what went on in the unit/units they managed. In written comments, some FLMs described a lack of control and being in a work environment that did not support their professional practice. They had a minimal sense of autonomy and did not receive support or encouragement when implementing change. They were unable to actively participate in organizational decisions. Instead, they were

constantly dealing with staffing issues and feeling as though there were not enough hours in the day to complete their work. Environments where resources were minimal were continuously challenging.

FLMs found it rewarding when they were involved in decision making, worked independently, and had a sense of autonomy. Senior management must build upon this as “the literature is abundantly clear that autonomy is the most important determinant of job satisfaction and retention and that it figures very strongly in the productivity of quality care” (Kramer & Schmalenberg, 2004, p. 46). Results of this study were also consistent with the literature that suggested work environments must support the FLMs’ professional practice, enable them to participate in organizational decisions, and provide them with sufficient support to enable them to have control over their practice as they fill their multiple roles (Gould et al., 2001a; Health Canada, 2002; Lowe, 2002; Scott et al., 1999; Spence Laschinger et al., 2001). The results were also similar to Remus et al.’s (2000) study as the front-line nurses experience gratification when their work environment enables them to practice with autonomy, independence and a high degree of responsibility.

To maximize the recruitment and retention of nurses into FLM positions, attempts must be made to ensure FLMs have control over their practice. A participatory structure that is a visible, viable, and well supported throughout the organization is essential. Governance councils or committees may be the first step (Kramer & Schmalenberg, 2004). FLMs must be involved in decision making and have autonomy, manageable workloads, and adequate resources if they are to meet the goals and expectations of the agency and to find their job rewarding. Research related to the degree of support needed and provided to nurses fulfilling FLM positions would be useful.

*5.1.3.4 Support and recognition.* Results of the EPS support and recognition subscale indicated FLMs perceived support and recognition positively in their work environment. When examining each item in the subscale, the majority of FLMs indicated that they were provided opportunities to participate in the administrative decision making process, were satisfied with the amount of praise and recognition their immediate supervisor gave them for their work, physicians respected their knowledge, and the staff appreciated them. At the same time, they also identified that organizations were not providing them with plenty of opportunities for advancement.

These results reinforced previous research that support and recognition, control over practice, and positive collaboration between nurses and other health team members contribute to positive perceptions of work environments (Rafferty et al., 2001; Spence Laschinger & Havens, 1996). One of the rewards identified by FLMs was being part of a team with open and respectful relationships and members treated equally. Written or a verbal thank you from the public or members of the health team provided positive reinforcement.

However, some FLMs described little to no support and recognition in their work environment. They had minimal access to senior management and received little support from them. In addition, some perceived inequities existing among FLMs in relation to monetary rewards. To minimize feelings of inequity and enhance their internal motivation to self improvement, successes must be recognized and rewarded through the provision of competitive and equitable compensation and benefits. Nurses who are provided support and recognition experience job satisfaction that leads to less staff turnover (Aiken et al., 1997; Bumgarner & Beard, 2003; Duffield et al., 2004; Havens & Aiken, 1999; Spence Laschinger, Almost, & Tuer – Hodes, 2003). This must be recognized by organizations wanting to recruit and retain nurses in

the FLM positions. Research involving the support and recognition of nurses in their practice environment tends to group all nurses together. Further research focusing specifically on FLMs is required.

*5.1.3.5 Professional development.* Care and Udod (2003) noted that, “there exists limited empirical data on the competencies needed of first-line managers within the Canadian health care context” (p. 2). Nurse managers in their study had varied perceptions of their own abilities surrounding managerial competencies and wanted more professional development opportunities to enable them to successfully achieve their professional goals. Care and Udod (2003) found that FLMs attempted to be involved in continuing education but were faced with challenges such as work overload, minimal support from senior management and staff, and minimal financial and human resources. In the current study, FLMs identified similar challenges. They too, experienced heavy workloads and lack of time. Some FLMs cited lack of organizational rewards for pursuing education and perceptions that employers did not value education. Accessibility to continuing education programs and time away from work and family were important factors that may negatively affect individuals in participating. The literature reveals that if FLMs are to experience a sense of satisfaction in their careers, they require support and adequate resources for continuing education in areas such as financial management, negotiation skills, personnel development, conflict resolution, and leadership (McGillis Hall & Donner, 1997; Thorpe & Loo, 2003; Wieck, 2005).

The results of the EPS scale indicated FLMs positively perceived (mean = 13.87 [70%]) professional development within their work environment. When examining each item in the subscales, the vast majority perceived that their knowledge was current. Although most have access to current information that could assist them in their job, 15% did not. Just over half have

enough opportunities to attend continuing education/staff development, and perceived that their work provides them the opportunity to learn new skills. Almost all noted that FLMs did not receive adequate orientation when changing practice areas.

The situation for staff nurses in Remus et al's (2000) study was less positive, as front line nurses experienced minimal inservices and educational programs that assist them to remain current, and the educational resources they had locally were often outdated.

According to McGillis Hall and Donner (1997), FLMs who do not receive adequate orientation support and continuing nursing education will have difficulty adapting to and working in the job. FLMs must receive the support and education required. Each facility must assess their FLMs' educational needs and strategically develop plans to meet the needs. This might include conferences, courses or workshops in the development or strengthening of leadership behaviors.

*5.1.3.6 Innovation and creativity.* Effective, creative problem solving resulting in resourceful solutions flows from core knowledge and expertise (Amabile, 1997; Gilmartin, 1999). Gilmartin (1999) noted that professional nurses were creative in discovering solutions for complex patient care. In an environment that is continuously changing, FLMs and their staff use creativity to generate new ideas. As FLMs and staff are stimulated and supported to stretch their knowledge, skill, and abilities, professional nursing practice will evolve and improvements in organizational performance and care delivery will occur. In the current study, creating and maintaining a work environment that values innovation, change and creativity was challenging for FLMs as they were overworked, experienced frequent interruptions, insufficient resources and increased demands from consumers, employers and other health team members.

Gould et al. (2001b) examined nurse managers' perceptions of factors affecting role performance by interviewing fifteen clinical nurse managers in four trusts in the United Kingdom. The results of the current study were similar to those of that study as both identified FLMPs deriving gratification from providing quality environments for their patients and staff, and making decisions and changes that had a positive impact on service delivery.

On the innovation and creativity subscale, FLMPs perceived themselves as having more opportunity for innovation and creativity than did FLMRs. Independent sample t-test for Equality of Means revealed a significant difference between the groups. The differences may result from FLMPs having access to more resources and increased educational opportunities, and a larger number of easily available individuals to collaborate and problem solve with than do FLMRs. Nurses in larger provincial hospitals have more opportunities to participate in research than do nurses in the regional hospitals. This would mean that FLMPs perceived their work environment more positively than do FLMRs in providing them with opportunities to be creative and innovative such as participating in nursing research, writing and publishing, being able to introduce ideas into their work place, and having opportunities to be creative. On the other hand, the apparent difference between FLMPs and FLMRs may be related to low reliability of the scale as the alpha for the scale was low. Further research in this area would be beneficial, as innovation and creativity in nursing contributes to a quality work environment and there is paucity of research on this topic.

*5.1.3.7 Perceived rewards and challenges.* The themes that emerged from what FLMPs perceived as most rewarding in their practice environments included being a positive change agent, observing staff growth, teamwork, providing optimal care, recognition by others, relationships, opportunity to work with others, and having control over their work environment.

FLMs identified positive characteristics within their work surroundings that coincided with the QWIs identified in the CNA's Quality Professional Practice Environment framework. When goals are achieved and effective management of resources occurs, professional satisfaction emerges (Thorpe & Loo, 2003). FLMs identified professional satisfaction when they and their staff collaboratively worked through a change process. Some FLMs identified enjoying the people they worked with and being part of the team as gratifying. It was rewarding to be recognized as providing patients with quality care, participating in the development of health team members and feeling as though their actions as an FLM had positive effects on others. One FLMP said that "I stay in my job because I love it & I love the staff that works for me – we have a great relationship ... I try to recognize, as much as possible, their achievements & successes in their day to day practice".

Some of the perceived rewards, such as relationships, identified by many FLMs have also been recognized by several FLMs as challenges. Other themes emerging from what FLMs perceived as most challenging were putting out fires, balancing system/personnel relationships, staffing issues, resources, time, and salary. FLMs' described their span of roles and responsibility as, at times, having expanded beyond their control, resulting in unmanageable workloads and feelings of frustration and pressure. Winslow (2001) identified manageable workloads for nurses as vital. Results of the current study were similar to those of Thorpe and Loo (2003), both finding that FLMs experienced staffing as well as managerial frustrations.

Personal satisfaction is derived from balancing professional and personal lives, resulting in a high quality of life (Thorpe & Loo, 2003). Of the FLMs in this study, almost 90% work forty-one to fifty-nine hours per week, with four reporting working sixty or more hours. Some

nurses described that balancing their lives is a continuous struggle leading to frustration. When balance is achieved it is extremely rewarding.

Bethune, Sherrod, and Youngblood (2005) state that quality work environments “ensure fair and equitable workloads, scheduling flexibility, competitive compensation and benefits, opportunities for learning and advancement, and successfully blending professional work with personal lifestyles” (p. 2). In this current study FLMs identified that their work environment fell short in many of these attributes. FLMs in Saskatchewan are not protected by a union and are therefore vulnerable. To conquer challenges and promote quality work environments for FLMs, identifying and addressing challenges is essential. In a health care environment where there is a nursing shortage, it is beneficial for everyone to strive towards improving the work environment for FLMs. Attracting and retaining individuals in FLM positions is essential because FLMs play a vital role in the health care team.

In Remus et al's. (2000) study, the front-line nurses described feelings of frustration with the inflexibility of their work schedules and the problems associated with shift work. FLMs in the current study enjoy the flexibility of their work schedule and not having to work weekends. FLMs are similar to the front-line nurses as both groups identified feelings of frustration having to be on call, especially when not scheduled to work.

The EPS in this study focused on the perceptions FLMs' have of their practice environment. The narrative responses provided valuable insights and descriptions further elaborating the quantitative data.

*5.1.3.8 Environment perception scale.* The Cronbach's alpha reliability coefficients for the six subscales were: control over workload 0.286, nursing leadership 0.321, control over practice 0.362, support and recognition 0.307, professional development 0.487, and innovation

and creativity 0.463. The total scale was 0.669. A reliability coefficient of 0.80 or higher is generally considered acceptable (Gliem & Gliem, 2003). Therefore, caution must be taken when interpreting all results, including the significant difference found between the groups in the innovation and creativity subscale. Because it is based on a scale with low reliability, the significant difference could also be a spurious Type I error (rejection of the null hypothesis when it is really true) based on the 6 univariate tests. The low alpha values on all the subscales may be a result of the small number of items per category, the small number of respondents, or it may have resulted from the tool itself. The reliability of the tool might increase if more questions were added to each QWI category. Further development and testing of this tool would be beneficial.

*5.1.3.9 Conceptual framework.* The CNA's Quality Professional Practice Environments framework was the conceptual framework for this study. This framework enabled the researcher to effectively discuss the literature overview and study results in a conceptually clear manner. The six QWIs are intertwined with one another resulting in much overlap between these categories. This overlap was expected as the characteristics describing excellence within the concept of quality work environments are interrelated. Further development and implementation of this framework may strengthen the framework.

## 5.2 Limitations of Study

The researcher recognizes the following limitations of the study:

1. Although efforts were made to ensure confidentiality, anonymity, and to build trust, participants may not have answered accurately or may not have participated for fear of workplace repercussions.
2. There may be differences between FLMs who took the time and had interest in

participating in this study and those who did not. Follow up on nonresponders would have been informative.

3. The unanticipated lengthy data collection period may have introduced variables that affected either the response rate, the responses themselves, or both.

4. The EPS scale had low reliability. Caution must be taken when interpreting the results based on a scale with low reliability. Significant findings could also be a spurious Type I error (rejection of the null hypothesis when it is really true) based on the 6 univariate tests. The presence of significant results may be undetected by this scale based on the 6 univariate tests.

### *5.3 Recommendations*

The following recommendations arise from this study. It is recommended that:

1. Health regions in Saskatchewan develop and use consistent research approval protocols to simplify the process for researchers.
2. Education programs at all levels include expanded leadership and management content and provide opportunities for skill development.
3. Each provincial and regional hospital assess their FLMs' educational needs and strategically develop a professional development plan to meet those needs.
4. Roles and responsibilities of FLMs be clearly identified, realistic and manageable, and as much as possible consistent at least within a region.
5. FLMs be provided with realistic and equitable compensation and benefits.
6. Initiatives to foster high quality work environments targeted at FLMs be implemented.
7. Each provincial and regional hospital strategically develop a succession plan to meet the needs of individuals moving into FLM positions.

#### *5.4 Future Research*

Results of this study lead to the following recommendations for future research.

1. Further refinement of the EPS and replication of the study elsewhere would be beneficial.
2. Further research is needed to determine the degree of support and recognition FLMs receive. This would enable rewards to be identified and built upon and challenges acknowledged and addressed.
3. Innovation and creativity in FLMPs and FLMRs needs to be further studied to determine if the difference found in this study are real. If so, research should be initiated to determine how best to encourage innovation and creativity in FLMRs.
4. Research exploring the impact of changes in roles and responsibilities of FLMs must continue.
5. Research to examine the validity of using current QWI's to assess the work environment of FLMs should be conducted.
6. Further research should be conducted to determine differences between the workplaces of the FLMRs and FLMPs, and the FLMs themselves and measures implemented to improve work conditions.
7. To maximize the recruitment and retention of FLMs, further research on nursing leadership within the work environment is required, as strengths must be recognized and reinforced.
8. Further development and implementation of the CNA's Quality Professional Practice Environments framework may minimize the overlap and strengthen the framework.

### *5.5 Conclusion*

As the health care system experienced a complex tapestry of transitions in the past decade, FLMs strived to maintain a sense of stability for themselves and their staff in chaotic work environments. This study examined FLMs' perceived roles, responsibilities, and perceptions of their work environment, adapting the descriptive survey design used by Remus et al. (2000) in their study of staff nurses.

FLMs in this study described intertwined, multidimensional roles and responsibilities with both challenges and rewards. Study results offer senior administrators, professional associations, government, educators, and others an opportunity to increase their understanding and awareness of the perceptions FLMs have of their practice environment.

Organizations that truly want better work environments for their nurses and better outcomes for their patients and who want to attract the best nurses will take the information from surveys such as [this] ours, ask their nurses what resonates with them, listen to the answers, and then accept ownership of the problems and fix them (Ulrich, Buerhaus, Donelan, Norman, & Dittus, 2005, p. 11).

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Appendix A  
Questionnaire

## **SASKATCHEWAN'S FIRST-LINE MANAGERS' PERCEPTIONS OF THEIR WORK ENVIRONMENTS**

The purpose of this questionnaire is to find out how you, as a first-line nursing manager in one of Saskatchewan's provincial or regional acute care hospitals, perceive your practice environment.

There are three sections in this questionnaire. In the first section you will be asked to identify the rewards and challenges you perceive in your work environment. Section two presents statements reflecting how some first-line managers perceive their practice environment. When responding to the statements, you simply answer on a scale indicating the degree to which you agree or disagree with the statement. Section three of the questionnaire will ask for relevant demographic information about you. If you want to elaborate on any of your answers, please use the space provided or the other side of the page.

Some of the questions may **not** apply to you and you will be instructed to skip these questions. To ensure the results of this questionnaire are as complete as possible, please answer all the questions that **do** apply to you. There are no right or wrong answers.

Remember to think about your **own** work environment when answering the questions. Remember, also, that there will be no way that you can be identified as having participated.

**In this section please write your answers in the space provided. If you require additional space, please use the back of the pages.**

- 1. From your perspective, please describe your roles and responsibilities as a first-line manager. Be as specific and complete as you can.**

**2. Please describe what you find most rewarding in your practice environment. Be as specific and complete as you can.**

**3. Please describe what you find most challenging in your practice environment. Be as specific and complete as you can.**

The following section contains statements describing the way first line managers may perceive their practice environments. Use the scale provided (not applicable; disagree; disagree somewhat; agree somewhat; agree) to indicate the degree to which each statement represents your perceptions of your practice environment.

Please reflect on your own practice experiences as you respond to the statements.

Please respond to every statement in this section.

		Not Applicable	Disagree	Disagree Somewhat	Agree Somewhat	Agree
4	I am not expected to cover additional areas/units if another first-line manager is away.	<input type="checkbox"/>				
5	I am able to take my meal/coffee breaks.	<input type="checkbox"/>				
6	I rarely feel pressured to get all my paperwork done.	<input type="checkbox"/>				
7	I often feel pressured because I don't have time to do all that I want to do.	<input type="checkbox"/>				
8	I am dissatisfied with the number of hours I work.	<input type="checkbox"/>				
9	I am not well informed on the matters in my workplace.	<input type="checkbox"/>				
10	There is low productivity on the unit I manage.	<input type="checkbox"/>				
11	There are strong feelings of belongingness on the unit I manage.	<input type="checkbox"/>				
12	There is high efficiency on the unit I manage.	<input type="checkbox"/>				
13	I am not involved in professional activities.	<input type="checkbox"/>				
14	I am dissatisfied with the amount of responsibility I have.	<input type="checkbox"/>				
15	I am satisfied with the amount of control I have over my working conditions.	<input type="checkbox"/>				
16	I am not satisfied with the amount of control I have over what goes on in the unit/units I manage.	<input type="checkbox"/>				
17	I feel uncomfortable making administrative decisions.	<input type="checkbox"/>				

		Not Applicable	Disagree	Disagree Somewhat	Agree Somewhat	Agree
18	In my job I can practice independently within the scope of my practice.	<input type="checkbox"/>				
19	There is rarely an opportunity for me to participate in the administrative decision-making process.	<input type="checkbox"/>				
20	There are plenty of opportunities for me to advance in this organization.	<input type="checkbox"/>				
21	I am dissatisfied with the amount of praise and recognition my immediate supervisor gives me for my work.	<input type="checkbox"/>				
22	Physicians respect my knowledge.	<input type="checkbox"/>				
23	I know that the staff appreciates me.	<input type="checkbox"/>				
24	I feel that my knowledge is current.	<input type="checkbox"/>				
25	I do not have access to current information that would help me in my job.	<input type="checkbox"/>				
26	Adequate orientation is not provided for first-line managers changing practice areas.	<input type="checkbox"/>				
27	I have enough opportunities to attend continuing education/staff development events.	<input type="checkbox"/>				
28	My work provides me the opportunity to learn new skills.	<input type="checkbox"/>				
29	I do not have opportunities to participate in nursing research.	<input type="checkbox"/>				
30	I have opportunities to write and publish.	<input type="checkbox"/>				
31	I am expected to introduce new ideas in my workplace.	<input type="checkbox"/>				
32	My job is boring.	<input type="checkbox"/>				
33	I rarely have opportunities to be creative at work.	<input type="checkbox"/>				

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**This is the final section of the questionnaire. You will be asked a few questions about yourself and your employment. This information is important so that the results of the study can be put more clearly into the context of front-line nurse managers' lives.**

- 34 What basic nursing educational program led to you being licensed as a RN/RPN for the first time?

Diploma in Nursing.....

Bachelor's Degree in Nursing.....

Other.....

Specify \_\_\_\_\_

- 35 Please identify formal qualifications other than your basic program. Do not include certifications required by your employer such as ACLS, ILS, BLS, etc.

*Mark all that Apply*

Bachelors Degree in Nursing.....

Bachelors Degree in another Field.....

Please Specify \_\_\_\_\_

Masters Degree in Nursing.....

Masters Degree in another Field.....

Please Specify \_\_\_\_\_

Doctoral Degree in Nursing.....

Doctoral Degree in another Field.....

Please Specify \_\_\_\_\_

Advanced Nurse Specialist/Nurse Practitioner Diploma...

Other (Please Specify) \_\_\_\_\_

36 How many hours are you **expected** to work per week? \_\_\_\_\_

37 How many hours do you actually **work** per week? \_\_\_\_\_

38 What are your usual hours of work?

Days (8 hour) .....

Days (10 hour) .....

Days (12 hour) .....

Comments: \_\_\_\_\_

39 Are you required to be on call?

Yes  No

If no, skip to number 42.

40. What type of calls do you receive when you are on call?

Comments: \_\_\_\_\_

\_\_\_\_\_

41 How frequently are you on call?

Comments: \_\_\_\_\_

42 How long have you been in your current position? \_\_\_\_\_

43 How many years have you been a first - line manager? \_\_\_\_\_

44 How long have you been employed by this health region? \_\_\_\_\_

45 Have you changed agencies in the last 5 years?

Yes, my choice.....

Yes, required by agency.....

No.....

Comments: \_\_\_\_\_

46 How many years have you practiced as an RN/RPN?

\_\_\_\_\_

47 How many years until you plan to retire? \_\_\_\_\_

*Thank you for completing this questionnaire.  
Please put the completed questionnaire in the  
addressed and stamped envelope to*

*Return it to:  
Ms. Signy Klebeck  
330 Rossmo Road  
Saskatoon, SK  
S7N 2Y3*

Appendix B

Study Outline Cover Letter



November 2004

Dear Colleague,

My name is Signy Klebeck, a graduate student in the College of Nursing at the University of Saskatchewan. As part of the requirements for my Masters in Nursing degree, I am conducting a survey of first-line managers of nursing in Saskatchewan. This study was approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board in September 2004. First-line managers have a vital leadership role in health care. The study I am conducting will describe the perceptions first-line managers employed in regional and provincial hospitals in Saskatchewan have of their practice environments. You are being invited to participate in the survey titled "Practice Environment Perceptions of First-Line Managers of Nursing".

If you choose to participate, you will be provided with a survey that will take you approximately 30 to 40 minutes to complete. You do not have to answer any questions that you do not want to. The code on the survey indicates whether you are an employee of a Provincial or Regional hospital. It cannot be linked to you. Although I will know the names of the invited participants, no name or any other identifying information will be on the survey. There will be no way of linking a participant with particular responses or even knowing if a particular manager has participated.

**The data collected will be available and accessed only by the researcher and her supervisor.** Only aggregated results will be reported in my Masters thesis and in articles submitted for publications in professional journals and/or conference presentations.

Your participation in this study is *strictly voluntary*, but I hope you will take part. Your participation will help provide a more complete picture of the practice environments of first-line managers. While this study may not benefit you directly, it will provide first-line managers like yourself an opportunity to share their perceptions of their practice environments with others. There are no foreseeable risks associated with you participating in this study. If you decide to withdraw, this will not affect your employment status. If you choose not to participate, your decision will have no consequences for you. The completion and return of the survey assumes consent to participate. **Please return your completed survey by Friday November 12<sup>th</sup>, 2004.**

Your anticipated participation is greatly appreciated. If you have any questions please do not hesitate to contact me, my supervisor Professor Barbara Smith, Assistant Dean for Life Long Learning at the College of Nursing University of Saskatchewan, or the Office of Research Services at the numbers provided below.

Signy Klebeck	Professor Barbara Smith	Office of Research Services
330 Rossmo Road	College of Nursing	University of Saskatchewan
Saskatoon, Sk.	University of Saskatchewan	Box 5000 RPO University
S7N 2Y3	Ph. (306)-966-6221	Saskatoon, SK.
Ph. (306)-249-2278	Fax (306)-966-6621	S7N 4J8
Fax (306)-249-2278	smithb@sask.usask.ca	Ph. (306)-966-2084
tsmklebeck@shaw.ca		VPR@sask.usask.ca

The results of this study can be obtained by returning the postage paid postcard that is provided for you with the questionnaire.

Thank you for your assistance.

Yours truly,

A handwritten signature in cursive script that reads "Signy Klebeck".

Signy Klebeck

**College of Nursing, University of Saskatchewan**

107 Wiggins Road, Saskatoon SK S7N 5E5, Canada Telephone: (306) 966-6221 Facsimile: (306) 966-6621

Appendix C

University of Saskatchewan Ethics Approval



**UNIVERSITY OF SASKATCHEWAN  
BEHAVIOURAL RESEARCH ETHICS BOARD**

<http://www.usask.ca/research/ethics.shtml>

**NAME:** Barbara Smith (Signy Klebeck)  
College of Nursing

Beh 04-147

**DATE:** August 17, 2004

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the Application for Ethics Approval for your study "Practice Environment Perceptions of First-Line Managers of Nursing" (Beh 04-147).

1. Your study has been APPROVED.
2. Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Committee consideration in advance of its implementation.
3. The term of this approval is for 5 years.
4. This approval is valid for one year. A status report form must be submitted annually to the Chair of the Committee in order to extend approval. This certificate will automatically be invalidated if a status report form is not received within one month of the anniversary date. Please refer to the website for further instructions <http://www.usask.ca/research/behavrsc.shtml>

I wish you a successful and informative study.

---

Dr. Scott Bell, Acting Chair  
University of Saskatchewan  
Behavioural Research Ethics Board

VT/ck

Appendix D  
Health Authority Cover Letter

Dear (CEO of the Health Authority)

My name is Signy Klebeck, a graduate student in the College of Nursing at the University of Saskatchewan. As part of the requirements for my Masters in Nursing degree, I am conducting a survey of first-line managers of nursing in Saskatchewan. This study was approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board in September 2004. First-line managers have a vital leadership role in health care. The survey I am conducting is titled "Practice Environment Perceptions of First-Line Managers of Nursing". It will describe the perceptions first-line managers employed in regional and provincial hospitals in Saskatchewan have of their practice environments.

I am requesting permission from you to conduct this research at XXXXXXXXXXXXXXXXXXXX Hospital. If your first-line managers choose to participate, they will be provided with a survey that will take them approximately 30 to 40 minutes to complete. Your first line managers do not have to answer any questions that they do not want to. The code on the survey indicates whether they are an employee of a provincial or regional hospital. It cannot be linked to them. Although I will know the names of the invited participants, no name or any other identifying information will be on the survey. There will be no way of linking a participant with particular responses or even knowing if a particular manager has participated.

The data collected will **be** available and accessed only by **the researcher and her supervisor**. Only aggregated results will be reported in my Masters thesis and in articles submitted for publications in professional journals and/or conference presentations.

The participation of your first-line managers is *strictly voluntary*, but I hope they will take part. Their participation will help provide a more complete picture of the practice environments of first-line managers. While this study may not benefit them directly, it will provide first-line managers an opportunity to share their perceptions of their practice environments with others. There are no foreseeable risks associated with their participating in this study. If they decide to withdraw, they will be aware that this decision will not affect their employment status. If they choose not to participate, their decision will have no consequences for them, The completion and return of their survey assumes consent to participate.

Enclosed is a copy of the questionnaire that will be provided to the first-line managers. If you have any questions please do not hesitate to contact me, my supervisor Professor Barbara Smith, Assistant Dean for Life Long Learning at the College of Nursing University of Saskatchewan, or the Office of Research Services at the numbers provided below.

Signy Klebeck  
330 Rossmo Road  
Saskatoon, Sk.  
S7N 2Y3  
Ph. (306)-249-2278  
tsmkklebeck@shaw.ca

Professor Barbara Smith  
College of Nursing  
University of Saskatchewan  
Saskatoon, SK.  
Ph. (306)-966-6221  
Fax (306)-966-6221  
smithb@sask.usask.ca

Office of Research Services  
University of Saskatchewan  
Box 5000 RPO  
Saskatoon, SK.  
S7N 4J8  
Ph. (306)-966-2084  
VPR@sask.usask.ca

Thank you.

Yours truly,

Signy Klebeck

## Appendix E

### Dimensions/Subscales of the EPS

## **Environment Perception Scale: Subscales**

### **Control over Workload**

- + 1. I am not expected to cover additional areas/units if another first-line manager is away.
- + 2. I am able to take my meal/coffee breaks.
- + 3. I rarely feel pressured to get all my paperwork done.
- 4. I often feel pressured because I don't have time to do all that I want to do.
- 5. I am dissatisfied with the number of hours I work.

### **Nursing Leadership**

- 6. I am not well informed on the matters in my workplace.
- 7. There is low productivity on the unit I manage.
- + 8. There are strong feelings of belongingness on the unit I manage.
- + 9. There is high efficiency on the unit I manage.
- 10. I am not involved in professional activities.

### **Control over Practice**

- 11. I am dissatisfied with the amount of responsibility I have.
- + 12. I am satisfied with the amount of control I have over my working conditions.
- 13. I am not satisfied with the amount of control I have over what goes on in the unit/units I manage.
- 14. I feel uncomfortable making administrative decisions.
- + 15. In my job I can practice independently within the scope of my practice.

**Support and Recognition**

- 16. There is rarely an opportunity for me to participate in the administrative decision-making process.
- + 17. There are plenty of opportunities for me to advance in this organization.
- 18. I am dissatisfied with the amount of praise and recognition my immediate supervisor gives me for my work.
- + 19. Physicians respect my knowledge.
- + 20. I know that the staff appreciates me.

**Professional Development**

- + 21. I feel that my knowledge is current.
- 22. I do not have access to current information that would help me in my job.
- 23. Adequate orientation is not provided for first-line managers changing practice areas.
- + 24. I have enough opportunities to attend continuing education/staff development events.
- + 25. My work provides me the opportunity to learn new skills.

**Innovation and Creativity**

- 26. I do not have the opportunities to participate in nursing research.
- + 27. I have opportunities to write and publish.
- + 28. I am expected to introduce new ideas in my workplace.
- 29. My job is boring.
- 30. I rarely have opportunities to be creative at work.

**Scoring** – higher score is more positive perception

**Positive statements** will be assigned the following scores: 0 = not applicable; 1 = agree; 2 = agree somewhat; 3 = disagree somewhat; 4 = disagree.

**Negative statements** will be assigned the following scores: 0 = not applicable; 1 = disagree; 2 = disagree somewhat; 3 = agree somewhat; 4 = agree.

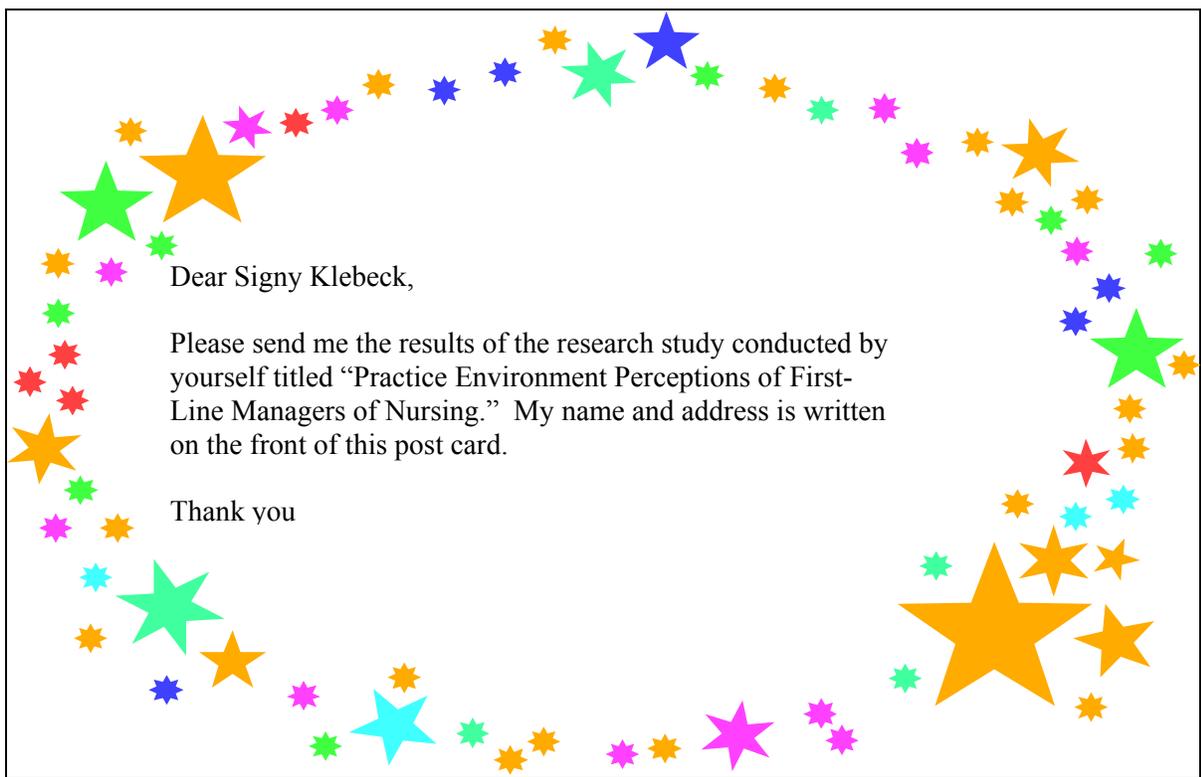
**After scoring each statement,** “a total score is derived by the summation of scores assigned to all items, which in turn are scored according to the direction of favorability expressed” (Polit & Hungler, 1999, p. 358).

Appendix F  
Requesting Study Results

From: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

STAMP

Ms. Signy Klebeck  
330 Rossmo Road  
Saskatoon, SK.  
S7N 2Y3



Appendix G  
Reminder Postcard

From:  
Ms. Signy Klebeck  
330 Rossmo Road  
Saskatoon, SK.  
S7N 2Y3

STAMP

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Dear Colleague,

In XXXXXXXX, you received an invitation to participate in a research study to identify the perceptions first-line managers employed in regional and provincial hospitals in Saskatchewan have of their practice environment.

If you have completed the questionnaire thank you. Every response is important, if you have not completed the questionnaire, it is not too late to participate. Your participation is critical. If a replacement questionnaire is required, please contact me. Your effort completing the questionnaire is greatly appreciated!

Sincerely,

Signy Klebeck  
306-249-2278  
tsmklebeck@shaw.ca

Appendix H

Saskatoon Health Region Ethical Approval

	<p style="text-align: center;"> <b>Research Services Unit</b>  <b>Strategic Health Information &amp; Planning Services (SHIPS)</b>          Joanne Franko, Manager          Suite 300 Saskatoon Square          410 22<sup>nd</sup> St E          Saskatoon, SK S7K 5T6          Phone: 306.655.3356 Fax: 306.655.3373       </p>
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**DATE:** January 19, 2005  
**TO:** Signy L. B. Klebech, Graduate Student, College of Nursing, U of S  
**FROM:** Joanne Franko  
 Manager, Research Services Unit  
**RE:** **RESEARCH PROJECT ETHICS COMMITTEE (EC)#:** B2004-147  
**PROJECT NAME:** Practice Environment Perceptions of First-Line managers of  
 Nursing  
**PROTOCOL #:** N/A

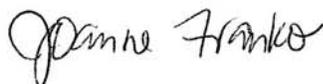
Saskatoon Health Region is pleased to provide you with operational approval of the above-mentioned research project.

Please advise me when the data collection phase of the research project is completed. I would also appreciate receiving a summary of the results for this research project. As well, any publications or presentations that result from this research should include a statement acknowledging the assistance of Saskatoon Health Region.

I would like to wish you every success with your project and encourage you to contact me if I can assist you with it.

If you have any questions, please contact my office at 655-3356.

Yours truly,



Joanne Franko, M.Sc.  
 Manager, Research Services Unit

cc: Susan Bazylewski, VP, Administration, Corporate  
 Father Mark, Mission Office, SPH

Appendix I

Regina Qu'Appelle Health Region Ethical Approval



## *Certificate of Approval* Research Ethics Board

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PRINCIPAL INVESTIGATOR	Ms. Signy Klebeck College of Nursing University of Saskatchewan 330 Rossmo Road Saskatoon SK S7N 2Y3	Co-Investigator: Prof Barbara Smith, U of S.
APPROVAL DATE	January 12, 2005	
RQHR PROJECT #	REB-04-76	
TITLE	Practice Environment Perceptions of First-line Managers of Nursing	

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### CERTIFICATION

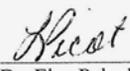
The protocol and consent form for the above named project have been reviewed by the Chair of the Regina Qu'Appelle Health Region Research Ethics Board and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

The Regina Qu'Appelle Health Region Research Ethics Board meets the standards outlined by Canada's Tri-Council Policy Statement for Ethical Conduct for Research Involving Humans.

The Regina Qu'Appelle Health Region Research Ethics Board has met the criteria for purposes of Section 29 of the *Health Information Protection Act*.

Please note that all future correspondence regarding this project must include the RQHR project number.

Best wishes in your continuing research endeavours.

  
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Dr. Elan Paluck, Chair  
Regina Qu'Appelle Health Region  
Research Ethics Board

/lgp  
cc. Ms. C. Klassen, Corporate Services, WRC

*This Certificate of Approval is valid provided there is no change in the experimental procedures. Any significant changes to the protocol must be reported to the Chair for the Board's consideration, in advance of implementation of such changes. You are required to provide a status report on an annual basis.*

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Please send all correspondence to: Research and Performance Support  
Regina Qu'Appelle Health Region  
2180 23<sup>rd</sup> Avenue, Regina SK S4S 0A5  
Phone: (306) 766-5451 Fax: (306) 766-5530 E-mail: linda.picot@rqhealth.ca

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