THE IMPACT OF FIRST-LINE NURSE MANAGERS LEADERSHIP DEVELOPMENT TRAINING PROGRAM ON WORKGROUP CLIMATE AND PERFORMANCE

Thesis
Presented to the Faculty of Nursing,
Alexandria University,
In Partial Fulfillment of the Requirements for the Degree

Of
Doctor of Nursing Science
In Nursing Administration

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2009
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ACKNOWLEDGMENTS

Thanks to Allah, most merciful and most compassionate. I know that is through Allah and only Allah that all things are possible. Thank you for the blessings given to me and those that will be provided in the future.

Sincere appreciation is extended to my committee chairperson, to Prof. Dr. Zeinab Mohamed Nabawy, professor of Nursing Administration, Faculty of Nursing, University of Alexandria, I am grateful for the support and encouragement and for her close observation, continuous valuable advice, constant encouragement, meticulous assistance, review and keen interest, which helped much in the accomplishment of this thesis, and in general, her suggestion of the subject.

I wish, also, to express my deep gratitude and appreciation to Prof. Dr. Alice Edward Reizian, professor of Medical and Surgical Nursing, Faculty of Nursing, University of Alexandria, for her valuable comments, constant support, and meticulous review that helped me much in the accomplishment of this thesis; she served as an inspiration for me.

I wish to extend my genuine appreciation to Prof. Dr. Magdala Habib Maximos, Professor of Psychiatric Nursing and Mental Health, Faculty of Nursing, University of Alexandria, I am forever indebted to her for her support and guidance in my time of need. I would like to thank her for serving on my committee for this study. Her suggestions were invaluable for continuous help, assistance and advice.

I am also indebted to Prof. Dr. Mohamed Hussein, Professor of Bio-Statistics, Higher Institute of Public Health, University of Alexandria, for his valuable consultation, cooperation and guidance regarding the statistical presentation.
My dear father and soul of my mother for their love, affection and support. I am grateful to both of them. You are always in my heart and I know that you are watching over me, guiding my steps.

I will never forget all that you did for me and all that you taught me.

You are my rock and my best friend. Without you, I would not be where I am today. I admire and adore your strength, courage, and perseverance. I thank God everyday that I have the privilege of having you as my parents. Thank you for your constant support, encouragement, and inspiration with this project and in life. I will always be here for you.

Their love, tolerant understanding and encouragement in all steps regarding this work, were the best motive I have ever needed in the accomplishment of my work.

Additionally, to all who supported and bearded me during my work, especially my family, Dr. Joan Galer, my close friends and colleagues.
INTRODUCTION

The uncertainty in the health care industry, particularly in nursing, makes the next millennium an important time for nurses to develop leadership skills. One of the greatest challenges faced in the nursing profession is developing future nurse leaders (1). A better understanding of what transformational leadership is, can improve our ability to provide effective leadership training programs and interventions (2). To respond to changing technological and social forces, new managerial responsibilities are placed on the nursing services requiring nurse administrators who are knowledgeable, skilled and competent in all aspects of leadership (3). To confront these expanding responsibilities and demands, the leader's role must take on new dimensions to facilitate quality outcomes in patient care and meet other strategic organizational goals and objectives (Porter-O'Grady, 2000) (4). Nursing practice and nursing leadership are not solo acts. Nurses do not practice nursing in isolation from others, and nursing leadership is not practiced in a vacuum (Reid-Ponte, 2006) (5). Therefore, nursing leadership plays a pivotal role in determining the future direction of the nursing profession and in preparing nurses to ensure quality health care for the future and to meet the inevitable challenges of the new millennium (1, 3).

Kouzes and Posner (2005) defined leadership as: "the art of mobilizing others to want to struggle for shared aspirations" (6). Leadership has four principles. First, leadership is everyone's business, as the concept of leadership is broad to include those on the front lines as well as those in the executive suites. Second, leadership is a relationship between those who aspire to lead and those who chose to follow. Third, leadership is learned either through trial and error, or observation of others, or education. Finally, leaders make a difference by being a positive force in the world and demonstrating the five practices of exemplary leadership (7).

In healthcare research, leadership has been measured by a variety of tools (8). However, previously used practices of nursing leaders are no longer sufficient for managing the health care environment. Nursing leaders will need to develop extraordinary leadership practices and behaviors through observing, role modeling and participating in formal education (Kouzes and Posner, 1987) (9). Identification of leadership practices and behaviors provide an opportunity to evaluate current practices and behaviors of nursing leaders and suggest guidelines for future education for first-line nurse managers (Horvath et al., 1994) (10). Therefore, the leadership behavior measurement instrument that has been used extensively across organizational sectors and whose use is increasingly more frequent in nursing research is the Leadership Practices Inventory (LPI), developed by Kouzes and Posner (2005) (11). It is a realistic framework for leadership practices backed by a reliable and valid instrument for informant and self-report measurement of the practices (3).

Kouzes and Posner (2005) developed a leadership model which purportedly measures five key leadership practices consistent with transformational leadership style, including behaviors associated with: (1) modeling the way, which involves two strategies: setting the example by behaving in ways that are consistent with shared values; achieving small "wins" that promote consistent progress and build commitment. (2) Inspiring a shared vision, which involves two strategies: envisioning an uplifting and ennobling future; enlisting others in a common vision by appealing to their values, interests, hopes and dreams. (3) Challenging the process, which involves two strategies: searching out challenging opportunities to change, grow, innovate, and improve; experimenting taking
risks, and learning from the accompanying mistakes. (4) Enabling others to act, which involves two strategies: fostering collaboration by promoting cooperative goals and building trust; strengthening people by giving power away, providing choice, and developing competence, assigning critical tasks, and offering visible support. (5) Encouraging the heart, which involves two strategies: recognizing individual contributions to the success of every project; celebrating team accomplishments regularly.

Transformational leadership seems particularly suited to the nursing environment and profession. That is characterized by being an empowering leadership style, and by being caring and highly ethical (Biordi, 1993). The transformational leader is the catalyst for creating new innovative organizational paradigms, which manoeuvre between the system, the staff and patient care.

The process of development should never be intrusive. Education should always be about releasing what is already inside. The quest for leadership is first of all an inner quest of self-discovery. Leadership development is self-development, and leadership developers are the creators of the climate in which self-development flourishes, in order to help people discover what they care about and value, what inspires them, what challenges them, what gives them power and competence, and what encourages them.

In nursing, the first-line management positions are filled by head nurses. The first-line nurse manager has been described as "vital to quality patient care", and was labeled as the "fulcrum of managerial influence in the hospital". The leader must have a relationship with a group. This type of group is a workgroup. A workgroup may consist of two members – the leader and the follower; or many members – head nurses and staff. The most important factor in effective group functioning is the climate of the group. Climate is defined by Management Sciences for Health (MSH) as: "the environment in which people work that affects how people behave at work". The practices and behaviors of the workgroup manager and staff influence their climate.

The Workgroup Climate Assessment (WCA) is designed to measure climate among workgroups in the health sector. It is measured according to employees' perceptions, in relation to: (1) climate perceptions, and (2) perceptions of productivity and quality. Understanding these dimensions of workgroup climate can help in thinking about interventions that can be used to improve climate and performance. Consequently, a positive workgroup climate is a primary outcome of a leadership development process aimed at improving the performance of leaders and their work groups.

Performance is defined by Meretoja, and Leino-Kilpi as: "the formal exhibition of a skill, ability, or aptitude of a professional nurse". Performance-related behaviors are directly associated with job tasks and need to be accomplished to achieve a job's objectives. Nurse leaders' performance provides an objective summary of leaders' strengths and areas of development along seven critical leadership performance factors, namely: (1) problem solving, (2) Planning, (3) Controlling, (4) Managing self, (5) Managing relationships, (6) Leading, (7) Communicating.

Most leaders who have achieved results recognize how much their achievements are due to a group effort involving their staff members. Staff nurses behaviors are mainly incorporated into four underlying nursing performance areas: (1) research; (2) education; (3) professional development; and (4) clinical skills.
Numerous studies have been conducted in U.S.A., Canada, U.K., Australia and Russia to develop leadership practices. Studies have been focused on assessing the nursing manager leadership skills (31), exploring nurse executive transformational leadership (32-33), leadership and the next millennium (34), new strategies for leadership (35), and challenges to develop and implement and sustain nursing leadership (36-37). Moreover, they searched for: the development and testing of a model of leadership learning (38), they, also elaborated a construct of transformational leadership (2). They concluded that, leadership challenges can be developed and that nurse leaders can help in establishing workplaces that are satisfying and rewarding (12); furthermore, leadership was in the first place among the key management functions (39), and that organization improvement starts with leadership (38).

The studies carried out in Egypt assessed: the relation between head nurses' transactional and transformational leadership styles and nurses job satisfaction (40), problem solving and leadership styles among nursing graduates (41), effect of leadership training program on leadership styles and satisfaction (42), types of management and supervision influencing nurses satisfaction (43), effective leadership styles as perceived by nurse managers and staff nurses (44), and finally, the pattern of decision-making employed by nurse educators as leaders (45). They were all dealing with the identification of leadership styles in relation to other variables. They concluded that democratic and/or transformational leadership style was the most effective and appropriate for the development of personnel. However, no study was carried out to develop transformational leadership style specifically.

In Egypt, Little is known about leadership challenges, as well as, transformational leadership and its development. This makes nurse leaders development and ability to face daily working challenges difficult in their workplace. Hence, the present study aimed to examine the impact of first-line nurse managers leadership development training program on workgroup climate and performance. Therefore, it is hoped that such a study had helped leaders in motivating people to great efficiency and effectiveness, as well as increasing awareness of necessary skills.

**Aim of the study**

**The study aims to:**

Determine the impact of first-line nurse managers' leadership development training program on:

a) Workgroup climate;

b) First-line nurse managers' performance; and

c) Staff nurses' performance.
REVIEW OF LITERATURE

Leadership is a critical challenge facing health care organizations and nurse leaders today as turbulent and fast paced organizational and environmental changes create the need for effective leaders throughout all levels of organizations. Available leadership models reflect a mindset that was established over one hundred years ago (46). A plethora of literature exists on the subject of leadership. In fact, leadership as a behavior is considered a universal human phenomenon (47). During the 30-year period, over 400 articles were listed under the heading of leadership in the Cumulative Index to Nursing and Allied Health Literature (CINAHL) (48), citing various anthropological reports on primitive groups in Australia, Fiji, the Congo, New Guinea and elsewhere, Smith and Krueger (1933) concluded that leadership behavior occurs universally among all people regardless of culture, class, education, or training (49).

An extensive literature review was conducted using: books, journals, dissertations, and online medical, nursing, and allied health databases. It is comprised of eight main sections. The first section provides a conceptual framework of leadership that is divided into two main parts. The first part discusses the view of the leadership concept from an Islamic perspective, since Islam is the legal constitution of Egypt. The second part provides a definition and description of the concept of leadership. The second section identifies different leadership themes, namely: characteristics/qualities, importance, principles, functions and roles, arch and dimensions, skills and competencies, factors and finally barriers. The third section explores the theoretical framework of leadership, by over-viewing the evolution of leadership theories leading up to the transformational leadership concept. This section contains two historical eras: before 1980s (before the transformational leadership theory) and after the 1980s (constitutes of transformational leadership theory). The fourth section visualizes leadership practice and behaviors and the importance of both the first-line nurse managers and the use of 360 degree feedback instrument. The fifth section involves an overview on conducting a staff development program. The sixth section determines the relationship between leadership and workgroup climate. The seventh section discusses the relationship between leadership and performance. Finally, the eighth section is a synthesis of the leadership research in nursing organizations and other disciplines as it relates to this study.

CONCEPTUAL FRAMEWORK

ISLAMIC VIEW OF THE LEADERSHIP CONCEPT

Egypt is an Islamic Republic whose population's majority are Muslims. Understanding the concept of leadership in Islam will help in understanding the leadership dynamic or leadership processes in this society. It will also help in understanding the commonality of the leadership concept among different societies, different religions and laws (50). Since there is great lack of locally valid Arab theories of leadership, the present findings may provide information that helps the assessment of imported theories and the development of new theories that are sensitive to the local culture (51).

The concept of leadership is among the most important eternal principles of Islam. It is also called Guardianship, Wilayah, or Imamah (50).
"And We appointed from among them leaders giving guidance under Our command so long as they preserved with patience and continued to have faith in Our signs"
(Holy Qur'an, 32:24) (52).

Muslims are urged to appoint a leader and follow him. Prophet Mohammed (saw), said: "When three are on a journey, they should appoint one of them as their commander" (Sahih Bukhari, 1996) (53).

This means that Muslims must appoint a leader during a trip, select a leader to lead the prayer, and always choose a leader for other group activities (50). For Muslims, Prophet Mohammed (saw) is the ideal and model leader to follow, whom Allah (God) describes in the noble Qur'an as: "Uswatun hasna" (means the most beautiful pattern of conduct) (52). Leadership in Islam is about trust, and it represents a psychological contract between a leader and his followers, by which the leader will try his best to guide the followers, to protect them, and to treat them justly. Hence, the focus of leadership in Islam is on doing well (Beekun and Badawi, 1999) (54).

There are many and different definitions for the concept of leadership given by Islamic scholars (50). The Islamic definition of leadership is that, leadership is the behavior of the occupant(s) of the position of leadership in political, economic, or social fields. Leadership position is vital to the welfare of the group and hence should be occupied only by competent people (51). Al-Talib (1999) defines leadership as "the process of moving people in a planned direction by motivating them to action through non-compulsive means" (55). Beekun and Badawi (1999), rely on two primary definition of leadership. First, "leadership is depicted as the process by which the leader seeks the voluntary participation of followers in an effort to reach organizational objectives". This suggests that leadership is essentially a social exchange process. Second, "leadership is the ability to persuade others to seek defined objectives enthusiastically. It is the human factor which binds a group together and motivates it toward goals. Management activities, such as planning, organizing, and decision making are dormant cocoons until the leader triggers the power for motivation in people and guides them toward their goals". This definition stresses that a leader is not necessarily a manager (54).

The Islamic leader has the following qualities: charismatic, a "great man", a man with some sort of "miracle" to lead his followers to their ideals. People under a prophetic leader would strive to perform their duties to their best because their love and free submission to the leader motivate them. The leader has a message: the loftiest of his duties is to develop leaders from among his people. This leader must be religious because he is the role model (Islamic principles suggest that the righteousness of the nation depends on the righteousness of its Caliph and the corruption of the nation is in his corruption). He must be responsible, in this respect Prophet Mohammed attests: "Everyone of you is a custodian and is responsible for his people". The leader should ensure justice among his people, applies the rule of Islamic law, preaches the good, dissuades from evil, and provides a decent livelihood for his people (Mostafa, 1986; Al-Obiedi, 1987) (56 - 57).

The Islamic administrative theory is based on the social philosophy of the Islamic system, which suggests that individuals' physiological needs must be satisfied to achieve organizational goals and that a balance should be achieved between spiritual and psychological needs. The theory is based on the principles of hierarchical organizational structure, chain and unity of command, obedience and compliance to formal authority, planning of work, consultation among members of the organization, clarification of roles

DEFINITION OF THE LEADERSHIP CONCEPT

Leadership is one of the least understood but most observed phenomena on earth (Burns, 1978) (60). It is often regarded as the most critical factor in the success or failure of an organization (Bass, 1990) (61). Two thousand years ago, Sun Tzu (1800), the somewhat mysterious Chinese warrior-philosopher said, "Leadership is a matter of intelligence, trustworthiness, humaneness, courage, and sternness" (62). Although the term "leader" has apparently been in use since the 1300s, it has been stated in Stogdill (1974) that the Oxford English Dictionary of 1933 noted the word "leader" in the English language (63); the word "leadership" was not known in the English language until the 1800s (the first half of the 19th century) (64).

In the past, leadership has been viewed as a form of social influence, but recently it began to be viewed as a form of organizing. Leadership can be viewed as both a perceptual and behavioral phenomenon (50). Finding a single definition of leadership appears difficult and fruitless, because an appropriate choice of a definition depends on theoretical, methodological, and substantive aspects of leadership being considered (Vance and Larson, 2002) (65). Leadership can be defined in numerous ways depending on the theoretical telescope one uses to view the subject. Despite its relatively new addition to the English language, leadership has been defined by Chapin (1924), as "a point of popularization for group cooperation" (66). Stogdill (1959) termed leadership as "the process of influencing the actions and activities of an organized group in its efforts toward goal setting and goal-attainment or achievement" (67). Both Bass (1985) and Burns (1978) defined leadership as "a transformative process through which leader creates visions of a future state for the organization and articulates new ways for the followers to accomplish the organizational goals" (68, 60).

De Pree (1987) asserted that "leadership is not a science or discipline; it is an art and as such, must be felt, experienced, created" (69). In line with him is Bennis (1989) who, opined that "leadership is like beauty – it is hard to define, but you know it when you see it" (70). While, Gardner (1990) identified leadership as "the process of persuasion and example by which an individual (or leadership team) induces a group to pursue objectives held by the leader or shared by the leader and his followers" (71). Robbins (1991) concurred, stating that "leadership is the process of empowering and teaching others to tap their full capabilities by shifting the beliefs that have been limiting them" (72).

This is similar to Oakley and Krug (1994) who viewed leadership as "the ability to elicit a vision from people and to inspire and empower those people to do what it takes to bring the vision into reality" (73). Leaders bring out the best in people. Chemers (1997) offered the following typical definition "leadership is a process of social influence in which one person is able to enlist the aid and support of others in the accomplishment of a common task" (74).

Kouzes and Posner (2005) defined leadership as "the art of mobilizing others to want to struggle for shared aspirations" (6). They contended that we are all leaders in this new, technological, fast paced business world, where hierarchies have been flattened, and it is almost impossible to label anyone a leader, manager, or employee. "Leadership is not
the private reserve of a few charismatic men and women; it is a process ordinary people use when they are bringing forth the best from themselves and others" (6). Similarly, Ellis and Hartley (2005) viewed leadership as "the process of guiding, teaching, motivating, and directing the activities of others toward attaining goals. It involves having the ability to influence others" (75). Moreover, Marquis and Huston (2009) defined leadership as "the process of moving a group or groups in some direction through mostly non-coercive means" (64).

Finally, Yoder-Wise (2007) used a broader definition stating that "leadership is the relationship between those who aspire to lead and those who choose to follow. Leadership is the use of personal traits and personal; power to constructively and ethically influence patients, families, and others toward an end point vision or goal". She pointed that "a leader is an individual who works with others to develop a clear vision of the preferred future and make that vision happen. The individual who has the most influence and who is expected to carry out the leadership role is the leader; other members are followers" (12). Therefore, it becomes clear that there is no single definition broad enough to encompass the total leadership process (3).

**LEADERSHIP AS AN IMPORTANT CONCEPT FOR NURSES**

Nurses must have leadership to move forward in harmony with changes in society and in health care. Within work organizations, certain nurses are designated as managers. These individuals are important to ensuring that care is delivered in a safe, efficient manner. Nurse leaders are also vital in the workplace to elicit input from others and to formulate a vision for the preferred future (12).

Moreover, leadership is a key for nursing as a profession. The public depends on nurses to advocate for the public's needs and interests. Nurses must step forward into leadership roles in their workplace, in their professional associations, and in legislative and policy-making arenas. Nurse leadership is vital. Nurses depend on their leaders to set goals for the future and the pace for achieving them. The public depends on nurse leaders to move the consumer advocacy agenda forward (12). Therefore, nurses can serve as leaders in a variety of roles (76). As with each leadership style, leadership necessitates numerous attributes and conditions to affect its qualities successfully (15).

In addition to that, leadership in nursing is a key element to the profession because of a number of factors. First, it is important to nurses because of the size of the profession. Nurses comprise the largest single healthcare occupation and one that is experiencing critical shortages. Pressures, including costs, in the healthcare environment are rapidly thrusting nurses into leadership roles in highly complex and stressful situations. Second, nursing's work is complex, often conducted in complex settings. Tremendous changes in nursing have occurred in the last 25 years. These are changes in philosophy, knowledge base, technological complexity, ethical dilemmas, and impacts from constant change and societal pressures. Thus leadership is needed to guide and motivate the nurses and healthcare delivery systems toward positive achievements for better patient care. Third, nurses enter the practice of nursing by licensure, but they come from a variety of educational backgrounds. A baccalaureate degree does not automatically confer advanced leadership skills. However, without this academic degree at minimum, nursing as a profession is disadvantaged when compared with other professions whose preparation is baccalaureate or above. Thus nurses will need strong leadership to resolve the
interprofessional dilemmas derived from educational diversity and the related issues of professionalization and being attractive providers to clients. For example, each nurse will need to develop leadership skills in relating to peers who have different educational backgrounds and value systems. Nursing needs strong leadership for public policy advocacy on behalf of nursing as a profession and for its own growth and advancement in the provision of cost-effective patient care (77).

CHARACTERISTICS/QUALITIES OF LEADERS

Kouzes and Posner (1993) have found that from the viewpoint of a follower, the characteristics of leaders are (78):

- **Organization.** Subordinates like leaders who plan and are well organized. They should follow the chain of command in issuing instructions. They should also delegate authority as necessary (78).
- **Fearlessness.** Leaders should not be afraid for their positions, nor afraid of their superiors, the toughness of a job, colleagues or the honest mistakes of their staff (78).
- **Respect for the work of others.** Leaders should recognize that the work of their teammates is as important as their own work, and deserves equal recognition. While they should be excited about their own work, leaders should simultaneously cultivate the right climate so that their teammates can also be enthused about their work (78).
- **Satisfaction.** Leaders should have a feeling of satisfaction and gratification when a teammate achieves something which they themselves thought would be impossible (78).
- **Promotion of the interests of subordinates.** If leaders believe that their subordinates are right, they should fight for them no matter what the odds and the situation (78).
- **Frankness.** Leaders should talk to subordinates directly and inform and explain without losing tempers or creating stress. They should be candid and criticize constructively (78).
- **Respect for the individual.** Subordinates prefer leaders who respect an individual's identity and experience. Leaders should never show bias (78).
- **Knowledge.** Subordinates want leaders who are knowledgeable and know most of the answers. At the same time, leaders should admit ignorance when they do not know the answer to a problem, and be willing to seek help from other sources. They should also be willing to learn from others. In fact, they should never stop learning (78).
- **Predictability.** Leaders should be predictable, usually the same all the time and not enigmatic (78).
- **Tolerance.** Leaders should be tolerant of small mistakes which teammates may occasionally make (78).
- **Understanding.** Subordinates should perceive their leaders to be human and understanding, and should not be afraid to go to them if they have committed a foolish mistake, are ashamed or are proud and satisfied. Leaders should create confidence and should be neither hasty nor rude (78).
- **Honesty and transparency.** Subordinates want leaders who are transparent in their dealings and cannot be bribed by anyone. Leaders should be able to see through pernicious designs in any form, and should cultivate strong moral fiber and earn the respect of their teammates. Leaders should always be committed to good moral principles (78).
- **Accessibility.** Leaders should be easily approachable when needed, and subordinates should be able to get away from their leader when their business is settled (78).
- **Providing opportunities.** Leaders should be willing to provide new opportunities and chance for work even if it is something new and the subordinate may not have experience in that work (78).
Guidance. Leaders should lead by training others. They should be able to show their subordinates how to do a job, but, in doing so, they must not show off. Subordinates like people who grow out of their own job to become leaders. Leaders should try to match people and jobs (78).

Willingness to listen. Leaders should be willing to listen when a subordinate has something to say, but should be able to end the conversation gracefully if necessary (78).

Genuineness. Subordinates should believe that their leaders sincerely wants them to succeed and will be proud of them when they do (78).

Discretion. Leaders should respect the privacy of their teammates. They should not admonish them in the presence of others, nor gossip about them. At the same time, leaders should give credit to and acclaim their people publicly when appropriate (78).

Informed. Leaders should be well informed about what is happening around them. They should not give credence to gossip (78).

Grace. Leaders should neither denigrate nor undermine a teammate for any reason (78).

Authority. Leaders should have authority to mete out rewards and punishment as necessary (78).

People orientation. Leaders should like people, be cooperative and inspire their teammates (78).

Positive personality. Subordinates like leaders who are active, humble, gracious, thoughtful and confident. Leaders should be firm but fair to everybody and, if necessary, should be able to compromise, but should not placate (78).

Good communication. Subordinates like to be informed of the actions of their leader and the reasons for them. Good leaders have to be good communicators and should not cover themselves in an unnecessary veil of secrecy (78).

Moreover, Larson (2000) developed the following list of qualities needed by a leader (79):

1. Passion:
   A leader has a passion for a cause that is larger than they are, a dream for how the world can be better and the part they can play – and rally others to join – in making their dream a reality (79).

2. Vision:
   Vision gives direction to, and is needed to breathe life into, a passionate dream. Vision answers the question, what is versus what can be (79)?

3. Holder of values:
   Leaders have values that legitimize an organization and characterize the organization's culture – values like respect for others, caring about people, and in the case of support groups, empathy for those who need support and encouragement (79).

4. Creativity:
   Leaders think outside the box. They are not afraid to try solutions that are new or different (79).

5. Intellectual drive and knowledge:
   Leaders are perpetual students of their craft. They read, they learn, and they get ideas from others (79).

6. Confidence and humility:
   Leaders have confidence that their vision is correct, yet they are humble enough to accept better ideas from other people (79).

7. Communicator:
   Leaders speak and write in ways that encourage others to follow (79).
8. **Interpersonal skills:**

   Leaders have the ability to listen well, resolve interpersonal conflicts, delegate well, and keep everyone moving along in the same direction (79).

   Although the environment and circumstances change, the characteristics/qualities necessary for a great leader remains constant. The importance of cultivating nursing leaders is imperative for a healthful society (1). In all nursing settings, the importance of leadership skills is great (75).

**MYTHS OF LEADERSHIP**

1. **Leadership is a rare skill:** nothing can be further from the truth. While great leaders may be rare, everyone has leadership potential. More important, people may be leaders in one organization and have quite ordinary roles in another. The truth is that leadership opportunities are plentiful and within reach of most people (80).

2. **Leaders are born, not made:** the truth is that major capabilities and competencies of leadership can be learned, and all people are educatable, at least if the basic desire to learn is there. This is not to suggest that it is easy to be a leader. There is no simple formula, no rigorous science, and no cookbook that leads inexorably to successful leadership. Instead, it is a deeply human process, full of trial and error, victories and defeats, timing and happenstance, intuition and insight (80).

3. **Leaders are charismatic:** some are, most are not. Charisma is the result of effective leadership, not the other way around, and that those who are good at it are granted a certain amount of respect and even awe by their followers, which increases the bond of attraction between them (80).

4. **Leadership exists only at the top of the organization or leaders populate the entire organization:** in fact, the larger the organization, the more leadership roles it is likely to have (80).

5. **The leader controls, directs, prods, and manipulates:** this is perhaps the most damaging myth of all. Leadership is not so much the exercise of power itself as the empowerment of others. Leaders are able to translate intentions into reality by aligning the energies to the organization behind an attractive goal. Leaders lead by pulling rather than pushing; by inspiring rather than ordering; by enabling people to use their own initiative and experiences rather than by denying or constraining their experiences and actions (80).

   Once these myths are cleared away, the question becomes not one of how to become a leader, but rather how to improve one’s effectiveness at leadership (80).

**IMPORTANCE OF LEADERSHIP**

1. **Incompleteness of organization design:**

   That is, because it is not possible to design the perfect organization and account for every member’s activities at all times, something must ensure that human behavior is coordinated and directed toward task accomplishment. Thus something is leadership (81).
2. **Adaptation to changing environmental conditions:**
   Leadership helps maintain the stability of an organization in a turbulent environment by allowing for rapid adjustment and adaptation to changing environmental conditions \(^{(81)}\).

3. **Internal dynamics of organizations:**
   Leadership can assist in the internal coordination of diverse organization units, particularly during periods of growth and change. It can act as a buffer between conflicting parties \(^{(81)}\).

4. **The nature of human membership in organizations must be recognized:**
   Organizations consist of individuals who pursue various needs and make difficult demands. Leadership can play a major role in maintaining a stable work force by facilitating personal need satisfaction and personal goal attainment \(^{(81)}\).

   To inspire workers into higher levels of work, there are certain principles that should be followed by leaders. These do not come naturally, but are acquired through continual work and study \(^{(82)}\).

## PRINCIPLES OF LEADERSHIP

The quest for leadership is first of all an inner quest of self-discovery. Principles that help to shape all designs of leadership according to Kouzes and Posner (2009) \(^{(83)}\):

- **Leadership is Everyone's Business**

  The Leadership Challenge may include stories of ordinary people who've gotten extraordinary things done. Men and women, young and old, from a variety of organizations, public and private, government and third sector, high-tech and low-tech, small and large, schools and professional services; they are not famous people or megastars and may be no one have heard of most of them; They are people who might live next door or work in the next cubicle. They are people just like us. The focus is on leaders like this because it is firmly believable that leadership is about relationships, credibility, and what people do. Leadership, in other words, is not the private reserve of a few charismatic men and women who are genetically endowed with some special power. Similarly, leadership is not about organizational power or authority. Leadership is a set of skills and abilities that are accessible and learnable by anyone who has the motivation and desire to learn it \(^{(83)}\).

  For far too long people have all allowed a number of myths to dominate our thinking about leadership and leadership development. The first of those myths is the one that associates leadership with superior position. It assumes that leadership starts with a capital “L”, and that when people are at the top they are automatically leaders. It is part of a larger hero myth that inhibits people from seizing the initiative. “It is not my job,” they say, and then they wait for someone to ride in and save the day. Well, forget it! It is pure myth that only a lucky few can ever understand the mystery of leadership. Leadership is not a place, it is not a position, and it is not a secret code that can’t be deciphered by ordinary people \(^{(83)}\).

  There is a fundamental truth about leadership that people must all embrace before fully developing themselves or facilitate the development of others. That truth is this: leadership is everyone’s business. People must all broaden their concept of leadership to include those on the front lines as well as those in the executive suites. The secret of high-performing organizations is that everyone within them knows that leadership-at-all-levels
is expected and rewarded, and that individuals everywhere are responsible for making extraordinary things happen (83).

- **Credibility is the foundation.**
  
  People need to believe in their leaders. “The First Law of Leadership”: If followers don’t believe in the messenger, they will not believe the message. Credible leaders walk the talk, practice what they preach, are consistent in word and deed, put their money where their mouth is, and follow through on promises. This has led us to the Second Law of Leadership: To become a credible leader you must **Do What You Say You Will Do**, or (DWYSYWD) for short (83).

- **Personal values drive commitment.**
  
  DWYSYWD has to fundamental parts to it—the say part and the do part. People expect their leaders to stand up for their beliefs. But to stand up for their beliefs, leaders have to know what to stand for. To walk the talk, leaders have to have a talk to walk. To do what was said, leaders have to know what they want to say. To earn and sustain personal credibility, leaders must first be able to clearly articulate deeply held beliefs. Leaders who are the clearest about their own values, and who see the fit between their own values and the values of the organizations they serve, are the most committed leaders. Personal values clarity is essential to commitment… and to integrity and authenticity (83).

- **Leaders either lead by example, or don’t lead at all.**
  
  The second part of earning credibility—or, DWYSYWD—is the “do” part. The only way people know that leaders value something is when they see it in action. When leaders practice what they preach they become role models for their constituents, and leaders who are seen as exemplary role models have higher performing units. If leaders could only do one thing as a leader to energize the performance of others, it would be to set an example based on a set of shared values (83).

- **Looking forward is a leadership prerequisite.**
  
  Exemplary leaders are able to envision the future, to gaze across the horizon of time and imagine the greater opportunities to come. They are able to develop a unique image of the future. This ability, more than any of the other leadership skills, differentiates leaders from individual contributors (83).

- **It is not just the leaders' vision.**
  
  At some point over the years about the importance of being future-oriented, leaders got the sense that they were the ones who had to be the visionaries. This is not what constituents expect. Of course, leaders are expected to be forward-looking, but they are not expected to be prophets. Exemplary leadership is not about uttering divinely inspired revelations. What people really want to hear is not just the leader’s vision. They want to hear about their own aspirations. They want to hear how their dreams will come true and their hopes will be fulfilled. The very best leaders understand that they are supposed to inspire a Shared Vision, not sell their idiosyncratic view of the world (83).

- **Challenge provides the opportunity for greatness.**
  
  When people are asked to tell about their personal best leadership experiences, they talk about times of crisis, adversity, change, and great difficulty. Leaders don’t do their best as leaders when maintaining the status quo or when feeling comfortable. The situations that bring out the best are those that challenge us. The study of leadership, then, is the study of how men and women guide people through adversity, uncertainty, hardship, disruption, transformation, transition, recovery, new beginnings, and other significant challenges. It is also the study of how men and women, in times of constancy and complacency, actively seek to disturb the status quo and awaken new possibilities. Leadership and challenge are simply inseparable (83).

- **Leaders are team players.**
Leaders can’t do it alone. No leader in history ever got anything extraordinary done by him/herself. When it comes to superior performance collaboration out produces both competition and individualistic efforts. And, at the heart of collaboration is trust. Without trust you cannot lead (83).

- **Leadership is a Relationship**

  Leadership is a relationship between those who aspire to lead and those who chose to follow. Exemplary leaders are devoted to building relationships based on mutual respect and caring, because they know that the quality of the relationship will determine the quality of the results. The emotional intelligence of a leader has more to do with their effectiveness than their experience and their expertise. Sometimes the relationship is one-to-many. Sometimes it is one-to-one. But regardless of whether the number is one or one thousand, leadership is a relationship. Evidence abounds for this point of view. For instance, in examining the critical variables for success it was found that the number one success factor is “relationships with subordinates.” The very best leaders know that their job is to make others feel powerful and capable, not to acquire power for themselves (83).

- **Caring is at the heart of leadership.**

  Contrary to a lot of public myth about how managers have to be cold and rational — “it is not personal, it is just business” — research indicates just the opposite. The highest performing managers and leaders are the most open and caring. The best demonstrate more affection toward others and want others to be more open with them. Exemplary leaders excel at improving performance through more attention to the human heart. The climb to the top of the summit is arduous and steep. The challenges are immense and often frightening. Against these odds leaders must sustain hope and offer encouragement. High hope leads to high performance (83).

- **Leadership is Learned**

  Whenever Kouzes and Posner (2009) are asked the question “Are leaders born or made?” — which is almost every time they give a speech or conduct a class or a workshop— they give the same answer, always with a smile: they have never met a leader who wasn’t born! So are all accountants, artists, athletes, parents, zoologists, anyone name it. Leaders are all born. That’s not the issue. It is what leaders do with what they have before they die that’s important. It is nonsense to assume that leadership is genetic. There is no hard evidence to support that assumption, and worse, it dooms every one of us to accept our limitations as our destiny. The truth is that leadership is an observable set of skills and abilities that is useful whether one is in the executive suite or on the frontline. And any skill can be strengthened, honed, and enhanced if leaders have the motivation and desire, the practice and feedback, the role models and coaching, and the support and recognition (83).

  It is our collective task to liberate the leader within each and every person. Rather than view leadership as an innate set of character traits, it is far healthier and more productive to assume that it is possible for everyone to learn to lead. By assuming that leadership is learnable, persons can discover how many good leaders there really are. Somewhere, sometime, the leader within each of us may get the call to step forward—for our school, our congregation, our community, our company, or our family. By believing in ourselves and our capacity to learn to lead, leaders will be prepared when that call comes. So how does a person become the best leader possible? To find the answer to that question, Kouzes and Posner (2009) asked the people in their study to tell them how they learned to lead. From our analysis of thousands of responses, three major opportunities for learning to lead emerge. In order of importance, they are: (1) trial and error; (2) observation of others; and finally (3) education (83).

  There is no suitable substitute for learning by doing. Whether it is facilitating team meetings, leading a special task force, heading a fundraising drive, or chairing a
professional association’s annual conference, the more chances people have to serve in leadership roles, the more likely it is that they’ll develop the skills to lead—and the more likely that they’ll learn those important leadership lessons that come only from the failures and successes of live action. Other people are essential sources of guidance. Everyone remember the parent whom are looked to for advice and support, the special teacher who filled us with curiosity, the coach who inspired us to give our best, or the first manager who taught us the ropes to skip and the hoops to jump. Although third on the list, formal training and education is an essential part of developing leadership skills. That’s because training is a high-leverage way of improving the chances of success. People can make mistakes in a safe learning environment. They can also be exposed to lots of different role models—ones they might not find in other places (83).

- **Leaders Make a Difference**

  If people are to become leaders, they must believe that they can be a positive force in the world. But some management scholars claim that leaders have little impact on organizations, that other forces—internal or external to the organization—are the determinants of success. Our evidence strongly demonstrates quite the contrary. Managers, individual contributors, volunteers, pastors, government administrators, teachers, school principals, students, and other leaders who use The Five Practices of Exemplary Leadership (model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart) more frequently are seen by others as better leaders. For example: (1) they are more effective in meeting job-related demands. (2) They are more successful in representing their units to upper management. (3) They create higher-performing teams. (4) They foster renewed loyalty and commitment. (5) They increase motivational levels and willingness to work hard. (6) They promote higher levels of involvement in organizations. (7) They enlarge the size of their congregations. (8) They raise more money and expand gift-giving levels. (9) They extend the range of their agency’s services. (10) They reduce absenteeism, turnover, and dropout rates; finally, (11) they possess high degrees of personal credibility (83).

  In addition, people working with leaders who demonstrate the previously mentioned Five Practices of Exemplary Leadership are significantly more satisfied with the actions and strategies of their leaders, and they feel more committed, excited, energized, influential, and powerful. In other words, the more people engage in the practices of exemplary leaders, the more likely it is that they’ll have a positive influence on others in the organization (83).

- **Leadership development is self-development.**

  Human beings are toolmakers. They are developers of technology and techniques that enable people to do their work more productively and live their lives more happily. The instrument of leadership is the self, and mastery of the art of leadership come from mastery of the self—not stuffing in a whole bunch of new information or trying out the latest technique, but liberating the leader within us. It is about setting ourselves free (83).

- **Leadership development is not an event, it is an ongoing process.**

  Workshops and other classes are one effective way to learn, but people know as well as others do that these are not the only way. Much of learning will happen after the participants leave the workshop. While leaders are going to help people develop their skills and abilities during this workshop, leaders want to emphasize that leadership development is an ongoing process that people must continue if they are to become the best leader they can be (83).

**Other principles involve:**

  DonClark (2007) identifies ten principles of leadership (82):

  1. **Be technically proficient:**
As a leader, he/she must know his/her job and have a solid familiarity with his/her employees' tasks (82).

2. **Seek responsibility and take responsibility for others' actions**
   Search for ways to guide the organization to new heights. And when things go wrong; they always do sooner or later – do not blame others. Analyze the situation, take corrective action, and move on to the next challenge (82).

3. **Make sound and timely decisions**
   Use good problem solving, decision making, and planning tools (82).

4. **Set the example**
   Be a good role model for the employees. They must not only hear what they are expected to do, but also see (82).

5. **Know workers and look out for their well-being**
   Know human nature and the importance of sincerely caring for your workers (82).

6. **Keep workers informed**
   Know how to communicate with not only them, but also seniors and other key people (82).

7. **Develop a sense of responsibility in workers**
   Help to develop good character traits that will help them carry out their professional responsibilities (82).

8. **Ensure that tasks are understood, supervised, and accomplished**
   Communication is the key to this responsibility (82).

9. **Train as a team**
   Although many so called leaders call their organization, department, section…etc. a team; they are not really teams --- they are just a group of people doing their jobs (82).

10. **Use the full capabilities of the organization**
    By developing a team spirit, the leader will be able to employ the organization, department, section …etc to its fullest capabilities (82).

   Broadly put, the function of leader is to persuade others to follow. In the organizational context, training, supervising, delegating, team building, rewarding are all leadership functions. So are active and empathetic listening, evaluating performance, maintaining effective interpersonal relations, and counseling when mistakes are made. An important leadership function is exercising power and influence to motivate staff members to do what they are supposed to (84).

**LEADER'S ROLE:**

Role as defined by the Business Dictionary is “A prescribed or expected behavior associated with a particular position or status in a group or organization”. Whereas, "Function" is playing the part that a person is responsible to play. As an employee, they have a function to do their job. All people have many functions. A "role" is when a person takes his/her function and builds an identity out of it (85).

On the word of Marquis and Huston (2009), they suggested that the leader roles include: (1) encourages followers to be actively involved in the quality control process. (2) Clearly communicates expected standards of care to subordinates. (3) Encourages the setting of high standards to maximize quality instead of setting minimum safety standards. (4) Embraces and champions quality improvement as an ongoing process. (5) Uses control as a method of determining why goals are not met. (6) Distinguishes between clinical standards and resource utilization standards, ensuring that patients receive at least
minimally acceptable levels of quality of care. Finally, (7) supports/actively participates in research efforts to identify and measure nursing sensitive patient outcomes (64).

According to Manfredi (1995), she identified five roles for the leader that serve as a challenge for leaders and those who aspire to leadership roles in the future (86).

1. Leaders create visions:

   Leaders frequently engage in the process of traveling into the future. When an individual plans a vacation, the months or weeks prior to the trip are often spent in a process the town elders might have humorously referred to as "anticipatory vacationalization". Like vacations, leaders dream of possibilities and envision the future (86). They spend a great deal of effort "gazing across the horizon of time..." (Kouzes and Posner, 1987) (9). In most instances the leader is an innovator: the creator of the idea who works with followers to bring the idea to fruition. In some instances, however, the leader is the advocate or the adopter: recognizing the value in the creative idea of another and working with followers to promote and implement the idea (87). "The leader's primary contribution is in the recognition of good ideas, the support of those ideas and the willingness to challenge the system" (Kouzes and Posner, 1987) (9).

2. Leaders create climates:

   Leaders build teams and create an esprit de corps that generates excitement within followers. Dreams and visions are more exciting when they can be shared with others, and they can only be achieved through the commitment and support of knowledgeable, informed followers. Leaders must earn that commitment and support, and they can do so by creating a climate wherein followers can challenge ideas and are encouraged to speak the truth. The truth is not always what leaders want to hear, but it may be what they need to hear if they are to bring about the changes that will lead to a better future (86).

3. Leaders create conflict:

   Promoting and facilitating the status quo only serve to stifle creativity and impede the healthy process of change and growth. Leaders must be willing to challenge existing ideas, structures, processes, and visions. Conflict generating strategies can be as simple as providing new information or promoting discussion of an idea. Too much conflict can lead to chaos and too little conflict can lead to stagnation. Conflict is an antecedent of change (86).

4. Leaders create change:

   Leaders sow the seed of change; they initiate discussions and engage in dialogue to stimulate thought and stretch the imagination of followers. In many respects, leaders create the window of possibility through which followers see a future crafted by the leader. The role of the leader is to work with followers to open possibilities to enable a changed future to emerge. Change represents a monumental threat to the status quo. The relationship between conflict, status quo and change can be a useful tool for change agents (figure 1). Leaders need to realize that too little conflict can lead to apathy and too much conflict can lead to chaos. Leaders must become skilled at creating a climate wherein the status quo is balanced by healthy conflict (86).
5. Leaders create leaders:
Leaders come from the ranks of followers (Rosenback and Taylor, 1993) (88). The preparation of leaders for the future falls to those who are currently exercising leadership. Leaders are charged with the responsibility of grooming potential leaders who will provide a new direction and create a new order. Creating new leaders has been associated with coaching and mentoring. The new leader will forge in a different direction, carve out a new role, and create a new order (86).

LEADER'S FUNCTIONS:
Grant and Massey (1999) reported the following functions of a nurse leader (89):
(1) Acting as a role model for others; (2) providing expert nursing care based on theory and research findings; (3) demonstrating knowledge about organizational theory to support and influence organizational policies; (4) collaborating with others to provide optimum health care; (5) assuming responsibility for providing information and support to patients; (6) using advocacy to help effect changes that will benefit patients and the health care organizations; and (7) using the nursing codes of ethics and standards of practice as guidelines for individual and professional accountability (89).

The nurse leader functions at different nursing management levels in various health care settings; thus the arch of leadership could provide guidelines for an effective leader for the future (90).

THE ARCH OF LEADERSHIP
The arch of leadership could be viewed with the dimensions of clarity, commitment, self-image, price, and behavior. This arch could have several uses, one being the lens of the characteristics of an effective leader, the other to identify and solve problems in the health management sector (figure 2) (90).

Figure (1): Conflict/status quo model (86).

Figure (2): The arch of leadership (90).

1. Clarity:
The two pillars of the leadership are clarity and behavior. Everything starts at clarity. The leader should conceptualize what is right and communicate the future picture of the service to followers. The compelling picture of the future should focus
more on people. The leader should communicate the future picture of managing the service more effectively to followers by: (1) Sharing the vision and mission of the service with them; (2) Setting time frames for their tasks; (3) Being positive, and having openness towards followers; (4) Establishing team building projects in the service; (5) Promoting research strategies in the service; (6) Operating within the legal/ethical/professional framework of the profession and country; and (7) Using his/her listening skills (90).

The leader is responsible for communication and should check for clarity of communication and should involve all followers in decision-making and setting standards, for more commitment. Less involvement leads to less commitment (90).

2. Commitment:
People are committed when they take action, and have the will to stick with something they have started to the very end. In order to be committed, a leader has facets of self motivation, inner norms and values, job satisfaction, the necessary challenges in the workplace, knowledge and expertise, good working conditions, incentives and people skills. Every leader has his/her own hot buttons that leads to more commitment (90).

3. Self-image:
This concept is the center of the arch. Knowing what you can and can not do. Inner leadership helps us to bring our hidden qualities of leadership into reality and to apply them in our lives and work situations. Inner leadership provides a practical process for: increasing self awareness, uncovering assumptions and beliefs which limit the effectiveness; using our awareness and inner will to realize our deepest resources and self-leading potentiality (90).

4. Price:
The way management treats their employees is exactly how the employees will treat the clients and provide total quality nursing care (90). Employee satisfaction towards the job and the organization has a positive effect on employee loyalty and behavior towards clients/patients (Mullins et al., 2001) (91). This promotes client retention, and is the most effective marketing strategy (90).

5. Behavior:
There are many different leadership styles that could be used to lead health care systems into the future (90). Transformational leadership is an empowering leadership style and one which is highly suited to the profession of nursing (13). Five of the fundamental practices in an effective leadership style should be pointed out the Five Practices of Exemplary Leadership (model the way, inspire a shared vision, challenge the process, enable others to act, and encourage the heart) (90).

Effective leaders are constantly striving to improve their leadership skills (12). For nurses to have a voice in the future of health care, nurses need to develop leadership skills and competencies and assume leadership positions (1).

LEADERSHIP SKILLS

According to the Australian National Training Authority (2009), a competency is the set of skills and knowledge required to perform particular job function successfully.
‘Knowledge’ is the foundation, knowledge required to understand what needs to be done, and ‘skill’ is the ability to actually do the task. A skill on its own is therefore one component of the overall competency. Some also include the concept of ‘attitude’ forming part of the overall competency requirement, however as ‘competency’ must be measurable, the question would be how to measure an attitude. So when a workplace assessor makes an assessment of competency, it is a statement of that person having real and demonstrated skills, knowledge and attitude to perform the task effectively, at or above the standard required as identified in the competency (92).

**Skills** are defined by Buckingham and Coffman (1999) as "the how to's of a role". **Skills** are capabilities that can be transferred from one person to another. Similar to skills is the term "knowledge", which is "what you are aware of" (93). There are five core leadership skills referred to as: technical/analytic, relational, strategic, financial/information technology, and personal and self-development Skills. These core leadership skills are requisite behaviors of all leaders – from supervisors to CEOs – in their everyday functioning. Demands of leadership at the supervisory level focus primarily on technical/analytic skills, and secondarily on relational skills, and to a lesser extent on strategic skills. The demands of leadership at the middle – management level primarily involve both technical/analytical and relational skill sets. Demands of leadership at the executive level are primarily on strategic skills and relational skills and secondarily on technical/analytic (94).

**ESSENTIAL LEADERSHIP SKILLS**

1. **Technical/Analytic Skills**
   a. **Mastering Job-Specific Skills:** Job-specific skills are the basic competencies related to a job position—that is, computer literacy, preparing a production schedule, budgeting, and so on. They are specified by a job description, job analysis, and job specifications. These specific skills can be learned in several ways: management training program, apprenticeship, and so forth (94).
   b. **Problem Solving and Decision Making:** Both decision making and problem solving are action processes that overlap—in other words, decision making is a step and a skill in the problem-solving process (94).
   c. **Time and Priorities Management:** Managing priorities is irrefutably linked with being a successful leader. Effective management of priorities is related to time management (94).
   d. **Project Management:** Unlike day-to-day responsibilities, projects are one-time undertakings that are divided into specific sections that can be sequenced and independently evaluated. Effective project management is a surefire test of both project team and leader performance (94).
   e. **Performance Monitoring:** Monitoring is the continuous process of checking progress on performance and goal outcomes. It involves both formal and informal checks, and when the leader renders feedback based on performance monitoring, the process becomes proactive (94).
   f. **Training and Development:** Training provides individuals with the necessary knowledge and skills to perform a job, whereas development prepares individuals for increasingly responsible or complex jobs or careers (94).

2. **Relational Skills**
   a. **Communication:** Communication is considered the most important of the leadership skills. It is the "bridge" for transferring knowledge and guidance, as well as for receiving information from inside and outside the organization (94).
b. **Team Development:** A team is a group of individuals that collaboratively accomplishes specified goals; effective leaders promote optimal teamwork (94).

c. **Diversity:** Diversity in a work team may involve gender, age, race, ethnicity, religion, and lifestyle factors. Effective leaders have the capacity of facilitating subordinates to work together as a team—despite their diversity—and to perform optimally (94).

d. **Motivation:** Motivating subordinates to function effectively is essential for both individual and team productivity. Leaders need to be sufficiently competent in understanding and utilizing motivation and recognizing and eliminating sources of job dissatisfaction (94).

e. **Conflict Resolution:** Resolving conflict is essential for both efficient and effective team performance. Most leaders would do well to increase their skill level in preventing and resolving conflict (94).

f. **Coaching:** Coaching is a process of guiding and encouraging subordinates to achieve optimal performance. It is considered the pinnacle of the relational skills, requiring a high degree of competence in the other relational skills. Assuming that the subordinate and the leader/coach have previously developed and agreed upon job standards and goals, coaching can proceed (94).

3. **Strategic Skills**

a. **Visioning and Strategy Formulation:** Vision is the capacity to perceive possibilities and to create an ideal depiction of where an organization will be or needs to be at a future time. It involves setting a clear, focused, desirable direction that points toward and energizes an organization toward a specific destination (94).

b. **Strategic Implementation and Management:** Strategy is an integrated, long-term way of perceiving, thinking, deciding, and acting that produces viable plans for achieving an organization's vision (94).

c. **Guiding Change:** Guiding change involves preparing for, initiating and implementing the change process (94).

4. **Financial/Information Technology Skills**

a. **Mastering the Budgeting Process:** This skill permits the leader to effectively plan, implement, and then evaluate a unit budget (94).

b. **Understanding Balance Sheets and Financial Reports:** Financial performance analysis and decision making that involves financial considerations both require sufficient understanding of financial statements (94).

c. **Monitoring Financial and Human Resources:** It is essential for leaders to have their own ongoing, informal measures and indicators of performance and financial indicators to compare with formal quarterly reports from finance, operations, human resources, and so on. These measures permit leaders to quickly and easily monitor and analyze critical financial and performance indicators (94).

d. **Using Data to Guide Management Decisions:** Managerial decision making can be greatly enhanced when data are appropriately utilized. The capacity to effectively utilize data in such decision making is essential for leadership effectiveness (94).

5. **Personal and Self-Development Skills**

a. **Stress and Lifestyle Management:** This skill set enhances the leader's capacity to control and cope with stress, on and off the job (94).

b. **Balancing Family, Work and Personal Life:** Because individuals who can effectively balance job, family, and personal dimensions tend to be healthier and more productive, leaders need to develop the skill of balancing competing expectations and demands on them (94).

c. **Developing/Utilizing a Personal Mission Statement and a Career Plan:** The trajectories of personal development and career development tend to remain in parallel and
in sync with job/organizational goals for highly effective individuals. Establishing a personal mission statement can facilitate both personal and career development (94).

**LEADERSHIP TALENTS**

Talents are natural abilities that influence an individual's "recurring patterns of thought, feeling, or behavior" (Buckingham and Coffman, 1999) (93). These abilities are inborn traits, which mean that they cannot be learned or coached like skills or "pure" competencies (94). Buckingham and Coffman (1999) isolated 39 talents that individuals manifested to excel in their leadership role. These talents can be classified in three categories: *striving talents, thinking talents*, and *relating talents* (93).

1. **Striving Talents:** These talents "explain the *why* of a person. They explain *why* he gets out of bed everyday, *why* he is motivated to push and push just that little bit harder" (Buckingham and Coffman, 1999) (93). Stamina and vision are two of the striving talents. Stamina is defined as the capacity for physical endurance, whereas vision is the "drive to paint valued-based word pictures about the future" (93).

2. **Thinking Talents:** These talents "explain the *how* of a person. They explain how he thinks, how he weighs up alternatives, how he comes to his decisions". Strategic thinking, formulations, and creativity are three of the thinking talents. Strategic thinking is defined as the ability to specify alternative scenarios in the future, whereas formulation is the ability to find coherent patterns amid incoherent data sets. Creativity is defined as the ability "to break existing configurations in favor of more effective/appealing ones". Anyone who has worked with a group involved in strategic planning quickly recognizes that some individuals, with this talent, can quickly envision future alternatives, whereas others—without the talent—struggle with some or all of the process (93).

3. **Relating Talents:** These talents "explain the *who* of a person. They explain whom he trusts, whom he builds relationships with, whom he confronts, and whom he ignores". Empathy, positivity, and ability to be an activator are 3 of the relating talents studied by Buckingham and Coffman (1999) (93). Empathy is the ability to identify feelings and perspectives in others, whereas positivity is the ability to see the bright side. Being an activator is defined as the "impatience to move others to action" (93).

**LEADERSHIP COMPETENCIES**

Competencies tend to be the reservoir that collects all of the knowledge, skills, and abilities (referred to as KSAs) of an individual, and an organization as a whole. Knowledge is typically defined as something that a person knows...what is learned either through study or experience. Skill is typically more role-specific or technical in nature, and is the ability to translate what the person knew and have learned in to an activity or behavior through which becoming skilled. Competencies include elements of knowledge, skills, and abilities, and add a critical behavioral and observable element. Competency models typically list the transparent and observable behaviors that are the end result of how KSAs are delivered to the world. There are many existing competency models (95).

Therefore, Competencies can be defined as capabilities that many corporations use to describe expected behavior in leaders (94). Buckingham and Coffman (1999) note that some competencies may actually be talents such as "remaining calm under fire", whereas other competencies may actually be skills, such as "implements basic operational systems". They urge executives to be very clear about the actual requirements of specific
competencies, because if a talent-based competency is specified for a given individual, unless the individual possesses that talent, it can not be learned (93). The ideal is to establish "pure" competencies – those that are primarily skill-based and not talent-based. The seven competencies are listed with regard to three levels of effectiveness—highly, moderately, and minimally effective—with each level specified in behavioral terms (94).

1. Acts with Integrity and a Sense of Balance
   The leader creates a committed organization that acts with full unparalleled integrity, courage, and authenticity; serves as a role model by acting in a consistent and fair manner; manifests a high degree of stability and balance among corporate, personal, and family needs and demands (94).
   **Behavioral indicators:**
   Genuinely lives with integrity and courage, consistently keeps ego in check, leads by example and models fairness, courage, and honesty, and finally balances among corporate, personal, and family demands (94).

2. Develops a Winning Strategy
   The leader creates and communicates a compelling vision of the future that reflects corporate values, resources, trends, and opportunities; establishes and commits to strategies and a course of action that will accomplish the vision (94).
   **Behavioral indicators:**
   Scans environment and develops long-term approaches, envisions the future when developing strategy, anticipates potential obstacles, competition, and alternate scenarios, fosters internal and external commitment for strategy, and finally effectively implements strategy throughout the organization (94).

3. Mobilizes Employee Commitment
   The leader inspires and motivates individuals to achieve and remain loyal to the organization's strategy, vision, and goals; develops and maintains a strong talent pool by continuously developing individuals' skills, knowledge, and capacities (94).
   **Behavioral indicators:**
   Identifies and develops organization strengths to match opportunities, anticipates needed competencies and actively develops them in others, effectively demonstrates how the organization meets customers' needs, is significantly involved in coaching, developing, and supporting staff, and finally increases employees' commitment by developing a culture of trust (94).

4. Possesses Requisite Job Capabilities and Understands Corporate Dynamics
   The leader possesses requisite job capabilities and a keen understanding of customers, markets, operations, and emerging issues to accomplish the corporate vision. The leader makes and accepts decisions based on facts, experience, and warranted assumptions about changes in markets, resources, or regulations (94).
   **Behavioral indicators:**
   Thoroughly and systematically analyzes strategic initiatives, achieves an equitable outcome in a negotiation, demonstrates the capacity to make and accept difficult decisions, and finally proactively develops contingency plans re: changing market, regulations, or resources (94).

5. Engenders Corporate Capability
   The leader sets high goals for organizational and personal performance and commits the organization's resources to achieve these goals. This individual utilizes performance monitoring to hold self and others accountable for achieving high-quality results (94).
   **Behavioral indicators:**
   Proactively develops partnerships for achieving goals throughout the organization, consistently sets the bar higher and searches for new tactics to improve results, challenges
current perceptions that limit effectiveness and results, and finally effectively maintains and manages organizational boundaries to deliver results (94).

6. Communicates Effectively and Encourages Knowledge Sharing

The leader creates a culture of open, honest communication and knowledge sharing. This individual regularly solicits ideas, provides honest feedback, and shares information with staff and others. The leader regularly practices effective listening and manifests good verbal and written communication skills (94).

**Behavioral indicators:**

Encourages and rewards diversity of opinion in discussing issues, redesigns structure to support effective corporate communication, seeks, quantifies, and responds to employee input in large and small issues, and finally utilizes communication networks for corporate exchange of best practices (94).

7. Exhibits a High Level of Energy and Health Status

The leader manifests significant energy reserves to achieve short- and long-range goals, despite arduous working conditions. This person also maintains a high level of physical and psychological well-being, despite adverse circumstances, demands, and emotional stress (94).

**Behavioral indicators:**

Exhibits and sustains a high level of energy and stamina, has unlimited capacity to effectively entertain business clients, recovers rapidly from minor illnesses, injury, exertion, and emotional stress, and finally retains excellent health, despite arduous job demands and deadlines (94).

Leadership is viewed as a social exchange process, which involves four basic variables or factors: the leader, followers, communication, and the situation (82).

**MAJOR FACTORS IN LEADERSHIP**

There are four major factors in leadership (figure 3) (82):
Figure (3): Factors of leadership \(^{(82)}\).

**Follower**

Different people require different styles of leadership. For example, a new hire requires more supervision than an experienced employee. A person who lacks motivation requires a different approach than one with a high degree of motivation. The leader must know his/her people! The fundamental starting point is having a good understanding of human nature, such as needs, emotions, and motivation \(^{(82)}\).

**Leader**

Leader must have an honest understanding of self, knowledge, and action. Also, note that it is the followers, not the leader who determines if a leader is successful. If they do not trust or lack confidence in their leader, then they will be uninspired. To be successful the leader have to convince the followers, not self or superiors, that are worthy of being followed \(^{(82)}\).

Leader leads through two-way communication. Much of it is nonverbal. For instance, when leader "set the example," that communicates to followers that would not ask them to perform anything that the leader would not be willing to do. What and how leader communicate either builds or harms the relationship between him and followers \(^{(82)}\).

**Situation**

All are different. What leader does in one situation will not always work in another. Leader must use judgment to decide the best course of action and the leadership style needed for each situation. For example, leader may need to confront an employee for inappropriate behavior, but if the confrontation is too late or too early, too harsh or too weak, then the results may prove ineffective \(^{(82)}\).

Various forces will affect these factors. Examples of forces are leader's relationship with seniors, the skill of followers, the informal leaders within the organization, and how the organization is organized \(^{(82)}\). Leadership demands a commitment of effort and time. Many barriers exist to both leading and following. Good leadership and good followership go hand in hand, and both make the mission of the organization stronger. However, there are barriers to leadership \(^{(12)}\).

**BARRIERS TO EFFECTIVE LEADERSHIP**

- **False assumptions:**
  
  Some people have false assumptions about leaders and leadership. For example, one believes that position and title are equivalent to leadership. Having a title of Chief Executive Officer (CEO) or Chief Nursing Officer (CNO) does not guarantee that a person will be a good leader. Inspired and forward-moving organizations often select these executives specifically because of their ability to forge a vision and lead others toward it. Others believe that worker who does not hold official management positions can not be leaders. Leaders are those who do the best job of sharing their vision of where
the followers want to be and how to get there. Many new nurse managers make the mistake of assuming that along with their new job comes the mantle of leadership (12).

- **Time constraints:**

  Leadership requires a time commitment; it does not just happen. The leader must fully comprehend the situation at hand, investigate and research options, assume the responsibility to communicate the vision to others, and continually reevaluate the organization or the team to ensure that the vision remains relevant and attainable. All of these activities take time (12).

  The 21st century has been described as the period of doing more with less. Everyone is busy. Finding time to lead is, therefore, a barrier for many who have inspirational ideas but lack time to develop the skills needed to lead effectively (12). Most researchers define leadership in a manner appropriate to their investigation, so it is necessary to be familiar with a variety of prospective from theorists and researchers and to accept leadership as a complex and multifaceted phenomenon (Marriner-Tomey, 2004) (96).

**THEORETICAL FRAMEWORK**

1) **The leadership theories before the 1980s**

   In the early 1900s, leadership theories focused on the leader’s personal traits, such as physical, mental, and personality characteristics. These traits were studied to determine what made certain people great and effective leaders (50). Early leadership theories were known as the “Great man” theories because they were based on the attributes of great social, political, and military leaders (Northouse, 1997) (97). The trait approach focuses exclusively on the leader, and not on the followers or the situation. Major leadership traits that were derived from the research during that time period include intelligence, self-confidence, determination, integrity, and socialability. It was believed that people were born with these traits, and that only great people possessed these traits (50). The early work of Stogdill (1948) contributes to this traits approach (98).

   During the 1950s, the emphasis in leadership theories changed from analyzing traits to identifying behaviors which resulted in effective leadership (Cole, 1999) (99). This behavior-centered approach, known as the style approach, attempts to determine what successful leaders do and how they act. The style approach provides a framework for assessing leadership in a broad way, as behavior with a task and relationship dimension (50). The main purpose of the style approach is to determine how leaders combine the two types of behaviors – task behaviors and relationship behaviors – to influence subordinates in their efforts to reach a goal (Northouse, 1997) (97).

   Studies, conducted at Ohio State and University of Michigan, explored the relationship between two variables: people and tasks. They reported that supervisors of high producing groups tended to be employee-oriented, allowed employee participation in decision making, and promoted team development and cohesiveness. In the other hand, supervisors with low producing groups were tasks oriented, focused more on tasks than employees’ needs, and monitored and controlled employees’ performance (Murphy, 2005) (15).

   A third approach, known as the situational approach, was created when researchers found that traits and behaviors could not fully explain leadership effectiveness, and at the
same time, it became apparent that behaviors in one circumstance did not produce the same effect in another circumstance (Rakich et al., 1985) (100). The situational approach was developed by Hersey and Blanchard (1993), and has been revised several times since its inception (101). The basic premises of the situational theory are that different situations demand different kind of leadership and that leadership is comprised of both a directive and supportive dimensions, and each has to be applied appropriately in a given situation (Northouse, 1997) (97).

Another approach to leadership theory deals with the interaction among the leader’s traits, the leader’s behaviors, and the situation in which the leader exists (50). This approach is known as the contingency theory or a leader-match theory, because it tries to match leaders to appropriate situations (Northouse, 1997) (97). The publication of Fiedler (1967) was the first one presented the new contingency approach (102). Fiedler’s model of leadership effectiveness emerged as an answer to Stogdill’s (1948) call for an approach based on the interaction of leader traits with situational parameters (50). According to Horner (1997), this contingency approach makes the assumption that the effects of one variable on leadership are contingent on other variables, and that leadership could be different in every situation (103). Several theories emerged from the contingency theory such as the path-goal theory, which deals with how leaders motivate subordinates, and the leader-member exchange theory, which centers on the interaction between leaders and followers (50).

2) The leadership theories after the 1980s

As the leadership research has grown and expanded, a broader look at leadership emerged and in the mid 1980s a major shift in the leadership appeared as a result of the work of a political historian Burn’s (1978) (50). Burns (1978) attempted to link the role of leadership and followership. He distinguished between two types of leadership: transactional and transformational (60).

TRANSACTIONAL LEADERSHIP

Transactional leadership is an exchange posture that identifies needs of followers and provides rewards to meet those needs in exchange for expected performance. It is a contract for mutual benefits that has contingent rewards. The leader is a caretaker who sets goals for employees, focuses on day-to-day operations, and uses management by exception. It is a competitive, task-focused approach that takes place in a hierarchy (96). A transactional leader is the traditional “boss” image. In a transactional leadership environment, employees understand that there is a superior who makes the decisions with little or no input from subordinates (12). Transactional leadership relies on three methods to move followers: (1) offering rewards to staff or followers for desired work, (2) monitoring work performance and correcting followers when a problem is noted, and (3) waiting until a problem occurs and then dealing with the issue retrospectively (Dunham-Taylor, 2000) (33).

Transactional leadership relies on the power of organizational position; and formal authority to reward and punish performance. Followers are fairly secure about what will happen next and how to “play the game” to get where they want to be. A transactional leader uses a quid pro quo style to accomplish work (e.g., doing “x” in exchange for others
The transactional leader is more likely to opt for status quo and is usually found in stable environments (12).

## TRANSFORMATIONAL LEADERSHIP

Since the early 1980s, a new paradigm of leadership has emerged as a result of the support of the organization to the great effectiveness of transformational leadership in comparison to transactional leadership, in generating followers’ willingness to exert extra effort, commitment, satisfaction, and contribution (Bass, 1985) (68).

Transformational leadership promotes employee development, attends to needs and motives of followers, inspires through optimism, influences changes in perception, provides intellectual stimulation, and encourages follower creativity (96). The transformational leadership style is described by Markham (1998) as collaborative, consultative, and consensus-seeking and as ascribing power to interpersonal skills and personal contact (104). The leader is a role model who uses individualized consideration, provides a sense of direction, and encourages self-management (96).

Kouzes and Posner (2005) identify five key practices in transformational leadership: (1) modeling the way, meaning that the leader must take an active role in the work of change; (2) inspiring a shared vision or bringing everyone together to move toward a goal that all accept as desirable and achievable; (3) challenging the process, which involves questioning the way things have been done in the past and thinking creatively about new solutions to old problems; (4) enabling others to act, which includes empowering people to believe that their extra effort will have rewards and will make a difference; (5) encouraging the heart by giving attention to those personal things that are important to people, such as saying “thank you” for a job well done and offering praise after a long day (6, 12, 96). This type of leader seems particularly suited to the nursing environment (12).

## NURSING LEADERSHIP PRACTICES

There are many leadership frameworks for practice; however, transformational leadership requires using specific practices that move people to purposeful action (3). Kouzes and Posner (2005) developed a realistic framework for leadership practices (6).

Kouzes and Posner (1987) developed a model of leadership after conducting extensive research, in which they explore the problem of what leaders do when they do their personal best. Information, was collected from over one thousand leaders on their exemplary leadership practices. They asked the leaders to write a description of one personal best leadership experience in which they accomplished something extraordinary in an organization. The narratives were analyzed and common patterns and themes began to emerge from these personal bests. Kouzes and Posner (1987) discovered that there was a fundamental pattern of leadership behavior that emerges more than 70% of the time when people are accomplishing extraordinary things in organizations. From the analysis of the personal best cases was developed a model of leadership (9). This can best be described as five leadership practices and ten behavioral commitments or strategies. The leadership practices are: modeling the way, inspiring a shared vision, challenging the process, enabling others to act, and encouraging the heart. The ten behavioral commitments directly
relate to the leadership practices as depicted in (figure 4) on the star diagram. There are two behavioral commitments for each leadership practice (105).

A manager may use one, two or even three of the practices and behaviors described by Kouzes and Posner, but it is the star manager who utilizes all five practices and ten behaviors and becomes an extraordinary leader (9). From this extensive research Kouzes and Posner (2005) developed a leadership measurement instrument called the Leadership Practices Inventory (6). The results of the research show that leaders do exhibit certain distinct practices when they are doing their best (Kouzes and Posner, 1987) (9). Good leadership is not only understandable but it is universal. It is a process that ordinary managers can use when they are bringing forth the best from themselves and others (105).

Figure (4): Extraordinary Leadership (105).

1) Model the way

The first leadership practice is to model the way (105). Modeling means going first, living the behaviors you want others to adopt. This is leading from the front. People will believe not what they hear leaders say but what they see leader consistently do. When the process gets tough, get your hands dirty. A boss tells others what to do...a leader shows that it can be done (6). Leaders establish principles concerning the way people should be treated and the way goals should be pursued. They create standards of excellence and then set an example for others to follow. Because the prospect of complex change can overwhelm people and stifle action, they set interim goals so that people can achieve small
wins as they work toward larger objectives. They unravel bureaucracy when it impedes action, put up signposts when people are unsure of where to go or how to get there, and create opportunities for victory (106).

Effective leaders should create a friendly environment, which supports collaboration, enthusiasm and commitment from staff. Leaders are people who get others to perform at consistently high standards – voluntarily. In these times of scarce resources and long hour working weeks, the leader should strive to create a fun place to work. Leaders should be flexible, using their own and everyone else’s skills to the limit. Leaders have fast reactions to change, encourage innovation, and have a questioning mentality. They are focused on specific goals, which are owned by everyone. Modeling the way is how leaders make their vision tangible (Kouzes and Posner, 1987) (9), Leaders take complex intricate plans and establish manageable and understandable steps so employees are able to successfully accomplish necessary tasks. The two behaviors that support modeling the way are setting the example and planning small wins (105).

**Setting the example** begins with a leader consciously behaving in ways that are consistent with stated values (Kouzes and Posner, 1987) (9). It understands the clarity and courage of a leader's convictions and daily actions is how visions are realized and how respect and credibility are gained. Leaders provide standards by which other people in the organization can measure their actions and effectiveness. Clarity, consensus, and intensity are three essential factors for aligning values of leaders with those of their followers. Strategies for accomplishing this include clarifying the values in which leader believe, translating these values into guiding principles for the organization, sharing leader's personal beliefs and organizational guidelines publicly, auditing leader's actions regularly in order to remain consistent with publicized values, teaching others about leader's values, and being emotional and caring about beliefs (105).

Modeling the way is **planning small wins** so success can be experienced (Kouzes and Posner, 1987) (9). When problems are too large they may seem overwhelming and insurmountable. Extraordinary leaders set up opportunities for small success thereby creating an environment of excitement, potential, confidence, accomplishment, and commitment to continuing the journey. Therefore, an effective leader will structure the change process incrementally, whereby big tasks are broken down into small, manageable steps, and accomplishment of each small step becomes a win. Strategies for facilitating small wins are planning and preparing for the journey, experimenting with changes along the journey, moving forward in small incremental steps, making progress visible, allowing for mistakes, and encouraging people to make choices so increased commitment and ownership is realized. Extraordinary leaders convince followers that the impossible is possible and that the journey begins with one small step (105).

2) **Inspire a shared vision**

The second leadership practice is to inspire a shared vision (Kouzes and Posner, 1987) (9). Leaders are people who thrive on change and inspire their followers by having and communicating a vision, which is arrived at jointly by their people, for whom they show a great deal of concern (Sofarelli and Brown, 1998) (13). The leader should have a personally created dream about how one would like things to be in the future, be committed to this vision and should empower others with that vision (Lambert and Nugert, 1999) (107).
People are motivated most not by fear or reward, but by ideas that capture their imagination. Leaders should share their vision in words that can be understood by their followers. Note that this is not so much about having a vision, but communicating it so effectively that others take it as their own (6). Leaders passionately believe that they can make a difference. They envision the future, creating an ideal and unique image of what the organization can become. Through their magnetism and quiet persuasion, leaders enlist others in their dreams. They breathe life into their visions and get people to see exciting possibilities for the future (106).

Inspiring a shared vision encompasses the leaders' ability to look forward into the future, see the possibilities that exist, and capture the hearts of others. Leaders create a vision that becomes the guiding common purpose of the organization and is an ideal and unique image of the future. Leaders are hopeful about the future and believe that it is people who make the difference in the future. Inspiring a shared vision means that leaders breathe life into their vision so that it becomes tangible and understandable to others. The two behavioral commitments of inspiring a shared vision are envisioning the future and enlisting others (105).

Envisioning the future is the process of creating a dream and getting others to buy into it with great passion and commitment (Kouzes and Posner, 1987) (9). Leaders look into the future and imagine that greater things can happen. Leaders have vision (105). Kouzes and Posner (1987) see vision as having four attributes: future orientation, image, ideal, and uniqueness. Future orientation is a statement of destination and the end ideal. Image is the ability to know what destination and the end ideal looks like. It is a mental picture of what things will be and is a window into the world of tomorrow. Ideal is defined as a vision that has the ultimate of possibilities and standards of excellence. Unique describes the quality that makes a vision distinct and different from everyone else in order to foster an atmosphere of pride and self respect (9).

The second behavioral commitment of inspiring a shared vision is enlisting others (Kouzes and Posner, 1987) (9). Enlisting others enforces the importance of having all employees understand and support a vision. Extraordinary leaders educate and clearly communicate their visions to everyone enlisting their support. An example of a vision is Reverend Martin Luther King's speech (1963) "I have a dream". King's speech comes from the heart, speaks to the people, is easily understood, and creates passion. So, this vision can be seen. It conjures up images, evokes enthusiasm and creates followers. Empowerment occurs in organizations when all employees align their energies to realize the vision (105).

3) Challenge the process

The third leadership practice is to challenge the process (Kouzes and Posner, 1987) (9). Leaders are prepared to take risks that bring about change, challenging the status quo. But change is not necessary synonymous with growth (Charlton, 2000) (108). The ability to initiate individual and organizational growth-directed change has become a core competence in the changing health care environment. As nurses are never far from change; it is a hallmark of the profession (90). Perhaps the biggest challenge that looms in the coming decades for leaders is the need to devise programs that will inculcate a global mindset in their people. To become a global leader, one must transform one’s mindset.
The emerging paradigms in health care require leaders who are able to be strategic in their thinking and facilitative in their style. Leaders find a process that they believe needs to be improved the most and they thrive on and learn from adversity and difficult situations. They are early adopters of innovation. Leaders search for opportunities to change the status quo. They look for innovative ways to improve the organization, and in doing so, they experiment and take risks. Because leaders know that risk-taking involves mistakes and failures, they accept the inevitable disappointments as learning opportunities.

The American Heritage Dictionary defines to lead as to show the way or to guide. It implies the process of a journey or a trip. Kouzes and Posner (1987) use this analogy throughout their description of challenging the process. Leaders are those who go first. They seize opportunities, venture out into an adventure, and explore new territory. These words do not lead one to think of the same trip that is taken day after day. It conjures up thoughts of newness, unchartered waters, uncertainties, risk and change. "Leaders look for ways to radically alter the status quo, for ways to create something totally new, for new revolutionary processes, for ways to beat the system." (Kouzes and Posner, 1987). With this comes mistakes but every false step is an opportunity of learning. The two behavioral commitments are searching for opportunities and experiment and take risks.

Searching for opportunities means to bring new ideas to the organization, to be a change agent, to constantly challenge the status quo, and to look for possibilities. However, not always is it the leader who brings forth the new ideas, sometimes it is the employees. It is a good leader who is able to listen and encourage other's ideas into operation. To search for opportunities as a leader is to treat every job as an adventure. Look at your job as if through the eyes of a new person and ask what could be done differently. Kouzes and Posner (1987) suggest making a list of the way things have always been done. For each item, ask if that is useful for becoming the best possible organization. If the answer is no, then change it, because extraordinary leaders do things innovation. There is always something that needs fixing. Adding adventure to every job is a method of motivating, and breaking free of the routines. Lastly, they recommend making the adventure fun.

The second behavior in challenging the process is: experiment and take risks. A leader should have openness to ideas and a willingness to listen. They must try untested approaches and accept the risks that accompany the experiments. Experimentation and risk bring stress, but the stress does not have to be harmful. Leaders take charge of the change, accept the challenge, foster hardiness and create an adventure so that the outcome of experimentation and risk remains healthy and positive. To encourage experimentation collect ideas and suggestions for change from customers, employees, suppliers, and other stakeholders. A leader must make gathering new ideas a personal priority and spend every day observing, listening, or searching out comments. This is pivotal to successful innovation. Experimentation and risk taking demands team renewal by providing educational offerings, refocusing on goals, and adding new members to enhance creativity and motivation. Leaders honor other risk takers and recognize those that try, as well as those that succeed in order to encourage further risk taking. Leaders analyze every failure as well as every success so that learning occurs at every opportunity and leaders also model risk taking and foster hardiness.
4) Enable others to act

The fourth leadership practice is to enable others to act (Kouzes and Posner, 1987) (9). Challenges facing our extraordinary profession include maintaining a skill mix and patient allocation that will safely and effectively meet our carefully conceived professional standards for care. Further challenges lie in working within multi-disciplinary teams with highly refined communication and negotiation skills. Some of the commandments for leadership in enabling others to act are: enlist others; strengthen others; foster collaboration; celebrate and cheer accomplishments; recognize contributions (90).

Encouragement and exhortation is not enough. People must feel able to act and then must have the ability to put their ideas into action. Give them the tools and methods to solve the problem (6). Leaders foster collaboration and build spirited teams actively involving others. Leaders understand that mutual respect is what sustains extraordinary efforts; they strive to create an atmosphere of trust and human dignity. They strengthen others, making each person feel capable and powerful (106).

Enabling others to act builds teams, empowers others, and encourages the accomplishment of visions through others. Building cooperation and collaboration among colleagues, and designing win-win solutions creates a positive, productive and motivating work environment. Extraordinary leaders create an environment which encourages employees to apply their skills and energies to the continuous improvement of the organization. The two behavioral commitments of enabling others to act are fostering collaboration and strengthening others (105).

**Fostering collaboration** begins with creating and sustaining cooperative goals (Kouzes and Posner, 1987) (9). Speaking in terms of we and of our goals and accomplishments and recognizing the efforts of others reinforces a collaborative relationship and shares credit. Additional strategies for fostering collaboration includes creating a climate of trust and mutual respect, encouraging employees to interact with one another, focusing on the gains and opportunities versus the losses, involving the employees in problem solving and planning, and honoring risk taking behavior in yourself and others. Extraordinary leaders realize that the key to doing well lies not in competition or in overcoming others but in gaining cooperation and collaboration (105).

**Strengthening others** is the second behavior that supports leaders to enable others (Kouzes and Posner, 1987) (9). Strategies for building power for leaders and followers include getting to know people, being sensitive to others, listening actively to what others have to say about themselves, developing interpersonal competence, giving power away by delegating and keeping people informed, using personal power to assist others in their goals and making heroes of others. Extraordinary leaders recognize the importance of making people feel valued and believe that human resources are the most important resource in an organization. Leaders acknowledge that strengthening others leads to higher job satisfaction and performance and greater organizational effectiveness by empowering employees (105).

5) Encourage the heart

The fifth leadership practice is to encourage the heart (Kouzes and Posner, 1987) (9). Leaders recognize contributions that individuals make celebrate accomplishments and
enable individuals to share in the rewards of others. Leadership is only partly about yourself and largely about those people around you. Leader has to look inward to have outward influence, and also he/she have to recognize that to keep on being acknowledged as a leader, he/she have to keep earning it (90). People act best of all when they are passionate about what they are doing. Leaders unleash the enthusiasm of their followers this with stories and passions of their own. Share the glory with your followers' heart, while keeping the pains within your own (6).

Accomplishing extraordinary things in organizations is hard work. To keep hope and determination alive, leaders recognize contributions that individuals make. In every winning team, the members need to share in the rewards of their efforts, so leaders celebrate accomplishments. They make people feel like heroes (Kouzes and Posner, 2005) (6). Encouraging the heart is visibly recognizing people's contributions to the common vision, expressing pride in the accomplishments of the team, and making hard work enjoyable work. Leaders let others know how much they mean to the organization, they make people feel like heroes and they take time to enjoy success. The two behaviors are recognizing contributions and celebrating accomplishments (105).

Recognizing contributions is linking rewards with performance (Kouzes and Posner, 1987) (9). It is important to take time to recognize all who have made contributions and to celebrate the successes and milestones. Recognizing contributions requires leaders to have high expectations of themselves and followers, to have an ability to directly link performance with reward, to creatively use a variety of rewards and to have a positive and hopeful outlook in order to promote courage. Leaders recognize that creating an environment of high expectations brings out the best in people and they achieve more than they thought possible. Leaders set standards for determining success and creatively reward people for achievement other than promotion and raises. Leaders publicly acknowledge accomplishment and coach people to success realizing that this gives courage and allows individuals to accomplish extraordinary things (105).

Celebrating accomplishments is the leaders' recognition that extraordinary things do not happen alone but through the efforts of the people in teams (Kouzes and Posner, 1987) (9). Celebrating accomplishments is the process of honoring and sharing the success with all who assisted in the victory and is based on focusing on key values, making recognition public, and being personally involved. Celebrating occurs when significant events happen and are necessary to call attention to the moment and reinforce key values. Leaders realize that celebrating is not an event that occurs only at the end of a project but is something that occurs continually throughout the journey to give courage and spread joy and care about people and the product (105).

In a nutshell, Kouzes and Posner (1987) call these behaviors “The Ten Commitments of Leadership”. These ten commitments serve as the guide for discussion of how leaders get extraordinary things done in organizations and as the structure for what’s to follow (9). The leadership practices are summarized with their commitments in (table 1) (6).

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<th>No.</th>
<th>PRACTICE</th>
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| 1   | Model the Way     | 1. Find your voice by clarifying your personal values.  
                             2. Set the example by aligning actions with shared values. |
Inspire a Shared Vision
1. Envision the future by imagining exciting and ennobling possibilities.
2. Enlist others in a common Vision by appealing to shared aspirations.

Challenge the Process
1. Search for opportunities by seeking innovative ways to change, grow, and improve.
2. Experiment and take risks by constantly generating small wins and learning from mistakes.

Enable Others to Act
1. Foster collaboration by promoting cooperative goals and building trust.
2. Strengthen others by sharing power and discretion.

Encourage the Heart
1. Recognize contributions by showing appreciation for individual excellence.
2. Celebrate the values and victories by creating a spirit of community.

Kouzes and Posner's inventory (2005) is a self-report, but it can also be a 360-degree instrument. This inventory has been selected as the instrument used to examine the leadership practices of nurse leaders, because these leadership practices would seem to require nursing leaders to have the ability to understand and manage themselves as well as others (6).

THE USE OF 360 DEGREE FEEDBACK FOR DEVELOPING LEADERSHIP

While the 360 degree feedback process can produce a great deal of anxiety in an organization, over the past decade it has revolutionized performance management (110). However, it is important to note that its intended use should be focused on personal and professional development and not as a performance evaluation tool. On the other hand, in order to identify the major areas of growth in relation to techniques for supporting leadership development; it would have to include use of 360 degree feedback (111). At two recent US conferences, dedicated to presentations by researchers and practitioners on the subject of leadership assessment and development, the topic of multi-rater or multi-source feedback, as it is also known, formed a key component (112 - 113).

This assessment method is a comparison of a person's self-perceptions against the perceptions of others who are familiar with his/her behavior relative to targeted competencies. A 360 degree feedback survey tool is effective and less time consuming. Generally, those providing the feedback are the person's direct manager, peers with whom he/she interacts, and the employees he/she manages. Responses are anonymous and shared with the manager by a coach or someone with well developed coaching skills. Once this process has been completed, the nurse leader can receive the training and coaching needed to leverage his/her strengths and fill any development gaps. The 360 degree process not only provides feedback for continuous development; it also facilitates integrated learning by giving the nurse leader an objective view of his/her perceived behaviors, leading to enhanced self-awareness. It also develops a blueprint for the types of additional learning experiences necessary for development. Feedback should continue to be presented throughout leadership development process. Organizations should realize that the 360 degree feedback process is not a one-time event but a continuous process (111). Organizations that have been successful with this process usually are open to learning and willing to experiment (114 - 115).

IMPORTANCE OF 360 DEGREE FEEDBACK TO TRANSFORMATIONAL LEADERSHIP

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<td>2. Celebrate the values and victories by creating a spirit of community.</td>
</tr>
</tbody>
</table>
Managers, in general tend to rate themselves higher in management competence and leadership effectiveness than do their colleagues who also rate them (i.e., their boss, peers, and staff). In addition to that, managers' self-ratings are less highly related to the ratings others make of them than peers', bosses', and staff's' ratings are with one another; also, managers' self-ratings are less accurate than others' ratings when compared to "objective criterion measures". Furthermore, taken together, the ratings that the managers' "others" provide for the manager, predict team performance; as well as, staff is more satisfied with their manager and their job when their perceptions of their manager matched the manager's self-perceptions. More "successful" managers (as rated by their staff and their boss) are less likely to inflate self-ratings of leadership. Moreover, managers who have "inflated" self-ratings: over-estimate their influence, are likely to misjudge and misdiagnose their own need for improvement, staff's' perceptions of a manager's effectiveness relate significantly to bosses' ratings of performance and promotion, but managers' self-ratings of leadership are not related to these measures. Finally, the stronger the relationship between a manager's self-perceptions with that of their staff, the more likely they are to be perceived by their staff as transformational (e.g., Smither et al., 1995; Bass and Avolio, 1994; Bass and Yammarino, 1991) (116 - 118).

Therefore, leadership is being conceptualized and extolled as an authority "bestowed" on a manager by his/her followers (e.g., Bennis, 1997; Kouzes and Posner, 1993) (119, 78). This process can be conducted by using a survey or an interview process. The interview process is usually reserved for senior-level positions. A 360 degree survey tool is effective, making it the method generally used for first and middle managers (111).

The first-line nursing manager, also called a head nurse, is a person who acts in hospital as a leader at a ward/unit or on similar level and who is a key individual in the nursing department administrative structure; it is this nurse who translates the goals and objectives of the department into action (120 - 121). It is at this level of management that patient unit costs may be investigated and controlled; while maintaining a careful eye on the quality of care delivered, thus combining clinical expertise with managerial competence (121).

First-level nurse managers have bidirectional responsibility. Their weightiest responsibility is to ensure safe, effective care for a group of patients so large that they can fulfill this responsibility only by working through others. To ensure high quality patient care, they must direct staff nurses to perform care tasks in accord with organization policies and standards. Their second responsibility is to protect subordinates' physical, emotional, and occupational welfare. To fulfill these responsibilities, they must possess considerable knowledge and skill (122). For these reasons, there has been an increased emphasis on the role of the first-line nursing managers, particularly related to their administrative responsibilities (121).

The role of the first-line nurse manager has been defined by the American Nurses' Association (ANA) as having the primary responsibility for the direction of staff members in the delivery of nursing care (Beaman, 1994). In addition, it is also assuring the availability of support services; acting as a resource to the staff; interpreting philosophy, goals, standards, policies, and procedures; participating in policy formation; and being responsible for delivery of therapeutic, cost-effective patient care (Beaman, 1994) (123).
Previously used practices of nursing leaders are no longer sufficient for managing the healthcare environment. Opportunities for creating educational programs in leadership are extensive for nursing leaders (105). Nursing leaders will need to develop extraordinary leadership practices and behaviors through observing, role modeling, and participating in formal education (Kouzes and Posner, 1987) (9). Identification of leadership practices and behaviors provides an opportunity to evaluate current practices and behaviors of nursing leaders and suggest guidelines for future education for first-line nurse managers (Horvath et al., 1994) (10).

Leadership development is a lifetime endeavor. Effective leaders are constantly striving to improve their leadership skills, which can be learned and improved. Leaders must continually read about new ideas and approaches, experiment with new concepts, capitalize on a changing world, and seek or create continuing education opportunities to enhance their abilities to lead (12).

Planning programs for adults is like swimming in the oceans. Some days the ocean is calm and welcomes people with open arms. On other days, when the surf is somewhat rough and the waves higher, the ocean provides challenges for even the best of swimmers. Experienced program planners on these rough days find their work especially exciting as they maneuver through the many tasks that just keep coming at them and negotiate with people with vastly different ideas and agendas. Conversely, novice planners may back away and just let the planning process take its course; unless more experienced planners willingly give them direction and support (124).

Education and training programs for adults come in all shapes, sizes, and formats. They vary from information or skill sessions lasting only an hour or two to day-long workshops and conferences to highly intensive residential study at corporate training centers and universities. Although employees may choose to attend some of these programs, many are mandatory, such as orientation sessions for new employees and skill updates (124).

Staff development is defined as: "the process of enhancing staff performance with specific learning activities". It can be divided into internal (on the unit) and external (off the unit) sources. Internal sources include on-the-job instruction, workshops for staff, and in-service programs. External sources are formal workshops presented by an education department within the hospital and educational activities outside the hospital, including college courses, conference, and continuing education workshops (125).

PURPOSES OF EDUCATION AND TRAINING PROGRAMS

Education and training programs for adults are conducted for five primary purposes. Firstly, to encourage ongoing, continuous growth and development of individuals. Secondly, to assist people in responding to practical problems and issues of adult life. Thirdly, to prepare people for current and future work opportunities. Fourthly, to assist organizations in achieving desired results and adapting to change. Finally, to provide opportunities to examine community and societal issues, foster change for the common good, and promote a civil society (124).

Staff development in healthcare organizations consists of a common group of program expectations. These standard programs make up the greatest part of a nursing
staff development curriculum. The needs of each organization, of course, dictate the priority placed on each of these program entities (126).

COMMON PROGRAMS CLASSIFICATION (SCOPE) FOR STAFF DEVELOPMENT

1. **Orientation:**
   The orientation of new employees to the organization and their new job responsibilities is a major staff development activity. Orientation consists of three core areas: organizational orientation, departmental orientation, and position orientation (126).

   **Organizational orientation** can be completed with all new employees in a large group. The major theme of organizational orientation is an understanding of the mission, vision, and values of the organization. Other elements include organizational systems and processes (e.g., quality processes and communication mechanisms), human resources issues (e.g., compensation, benefits, job transfer, and promotion), and general safety information (e.g., infection control, hazardous waste disposal, and back safety) (126).

   **Departmental orientation** typically follows organizational orientation. A large department with many similar processes such as nursing may have departmental orientation in large groups. Departmental orientation involves sharing information regarding the environment and facilities, department-specific standards, and departmental application of organization-wide systems and processes. Another important element of departmental orientation is the integration of the new employee into the work team (126).

   Finally, new employees are oriented to their position and specific job description in the organization. This orientation often involves a precepted experience and competency evaluation (126).

2. **In-service education**

   The ever-changing practice of healthcare requires continual updates (126). In-service education provides learning experiences intended to help staff members acquire, maintain, or increase competence in fulfilling expectations of employers regarding the application of technology, equipment, medications, procedures, and techniques in the specific work setting (ANA, 1994) (127). The staff development specialist may accomplish this through direct delivery or the organization of materials presented by other specialists provided by the product vendor. Establishing good relationships with the companies doing business with the organization can prove very helpful (126).

3. **Continuing education**

   Continuing education consists of professional learning experiences designed to enrich the employee's healthcare practice and contribute to quality healthcare (ANA, 1994) (127). Unlike in-service education, continuing education builds on the learner's current knowledge with information that is applicable to care provision in a wide variety of practice settings. All employees working in a healthcare setting have continuing educational needs. These needs are of varying degree and priority. The goal in nursing staff development curriculum development is to meet the continuing education needs of employees that will also move the organization toward its intended goals (126).
4. Leadership and management

Most healthcare organizations require some form of leadership development as part of the staff development curriculum. Supervisory and management staffs who are promoted from within due to their clinical expertise will need development in employee management, communication, budgeting, and strategic planning. In addition, leadership principles such as motivation, change management, delegation, and meeting management are necessary elements of successful manager development. Large nursing departments may have specialized nursing management courses, but more often staff development specialists provide leadership development for a broad range of novice healthcare managers (126).

Leadership courses are an excellent training ground for the development of multidisciplinary efforts in the healthcare organization. Attention to the socialization of leaders is necessary. Courses should promote the development of problem-solving and critical thinking skills in the real-life framework of actual organizational challenges (126).

STAFF DEVELOPMENT PROGRAM

Healthcare organizations face major challenges in upgrading skills of the workforce and in maintaining a competent staff. Staff development has always been important, but in times of exploding knowledge and technology, educating staff has become critical (126). Kramer and Schmalenberg (2004) state that educational support is essential for creating a magnetic work environment (128). Educational needs of staff are partially dependent on the staffing mix and position responsibilities that were developed during the organizing and planning phases of management. Education and training are two components of staff development that occur after an employee’s indoctrination. Early staff development emphasized orientation and in-service training. In the last 20 years, however, other forms of education have become common in healthcare organizations. The staff’s knowledge level and capabilities are a major factor in determining the number of staff required to carry out unit goals. The better trained and more competent the staff, the fewer staff required, which in turn saves the organization money and raises productivity (12).

I. PLANNING FOR STAFF DEVELOPMENT PROGRAM

The leader has a responsibility for maintaining a competent staff, but this responsibility is shared with other members of the organization. Program planning is the responsibility of the staff development specialist in collaboration with content experts, managers, and learners. The content expert knows what should be taught; the manager directs what the learners should know; the learner should be able to identify what is needed to be effective on the job; and the staff development specialist brings it all together (124). Aucoin (1998) defined a program as: "any educational activity designed to meet a particular learning need" (129).

1. Identifying learning needs:

A highly structured needs assessment is defined as: "a systematic way, usually involving a rather lengthy process and based on formal needs assessment models or analyses for identifying education and training problems, needs and issues. Conducting a highly structured needs assessment is one of many ways that ideas and needs are identified..."
for education and training programs (124). When a topic has been selected for a staff development program, the instructor should write course objectives. These objectives should be few and written to describe observable behavior. This phase encompass assessing the learning needs assessment of the learners, it is the most important step to plan the program (126).

Elements of a formally structured needs assessment

**Decide to conduct needs assessment:** make a conscious decision to complete a needs assessment with a commitment to planning. **Identify staff and develop management plan:** identify individuals to be involved in planning and overseeing the needs assessment, and develop a management plan. **Determine context, purpose, and objectives:** develop context, purpose, and specific objectives for the needs assessment (to ensure that it answers the questions one really wants to know). **Determine logistics:** lay out the target dates, time lines, budget, and staff. **Choose respondents:** choose the specific individuals and/or groups to be the respondents for the needs assessment. **Select techniques:** determine data collection techniques. **Collect data:** ensure data are collected in an appropriate and timely manner. **Analyze data:** breakdown collected information to determine: (a) the basic findings in terms of quantitative and qualitative descriptions; (b) points of agreement and disagreement; and (c) agreed upon findings and conclusions concerning identified ideas and needs. **Sort and prioritize needs:** sort and prioritize each of the identified needs and indicate: (a) which needs should be responded to first, second, and so on, and (b) needs for which alternative interventions are more appropriate. **Communicate results:** distribute the results of the needs assessment to appropriate individuals and groups within and external to the organization (12, 64, 96, 130).

There are multiple strategies to identify learning needs assessment and methods of identifying learning needs; as: (1) advisory groups: group of people who represent the total populations who can or may be internal and/or external member of the organization; (2) interviews: through face to face communication to express and share opinions; (3) anecdotal notes: reflects observation to identify performance discrepancy; (4) brainstorming: by a representative group of member who are open about discrepancies in their clinical settings; (5) literature analysis: of new knowledge about the new delivery system; (6) focus group: by close understanding of consumers by asking their opinion or their appraisal; (7) nominal group process: by exploring emerging need; (8) Delphi technique: a specific strategy to obtain consensus and priority of needed topics; (9) position analysis: to describe the contend and level of performance desired; (10) analysis of records and reports: such as, nursing audit system, incident report, turnover and absentee records, statistical records, employment application, observation, performance appraisal, and tests (pre and post test) (131 - 132).

2. **Establishing priorities**

This depends on certain factors, such as: economical, time, personnel abilities, and degree of discrepancy in performance. Moreover, needs should be categorized based on: needs related to administration of the program and learning needs related to individuals (131 - 132).

3. **Formulating objectives**

Program objectives provide clear statements of the anticipated results to be achieved through education and training programs. In constructing program objectives,
program planners should be cognizant of the following tasks: write program objectives that reflect what participants will learn, the resulting changes from that learning, and the operational aspects of the program. Second, ensure that both measurable and non-measurable program outcomes are included. Third, check to see whether the program objectives are written clearly, following the SMART principles (specific, measurable, actionable, realistic, and timely); so they can be understood by all parties involved. Fourth, use the program objectives as an internal consistency and “do-ability” checkpoint. At the end, negotiate changes in program objectives among the parties involved with the planning process.

Stating objectives provide criteria for selecting content of the program and selecting teaching strategies and basis for evaluation. Types of objectives are either: (1) general: learner should be able to demonstrate at end of the program and it is stated in the introduction of the program; and (2) specific: is the performance demonstrated by the learner at the end of each session. The three objective domains of learning, that should be used in order to serve its purpose, are: (cognitive, affective and psychomotor). Cognitive domain is concerned with intellectual skills such as problem solving; while the affective domain is concerned with feeling and emotions such as attitudes and interests; whereas the psychomotor domain is mainly concerned with manipulative skills and coordination skills.

4. Selecting and organizing of learning materials

Identify knowledge underlying the central concept of selection of learning materials in relation to desired objectives maximizing the effect of organizing learning materials, which depend on: (1) continuity: indicating relationship between different levels of the same subject; (2) sequence: building on existing knowledge and skills to develop more comprehension ability; and finally (3) integration: relating what is taught in one part of development program to what is taught in another part.

5. Designing plans for learning experience

The actual development of the program includes: teaching plan, time schedule and staff assignment. Teaching plans are the plans that outline what the teacher will do and reflect desired outcome. The plan should identify behavioral objective, content, teaching strategies and aids, teacher, and time block. Time schedule should be used to show each instructor, trainer’s class and clinical schedule in order to determine where the staff development educators are located and what learning offerings are schedule for the designated time. Staff assignment is based on clinical expertise because it is impossible for all staff development educators to be experts in all of clinical areas.

6. Selecting teaching strategies

The most effective teaching strategy that permits interaction, discussion, exchange of view points and participation. Teaching strategy varies according whether learner must receive information, be shown objective and participate actively in their own learning. At that time, choose instructional techniques that match the focus of the proposed learning outcomes, that the instructor is capable of using, and that take into account the backgrounds and experiences of the learners and the learning context. Examples of instructional techniques appropriate for each learning outcome category that are commonly used in staff development are.
Table (2): Examples of instructional techniques appropriate for each learning outcome category (124).

<table>
<thead>
<tr>
<th>Acquiring knowledge:</th>
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<tbody>
<tr>
<td>1. Lecture:</td>
</tr>
<tr>
<td>A one-way organized, formal talk is given by a resource person for the purpose of presenting a series of events, facts, concepts, or principles (124).</td>
</tr>
<tr>
<td>2. Face-to-face group discussion:</td>
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<tr>
<td>A group of five to 20 people have a relatively unstructured exchange of ideas about a specific problem or issue (124).</td>
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<tr>
<td>3. Buzz group:</td>
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<tr>
<td>A large group is divided into small &quot;huddle&quot; groups for the purpose of discussing the subject matter at hand (124).</td>
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<table>
<thead>
<tr>
<th>Enhancing cognitive skills:</th>
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</thead>
<tbody>
<tr>
<td>1. Case study:</td>
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<tr>
<td>A small group analyses and solves an event, incident, or situation presented orally, in written form, or through computer-based means (124).</td>
</tr>
<tr>
<td>2. In-basket exercise</td>
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<tr>
<td>In a form of simulation that focuses on the &quot;paper symptoms&quot; of a job, participants respond to materials people might have in their in-baskets in a work situation (124).</td>
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<tr>
<td>3. Critical incident</td>
</tr>
<tr>
<td>Participants are asked to describe an important incident related to a specific aspect of their lives. This incident is then used as a basis for analysis (124).</td>
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<tr>
<td>4. Observation</td>
</tr>
<tr>
<td>After an individual or group systematically observes and records an event using a specific focus (for example, leadership style, group interactions), the data are analyzed and discussed (either one-on-one or in a group format) (124).</td>
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<thead>
<tr>
<th>Developing psychomotor skills:</th>
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</thead>
<tbody>
<tr>
<td>1. Demonstration with return demonstration</td>
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<tr>
<td>A resource person performs a specified operation or task, showing others how to do it. The participants then practice the same action (124).</td>
</tr>
<tr>
<td>2. Behavior modeling</td>
</tr>
<tr>
<td>A model or ideal enactment of a desired behavior is presented via an instructor, videotape, or film, and is usually followed by a practice session on the behavior (124).</td>
</tr>
<tr>
<td>3. Trial and error</td>
</tr>
<tr>
<td>Participants are encouraged to figure out individually or in groups a way to do a hands-on task effectively. The tasks may be simulated or set in &quot;real-life&quot; settings (124).</td>
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<table>
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<tr>
<th>Strengthening problem-solving and –finding capabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Problem-based learning</td>
</tr>
<tr>
<td>The content for the instruction is centered on fundamental or critical problems of practice. Participants focus on solving the presented problems with the end product being enhanced problem-solving skills, content knowledge related to the problems presented, and improved thinking skills. Problem-based learning can be carried out face-to-face, through computer-mediated formats, or a combination of both (124).</td>
</tr>
<tr>
<td>2. Reflective practice</td>
</tr>
<tr>
<td>This practice involves thoughtful reflection on one's actions, focusing on alternative ways one would approach a similar problem or incident, which can be done individually, as part of a small group discussion, or some combination of the two (124).</td>
</tr>
<tr>
<td>3. Simulations</td>
</tr>
<tr>
<td>Participants are asked to solve problems in activities that closely mimic real-life situations. The feedback given as they move through the simulation is life-like and immediate, especially in computer-based simulations (124).</td>
</tr>
</tbody>
</table>
4. Brainstorming

It is an interaction strategy used to generate ideas or to help determine the exact nature of content to be discussed. Through brainstorming technique, individuals are encouraged to identify a wide of ideas. Usually one member of the group records all the ideas on a chalk board or writing pad, and no one may criticize or even comment on them until the end of the process (133). This approach encourages group members to think creatively and to expand up on ideas of fellow group members (134).

Brainstorming requires a facilitator, who initiates the activity by posing a problem or topic area and by asking for ideas from the participants. The facilitator is then responsible for recording on a device such as chalk board or flip chart a few key words that capture the essence of each expressed idea. During this process, the facilitator tries to maintain a constant flow of ideas from the participants and to prevent the group from diverting their creative energy to criticism or discussion of the proposed ideas (125, 134).

In addition to choosing appropriate instructional techniques, it is important that staff members who design instruction also know how to select and use appropriately a variety of instructional resources (124).

Table (3): Types of resources available (124).

<table>
<thead>
<tr>
<th>Category</th>
<th>Resources and aids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real things</td>
<td>People, objects and devices, models or simulators, outdoor environment, job aids.</td>
</tr>
<tr>
<td>Printed materials</td>
<td>Handouts, notebooks, manuals, pamphlets, articles, reference lists, workbooks, worksheets.</td>
</tr>
<tr>
<td>Visual aids</td>
<td>Transparencies, chalk and white boards, graphs, posters, flip charts, diagrams, slides.</td>
</tr>
<tr>
<td>Audio and video materials</td>
<td>Videotapes, audiotapes and CD recordings, television.</td>
</tr>
<tr>
<td>Computer-based resources</td>
<td>PowerPoint presentations, LCD panel, computer-generated images, World Wide Web.</td>
</tr>
<tr>
<td>Interactive technologies</td>
<td>Interactive CD-ROMs, web-based tools (chat rooms), video and audio conferencing.</td>
</tr>
</tbody>
</table>

II. Implementation of the program

This refers to actual presentation of the content and learning experience that were selected and organized during the planning phase. It requires preparation of the environment and climate setting which is significant in program implementation because it facilitate or hinder the achievement of teaching learning process (124, 129).
III. **Evaluation of the program**

Program evaluation is most often defined as: "a process used to determine whether the design and delivery of a program were effective and whether the proposed outcomes were met" (124). Evaluation becomes a continuous process that begins in the initial phase and continues throughout the life of the program (Guskey, 2000; Sork, 2000) (135 - 136). The heart of program evaluation lies in judging the value and worth of a program, which is not an easy assignment. The program design and delivery are usually easier to evaluate than program outcomes; outcome measures are often elusive (124).

Evaluation is the gathering of information that will assist in decision making leading to improvement of teaching and learning transaction and determine effectiveness of staff development process. Afterwards, select and/or develop instructional resources that enhance the learning effort. Then, choose an assessment component for each instructional segment. Next, use instructional assessment data in formative and summative ways for both instructional and program evaluation (124). Formative evaluation is ongoing, day to day efforts that provide data to allow for change and adjustment in both content and methods (during implementation); whereas the summative evaluation examines the achievement of specific learning objectives as change in knowledge, practice and attitudes through measuring practice in the clinical area and patient outcome (at the end and after the implementation). The starting point for assessing the results or outcomes of the instructional unit is the learning objectives (124, 126).

**Table (4):** Assessment techniques by learning outcomes category (124).

<table>
<thead>
<tr>
<th>Acquiring knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>Closed-answer tests:</strong> participants answer a set of standardized or instructor-developed test item. The test may consist of multiple-choice, true/false, matching, and/or sentence-completion items.</td>
</tr>
<tr>
<td>- <strong>Essays:</strong> participants respond in writing to one or more questions or problem situations. They may be asked to compare, discuss, analyze, criticize, evaluate, or apply.</td>
</tr>
<tr>
<td><strong>Oral tests:</strong> learners react to a set of questions orally individually or in groups.</td>
</tr>
<tr>
<td><strong>Self-report evaluation forms:</strong> learners respond to structured or open-ended questions or matrixes and describe what they have learned.</td>
</tr>
<tr>
<td><strong>Oral presentations:</strong> participants give formal presentations to a selected group on a specific topic area.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enhancing cognitive skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Case studies:</strong> participants analyze and give alternative solutions to an event, incident, or situation that is problematic. This process may be done in written or oral form and can be either a group or individual exercise.</td>
</tr>
<tr>
<td><strong>Concept maps:</strong> learners make diagrams and drawings that represent the mental connections between and among major concepts and ideas.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Developing psychomotor skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance reviews and tests:</strong> participants perform a skill, operation, or practical application.</td>
</tr>
<tr>
<td><strong>On-the-job observations:</strong> participants, under the eye of the evaluator, carry out a set of performance behaviors on the job.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Strengthening problem-solving and –finding capabilities</th>
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<tbody>
<tr>
<td><strong>Reflective journals:</strong> participants are required to keep written reflective entries on how they solved specific problems and/or the processes they used in problem identification.</td>
</tr>
<tr>
<td><strong>Computer-based simulations:</strong> learners solve problems through computer simulations that allow them a range of responses to the various problem-based situations they encounter.</td>
</tr>
</tbody>
</table>
Changing attitudes, beliefs, values, and/or feelings

<table>
<thead>
<tr>
<th>Role playing: learners role play a situation, focusing on attitudes, beliefs, values, and/or feelings.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed-ended tests: participants answer questions that focus on specific attitudes, beliefs, values, or feelings.</td>
</tr>
<tr>
<td>Free form writing: participants are asked to respond to a stem sentence or just write about a topic, situation, or proposition</td>
</tr>
</tbody>
</table>

One of the assessment tool – the portfolio – has become more popular in the educational community. Depending on how it is constructed, it can address all of the different types of learning outcomes (McMillan, 2001; Dietz, 1999) (137 - 138).

A portfolio, when used in a professional context, is simply a collection of documents that present a picture of the practitioner. It is like a photo album, but in word, not visual, pictures (139). The commonest and most widely accepted definition of a portfolio is that by Brown (1995) who identifies it as: "a private collection of evidence which demonstrates the continuing acquisition of skills, knowledge, attitudes, understanding and achievements. It is both retrospective and prospective, as well as reflecting the current stage of development and activity of the individual" (140).

However, McMullan et al. (2003) added to this definition by suggesting that a portfolio is: "a collection of evidence, usually in written form, of both the products and processes of learning. It attests to achievement and personal and professional development, by providing critical analysis of its contents" (141). This moves the concept of a portfolio on from being a recording device, to one of activity and interaction used on a continuous basis through a practitioner’s life (139).

Features of portfolios:
(1) Portfolios are individual nature: portfolios are unique to the person compiling them and provide a permanent record of that person's professional history. (2) They are dynamic in nature: in that they reflect the past but anticipate and plan for the future. (3) They document and record specific attributes of the individual concerned. (4) They comprise various types of evidence (139).

Uses of portfolio:
The demonstration of professional competence is a crucial element of being a registered, accountable practitioner. This is seen as the responsibility of the individual practitioners when re-registering every three years; they will have their portfolios audited to ensure they comply with the minimum requirements for their education and practice code (139).

The purpose of a portfolio:
A portfolio is always kept for a particular purpose, and everything concerned with the portfolio, from the structure used to organize it, its content, and the ethical issues related to it, derive from this purpose. The purpose of portfolio construction is to: (1) demonstrate competence and fitness to practice; (2) provide evidence of accountability as a practitioner; (3) as a way of working through and documenting experiences; (4) as a requirement for annual appraisal with employer; (5) in preparation for a new job application; and finally (6) as part of personal development plan (139).
Models of portfolios:

Endacott et al. (2004) identified four approaches to portfolio construction, which increase in sophistication in both content and processes involved in their compilation. 

(1) The shopping trolley model: this is a collection of papers amassed during the time covered by the portfolio, such as handouts and lecture notes, photocopies of articles, practice assessment documents, and kept within a larger folder. 

(2) The toast rack model: the portfolio consists of separate elements that assess different aspects of practice or theory, such as a skills log or a reflective account. The folder or binder in which it is kept acts as a convenient organizer using the required headings for assessment, but there is no overarching attempt at cohesion between the parts. 

(3) The spinal column model: this model is structured around practice competencies, with the competency forming the "vertebra" and the supporting evidence slotted in to demonstrate how each competence is met. Analytical accounts are often included to show how theory informs practice, or reflective accounts of incidents or case studies support the achievement of the competencies as evidence. 

(4) The cake mix model: in this model, the sum total of the parts, its content is seen to be more than the individual components in terms of what it demonstrates about the practitioner concerned. The emphasis is on the integration of all the parts within an overarching narrative which forms the basis of assessment. Thus, essential elements of the model are reflectivity, practice and professional development (142).

The use of cake mix model was found predominantly in programs leading to advanced practice or master's level. The toast rack model was more likely to be found where beginning students were being introduced to the notion of portfolios as collecting evidence to support the development of practice and the student's own expression of competence (142).

The Program Planning provides practical descriptions of and ways that planners engage in the complex and often befuddling process of organizing education and training programs for adults. The tasks are technical in nature and comprise the knowledge and skills that planners use in their everyday planning activities. Organizational leaders may either strongly endorse professional development as a critical component of a healthy organization and put funds into these programs, or just give "lip service" to the idea (124).

In a hospital setting, the first-line representative of hospital administration is the head nurse (Bates, 1992) (143). Most head nurses are selected because they have excellent clinical skills or have been on the unit longer than the other staff nurses (Meighan, 1990) (144). But the climate in hospitals today demands that greater emphasis be placed on leadership behavior of head nurse rather than clinical expertise or longevity (145). Meighan (1990) stated that "leadership in nursing is becoming more important everyday in the turbulent environment of the hospital, where major changes have increased, and available nurses have decreased." (144) The nurse leader, therefore, holds a position of authority over the staff nurse and has the power to shape and influence the climate of the group (145).

WORKGROUP CLIMATE

Every organization has a climate that is constantly evolving because of the interaction of its members. One of the key healthcare players in creating a climate conducive to achieving healthcare goals is the healthcare manager closest to the bedside of a hospitalized patient. This first-line manager is the head nurse who is the person responsible to patients, families, and staff for interpreting and achieving the organization's
mission and goals. They control or influence the total climate of a patient care unit as they are the pivotal provider of care in acute care organizations (146).

The climate of an organization, an aspect of every organization, has been shown to influence the attitudes and behaviors of its members. Climate is considered beneficial for organizational development efforts. Leadership behavior has been found to be a significant determinant of organizational climate (147). A workgroup may consist of two members – the leader and the follower; or many members – head nurses and staff. The most important factor in effective group functioning is the climate of the group (19). The Management Sciences for Health (MSH) (2005) defined a workgroup as: "a group of people who work together on a regular and routine basis toward the same project goal or outcome and to produce results". Members of the workgroup may work in the same physical site as employees in a structured reporting relationship, such as in a department or clinic; or in separate locations, as ad hoc team brought together to carry out specific tasks to develop or refine a service or product, or produce another result (20, 25).

Organizational members create the climate when they perceive, select, and interpret organizational characteristics (Field and Abelson, 1982) (148). Climate has enduring measurable qualities that influence the behavior of individuals within the organization. People behave in ways that fit the perception of their work climate (Schneider, 1975) (149). The climate could be created in short periods of time and had stable characteristics. Once created, this climate had significant influences on motivation, performance, and job satisfaction (147). Some researchers, in their classic work, found that leadership behavior is a very significant determinant of organizational climate and climate an attribute amenable to change (150).

The climate is the feel of the organization, the individual and shared perceptions and attitudes of the organization's members. Climate is a short-term phenomenon created by the current leadership. Climate represents the beliefs about the "feel of the organization" by its members. This individual perception of the "feel of the organization" comes from what the people believe about the activities that occur in the organization. Organizational climate is directly related to the leadership and management style of the leader, based on the values, attributes, skills, and actions, as well as the priorities of the leader. The behavior of the leader is the most important factor that impacts the climate (82).

The concept of organizational climate was first described in the late 1950s. Different definitions and measurements of organizational climate exist, but some basic properties of organizational climate have emerged over time. Organizational climate characterizes properties of an organization and describes a unit of organization rather than evaluating it. In addition, organizational climate results from routine organizational practices and influences members' attitudes and behaviors (147).

Verbeke et al. (1998) define climate as "the way people perceive their work environment" (151). The organizational climate is regarded as a conglomerate of the attitudes, feelings and behaviors which characterize life in an organization (Isaksen and Ekvall, 2006; Glisson and James, 2002) (152 - 153). A climate must be more innovative for the focus to be on renewal and change (154). According to Ekvall et al. (1983), a climate that emulates innovativeness (creative work climate) includes: (1) maintaining support for ideas; (2) open relationships; (3) mutual trust and confidence; (4) challenge and motivation; (5) commitment to the goals and operations of the organization; (6) the
freedom to seek information and show initiative; (7) maintain pluralism in views, knowledge and experiences; and (8) having an open exchange of opinions and ideas (155).

Ellis and Hartley (2005) defined organizational climate as "the perceptions employees have of an organization with regard to the prevailing feelings and values of the organization". Just as physical climate – hot versus cold, rainy versus sunny – affects your engaging in outdoors activities, the psychological climate affects the ability to carry out activities in an organization (75).

According to the Management Sciences for Health (MSH) (2005) climate is viewed as: "the environment in which people work that affects how people behave at work". Workgroup climate is the prevailing workplace atmosphere as experienced by employees. It is what it feels like to work together in a group. Every organization and every workgroup has a climate. The climate of an individual workgroup may be similar to or different from the overall organizational climate (20).

FACTORS INFLUENCING THE WORK CLIMATE

Workgroup climate is influenced by external and internal factors. External factors are beyond the control of the workgroup and include: organizational history, organizational culture, management strategy, management structure and external environment. Internal factors are what happens inside the workgroup and can be usually controlled; consist of practices and competencies of the manager (20, 25) (figure 5).

Figure (5): Causes and effects of work climate (20).

PROTOTYPICAL CLIMATES.
There are three prototypical workgroup climates (i.e., climate for learning, a climate for performance, a climate for avoiding failure). These climates are not mutually exclusive; instead, each of these climates may be present within the same workgroup to varying degrees. Because limited organizational resources demand focused attention on a limited set of valued behaviors and outcomes, it is likely that one, perhaps two, particular climate(s) is/are more dominant than the others as a way to help workgroup members focus on the more important priorities. 

(1) Climate for learning. The concept of a climate for learning builds on previous work in the employee developmental literature and has been referred to as a “continuous learning culture” (Tracey et al, 1995) and “a climate for technical updating” (Kozlowski and Farr, 1988; Kozlowski and Hults, 1987). Training researchers have explored a similar concept, namely a “transfer of training climate” (Burke and Baldwin, 1999; Rouiller and Goldstein, 1993). Consistent with this prior research, a climate for learning emphasizes continuous development of knowledge and skills. Employees perceive that continuous learning and ongoing engagement in developmental activities is valued, supported, and the expected means for achieving individual and workgroup goals (Rosow and Zager, 1988; Tracey et al, 1995). In this type of climate, informal practices and formal systems provide opportunities for development and reinforce learning. Intrinsic rewards such as satisfaction gained from continuous improvement and learning are stressed as important rewards; extrinsic rewards, such as public acknowledgement for learning and promotion based on demonstrated dedication to continuous improvement of one’s skills, are also emphasized.

Co-workers in climates for learning provide the necessary social support, challenge, encouragement to learn, and feedback to assist in developing and maintaining motivation in the face of challenges. In development, and access to other developmental activities. Moreover, in this type of climate, incumbents perceive themselves as being an active participant in deciding when, how, and which skills they need to develop. Lastly, given this description of the structure, rewards, support structure, and decision-making, it is probably not surprising that issues of employee development, learning, feedback, and developmental activities are perceived as being commonly discussed within the group.

(2) Climate for performance. The construct of a climate for performance is similar to what safety climate researchers have referred to as “high reliability organizations.” High reliability organizations are defined as “organizations in which complex technology must be controlled and complex processes carried out in an error free manner” (Hofmann et al., 1996). The central theme here is on high levels of productivity, without error. A climate for performance is a bit broader than observations from the safety climate literature in that performance is not limited to productivity levels and/or efficiency.

Performance, as in many knowledge-based organizations, also refers to effectiveness in completion of complex tasks or projects. In a climate for performance, employees perceive achieving the performance standard as the most valued outcome. It is expected that these performance standards will be attained efficiently, effectively, and accurately through applying team members’ current skills, knowledge, and abilities.
Informal practices and policies support the accomplishment of work tasks, specifying clear methods or task approaches. Extrinsic rewards, such as promotion and salary, are consistently provided for individuals who are viewed as having high ability in meeting or exceeding performance standards (156).

Group members perceive satisfaction (i.e., intrinsic rewards) when particularly difficult, challenging performance standards are met (Locke and Latham, 1990) (170). Perceived support focuses on removing possible barriers to achieving performance goals, such as a lack of materials, information, staff, or time. In addition, group members support one another to accomplish the task by providing advice on difficult issue and encouragement to meet performance standards. In this type of climate, group members perceive themselves as involved in decisions regarding performance issues, such as goal-setting and performance strategies and approaches, and workgroup communication primarily centers around goals, goal accomplishment, and performance strategies (156).

Many of these points complement Locke and Latham’s (1990) high performance cycle in which they detail how performance goals and standards motivate high levels of performance. Consistent with their view, rewards in this climate are seen as contingent upon performance, and situational constraints are seen as barriers to performance, and therefore, need to be removed. While the concept of a climate for performance emphasizes more of the environmental conditions, Locke and Latham (1990) work parallels the central emphasis of this particular climate and supports some of its major distinctions (170).

(3) Climate for avoiding failure. In this context, avoiding failure (i.e., making errors) is extremely valued because it is perceived to be instrumental in maintaining the appearance of competence. Being labeled as “incompetent” risks future opportunities (e.g., promotion), limits access to resources (e.g., information, salary increases), and respect and acceptance from colleagues and organizational leaders (156). The teams and climate literatures documents how some workgroups foster a climate that is not supportive of admitting errors, discussing mistakes, or offering dissenting opinions (e.g., Edmondson, 1999; Hofmann and Stetzer, 1998) (171 - 172).

In a climate for avoiding failure, the common practice is to engage in “face saving” behaviors (e.g., avoid discussions of errors and mistakes, asking for help, shifting blame). Typically, group members perceive that they are encouraged to avoid blame, resist taking on assignments that risk failure, and/or avoid taking action so as to evade revealing low ability of a particular group member. Group members perceive being rewarded for “not screwing up” with verbal acknowledgements, promotion, and salary increases (156). It is perceived that committing errors carry significant punishment such as constant reminders of one’s mistake and brutal, demeaning confrontations by others (Edmondson, 1996) (173).

Because this environment is unforgiving of even the slightest error, group members do not perceive the same type of social support from their colleagues as in a climate for learning or performance. Here, support comes in the form of covering up for one another (156). This phenomenon of attributing mistakes to external events to shift blame away from group members has been documented in Hofmann and Stetzer’s (1998) work on safety climate (172). Moreover, because errors are not discussed, group members in this climate are not involved in decisions regarding how to improve group functioning. Workgroup discussions center around anything but errors and mistakes, potentially at the expense of addressing key issues preventing members from effectively performing their jobs (156).
There is a strong historical tradition documenting the key role of leadership in establishing workgroup climate. In their classic works, some researchers asserted that leaders transmit their beliefs and expectations through the climate they create. Moreover, they suggested that managers convey their attitudes about workers, consistent with Theory X or Theory Y, through their behavior. In turn, this behavior establishes the workgroup climate (174 - 175). More recently, Eden and his colleagues’ research (2000) on the Pygmalion Leadership Effect, shows how leaders transmit their expectations and beliefs regarding their group member ability to create a supportive climate. These findings suggest a group-level phenomenon that is shaped by the leader and, in turn, affects the behaviors and attitudes of group members (176).

Schneider and Reichers (1983) provide three theoretical explanations for why climates emerge, two of which are relevant to this discussion. First, they suggest one way in which climate is influenced, is through organizational members’ perceptions of objective characteristics of the work setting, such as the extent of centralization of decision making and the degree to which rules and policies constrain behavior. Accordingly, this structure shape how organizational members perceive organizational events (177).

This structural argument complements early and contemporary leadership theory. According to researchers involved in the Ohio State and University of Michigan studies (as cited in Bass, 1990; Porter, Steers, and Bigley, 1996), leaders structure the work of their employees through rules, policies and goal setting (178 - 179). This basic idea can be seen in more recent theorizing of leadership in climate. For example, Kopelman et al. (1990) and Ostroff and Bowen (2000) argue that human resource practices give rise to climate (180 - 181). In workgroup settings, human resource practices are executed in large part by group leaders (Zohar, 2000) (182) and are used to organize and guide the work of group members (156). In turn, this imposed structure influences group member perceptions of group events and rewards (156). As an example, Smith-Jentsch et al. (2001) document that team leadership as exercised through specific job assignment practices, such as delegation of opportunities to perform trained tasks (e.g., Ford et al., 1992), lead to a transfer of training climate (183 - 184).

An additional argument presented by Schneider and Reichers (1983) posits an interactionist perspective, stating that “climates emerge out of the interactions that members of the workgroup have with each other”. Through these interactions, shared meaning and perceptions of objective aspects of the work environment emerge (177). Drawing on social comparison and social conformity theory, Ashforth (1986) argues greater conformity of perceptions and meaning converge on a particular “fulcrum” when a “compelling referent” exists in the workgroup (185).

A leader acts as a “compelling referent” in the workgroup. Their formal status in the organization provides them a heightened degree of saliency and value within the group (156). Drawing from the safety climate literature, Hofmann et al (1995) echo Ashforth’s (1986) assertions by arguing that workers motivation and attitudes mirror the leaders’ priorities on safety, thereby impacting the efficacy of safety climate (169). Leader-group communications have been shown to impact how members perceive the openness of the climate, and in turn, shape their attributions of work events and willingness to admit mistakes (Hofmann and Stetzer, 1998; Edmondson, 1996) (172 - 173). In addition, Scott and Bruce (1994) find that leader expectations affect a climate for innovation, and in turn, innovative behavior (186). Lastly, Barling et al (2002) show that transformational leaders
influence climate; thus providing opportunities for interaction between leaders and their group members. These interactions convey the leader priorities, thereby shaping climate perceptions (187).

Work climate is the “weather of the workplace.” Just as the weather can affect daily activities, the work climate influences employee behavior. Every organization has a work climate. Within an organization, the climate of an individual workgroup may differ from the prevailing organizational climate. High-performing workgroups can operate well even in organizations that are troubled by declining funding, weak senior leadership, or similar problems (20).

How managers perform is crucial to organizational outcomes. Workgroup climate itself is an intermediate outcome of effective leadership and management (25). At least 50 percent of the differences in workgroup climate can be attributed to differences in day-to-day practices of the people who manage the workgroup (Buckingham and Coffman, 1999) (93). Organizational practices that managers can influence, such as the design of tasks and jobs, reward systems, policies and procedures, and strategy, can also have a large impact (Stringer, 2002) (188).

Workgroup's climate is the key to unleashing the discretionary effort available in the workgroup. In order to influence a workgroup's climate, a manager need to (21):

1. Understand three key dimensions of climate.

   In order to influence climate, manager can survey employees' perceptions of three key aspects of work climate that have a predictable impact on motivated behavior (25):

   - **Clarity:**
     An environment provides clarity when the group knows its roles and responsibilities within the big picture (overall organization). Each member understands "what has to be done and why" and perceives his/her role as aligned with the purpose of the group and the organization. Standards of performance are clearly expressed, and the consequences of failing to achieve these standards are understood (25).

   - **Support:**
     In a climate of support, group members feel they have the resources and backing they need to achieve the workgroup's goals. Resources include essential supplies, equipment, tools, staff, and budget, without which their performance would be severely constrained. Emotional support includes an atmosphere of trust, mutual support, and deserved recognition; in addition to individuals' inner resources. Such an atmosphere is created when group members feel their capabilities are acknowledged, when they participate in decisions that impact the workgroup, and when they sense appreciation and reward for both individual and group successes (25). Moreover, support is the extent to which group members perceive that the necessary resources and social support, including feedback from colleagues, is available to promote learning, performance, and/or avoiding failure (Gonzalez-Roma et al., 2002; Tracey et al., 1995; Rouiller and Goldstein, 1993) (189, 157, 161).

   - **Challenge:**
     A climate of challenge exists when group members experience opportunities to stretch, take on challenges with reasonable risks, and discover new ways of doing things to be more effective. Group members feel a sense of pride in belonging to their workgroup and a commitment to shared goals, purposes, and activities. They are willing to learn from mistakes and feel prepared to adopt alternative activities when required.
take responsibility, develop skills and capabilities to deliver appropriate services, and are better equipped to take reasonable risks (25).

- **Interaction among the dimensions:**
  All three dimensions are critical for fostering performance and achieve better health care results. For example, staff members who work in an environment of challenge but who lack support or clarity often experience stress and frustration that prevent them from becoming more effective. Similarly, without challenge or support, even employees who are clear about what is expected of them often find little intellectual or professional stimulation in their work. In contrast, the right balance of clarity, support, and challenge in a work group’s climate enables the staff to improve performance and achieve better results. Supported staff will not stretch themselves or build their skills if they feel unchallenged (25).

2. **Assessing workgroup climate:**

   To improve the workgroup's climate, the manager needs to understand how his/her employees perceive their work environment. Their perceptions guide how they respond to workplace situations. To get a better idea about what may be reducing the productivity of your workgroup, you can assess its climate using one of several available surveys (25). The Workgroup Climate Assessment (WCA) developed by the Management Sciences for Health (MSH) (2005), is a simple, reliable, and validated tool designed to measure climate among intact workgroups in the health sector, at all levels of the organization (21). It is a straightforward process that will give insight into the previously three key dimensions – clarity, support, and challenge – that describe workgroup climate (20).

   The workgroup climate assessment is an instrument for scanning workgroups of three or more people and the group's manager. It is measured according to the perceptions of the individual workgroup members. The Workgroup Climate Assessment (WCA) consists of 12-climate perceptions, which, together, measure the group's climate, and which represent the three key dimensions – clarity, support, and challenge. The tool has two additional items that capture perceptions of productivity and quality within the workgroup (21).

3. **Taking action to improve workgroup climate assessment**

   After discussing the results of the workgroup climate assessment with staff, it is important for the manager to work on improving the climate of his/her workgroup. The manager should think about what changes in leadership practices can be made so that employees in his/her workgroup are clear about the purpose and direction of the work that all of you are engaged in. Individual employees need manager's feedback, and the group needs up-to-date information that relates to their work. Nothing is more encouraging to an employee than a manager who recognizes the positive contributions an individual makes (25).

   Because workgroup climate is influenced by the actions of the workgroup manager and members, improving managerial leadership and operational practices will improve the climate. Depending upon the deficiencies identified by the WCA process, workgroups could undertake the following activities: (1) get to know one another better through routine or periodic events scheduled during or after work hours; (2) clarify mutual expectations for performing work; (3) define and align the work group around shared goals and aspirations; (4) inspire team members by recognizing their accomplishments; schedule regular
meetings to exchange information on progress towards goals and learning; (5) Strengthen organizational management systems, especially those that promote work efficiency; (6) monitor progress; and finally (7) Use mistakes as opportunities for learning to do things better. 

No matter what actions managers or other members of a workgroup take, they should communicate effectively with each other in ways that encourage understanding and learning. The way individuals relate on a personal basis within an organization has a profound effect on the climate. When employees support one another, provide assistance as needed, and help answer questions or solve problems, a climate of cooperation and collaboration is fostered. If the informal relationships are based on trust, honesty, and working cooperatively, these feelings will permeate the organization. Conversely, if fellow employees focus on themselves and their own needs to the exclusion of the needs of others, the climate will be very different. If the accepted approach to the job is one of "me first", without concern for the effects of one's actions on others, the climate will be one of isolation and estrangement. Some organizations have a high level of competition, but this competition is accompanied by respect for others and a sense of fair play. Consequently, it creates a positive climate. Organizational climate is not static; it can change. Although most changes in organizational climate occurs gradually as the people in the organization change and each brings a different approach to the work setting, organizational climate can be changed through deliberate action.

Reasons for changing the climate of an organization: (1) Efforts and accomplishments of the employees receive too little recognition. (2) Policies or processes exist that are not appropriate for the situation. Lastly, (3) Steps could be taken to provide nurses with greater autonomy or involvement in decision making. Steps for changing organizational climate: (1) Assess the current organizational climate. What is the climate of the work setting? Clearly state the problem seen with the climate. (2) Assess the factors that contribute to the climate in this particular setting. There will be both negative and positive factors. Is there a particular individual within the organization who is responsible for the climate? Are there policies and procedures that have an effect on the climate? Once, the situation is clearly understood and problem identified, then (3) set a clear goal for a new, changed culture. Try to set goal in a realistic way. All would enjoy a perfect work setting, but that is not going to happen; however, they may be able to improve the work situation. Finally, (4) plan actions that will get to the specified goals. Some factors are out of control, but someone may be able to affect others directly. Policies and procedures may be changed through the prescribed route, which may involve the actions of committees and consultants as well as of those individuals in the specific situation.

Consequently, a positive workgroup climate is a primary outcome of a leadership development process aimed at improving the performance of managers and their workgroups. Workgroup climate influences results. A positive workgroup climate motivates employees to improve their performance by going above and beyond job expectations. Better performing workgroups contribute to better organizational performance, which in turn leads to better results. In the health sector a good workgroup climate leads to improved service delivery and thus to better health outcomes. Workgroups with a positive, supportive climate tend to perform well and to achieve their desired results. As leaders in hospitals and other care delivery organizations find themselves confronting greater challenges, they are requiring more effective contributions from either entire leadership team ranging from strategic positioning to operational
management. In turn, this has led to greater awareness and use of management and leadership development programs to improve performance (190).

**PERFORMANCE**

Although good leadership may not be a panacea for all performance ills of organizations, there are many instances in which leaders can make a real difference (81). Despite the heightened interest in performance assessment, there are a number of problems in relation to performance and its measurement in healthcare. First, is the definition of "performance" and its differentiation from "competence" (191). The confusion and considerable overlap between these terms has been previously deliberated from several perspectives (While, 1994; Worth-Butler et al., 1994) (192 - 193). While (1994) makes an important distinction between the concepts of “competence” and “performance”; and concluded that since competence is concerned with perceived skills, it cannot be directly measured, whereas performance as actual situated behavior is open to measurement and reflects what nurses actually do in clinical practice (192). Moreover, Benner (1994) pointed out that performance measurement can only be as productive and accurate as the competencies selected to be measured (194). However, some 20 years on, whether performance is required in order to demonstrate competence, or that competence merely represents the potential to perform, continues to lack consensus (Watson et al., 2002) (195). For many managers, conducting performance assessments is considered as one of the most difficult aspects of their job (Chandra and Frank, 2004) (196). Hamilton et al. (2007) defines performance assessment as "a coherent evaluation system which assesses whole occupational functioning including its constituent parts" (191).

Wolgin (1998) viewed performance as "something a person or organization does (processes, procedures) or achieves (outcomes)" (197). Performance can be quantified to produce neutral numbers to which qualitative meaning is attached. The performance data are evaluated to determine if they represent predeterminant levels of quality. Accurate, complete, and relevant performance data can provide managers and users of organizational services with objective evidence on which quality judgments can be made. A variety of innovative approaches can be used to demonstrate an objective performance evaluation system (132). In the 1996 Comprehensive Accreditation Manual for Hospitals, JCAHO Standard HR.3 states, "leaders ensure that the competence of staff members is assessed, maintained, demonstrated, and improved continually". JCAHO Standard HR. 3.1 states, "The hospital encourages and supports self-development and learning for all staff". This standard recognizes that job performance is the result of both individual competence and the work environment created by leadership (198).

Bishop (1998) and Scotter and Motowidlo (1996) defined job performance as "fulfilling the assigned roles and responsibilities effectively" (199 - 200). AbuAlRub (2004) defined job performance as "the overall effectiveness of the person in carrying out his or her roles and responsibilities related to direct patient care" (201).

Performance is defined by Meretoja, and Leino-Kilpi (2001) as: "the formal exhibition of a skill, ability, or aptitude of a professional nurse" (22). Performance assessment raises several challenges for nurses and managers in relation to the selection and implementation of an effective assessment strategy (191). The primary aims of performance assessment are to provide an equitable measurement of a nurse’s contribution to the healthcare team, to promote a high level of quality in the care provided and to
optimize development pathways for the nurse (Schuwirth and van der Vleuten, 2004; Capko, 2003) (202 - 203).

FACTORs AFFECTING PERFORMANCE

According to Rai Business School (2008) performance depends on the following factors (204):

(1) Motivation: level of motivation derives an individual for work. Motivation is based on motive which is a feeling that an individual lacks something. This feeling creates some sort of tension in the individual's mind. In order to overcome this tension, the person engages in goal-directed behavior that is, taking those actions through which needs are satisfied. Thus, motivation becomes a prime mover for efforts and better work performance (204).

(2) Sense of competence: sense of competence denotes the extent to which an individual consistently regards oneself as capable of doing a job. Sense of competence of an individual depends to a very great extent on his/her locus of control. Locus of control means whether people believe that they are in control of events or events control them. Those who have internal locus of control believe that the course of events in their lives can be controlled and shaped. Those who have external locus of control, tend to believe that events occur purely by chance or because factors beyond their own control. An individual with internal locus of control tends to be high performer than those with external locus of control. This sense of competence is not an independent factor and depends on the ability of the individual (204).

(3) Ability: while sense of competence is a type of perception about oneself, ability is a personal attribute that is relevant to any job type. Often, ability is expressed in the form of the following equation: Ability = knowledge X skill. Knowledge refers to the possession of information and ideas in a particular field which may be helpful in developing relationships among different variables related to that particular field. Skills refer to expertness, practical ability or facility in an action or doing something. Thus, if the individual has the ability relevant to the job, their performance tends to be higher than those who do not possess such ability (204).

(4) Role perception: a role is the pattern of actions expected of a person in activities involving others. Role reflects a person's position in the social system with its accompanying rights and obligations. In an organization, activities of individuals are guided by their role perception, that is, how they are supposed to act in their own role and how others act in their role. This role perception is based on reality and the role is clear. In this case, the individual tends to perform well. There are two types of problems which emerge in role specification, role ambiguity and role conflict. Role ambiguity denotes the state in which the individuals are not clear of what is expected from them in the job situation. Role conflict is the situation in which the individual engages in two or more roles simultaneously and these roles are mutually incompatible. In both these situations, the individual's performance is likely to be affected adversely (204).

(5) Organizational resources: organizational resources denote various types of facilities (physical and psychological). These are available at workplace. Physical facilities include appropriate layout of the workplace and conductive physical environment. Psychological
facilities include appropriate reward system, training and development facilities, harmonious workgroup, appropriate and motivating leadership styles, motivating work …etc. These organizational resources work in two ways in increasing individual performance. First, it facilitates job performance. Second, it works as motivating factors which enhance individual enthusiasm to perform well (204).

The impact of poor performance is widespread and affects the whole team including the manager and the wider organization. Great managers master the essential leadership skill of dealing with underperformance. The key is to be consistent and using the following process will help avoid the anxiety associated with dealing with underperformance for both manager and nurse (205).

**MANAGEMENT OF POOR PERFORMANCE**

(1) **Check that Poor Performance Exists**

It is vital to be certain that genuine poor performance actually exists and to be sure where the real issue lies. True underperformance occurs when someone has not achieved agreed outcomes. Clarify the issue, whether the outcomes were never defined; or were defined badly, making it impossible to determine whether the outcomes were met; or if there really is an underperformance problem. The first management step is to determine whether a problem exists and identify the real issue (205).

(2) **Define the Desired Performance Results**

Once the issue has been identified, collect all the facts and information available, including the impacts of the underperformance. Explaining why an outcome is important can be helpful during the performance meeting. Managers must work out what results are required, both in terms of outcomes for the future and more immediate improvements to be made. These results must be realistic and achievable by the nurse (205).

(3) **Conduct the Poor Performance Meeting**

It is important to remove opinions and emotions from any poor performance discussions, present facts and be respectful towards the nurse at all times. This is not a personal attack it is a problem to be solved and actions to be taken must be agreed upon. Give the employee time to prepare for the meeting. Explain the situation from a management point of view and invite comments and questions. Ensure that both the manager and the nurse agree there is an issue. Work with the nurse to define an action plan. Actions to rectify the situation must be specific and are best defined by the employee not the manager as this helps ensure ownership (205).

(4) **Managers must keep an open mind and be flexible:**

The nurse may not realize there is a problem and only needs expectations to be made clear. The nurse may know there is a problem but genuinely have no idea how to resolve it and may need some help. The nurse may come up with a surprising or unusual action plan and managers should be wary of dismissing such ideas without consideration. Agree a date for a follow-up meeting, what outcomes must be achieved by then and how the nurse can ask for extra support if required (205).

(5) **Follow up and Review Performance Results**

The final step in managing underperformance is to follow up on agreed upon actions, monitor the situation and review results. If performance is not improving, then
follow these steps again and conduct another meeting. Do not wait until the scheduled meeting date. Reinforce all performance improvements immediately. The size or scope of improvement is less important than the general direction. Ensure the agreed upon follow-up meeting takes place as scheduled. Learning how to deal with underperformance is an essential leadership skill which, once mastered, will lead to improved performance for the whole team, including the manager (205).

Actually, a manager may work harder to help a nurse succeed during the improvement timeframe. In order to change a nurse’s behavior, a manager might have to change his or her behavior. When placing someone on a disciplinary probation or development plan, managers often make the mistake of focusing solely on documenting positive or negative nurse behavior rather than continuing to coach the nurse. Although documentation is necessary when the behavior is not changed and a further step in the discipline process is needed, in most cases managers should hope that their nurse can successfully improve (205).

WAYS TO IMPROVE PERFORMANCE

(1) **Make the job important in the eye of the employee.** People who feel their jobs are important are more apt to try their best, because it is realized that it does make a difference how well the job is done. When the manager increases the scope and importance of the job, people are more apt to put forth maximum effort (206).

(2) **Select the right person who has the potential to perform the job.** People tend to rise to their level of incompetence. One reason for incompetence is that people are promoted on the basis of performance. Where the old job and the new ones are alike, performance is a valid basis for promotion. But where the jobs are different, performance may be a poor criterion for promotion. When considering a person for a job, whether it is an entry-level job or a promotion, the problem is to match the person to the job. Usually the match is not a perfect one because the candidates have never done that exact job before. Therefore, the potential of the person must be determined. There is a good evidence that many people are promoted to supervisory positions who never should have been. The typical selection process places undue emphasis on performance, years of service, and cooperative attitude. A more systematic approach stresses the importance of desire – wanting to be a supervisor – as well as leadership qualities (206).

(3) **Clarify what’s expected of the employee in the job.** Many frustrations and failures occur because employees don’t understand exactly what’s expected of them by their leaders. Employees put forth much effort doing what is thought is wanted, rather than what is wanted (206).

(4) **Train the employee in the necessary knowledge, skills, and attitudes.** No matter how well the person matches the job, some training is always necessary. Training includes the teaching of knowledge, skills, and attitudes. The first step is to decide who will be the trainer. The qualifications necessary are: knowledge and skill in doing the job, a desire to teach, communications skills, patience, a positive attitude toward the organization and the job to be learned, a knowledge of teaching methods and procedures and time to train (206).
(5) **Evaluate performance, and communicate results and expectations to the employee.** People want to know how they are doing on the job, and it is the responsibility of the manager to evaluate their performance and communicate the appraisal to them. This process of appraisal and communication should be regular and ongoing and not just on yearly basis\(^{(206)}\).

(6) **Help employee improve performance.** The appraisal should measure how well the various parts of the job are being performed. It should identify the employee’s strengths, as well as the aspects of the job where improved performance is needed. When these have been identified and agreed on between manager and employee, a performance improvement plan should be developed and implemented\(^{(206)}\).

(7) **Build and maintain rapport with the employee.** Rapport can be defined as a good working relationship or climate of mutual trust and respect between manager and employee. To build rapport, the manager must try to understand and meet the employee’s needs and wants, not just the organizations. There are many ways to build rapport. An obvious one is for the manager to praise good work and give credit when due. Another is for the manager to take a personal interest in the hobbies, family and problems that are dear to the heart of the employee. Also, the manager must show an interest in the future of the employee with the organization\(^{(206)}\).

(8) **Reward for performance.** Rewards can be monetary, such as wage incentives, merit salary, increases and prizes. Or they can be nonmonetary, such as praise, special job assignments, more responsibility, delegated tasks, better working conditions and authority\(^{(206)}\).

**APPROACHES TO PERFORMANCE IMPROVEMENT**

(1) **Utilize the strategy matrix**

![Strategy Matrix](image)

*Figure (6):* Strategy Matrix\(^{(207)}\).
The leader carefully considers the specific staff member and assesses that nurse’s level of knowledge about the job (the nurse may have a low or a high level of job knowledge). The leader also attempts to assess the nurse’s attitude toward the job (this can range from “good” to “poor”). Note: recall that the consideration of the staff members’ attitudes is being undertaken by the leader. It is doubtful that any nurse, if questioned, would state that he/she has a poor attitude. In effect, the leader making this assessment is likely thinking, “The nurse’s attitude is different than mine; my attitude is the correct one for the situation. Therefore, the nurse’s attitude must be incorrect” (207).

What does the strategy matrix suggest to the leader aiming to identify the type of corrective actions, if any, that can help improve the nurse’s performance? The matrix suggests from possible strategies based upon the leader’s perception of the nurse’s attitude and knowledge (207):

- **Box A** – Training is needed. This strategy is often best when the leader believes the nurse has a good attitude but a low level of knowledge. In fact, training is most useful to develop (improve) knowledge and skills. If, therefore, the leader believes that the nurse wants to do the work (having a good attitude) but does not know how to do so, this tactic for problem resolution should be chosen (207).

- **Box B** – leader must do something. In this situation, the leader believes that the nurse has a high level of job knowledge (knowing how to do the job) and, at the same time, has a positive attitude (the nurse wants to do the job). If the nurse knows how to do the work and wants to do it, something outside of the nurse’s control must be at fault (207).

Perhaps there is a facility and/or work design, equipment malfunction, work overload or some other problem (which, hopefully, is within the control of the leader) but is not within the nurse’s ability to resolve. In this situation, the staff member is not at fault because the problem involves a nurse who has a positive attitude and high level of job knowledge. Instead, the leader must do something to help the affected nurse become successful on the job. It is, after all, the leader who selects, orientates, trains, supervises and evaluates the work of nurses. It is also the leader who provides (or fails to provide) the resources which the nurse needs to do the job (207).

- **Box C** – A human resource action is needed. In this instance, the leader identifies that the nurse has a low level of job knowledge (does not know how to do the work). At the same time, the nurse is judged to have a poor attitude (does not do the work). In this instance, a human resource action may be the best tactic. Depending upon the healthcare facility’s policy, an oral or written reprimand may be in order. If there is still not an improvement in performance, additional human resource actions such as transfer, demotion or even discharge may be necessary (207).

- **Box D** – Motivation is the tactic. Here the leader believes that the affected nurse has the knowledge required to do the work but has a poor attitude and, therefore, does not want to do the work. A “Box D” situation requires a motivation tactic (207).

**2) Identify the Behavior for Change**

In the nurse discipline meeting, the behavior for improvement should be well identified for the nurse, according to guidance from the human resource staff. Quite often, the problems with a nurse’s performance are identified as a need for improvement of a
competency (i.e., organization, communication, attitude, teamwork) or a task-related skill (i.e., data entry, written communication, public speaking, relationship management) (208).

(3) Provide Specific Examples
Once the behavior has been clearly identified for improvement, it is important to provide specific examples of poor past performance and positive future expectations. It is difficult for a nurse to know what positive attitude looks like, for example. First, show a specific example of poor performance. Then, describe the positive future expectations (208).

(4) Focus on Feedback
Frustration, anger, disappointment or sometimes the tension of the disciplinary meeting can change the personal relationship between the leader and nurse. Many times a barrier is constructed where the two feel that conversations are not allowed outside of the scheduled performance discussion meetings. But, if successful improvement of the behavior is the goal, it is crucial to continue the relationship with the nurse in addition to documenting, as needed. Moreover, increase the feedback during the improvement period. For example, provide positive feedback to reinforce any improvement in behavior. It is important to reflect the nurse’s positive changes in the documentation, but, more important, do not neglect to communicate positive reinforcement to the nurse. This assures the nurse that the leader is interested in his or her success and is providing specific direction on how to successfully change behavior (208).

In the event that discipline problems are more serious, documentation and direction from the human resources staff is critical in any nurse intervention. However, for most nurses, the process of pointing out problem areas, providing specific examples of negative and positive behaviors and supporting efforts with appropriate feedback will help improve performance. As their leader, with a little dedication and effort, more than anyone have the power to help nurses succeed (208).

Coaching performance improvement is an important part of leading a team. Underperformers can turn into star talent with some coaching and guidance. Creating a professional development plan that clearly states the milestones that must be obtained is a critical step in motivating positive performance (208).

PLAN FOR PERFORMANCE IMPROVEMENT

(1) State the Final Goal
Start by determining the final performance improvement goals. These goals could be to improve production time by a certain amount, to improve the speed of a task, to increase skills and knowledge in a certain area or to improve relationships with certain people. Use the SMART (specific, measurable, actionable, realistic and timely) goal setting process to articulate the goal statements (209).

(2) State the Progress Goals to Milestones
Set milestones over the next year (for example, at the end of each quarter) that will need to be accomplished to attain the final goal. This is a simple process if the final goal is a number (figure or percentage) as the final number can be divided by four, for the four quarters or twelve to create monthly progress goals. For final goals that are not numbers,
the leader will need to brainstorm with the nurse to figure out the steps to get to the final goal. Those steps then become the milestones along the way (209).

(3) **Determine the Resources and Training Needed**

The next section of the plan is dedicated to determining the resources (support staff, equipment, resources, etc.) and the training needed to reach the process goals and final goal. Resources may require a budget so it is imperative that a room for performance improvement initiatives is left when budget planning. When determining training needs, start with the obvious, for example, in-service training that is available or mentors that could coach the nurse. Once the in-service options are exhausted, look to external sources of training such as local college or outsourced training vendors (209).

(4) **Determine Incentives for Attaining Process and the Final Goal**

Incentives can be a terrific way to reward the nurse for their efforts, if and only if meeting their motivational needs. Take the time to think creatively and/or discuss with the nurse to determine suitable incentives (209).

(5) **Record the Plan**

Create a document with the following sections:

a. Performance Improvement Timeline – a map of the final and process goals along a timeline;
b. Resources and Training;
c. Incentives (209).

Therefore, the role of the first-line nurse manager is one of the most difficult, demanding, and challenging jobs in any organization. The first-line manager is continually caught in the crossfire between upper-level administration's demands and priorities and those of the staff. The conceptualization of the head nurse as a first-line nurse manager has evolved over the past decade (121).

Three specific phases of head nurse role development have been identified since the inception of the role in the late 1800s: the unit controller (1900 – 1940), the master coordinator (1940 – 1970), and the head/manager (1970 – present). Early head nurses were expected to control the activities of their units, which included the supervision of patient care and the teaching of students who were enrolled in the hospital school of nursing and who provided the majority of patient care services on the unit. The role of coordinator evolved as the shortage of registered nurses during and after the world wars led to the development of ancillary nursing roles (e.g. licensed practical nurses, nursing aides, volunteers, etc.) and the growth in medical technology created the need for increased specialization. It is usually assumed that those promoted to management skills, therefore in studying the first-line nurse managers position, the emphasis is placed upon managerial and leadership skills (121).

Skills refer to the professional and personal facility needed to be "leader-full". It is important to distinguish between competencies and skills because the skills are generally specific to techniques and knowledge that apply to a profession. A focus on these professional skills therefore takes away from an assessment of leadership competencies, which are a greater indicator in determining performance (Zwell, 2000) (210).

Nurse leaders' performance provides an objective summary of leaders' strengths and areas of development along seven critical leadership performance factors, namely:
(1) problem-solving that deals mainly with recognizing trends and generating and evaluating ideas; (2) planning, which focuses on future, change, goals and objectives; (3) controlling, which focuses on events, performance, productivity and commitments; (4) managing self, which deals with pressure, feedback and personal life; (5) managing relationships, which deals with others and ways to resolve conflict; (6) leading, which focuses on leadership skills and competencies; (7) communicating, which enlists basic communication skills. This instrument was designed for improving leaders' performance by evaluating individual effectiveness (24).

As a consequence, well-trained leaders have the ability to inspire and bring out the best in their staff (211). Nurses must work competently in critical situations, use teaching aids and resource materials in teaching patients and their families, initiate planning and evaluation of nursing care and others, promote the inclusion of patients' decisions and desires concerning their care (this is an essential part of interpersonal relations) and use learning opportunities for on-going personal growth (this would promote nurses' professional development) (Caffarella and Zinn, 1999) (212).

The literature review addressed a myriad of nursing behaviors that can be clustered into four underlying nursing performance areas: (1) research: it is important to have research done by nurses who are members of the profession in order to prevent nursing from "executing its functions by imitation rather than by understanding". The research function is an essential dimension of the nursing role (25 - 30); (2) education: the nurses' responsibility for comprehensive healthcare through education and teaching is well-documented in the literature (Redman, 1980) (213); (3) professional development: a definitive characteristics of nursing behaviors is not only that the nurses possess a unique body of knowledge, but that they are able to apply a unique body of skills as well. Knowledge and skills should be developed continuously; (4) clinical skills: skills can imply intellectual as well as technical skills. The last one is directly related to nursing procedures, patient referral and health teaching (26 - 30).
RELATED STUDIES
In the last twenty years (1989 – 2009) nineteen studies have been published which give some consideration to the effectiveness of in-service leadership development training program on workgroup climate and performance.

- Tourangeau et al., (2009) investigated nursing leadership in Ontario long-term care facilities. The purpose of this quasi-experimental study was to test the effectiveness of one strategy targeted to promote nursing leadership development in Ontario long-term care facilities. In this study, the effects of a leadership development intervention on the following four categories of outcomes: 1) participant leadership practices, 2) characteristics of work environments, 3) responses of multidisciplinary staff (including nursing staff) to their work and work environments, and 4) the organizational outcome of intention to remain employed, were examined. The study consisted of a pre-test survey completed one month prior to participants attending a leadership intervention and up to two post-test surveys completed 6 and 12 months following the intervention. The study included 26 nurse dyads consisting of an established nurse and an aspiring nurse leader that were selected from 26 Ontario long-term care facilities representing all 14 Local Health Integration Networks. Each nurse leader was asked to complete a series of surveys assessing their own leadership practices, characteristics of their work environment, responses to work and work environments, and intent to remain employed in long-term care. Participants invited their immediate supervisors and up to 10 co-workers to complete a similar survey assessing the leadership practices of the participant, characteristics of their work environments, responses to their work environments, as well as their intentions to remain employed. Key Study Findings were: (1) both participants and their co-workers reported significant increases in aspiring nurse leader’s cognitive leadership practices from pre-test to post-test time periods. (2) Established nurse leaders self-reported significant improvements in their cognitive and supportive leadership practices from pre-test to post-test time periods. (3) A significantly smaller proportion of participants reported low depersonalization scores from pre-test to post-test time periods, suggesting that participants observed a decline in the quality of provider-patient relationships from pre-test to post-test times. (4) Supervisors reported significantly higher organizational support, while participants reported significantly lower organizational support from pre-test to post-test time period. (5) Co-worker job satisfaction scores improved significantly from pre-test to post-test time periods. The interview results showed that participants were enthusiastic about the leadership development intervention and were strongly appreciative of the skills they learned. Moreover, participants expressed frustration with the lack of time, management support, and resources to enact their newly acquired leadership knowledge and skills in the workplace. This lack of support coupled with the challenge of a lack of nurses in management positions within some long-term care facilities resulted in some participants feeling that nursing leadership in long-term care settings was undervalued. The leadership intervention increased participants’ awareness of the importance of leadership in the work place, and also the importance of the recruitment and retention of nurse leaders in long-term care (214).
- Strapasson and Medeiros (2009) used a qualitative research aiming at verifying if the presuppositions of Transformational Leadership are present in the nurses practice in a medium size hospital in the countryside of Rio Grande do Sul. The researched people were eleven head nurses in different sectors of the hospital, who have been working for one year or more in the inquired medical institution. The tools used for the research was a semi-structured interview. The data have been analyzed through content analyses method, in which five categories emerged: the meaning of leadership; essential abilities for leadership activity; leadership ability in everyday nurse activity; participation of the Institution in leadership development; and the resistance of nurses to the changing process. Some of the presuppositions are identified and noticed as important, although not totally present in everyday activity of nurses (215).

- Sellgren, Ekvall, and Tomson (2008) examined how nurse managers' leadership behavior relates to job satisfaction and a creative work climate. They studied 770 subordinates at a large university hospital. They found that subordinates with a manager perceived as transformational have the highest rates on job satisfaction. The correlation between leadership and creative work climate is stronger than between leadership and job satisfaction. Also, a manager's ability to lead has a major affect on work climate (154).

- Cummings et al., (2008) reviewed systematically the multidisciplinary literature to examine the factors that contribute to nursing leadership and the effectiveness of educational interventions in developing leadership behaviors among nurses. The search strategy began with 10 electronic databases (e.g. CINAHL, Medline). Published quantitative studies were included that examined the factors that contribute to leadership or the development of leadership behaviors in nurse leaders. Quality assessments, data extraction and analysis were completed on all included studies. Results showed that a total of 27,717 titles/abstracts were screened resulting in 26 included manuscripts reporting on 24 studies. Twenty leadership factors were examined and categorized into four groups – behaviors and practices of individual leaders, traits and characteristics of individual leaders, influences of context and practice settings, and leader participation in educational activities. Specific behaviors and practices of individual leaders, such as taking on or practicing leadership styles, skills and roles, were reported as significantly influencing leadership in eight studies. Traits and characteristics of individual leaders were examined in six studies with previous leadership experience (three studies) and education levels (two of three studies) having positive effects on observed leadership. Context and practice settings had a moderate influence on leadership effectiveness (three of five studies). Nine studies that examined participation in leadership development programs all reported significant positive influences on observed leadership.

They concluded that leadership can be developed through specific educational activities, and by modeling and practicing leadership competencies. However, the relatively weak study designs provide limited evidence for specific factors that could increase the effectiveness of current nursing leadership or guide the identification of future nurse leaders. Robust theory and research on interventions to develop and promote viable nursing leadership for the future are needed to achieve the goal of developing healthy work environments for health care providers and optimizing care for patients (216).

- The Management Sciences for Health (MSH) (2000 – 2005) had conducted a Virtual Leadership Development Programs (VLDP), based on transformational leadership practices, in 49 developing countries in order to build the leadership and management
capacities of health managers and strengthen the management systems required to deliver quality health services in a sustainable fashion. Every program lasted from four to nine months and was intended for members of preexisting teams. The program content consisted of seven modules on topics such as leadership in health institutions, how to address a leadership challenge, leadership competencies, communication and change management. The programs were constructed under the assumption that leadership can be learned and therefore is supported by the idea that leadership outcomes can be measured. The leadership outcomes varied from intermediate outcomes such as change in workgroup climate to long-term outcomes such as service delivery results. The programs resulted in performance improvement which occurred at two levels: intermediate changes within the team (workgroup climate) and within the organization (systems) and outcomes at the service delivery level (20).

- A study conducted in Kuwait by Al-Mailam (2004) was designed to determine whether employees working for transformational leader perceive their leader to be more effective than did those working for a transactional leader. The study also compared the private and public sector with regard to leadership style. The result of this study indicated that the transformational leadership style was linked to high level of leadership efficacy, and that employees in private hospitals were more likely to perceive their leaders more transformational than employees in the public hospitals (217).

- Tourangeau and McGilton (2003) reported on the evaluation of an intervention administered to a group of Canadian nurses designed to assist participants to value leadership and to develop knowledge, skills and attitudes required for effective leadership. A one-group pre-test, post-test quasi-experimental design guided the study. All participants received a five-day residential leadership development intervention. Participants acted as their own controls and were assessed, both immediately before intervention implementation and three months later, on the self- and observer-reported leadership practices as well as self-reported levels of burnout. Results indicated that a concentrated, residential leadership development intervention is effective in strengthening leadership behaviors performed by both already established and aspiring nurse leaders from the perspective of observers, but not from self-reported assessments. No significant changes in self-reported burnout levels were found. They concluded that it is possible to deliver leadership development interventions to both established and aspiring nurse leaders that result in fairly rapid improvements in observed leadership practices (8).

- Dunham-Taylor (2000) examined a national sample of 396 randomly selected hospital nurse executives to explore transformational leadership, stage of power, and organizational climate. Nurse executives (396) and staff reporting to them (1,115) rated the nurse executives' leadership style, staff extra effort, staff satisfaction, and work group effectiveness. Executives' bosses (360) rated executive work group effectiveness. Executives completed Hagberg's Personal Power Profile and ranked their organizational climate using Likert's Profile of Organizational Characteristics. The results: Nurse executives used transformational leadership fairly often; achieved fairly satisfied staff levels; were very effective according to bosses; were most likely at stage 3 (power by achievement) or stage 4 (power by reflection); and rated their hospital as a Likert System 3 Consultative Organization. Staff satisfaction and work group effectiveness decreased as nurse executives were more transactional. Higher transformational scores tended to occur with higher educational degrees and within more participative organizations. Conclusions: Transformational qualities can be enhanced by further education, by achieving higher power stages, and by being within more participative organizations (33). This result was
similar to the result of Chen (2004) who studied the relationship between nursing faculties' perceptions of nursing deans' and directors' leadership style and faculties' job satisfaction level in Taiwan. Chen (2004) found that Taiwanese nursing deans and directors tend to display transformational leadership more frequently than transactional leadership.

- Allen (1998) studied perceptions and beliefs about leadership development by interviewing 12 nursing leaders. Five important factors were self-confidence, innate leader qualities, a progression of experiences and successes including education, influence of significant people who expressed confidence in, and encouraged the nursing leaders, and finally personal life factors such as family reasons with a daytime job or finding a less strenuous position. For future nurse leaders, they recommended reinforcing self-confidence, acting as role models and mentors, creating opportunities for progressive experiences and successes and fostering continuous learning. All 12 participants described a sense of self-confidence that had developed since childhood with additional attributes of risk-taking and education. Natural leadership tendencies and easily getting involved were described by eight participants, but only two nurse leaders described a desire to change and improve nursing.

- A descriptive correlational research study conducted by Cress (1996) examined "the relationship between the self assessment and the subordinate's assessment of the leadership practices of the first-line nurse managers". The data consisted of 84 managers and subordinates. The study revealed that the managers moderately performed the leadership practices and a significant positive relationship was found between the manager and subordinate's assessment of challenging the process and inspiring a shared vision.

- Dunham and Klafehn (1990 and 1995) uses a questionnaire in an exploratory study of 80 perceived extraordinary managers and 213 staff nurses to determine if managers demonstrated characteristics of a transformational leader. A transformational leader was defined as having intellectual stimulation which supports challenging the process. Intellectual stimulation encourages staff members to try something new and to take risk even if they fail. Study findings indicate that transformational leaders view change as opportunities to discover new perspectives. This research supported that extraordinary leaders demonstrated characteristics of transformational leaders.

- Horvath et al. (1994) conducted an interpretive, phenomenological study of 29 first-line nurse manager identifying their skills and expertise. One of the key role responsibilities of the first-line nurse manager is operationalizing the core values of the institution. Horvath et al. reported that first-line nurse managers are responsible for creating and sustaining an environment that supports excellence in clinical practice and the care of the patient. The nurse manager utilizes modeling the way to make these values come to life. The nurse manager recognizes the importance of setting the stage, working in congruence with the values of the institution and modeling the way.

- Chases (1994) conducted a descriptive research study of 300 members of the American Organization of Nurse Executives to delineate specific behavior competencies that increase effectiveness in the nurse manager role. The author found human and leadership competencies were perceived as the moist important for effectiveness in the nurse manager role. Leadership competency supports enabling others in the expected skills of empowerment and motivation.
- Howell and Avolio (1993) studied 78 managers in a financial institution to examine whether transformational leadership behavior predicts unit performance over a one-year period. Results of this study indicate that leaders who display transformational leadership behaviors do contribute to the achievement of organization goals (221).

- Pedersen (1993) using a qualitative design interviewed five nurse managers and 11 staff nurses to identify the qualities of extraordinary nurse managers. They identified forward thinking that encourages being a change agent, challenging the status quo, being courageous, and taking risks. This leader motivates, facilitates and coaches staff to experiment with the understanding that occasionally there is failure (222).

- Keller (1992) used a convenience sample to examine the performance of project groups in three industrial research and development organization. The longitudinal design of this study allowed examination of the relationship between group performance ratings at time one and leadership at time two. Results indicate that transformational leadership predicted higher project quality and budget scheduling performance as rated by leaders and follower for both time one. Also, project quality, as rated by both followers and leaders at time one, predicted higher ratings of transformational leadership at time two (223).

- Bass and Yammarino (1991) examined self and rater ratings of naval officers to determine the congruence of the transformational leadership ratings by leaders and followers. They hypothesized that leaders overestimate the frequency of their own transformational leadership behavior in comparison to the subordinate (follower) rating. Results also indicates that transformational leadership self rating did not correlate with performance and whether officers were promotable; however, transformational leadership rater (follower) ratings were associated with performance and promotability of the officers. These findings suggest that the amount and intensity of a leader's transformational behaviors as perceived by followers is as important as what the leader actually does (118).

- Dunham and Fisher (1990) asked nurse leaders to identify characteristics of excellent nurse leaders (224); while Murphy and DeBack (1991) asked nurse leaders to describe how they are orchestrating change in their own workplace (225). In both of these qualitative investigations, where the sample sizes were 80 for Dunham and Fisher (1990) and 13 for Murphy and DeBack (1991), nurse leaders identified characteristics and behaviors of the transformational leader. Characteristics and behaviors such as strong value systems, high morals, creating a vision, empowering others, taking risks, involving nurses in the process, and enabling others in the process are mentioned. These characteristics represent the transformational leadership style (224 - 225).

- Bennis (1989), in a descriptive research study, interviewed 28 leaders to identify the practices of leadership. Bennis discovered that it was easy to talk about leadership, but difficult to practice. His study attempts to make leadership practical and reinforces the premise that leaders are made not born. Bennis supports two basic ingredients to leadership: curiosity and daring, both of which are congruent with challenging the process. Curiosity and daring encourage risk taking, experimentation, and embraces errors knowing that learning will occur (70).

**MATERIALS & METHOD**

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The study aims to determine the impact of first-line nurse managers' leadership development training program on workgroup climate; and performance. The present study is mainly composed of three parts:

I. An exploratory study conducted to assess:
   a. Leadership practices of the first-line nurse managers.
   b. Workgroup climate of first-line nurse managers and staff nurses.
   c. First-line nurse managers performance.
   d. Staff nurse performance.

II. Planning, development, and implementation of a leadership development training program for first-line nurse managers based on the results of the exploratory study.

III. Evaluation of the impact of first-line nurse managers' leadership development training program on workgroup climate; first-line nurse managers’ performance; and staff nurses’ performance.

MATERIALS

Research Design:
A quasi-experimental design was used to conduct this study.

Setting:
The study was conducted in all inpatient surgical and medical units and their specialties, at Alexandria Gamal Abd El Nasser – Health Insurance Hospital. It is the central health insurance hospital in Alexandria (out of three hospitals) equipped with 1000 beds, with a wide range of ambulatory care services such as out-patient, pharmacy, emergency, x-ray, physiotherapy, and paramedical services as dietary, laundry and maintenance.

The surgical units included in the study were, namely: general surgery A, general surgery B, general surgery C, general surgery – female, plastic surgery, ophthalmology surgery, urology surgery, ear, nose and throat surgery (ENT), obstetrics & gynecology surgery, orthopedics A, orthopedics B, orthopedics – female, neuro-surgery, surgery G1, surgery G2. Whereas the medical units included in the study were: general medical A1 (male), A2 (female), and A intermediate; general medical B1 (male), B2 (female), and B intermediate; general medical C1 (male), C2 (female), and C intermediate; neurology 1 (male), and intermediate; oncology; chest A (male) and B (female); and general medical G4.

Subjects:
Subjects of the study comprised all first-line nurse managers and all staff nurses, who were working with the first-line nurse managers; in the previously mentioned units, who were available at the time of data collection at Alexandria Gamal Abd El Nasser – Health Insurance Hospital. The number of first-line nurse managers = 30 and staff nurses = 170; other 30 nurses were not available at the time of data collection, 12 were transferred to Tosson Health Insurance Hospital, 13 had resign their job and five was in labor vacation.
Nursing staff ranged from 5-9 nurses in each unit. All the first-line nurse managers in the previously mentioned units were included in the study (one / each unit). Staff nurses in surgical and medical units were distributed as follows: general surgery A (6 nurses), general surgery B (5 nurses), general surgery C (5 nurses), general surgery – female (5 nurses), plastic surgery (6 nurses), ophthalmology surgery (4 nurses), urology surgery (5 nurses), ear, nose and throat surgery (ENT) (5 nurses), obstetrics & gynecology surgery (6 nurses), orthopedics A (6 nurses), orthopedics B (7 nurses), orthopedics – female (6 nurses), neuro-surgery (6 nurses), surgery G1 (6 nurses), surgery G2 (5 nurses); general medical A1 (male) (5 nurses), A2 (female) (7 nurses), and A intermediate (6 nurses); general medical B1 (male) (5 nurses), B2 (female) (5 nurses), and B intermediate (5 nurses); general medical C1 (male) (6 nurses), C2 (female) (6 nurses), and C intermediate (5 nurses); neurology 1 (male) (6 nurses), and intermediate (8 nurses); oncology (6 nurses); chest A (male) (5 nurses), and B (female) (6 nurses); and general medical G4 (6 nurses).

**Tools:**

I. **Exploratory phase tools:**

Four tools were used in this phase, namely: Leadership Practices Inventory (LPI), Workgroup Climate Assessment (WCA), Performance Appraisal tool (Leader View 360), Staff Nurse Performance Questionnaire.

**Tool 1: Leadership Practices Inventory (LPI):**

The Leadership Practices Inventory LPI – (Self and Observer form) – developed by Kouzes and Posner (2005), was used to assess leadership behavior of nurse manager by herself and observers (staff nurses). It consists of 30-items that measures five leadership practices consistent with transformational leadership style, including behaviors associated with: modeling the way (6-items), inspiring a shared vision (6-items), challenging the process (6-items), enabling others to act (6-items), and encouraging the heart (6-items). Responses were measured on a 5-point rating scale ranging from 1 ("almost never") to 5 ("almost always"). The theoretical range for each of these five subscales ranged from the lowest possible total of 6 to the highest possible total of 30. More frequent use of a leadership behavior is indicated by a higher value on the scale. Scores are calculated by summing items related to each leadership practice, then dividing by six to calculate the mean for each leadership category. (Appendix I)

**Tool 2: Workgroup Climate Assessment (WCA):**

The Workgroup Climate Assessment tool (WCA) developed by the Management Sciences for Health (MSH) (2005) was used to measure change in assessment of workgroup climate. It consists of 14-items that measures two dimensions of perceptions, including: climate perceptions (12-items) which was composed of clarity (4-items), support (4-items) and challenge (4-items); and productivity and quality perceptions (2-items). Responses were measured on a 5-point rating scale ranging from 1 ("not at all") to 5 ("to a very great extent"). The theoretical range for each of these first three subscales is 4 (lowest) through 20 (highest); while for the last two subscales, it is 1 (lowest) through 5 (highest). Scores are calculated by summing items related to each dimension, and then dividing by number of items for each dimension to calculate the mean for each category. (Appendix II)

**Tool 3: Performance Appraisal tool (Leader View 360):**
The Leader View 360 developed by Nowack (2005) was used to assess performance effectiveness of leaders. It consists of 35 behaviors that are grouped into seven job performance factors, namely: problem solving (3 items), Planning (3 items), Controlling (6 items), Managing self (5 items), Managing relationships (6 items), Leading (6 items), and Communicating (6 items). Responses were measured on a 5-point rating scale ranging from 1 ("Needs considerable development") to 5 ("Very effective"). The theoretical range for each of these seven subscales varied from 3 (lowest) to 30 (highest), according to each subscale and its related items. Scores are calculated by summing items related to each job performance factors, and then dividing by number of items related to each category to calculate the mean for each performance group (24). (Appendix III)

**Tool 4: Staff Nurse Performance Questionnaire:**

The Staff Nurse Performance Questionnaire was developed by the researcher based on their job description and review of related literature; in order to assess job performance behaviors of staff nurses. It consists of behaviors that were grouped into four performance dimensions, namely: research (5 items), education (6 items), professional development (20 items), and clinical skills (16 items). Responses were measured on a 5-point rating scale ranging from 1 ("Unsatisfactory") to 5 ("Excellent"). The theoretical range for each of these four subscales varied from 5 (lowest) to 100 (highest), according to each subscale and its related items. Scores are calculated by summing items related to each performance dimension, and then dividing by number of items pertaining to each dimension to calculate the mean for each performance category (26–30). (Appendix IV)

In addition, a socio-demographic characteristics data sheet was developed by the researcher; it included questions related to unit, age, qualifications, nursing experience, experiences [either as a first-line nurse managers (for first-line nurse managers) or with first-line nurse managers (for staff nurses)], and marital status.

II. Planning, and development of a first-line nurse managers leadership development training program tools:

a. **Content topics of the program were:**

- **General introduction:**
  - Concept of leadership and leader,
  - Importance of leadership,
  - Principles of leadership,
  - Differences between manager and leader,

- **Model the way:**
  - Goal setting,
  - Action plan,
  - Decision making,

- **Inspire a shared vision:**
  - Vision and mission,
  - Interpersonal communication skills,

- **Challenging the process:**
  - Problem solving,
  - Innovation,
  - Risk taking,

- **Enabling others to act:**
  - Team building and teamwork,
• Coaching,
- Encouraging the heart:
  • Setting priorities,
  • Creativity.

b. Needs assessment questionnaire: was developed to assess first-line nurse managers' needs for leadership development training program and their educational preparation. (Appendix V)

c. Participants' reaction form:
A structured questionnaire form was developed based on review of current related literature to evaluate the outcome of the program from the first-line nurse managers' points of view. It included 12 questions that measure the strong and weak points of the objectives, time period, contents, time schedule of the program and methods of teaching used. (Appendix IX)

d. Knowledge test (pre, post and retention test):
A questionnaire was developed based on review of current related literature to collect data related to first-line nurse managers' level of knowledge regarding leadership development at the beginning, end and after three months of the training program's implementation. It consists of questions related to the five leadership practices, as follows: concept of leadership and leader, importance of leadership, principles of leadership, differences between manager and leader; (1) Model the way: [a] goal setting: concept of goal setting, criteria of goals, characteristics of well-written objectives, [b] action plan: definition of action plan, [c] decision making: concept, factors affecting decision making, guidelines for decision making, steps to implement decision making; (2) Inspire a shared vision: [a] vision and mission: concept of vision and mission, components (elements) of vision, flow of vision, tips for setting and communicating the vision, the visioning process model (or visioning pathway), the characteristics and qualities of Visionary leaders, the elements of mission [b] interpersonal communication skills: definition of the communication process, the elements of communication process, the types of messages, the contacts role in achieving effective communication, the barriers to effective communication and how to overcome them, the listening role in effective communication, the roles of excellent listener, rules to effective speaking, the aim of feedback, and how to give feedback; (3) Challenging the process: [a] problem solving: concept of problem solving, approaches of problem solving, the problem solving process, [b] innovation: the concept of innovation, the levels of innovation, the issues for the success of innovation, [c] risk taking: the concept of risk taking, the phases or steps in risk taking, the components of risk taking, the barriers to risk taking; (4) Enabling others to act: [a] team building and teamwork: the concept of team and breakdown, the values of team building, the characteristics of effective team, the stages of building a team and team development, the success elements necessary in preparing a team meeting, the preparation necessary for team meeting, the problems that arise from breakdown, the most suitable exercise during breakdown, the team members' roles, the causes of conflict in teams, [b] coaching: the concept of coaching, the aims of coaching, effective coaching, the principles of coaching, the coach roles, the leader as a coach; (5) Encouraging the heart: [a] setting priority: the concept of prioritization, the types of activities, the priority setting traps, [b] creativity: the concept of creativity, the technique for generating
creative thinking, the barriers to creative thinking, the development of creative thinking. (Appendix VII)

e. **Teaching sessions and time schedule:** which were developed. (Appendices VIII, VI)

III. Evaluation of the first-line nurse managers’ leadership development training program:

a. **Participants’ reaction form:** was used at the end of the program to evaluate the outcomes of the program from the first-line nurse managers’ points of view.

b. **Knowledge test (post and retention test):** that was used before the program implementation, was used again at the end of the program and later after three months from program implementation.

c. **The four tools that were used in the exploratory phase:** for the assessment of Leadership Practices, Workgroup Climate, Performance Appraisal tool for first-line nurse managers, and Staff Nurse Performance; were used twice – at the end of the training program and later after three months from program implementation – to validate the effect of the program mainly on the first-line nurse managers’ leadership practices, workgroup climate, leader performance appraisal, and staff nurses performance.

**METHOD**
1. An official permission was obtained from the director of the Health Insurance North-West Delta Branch, and the hospital administrators to collect the necessary data.

2. The research tools were translated into Arabic; and tested by 5 experts in the field of study – from Faculty of Nursing, Alexandria University – for its content validity and translation, and accordingly, the necessary modifications were done based on their comments. They were one professor of psychiatric nursing and mental health, one professor of nursing education, one professor of emergency and critical care nursing, and two professors of medical and surgical nursing.

3. The developed questionnaire was tested for reliability using the cronbach’s alpha, to measure the internal consistency of the items composing each dimension of staff nurse performance questionnaire tool, yielding $\alpha = 0.95$ indicating high reliability. For testing stability over time, the adopted and developed tools were tested for reliability (test – retest method) using Spearman's correlation coefficient ($r$) most of which were greater than 0.65 indicating good reliability; whereas the time between test and retest for each scale was four weeks (22/11/2007 – 22/12/2007).

4. Informed consent was obtained from the subjects of the study for collecting needed data and program implementation.

5. A pilot study for the questionnaires was carried out on 3 first-line nurse managers; and 20 staff nurses (10 %) from Students' Health Insurance Hospital, who were not included in the study sample; in order to check and ensure the clarity of the questionnaires, identify obstacles and problems that may be encountered during data collection. Based on the findings of the pilot study, no modification was done.

6. Data collection:

   **I. Exploratory or Assessment phase:**
   
   Data were collected by the researcher after obtaining an official permission from the director of the Health Insurance North-West Delta Branch, and the hospital administrators to collect the necessary data. Meeting with the director of nursing services was conducted by the researcher on an individual basis to explain the objectives of the study and to gain cooperation.

   **A. Individualized schedule interviews were conducted for first-line nurse managers and staff nurses included in the study to collect data concerning:**
   
   a) The leadership behavior using Leadership Practices Inventory LPI – Self and Observer.
   
   b) Workgroup climate perception using Workgroup Climate Assessment (WCA).
   
   c) Performance appraisal of first-line nurse managers using Leader View 360.
   
   d) Staff nurse Performance appraisal using developed questionnaire.

   Every interview with each first-line nurse managers took from 40 to 45 minutes while it took 50 – 60 minutes with each staff nurse. Three to four first-line nurse managers and six to seven staff nurses were interviewed daily.
B. Needs assessment questionnaire was distributed to first-line nurse managers before program implementation, to assess their needs for leadership development training program and their educational preparation. Data were collected in four weeks, started from 27th of December 2007 to 26th of January 2008.

II. Development of the program:

1. The program was developed based on the result of the exploratory study, first-line nurse managers’ leadership practices, workgroup climate, performance appraisal of first-line nurse managers, and staff nurses performance appraisal; needs assessment; as well as review of related literature.

1. The objectives of the leadership development training program were developed as well as designing teaching plans for learning experience, which includes: behavioral objectives, content, teaching strategies and aids, staff assignments, and time schedule. Time plan was established and the first-line nurse managers were organized into two groups (Medical units group = 15, and surgical units group = 15). Data analysis and development of the program took a period of two months from 30th of January to 29th of March 2008.

III. Implementation of the program:

1. Before application of the training program for first-line nurse managers, permission was secured through the hospital director, and the director of nursing services.

2. A knowledge test was self-administered to first-line nurse managers at the beginning of the program to collect data related to their level of knowledge. The test was completed in 30 minutes.

3. The program was implemented for first-line nurse managers in the training center of Gamal Abd El Nasser Health Insurance Hospital. An opening ceremony was held, for the two groups at the first day of their training week for every group, and was attended by the director of nursing services of the Health Insurance North-West Delta Branch; and also by the director of nursing services of the Health Insurance Hospital (Gamal Abd El Nasser).

4. The following teaching sessions and topics were included in the training program and delivered to the participants: General introduction (concept of leadership and leader, importance of leadership, principles of leadership, differences between manager and leader); and the five leadership practices: (1) Model the way (Goal setting, Action plan, and Decision making); (2) Inspire a shared vision (Vision and mission, and Interpersonal communication skills); (3) Challenging the process (Problem solving, Innovation, and Risk taking); (4) Enabling others to act (Team building and teamwork, and Coaching); and finally (5) Encouraging the heart (Setting priorities, and Creativity).

5. The following teaching methods were utilized: lectures, discussions, brainstorming, role play, behavior modeling, reflective practice, group work; while computer-based resources (PowerPoint presentations), visual aids (chalk and white boards, and flip charts) and printed materials (handouts and worksheets) were used as teaching media and instructional resources. Daily sessions of 4 hours were given, each
session varied from an hour and quarter to an hour and a half. The program in the hospital was carried out in a one week period for each group of first-line nurse managers. (From 2nd to 15th of April 2008).

**IV. Evaluation of the leadership development training program:**
Evaluation of the program was carried out immediately after program implementation and after three months from implementation for first-line nurse managers using the following steps:

1. Participants' reaction questionnaire, that was distributed immediately after program implementation to reveal first-line nurse managers’ reactions to benefits gained from the program. The questionnaire was explained to first-line nurse managers regarding how to answer it. First-line nurse managers were given enough time to respond to questions (25 – 30 minutes).

2. The knowledge test, which was used at the beginning of the program, was given again to first-line nurse managers at the end of the program; to evaluate the gained knowledge in comparison with the pre-test and, also, it was used after three months from program implementation to identify the participants' retention of knowledge.

3. Assessment tools (The Leadership Practices Inventory LPI – Self and Observer, Workgroup Climate Assessment (WCA), Performance appraisal of first-line nurse managers using Leader View 360, and Staff nurse Performance appraisal using developed questionnaire), that were used in the exploratory phase of the study, were used immediately at the end of the program and after three months of the program implementation to reveal the changes in first-line nurse managers and staff nurses’ behaviors and perceptions towards leadership practices, workgroup climate perception, performance appraisal of first-line nurse managers, and staff nurse performance appraisal.

All data were collected in eight months from November 2007 to July 2008.

- **Statistical analysis:**
  Statistical analyses were conducted using the personal computer with the software SPSS V 13.0 (Statistical Package for the Social Sciences).
  1. **Descriptive statistics:**
     1.1. **Frequency and percentage:**
     Simple frequency tables and cross-tabulations with counts and percentages.
1.2. **Arithmetic mean** ($\bar{X}$), and **Standard Deviation** (SD):

\[
\bar{X} = \frac{\sum X}{n}
\]

\[
SD = \sqrt{\frac{\sum X^2 - \left(\frac{\sum X}{n}\right)^2}{n-1}}
\]

where:

- \(\sum X\) = Sum of observations
- \(\sum X^2\) = Sum of squared observations
- \(n\) = number of observations

2. **Analytical statistics:**

2.1. **Chi square test**

\[
\chi^2 = \sum \frac{(O_i - E_i)^2}{E_i}
\]

where:

- \(O\) = Observed cell frequency
- \(E\) = Expected cell frequency

The chi square test is not valid if more than 20% of the cells have expected values <5 or if the expected value of one or more cells =0 in which case the Fisher’s exact test is used.

2.2. **Fisher's Exact Test probability for Fourfold Tables:**

\[
P = \frac{R_1!R_2!C_1!C_2!}{N!O_1!O_2!O_3!O_4!}
\]

where:

- \(R\) = Row total
- \(C\) = Column total
- \(O\) = Observed cell frequency
- \(N\) = Sample size
- \(!\) = Factorial

*The formula can be extended for larger tables according to the same pattern.*

2.3. **Student's t-test for independent samples:**

\[
t = \frac{\bar{X}_1 - \bar{X}_2}{\sqrt{\frac{S^2P}{n_1} + \frac{S^2P}{n_2}}}
\]

where:

- \(\bar{X}\) = Mean of sample i.
- \(n_i\) = number of observations.
- \(S^2P\) = Pooled variance of the 2 samples.

3. **Graphical presentations:**

Graphical presentations were done for data visualization by using Microsoft Excel.

**RESULTS**

The present study is mainly concerned with the following:

Evaluating the impact of the leadership development program on:

a) Leadership practices of the first-line nurse managers.

b) Workgroup climate of first-line nurse managers and staff nurses.

c) First-line nurse managers performance.

d) Staff nurses performance.
The results of the study will be presented in the following sequence:

1- Socio-demographic characteristics of first-line nurse managers and staff nurses working in the medical and surgical units at Gamal Abd El Nasser Health Insurance Hospital.

2- First-line nurse managers’ and staff nurses' perceptions of leadership practices before program implementation, immediately after, and three months later.

3- First-line nurse managers’ and staff nurses' perceptions of workgroup climate before program implementation, immediately after, and three months later.

4- First-line nurse managers' and staff nurses' perceptions of leader's performance before program implementation, immediately after, and three months later.

5- First-line nurse managers' and staff nurses' perceptions of staff nurses' performance before program implementation, immediately after, and three months later.

6- Difference between first-line nurse managers' and staff nurses' perceptions of the first-line nurse managers' leadership practices before program implementation, immediately after, three months later.

7- Difference between first-line nurse managers' and staff nurses' perceptions of workgroup climate before program implementation, immediately after, three months later.

8- Difference between first-line nurse managers' and staff nurses' perceptions of leader's performance before program implementation, immediately after, three months later.

9- Difference between first-line nurse managers' and staff nurses' perceptions of staff nurses' performance before program implementation, immediately after, three months later.

10- Relationship of first-line nurse managers' and staff nurses' perceptions between leadership practices and socio-demographic characteristics before program implementation, immediately after, and three months later.

11- Assessment of first-line nurse managers' perceptions for their educational preparation, previous training and their desire to attend a leadership development training program.

12- Assessment of first-line nurse managers' knowledge before program implementation, immediately after, and three months later.

13- Evaluation of the leadership development training program and its contents from the first-line nurse managers’ point of view at the end of the training program.

Socio-demographic characteristics of first-line nurse managers and staff nurses working in medical and surgical units at Gamal Abd El Nasser Health Insurance Hospital.

Table 1 illustrates that the number of first-line nurse managers were equal in both medical and surgical units (15 each); while staff nurses were 87 constituting 51.2 % of the total sample size in the medical units and 83 staff nurses representing 48.8 % of the total sample in surgical units.
In relation to age, the highest percentage of first-line nurse managers 70% was in the age group from 30 to less than 40 years old. On the other hand, the lowest percentage of first-line nurse managers 30% was in the age group of 40 and above, and none was in the age groups from less than 20 to less than 30 years old; as for staff nurses, the highest percentage was in the age group of 20 to less than 30 years old 63.5%; while below 20 years and from 30 to less than 40 years old were 17.7% and 17.1%, respectively. The minority of staff nurses had 40 years and above 1.8%.

Concerning the nursing educational qualification, both first-line nurse managers and staff nurses 100% were holding a Diploma of Secondary Technical Nursing School. Regarding years of nursing experience, the table shows that almost half of first-line nurse managers 46.7% were having from 15 to less than 20 years of nursing experience. whereas, 20% had from 10 to less than 15 years of the same experience, while the same percentage 16.7% was for each of the two groups: from 20 to less than 25 and above 25 years of nursing experience. Pertaining to staff nurses, the greatest proportion had from 1 to less than 5 years of nursing experience representing 49.4% of the total sample. Only one nurse, 0.6%, had above 25 years of experience. Staff nurses who had from 10 to less than 15 years of experience constituted 22.9%, while from 5 to less than 10 years of experience represented 18.8%. The lowest percentage 8.2% had from 15 to less than 20 years of nursing experience.

In relation to years of experience as a first-line nurse managers, the table indicates that two groups – from 1 to less than 5 years and from 15 to less than 20 years – were both representing 10% each. Additionally, from 5 to less than 10 years of the same experience were 33.3%. 30% and 16.7% of first-line nurse managers had from 10 to less than 15 years and from 20 to less than 25 years of the same experience, respectively.

As regard years of experience with first-line nurse managers, the majority of staff nurses 65.9% had from 1 to less than 5 years of experience with first-line nurse managers. The lowest percentage of staff nurses 5.9% had from 10 to less than 15 years of experience. About quarter of the staff nurses sample 27.7% had from 5 to less than 10 years; while only one nurse, representing 0.6% had from 15 to less than 20 years of experience with first-line nurse managers.

Concerning the marital status, married and single were almost equal representing 99 out of 200 (49.5%) and 97 out of 200 (48.5%) of the total sample, respectively. More than three quarter of first-line nurse managers 76.7% were married compared to 44.7% of staff nurses. In addition to that, more than half of staff nurses 53.5% were single compared with 20% of first-line nurse managers. The divorced nurses were 1.2% and were present only in staff nurses. The widow nurses were of equal proportion between first-line nurse managers and staff nurses – one for each group – (3.3% and 0.6%, respectively).
Table 1: Socio-Demographic characteristics of first-line nurse managers and staff nurses working in medical and surgical units at Gamal Abd El Nasser Health Insurance Hospital.

<table>
<thead>
<tr>
<th>Socio-Demographic characteristics</th>
<th>first-line nurse managers (N = 30)</th>
<th>Staff nurses (N = 170)</th>
<th>Total (N = 200)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>- Unit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical</td>
<td>15</td>
<td>50.0</td>
<td>87</td>
</tr>
<tr>
<td>• Surgical</td>
<td>15</td>
<td>50.0</td>
<td>83</td>
</tr>
<tr>
<td>- Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• &lt; 20</td>
<td>0</td>
<td>0.0</td>
<td>30</td>
</tr>
<tr>
<td>• 20 - &lt; 30</td>
<td>0</td>
<td>0.0</td>
<td>108</td>
</tr>
<tr>
<td>• 30 - &lt; 40</td>
<td>21</td>
<td>70.0</td>
<td>29</td>
</tr>
<tr>
<td>• 40 +</td>
<td>9</td>
<td>30.0</td>
<td>3</td>
</tr>
<tr>
<td>- Qualification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diploma of Secondary Technical Nursing School</td>
<td>30</td>
<td>100.0</td>
<td>170</td>
</tr>
<tr>
<td>• Diploma of Technical Health Institute</td>
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<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>• Bachelor of Science in Nursing</td>
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</tr>
<tr>
<td>- Nursing experience</td>
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<tr>
<td>• 1 - &lt; 5</td>
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<td>0.0</td>
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</tr>
<tr>
<td>• 5 - &lt; 10</td>
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<tr>
<td>• 10 - &lt; 15</td>
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<td>- Experience as a first-line nurse managers</td>
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<tr>
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<td>3</td>
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<td>16.7</td>
<td></td>
</tr>
<tr>
<td>• 25 +</td>
<td>0</td>
<td>0.0</td>
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</tr>
<tr>
<td>- Staff nurses’ experience with first-line nurse managers</td>
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</tr>
<tr>
<td>• 1 - &lt; 5</td>
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</tr>
<tr>
<td>• 5 - &lt; 10</td>
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</tr>
<tr>
<td>• 20 - &lt; 25</td>
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</tr>
<tr>
<td>• 25 +</td>
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</tr>
<tr>
<td>- Marital status</td>
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<tr>
<td>• Married</td>
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<td>Socio-Demographic characteristics</td>
<td>first-line nurse managers (N = 30)</td>
<td>Staff nurses (N = 170)</td>
<td>Total (N = 200)</td>
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<tr>
<td>-----------------------------------</td>
<td>-----------------------------------</td>
<td>------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
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</tr>
<tr>
<td>Widow</td>
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<td>3.3</td>
<td>1</td>
</tr>
</tbody>
</table>
First-line nurse managers' mean scores for leadership practices before program implementation, immediately after, and three months later.

Table 2 illustrates that there were a high significant difference between all the components of leadership practices for first-line nurse managers before, and after three months of program implementation. Moreover, approximately all the components of leadership practices were highly significant different between before and immediately after program implementation except for "enabling others to act" (t = 1.382). In addition to that, both "challenging the process" and "enabling others to act" had high significant difference (t = 4.176, and 3.207), respectively, between immediately after and after three months of program implementation. Furthermore, a significant difference was found for total leadership practices (t = 2.466); while the other components were not significant for the same period.

Concerning "enabling others to act", there was a high significant differences between before and after three months of program implementation and between immediately after and after three months of program implementation (t = 3.712, and 3.207), correspondingly. Moreover, this item got the highest mean score – before the program and after three months – its mean score and standard deviation (SD) were (23.90±3.93, and 26.73±1.41), respectively. Whereas, immediately after the program, “modeling the way” got the highest mean score and SD (26.23±2.27). As for "inspiring a shared vision", "modeling the way", and "encouraging the heart", their mean scores were not significantly different between immediately after and after three months of program implementation, where (t = 1.293, 1.054, and 0.920), respectively.

Regarding "encouraging the heart", there was a high significant difference between before and immediately after program implementation (t = 3.674); and between before and after three months of implementation (t = 4.466). Pertaining to "modeling the way", a high significant difference was found between before and immediately after program implementation, as well as, between before and three months later from program implementation (t= 3.631, and 3.203), correspondingly. As regards "challenging the process", the three times of program implementation (before, immediately after and after three months) were highly significant different where t = 3.921, 7.362, and 4.176, respectively.

In addition to that, a high significant difference was found between before and immediately after and between before and after three months of program implementation for total leadership practices (t = 4.242, and 6.229), correspondingly. On the other hand, a significant difference was found between immediately and after three months of program implementation for the same component (t = 2.466). The table presents that the highest mean score and SD for the total leadership practices was, after three months of program implementation, (131.33±3.04); followed by (127.10±8.89) immediately after program; compared with (113.10±15.74) before program implementation.
Table 2 a: First-line nurse managers' mean scores for leadership practices before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Components of leadership practices</th>
<th>Before program implementation (B)</th>
<th>After program implementation (A)</th>
<th>After 3 months from program implementation (A3)</th>
<th>t value (B &amp; A)</th>
<th>t value (B &amp; A3)</th>
<th>t value (A &amp; A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>- Modeling the way</td>
<td>23.33</td>
<td>3.74</td>
<td>26.23</td>
<td>2.27</td>
<td>25.70</td>
<td>1.56</td>
</tr>
<tr>
<td>- Inspiring a shared vision</td>
<td>21.13</td>
<td>3.96</td>
<td>25.43</td>
<td>1.77</td>
<td>25.97</td>
<td>1.45</td>
</tr>
<tr>
<td>- Challenging the process</td>
<td>21.43</td>
<td>3.24</td>
<td>24.23</td>
<td>2.19</td>
<td>26.33</td>
<td>1.67</td>
</tr>
<tr>
<td>- Enabling others to act</td>
<td>23.90</td>
<td>3.93</td>
<td>25.07</td>
<td>2.46</td>
<td>26.73</td>
<td>1.41</td>
</tr>
<tr>
<td>- Encouraging the heart</td>
<td>23.30</td>
<td>3.63</td>
<td>26.13</td>
<td>2.15</td>
<td>26.60</td>
<td>1.79</td>
</tr>
<tr>
<td>Total leadership practices</td>
<td>113.10</td>
<td>15.74</td>
<td>127.10</td>
<td>8.89</td>
<td>131.33</td>
<td>3.04</td>
</tr>
</tbody>
</table>

> 0.05 ⇔ Not significant, * ≤ ⇔ 0.05 significant, ** ≤ ⇔ 0.01 highly significant
Staff nurses' perceptions mean scores for leadership practices before program implementation, immediately after, and three months later.

Table 2 b indicates that there were high significant differences for staff nurses of all the components of leadership practices; as well as toward total leadership practices at the three times of program implementation; except for "modeling the way" which was significantly different between immediately after and after three months of program implementation (t = 2.707), as after three months from program implementation got higher mean score and SD than immediately after the program (26.35±1.57).

As regards "challenging the process", the mean score was higher after three months of program implementation than for the other two times of implementation as mean and standard deviation (SD) were (26.05±1.72); and there were highly significant difference between the three times of program implementation as between before and immediately after (t = 4.600); compared with before and after three months (t = 9.033); and with immediately after and after three months of program implementation (t = 3.467).

This is in accordance with "inspiring a shared vision", "enabling others to act", "encouraging the heart", and the total leadership practices which got a high mean scores and SD after three months of program implementation than the other two times of program implementation (mean ± SD = 26.44±1.36, 26.47±1.30, 26.55±1.46, and 131.85±3.42), correspondingly.
Table 2 b: Staff nurses' perceptions mean scores for leadership practices before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Components of leadership practices</th>
<th>Before program implementation (B)</th>
<th>After program implementation (A)</th>
<th>After 3 months from program implementation (A3)</th>
<th>t value (B &amp; A)</th>
<th>t value (B &amp; A3)</th>
<th>t value (A &amp; A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
<td>t value (B &amp; A)</td>
</tr>
<tr>
<td>Modeling the way</td>
<td>21.79</td>
<td>3.19</td>
<td>24.87</td>
<td>2.55</td>
<td>26.35</td>
<td>1.57</td>
</tr>
<tr>
<td>Challenging the process</td>
<td>20.95</td>
<td>2.57</td>
<td>24.05</td>
<td>2.65</td>
<td>26.05</td>
<td>1.72</td>
</tr>
<tr>
<td>Enabling others to act</td>
<td>22.55</td>
<td>3.12</td>
<td>24.97</td>
<td>2.51</td>
<td>26.47</td>
<td>1.30</td>
</tr>
<tr>
<td>Encouraging the heart</td>
<td>22.66</td>
<td>3.37</td>
<td>24.92</td>
<td>2.52</td>
<td>26.55</td>
<td>1.46</td>
</tr>
<tr>
<td>Total leadership practices</td>
<td>108.38</td>
<td>12.46</td>
<td>123.72</td>
<td>10.48</td>
<td>131.85</td>
<td>3.42</td>
</tr>
</tbody>
</table>

> 0.05 ⇔ Not significant, * ≤ 0.05 significant, ** ≤ 0.01 highly significant
Figure 7: The effect of the leadership development training program on first-line nurse managers and staff nurses’ perceptions mean scores for leadership practices.
First-line nurse managers' perceptions mean scores for workgroup climate before program implementation, immediately after, and three months later.

Table 3a illustrates that there were a high significant difference between almost all components of workgroup climate for first-line nurse managers for the three times of program implementation, especially between before and immediately after and between immediately after and after three months of program implementation.

The highest mean score and SD were found after three months of program implementation for all the components of workgroup climate except for "quality" which was higher at immediately after program implementation. As for between before and after three months of program implementation, the workgroup climate’s components that were highly significant different were "clarity", "support", "challenge", and total workgroup climate (t = 5.418, 6.204, 3.232, and 5.415), respectively.

Pertaining to between immediately after and after three months of program implementation, there were high significant difference for the components of "clarity", "support", "quality" and total workgroup climate (t = 3.363, 3.339, 2.964, and 3.336), correspondingly.

The highest mean score for the item "quality" was found immediately after the program; while the highest mean score for "productivity" was found after three months from program implementation. Concerning between before and immediately after program implementation, there was a high significant difference for the components of "support", "quality", and total workgroup climate; whereas a significant difference was found for the same period of time for the components "clarity", and "challenge" (t = 2.770, and 2.167), respectively.
Table 3a: First-line nurse managers' perceptions mean scores for workgroup climate before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Components of workgroup climate</th>
<th>Before program implementation (B)</th>
<th>After program implementation (A)</th>
<th>After 3 months from program implementation (A3)</th>
<th>t value (B &amp; A)</th>
<th>t value (B &amp; A3)</th>
<th>t value (A &amp; A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>- Workgroup climate – clarity</td>
<td>15.63</td>
<td>2.06</td>
<td>16.87</td>
<td>1.33</td>
<td>17.87</td>
<td>0.94</td>
</tr>
<tr>
<td>- Workgroup climate – support</td>
<td>15.23</td>
<td>2.14</td>
<td>16.93</td>
<td>1.26</td>
<td>17.93</td>
<td>1.05</td>
</tr>
<tr>
<td>- Workgroup climate – challenge</td>
<td>15.90</td>
<td>2.25</td>
<td>16.93</td>
<td>1.31</td>
<td>17.37</td>
<td>1.07</td>
</tr>
<tr>
<td>- Productivity</td>
<td>4.37</td>
<td>0.61</td>
<td>4.57</td>
<td>0.50</td>
<td>4.73</td>
<td>0.45</td>
</tr>
<tr>
<td>- Quality</td>
<td>4.27</td>
<td>0.69</td>
<td>4.73</td>
<td>0.45</td>
<td>4.37</td>
<td>0.49</td>
</tr>
<tr>
<td>Total workgroup climate</td>
<td>55.40</td>
<td>6.59</td>
<td>59.97</td>
<td>3.12</td>
<td>62.10</td>
<td>1.58</td>
</tr>
</tbody>
</table>

> 0.05 ⇔ Not significant, * ≤ ⇔ 0.05 significant, ** ≤ ⇔ 0.01 highly significant
Staff nurses' perceptions mean scores for workgroup climate before program implementation, immediately after, and three months later.

Table 3 b indicates that there were high significant differences for staff nurses toward all components of workgroup climate between before and after three months of program implementation; as well as towards approximately all the components of workgroup climate between before and immediately after program implementation, except for "productivity". Moreover, a high significant difference was found between immediately after and after three months of program implementation for the components "support", and total workgroup climate (t = 3.650, and 4.089), respectively; in addition to a significant difference for the components "clarity", and "challenge" (t = 2.209, and 2.058), correspondingly.

Pertaining to workgroup climate, "challenge" was a little bit higher than "clarity" in mean score and SD – after three months of program implementation – 17.65±1.13, and 17.65±1.04, respectively. These same two components were highly significant different between before and both immediately after and after three months of program implementation; while there were a significant difference between immediately after and after three months of program implementation for these same components. Concerning "quality", it was highly significant difference between before and immediately after (t = 5.061); and between before and after three months of program implementation (t = 7.064); while no significant difference was found between immediately after and after three months of program implementation.

Immediately after program implementation, "clarity" had the highest mean and SD 16.94±1.42; compared with "support", after three months of program implementation, which got the highest mean and SD 17.85±0.95. Concerning "productivity", it was higher significantly different between before and after three months of program implementation (t = 5.113) than the other two times of program implementation which was not significant. As for total workgroup climate, the three times of program implementation were highly significant (t = 5.125, 8.891, and 4.089), respectively; as well as "support" (t = 4.965, 7.863, and 3.650), correspondingly.
Table 3 b: Staff nurses' perceptions mean scores for workgroup climate before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Components of workgroup climate</th>
<th>Before program implementation (B)</th>
<th>After program implementation (A)</th>
<th>After 3 months from program implementation (A3)</th>
<th>t value (B &amp; A)</th>
<th>t value (B &amp; A3)</th>
<th>t value (A &amp; A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>Workgroup climate – clarity</td>
<td>14.84</td>
<td>2.08</td>
<td>16.94</td>
<td>1.42</td>
<td>17.65</td>
<td>1.04</td>
</tr>
<tr>
<td>Workgroup climate – support</td>
<td>14.41</td>
<td>2.20</td>
<td>16.75</td>
<td>1.35</td>
<td>17.85</td>
<td>0.95</td>
</tr>
<tr>
<td>Workgroup climate – challenge</td>
<td>15.15</td>
<td>1.88</td>
<td>16.88</td>
<td>1.71</td>
<td>17.65</td>
<td>1.13</td>
</tr>
<tr>
<td>Productivity</td>
<td>4.42</td>
<td>0.65</td>
<td>4.49</td>
<td>0.51</td>
<td>4.73</td>
<td>0.45</td>
</tr>
<tr>
<td>Quality</td>
<td>4.12</td>
<td>0.64</td>
<td>4.44</td>
<td>0.52</td>
<td>4.56</td>
<td>0.50</td>
</tr>
<tr>
<td>Total workgroup climate</td>
<td>52.94</td>
<td>5.71</td>
<td>59.41</td>
<td>3.90</td>
<td>62.54</td>
<td>1.54</td>
</tr>
</tbody>
</table>

> 0.05 ↩ Not significant, * ≤ 0.05 significant, ** ≤ 0.01 highly significant
Figure 8: The effect of the leadership development training program on first-line nurse managers and staff nurses’ perceptions mean scores for workgroup climate.
First-line nurse managers' mean scores of their performance before program implementation, immediately after, and three months later.

Table 4a illustrates that a highly significant difference was found for the first-line nurse managers' mean scores toward all components of leader's performance before and immediately after program implementation, and between before and after three months of program implementation; while, between immediately after and after three months of program implementation, approximately all the components were highly significant, except for "managing relationships" which shows no significant difference (t = 2.013).

Concerning the components of leader’s performance, "managing relationships" was the highest in mean and SD among the other components, before and immediately after program implementation 21.50±3.63, and 25.23±2.49, respectively; compared with "controlling" after three months of program implementation 27.27±1.46. As regards total leader's performance's mean score and SD, it was the highest 155.17±4.85 after three months of program implementation.
**Table 4a:** First-line nurse managers' mean scores of their performance before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Components of leader's performance</th>
<th>Before program implementation (B)</th>
<th>After program implementation (A)</th>
<th>After 3 months from program implementation (A3)</th>
<th>t value (B &amp; A)</th>
<th>t value (B &amp; A3)</th>
<th>t value (A &amp; A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>Problem solving</td>
<td>10.20</td>
<td>2.19</td>
<td>11.77</td>
<td>1.81</td>
<td>13.27</td>
<td>1.11</td>
</tr>
<tr>
<td>Planning</td>
<td>9.57</td>
<td>2.11</td>
<td>12.07</td>
<td>1.60</td>
<td>13.33</td>
<td>0.80</td>
</tr>
<tr>
<td>Controlling</td>
<td>21.07</td>
<td>3.88</td>
<td>24.57</td>
<td>2.60</td>
<td>27.27</td>
<td>1.46</td>
</tr>
<tr>
<td>Managing self</td>
<td>15.87</td>
<td>3.02</td>
<td>20.13</td>
<td>1.94</td>
<td>21.43</td>
<td>1.30</td>
</tr>
<tr>
<td>Managing relationships</td>
<td>21.50</td>
<td>3.63</td>
<td>25.23</td>
<td>2.49</td>
<td>26.30</td>
<td>1.51</td>
</tr>
<tr>
<td>Leading</td>
<td>20.60</td>
<td>3.55</td>
<td>24.90</td>
<td>2.67</td>
<td>27.13</td>
<td>1.20</td>
</tr>
<tr>
<td>Communicating</td>
<td>18.67</td>
<td>3.67</td>
<td>24.63</td>
<td>2.98</td>
<td>26.43</td>
<td>1.01</td>
</tr>
<tr>
<td>Total leader’s performance</td>
<td>117.47</td>
<td>18.41</td>
<td>143.30</td>
<td>13.50</td>
<td>155.17</td>
<td>4.85</td>
</tr>
</tbody>
</table>

> 0.05 ⇔ Not significant, * ≤ ⇔ 0.05 significant, ** ≤ ⇔ 0.01 highly significant
Staff nurses' perceptions mean scores for leader's performance before program implementation, immediately after, and three months later.

Table 4b indicates that there were high significant differences for all components of leader's performance between before and immediately after and after three months of program implementation. Whereas, high significant differences exist between immediately after and after three months of program implementation, for "controlling", "leading", "communicating", and finally total leader’s performance (t = 4.717, 3.964, 4.500, and 4.133), respectively; while a significant difference was found for the components "problem solving" (t = 2.407) for the same time; and no significant difference were found for the other components at the same time.

Concerning staff nurses’ mean score and SD toward leader performance, before program implementation, the highest mean score and SD was for "leading" and "managing relationships", which were approximately the same, (20.19±3.25, and 20.16±3.14), correspondingly; compared with "leading" (25.05±2.38), at immediately after the program implementation, and with "controlling", after three months of program implementation, (27.07±1.42).

Moreover, "problem solving" and "planning" were the lowest in mean and SD – at the three times of program implementation and were approximately the same – before (9.53±1.69, and 9.26±1.62), respectively; compared with (12.25±1.74, and 12.43±1.30), correspondingly, immediately after program; and with (13.15±1.08, and 12.94±0.95), respectively, after three months of program implementation. Coming to total leader’s performance, it was high significantly different between the three times of program implementation (before and immediately after, before and after three months, and immediately after and after three months) (t = 8.988, 14.281, and 4.133), respectively.
### Table 4 b: Staff nurses' perceptions mean scores for leader's performance before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Components of leader's performance</th>
<th>Before program implementation (B)</th>
<th>After program implementation (A)</th>
<th>After 3 months from program implementation (A3)</th>
<th>t value (B &amp; A)</th>
<th>t value (B &amp; A3)</th>
<th>t value (A &amp; A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>Problem solving</td>
<td>9.53</td>
<td>1.69</td>
<td>12.25</td>
<td>1.74</td>
<td>13.15</td>
<td>1.08</td>
</tr>
<tr>
<td>Planning</td>
<td>9.26</td>
<td>1.62</td>
<td>12.43</td>
<td>1.30</td>
<td>12.94</td>
<td>0.95</td>
</tr>
<tr>
<td>Controlling</td>
<td>19.35</td>
<td>3.45</td>
<td>24.42</td>
<td>2.73</td>
<td>27.07</td>
<td>1.42</td>
</tr>
<tr>
<td>Managing self</td>
<td>16.21</td>
<td>2.52</td>
<td>20.72</td>
<td>2.03</td>
<td>21.48</td>
<td>1.32</td>
</tr>
<tr>
<td>Managing relationships</td>
<td>20.16</td>
<td>3.14</td>
<td>24.88</td>
<td>2.44</td>
<td>25.98</td>
<td>1.71</td>
</tr>
<tr>
<td>Leading</td>
<td>20.19</td>
<td>3.25</td>
<td>25.05</td>
<td>2.38</td>
<td>26.96</td>
<td>1.17</td>
</tr>
<tr>
<td>Total leader’s performance</td>
<td>113.11</td>
<td>14.57</td>
<td>143.99</td>
<td>11.91</td>
<td>153.98</td>
<td>5.78</td>
</tr>
</tbody>
</table>

> 0.05 ➔ Not significant, * ≤ ➔ 0.05 significant, ** ≤ ➔ 0.01 highly significant
Figure 9: The effect of the leadership development training program on first-line nurse managers and staff nurses’ perceptions mean scores for leader’s performance.
First-line nurse managers' perceptions mean scores of staff nurses' performance before program implementation, immediately after, and three months later.

Table 5a illustrates that a highly significant difference was found for the first-line nurse managers' mean scores toward all components of staff nurses' performance between before and immediately after, before and after three months, and between immediately after and after three months of program implementation.

Regarding staff nurses' performance, "professional development" was the highest in mean score and SD—at the three times of program implementation—before (68.00±9.53), immediately after (78.87±9.21), and after three months (89.10±2.50). The lowest mean and SD was for research—at the three times of program implementation—before (15.00±3.25), immediately after (18.20±2.30), and after three months (22.60±1.54). In relation to total staff nurse performance, after three months of program implementation was, the highest among the two other times in mean and SD, 209.13±2.32.
Table 5 a: First-line nurse managers' perceptions mean scores of staff nurses' performance before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Components of staff nurses' performance</th>
<th>Before program implementation (B)</th>
<th>After program implementation (A)</th>
<th>After 3 months from program implementation (A3)</th>
<th>t value (B &amp; A)</th>
<th>t value (B &amp; A3)</th>
<th>t value (A &amp; A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
</tr>
<tr>
<td>- Research</td>
<td>15.00</td>
<td>3.25</td>
<td>18.20</td>
<td>2.30</td>
<td>22.60</td>
<td>1.54</td>
</tr>
<tr>
<td>- Education</td>
<td>19.00</td>
<td>3.79</td>
<td>23.83</td>
<td>3.36</td>
<td>26.47</td>
<td>1.17</td>
</tr>
<tr>
<td>- Professional development</td>
<td>68.00</td>
<td>9.53</td>
<td>78.87</td>
<td>9.21</td>
<td>89.10</td>
<td>2.50</td>
</tr>
<tr>
<td>- Clinical skills</td>
<td>55.83</td>
<td>8.68</td>
<td>64.30</td>
<td>6.49</td>
<td>70.97</td>
<td>2.50</td>
</tr>
<tr>
<td>Total staff nurses’ performance</td>
<td>157.83</td>
<td>22.73</td>
<td>185.20</td>
<td>19.43</td>
<td>209.13</td>
<td>2.32</td>
</tr>
</tbody>
</table>

> 0.05 \( \equiv \) Not significant, * \( \leq \) 0.05 significant, ** \( \leq \) 0.01 highly significant
**Staff nurses' mean scores for their performance before program implementation, immediately after, and three months later.**

Table 5 b indicates that there were high significant differences for staff nurses’ mean scores toward all components of staff nurses' performance between before and immediately after, before and after three months, and between immediately after and after three months of program implementation.

As regard staff nurses' perception toward total staff nurses’ performance, it was high in mean and SD (209.69±2.31) after three months of program implementation. As for the components of staff nurses’ performance, staff nurses viewed that "professional development" was the highest in mean and SD, especially after three months of program implementation, (88.99±2.02); compared with before, and immediately after program implementation (65.12±7.27, and 81.94±6.30), respectively. Concerning the item "research", it got the lowest mean ± SD – for the three times of evaluation – (13.95±3.19 before program, 19.49±1.89 immediately after program, and 22.54±1.29 after three months of implementation).
Table 5 b: Staff nurses' mean scores for their performance before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Components of staff nurses' performance</th>
<th>Before program implementation (B)</th>
<th>After program implementation (A)</th>
<th>After 3 months from program implementation (A3)</th>
<th>t value (B &amp; A)</th>
<th>t value (B &amp; A3)</th>
<th>t value (A &amp; A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
<td>X</td>
<td>SD</td>
<td>t value (B &amp; A)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>----------------</td>
</tr>
<tr>
<td>- Research</td>
<td>13.95</td>
<td>3.19</td>
<td>19.49</td>
<td>1.89</td>
<td>22.54</td>
<td>1.29</td>
</tr>
<tr>
<td>- Education</td>
<td>18.48</td>
<td>3.05</td>
<td>24.66</td>
<td>2.88</td>
<td>26.51</td>
<td>1.33</td>
</tr>
<tr>
<td>- Professional development</td>
<td>65.12</td>
<td>7.27</td>
<td>81.94</td>
<td>6.30</td>
<td>88.99</td>
<td>2.02</td>
</tr>
<tr>
<td>- Clinical skills</td>
<td>53.65</td>
<td>5.87</td>
<td>65.60</td>
<td>5.72</td>
<td>71.65</td>
<td>2.38</td>
</tr>
<tr>
<td>Total staff nurses' performance</td>
<td>151.21</td>
<td>16.31</td>
<td>191.69</td>
<td>14.67</td>
<td>209.69</td>
<td>2.31</td>
</tr>
</tbody>
</table>

> 0.05 ⇔ Not significant, * ≤ ⇔ 0.05 significant, ** ≤ ⇔ 0.01 highly significant
Figure 10: The effect of the leadership development training program on staff nurses and first-line nurse managers’ perceptions mean scores for staff nurse performance.
Difference between first-line nurse managers and staff nurses' perceptions for leadership practices before program implementation, immediately after, and three months later.

Table 6 illustrates difference between first-line nurse managers' and staff nurses' perceptions of leadership practices before program implementation, immediately after, and three months later. It shows that there was no significant difference between first-line nurse managers and staff nurses in relation to the components and total leadership practices before program implementation, immediately after, and three months later. Conversely, the table points out a significant difference between first-line nurse managers and staff nurses toward "enabling others to act" before the program implementation ($\chi^2 = 0.013$).

The majority of first-line nurse managers – before the program – had high scores in "challenging the process" (86.7 %); this is in line with staff nurses who scored high for the same component at the same time (84.7 %); while "enabling others to act" and "encouraging the heart" got the same percentage, as high scores, and were approximately more than half of first-line nurse managers (66.7 %); whereas "modeling the way" scored high and got (53.3 %) for the same group; while more than half of staff nurses scored moderate at the same component (62.4 %). However, "inspiring a shared vision" and total leadership practices were moderate and got half of the percentage (56.7 %, and 50.0 %), correspondingly. This is in accordance with staff nurses who scored (75.9 % and 66.5 %), respectively, in addition to "enabling others to act" (57.1 %).

As regard immediately after program implementation, the majority of first-line nurse managers and staff nurses were high in the three components "enabling others to act", "modeling the way", "encouraging the heart" as well as for total leadership practices (90.0 %, each). Concerning "challenging the process" and "inspiring a shared vision", all head nurses were high immediately after the program; while the majority of staff nurses were high for these same practices (97.6 %, and 89.4 %), respectively.

After three months from program implementation, all head nurses and staff nurses reported a high degree in all leadership practices and its total score except for the item "challenging the process" which was 96.7 % for head nurses and 94.7 % for staff nurses.
Table 6: Difference between first-line nurse managers and staff nurses’ perceptions for leadership practices before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Components of leadership practices</th>
<th>Before program implementation</th>
<th>After program implementation</th>
<th>After 3 months from program implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First-line nurse managers</td>
<td>Staff nurses</td>
<td>First-line nurse managers</td>
</tr>
<tr>
<td></td>
<td>(N = 30)</td>
<td>(N = 170)</td>
<td>(N = 30)</td>
</tr>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>No. %</td>
</tr>
<tr>
<td>- Modeling the way</td>
<td>High</td>
<td>16 53.3</td>
<td>27 90.0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>13 43.3</td>
<td>3 10.0</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 3.3</td>
<td>0 0.0</td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>12 40.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>17 56.7</td>
<td>0 0.0</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 3.3</td>
<td>0 0.0</td>
</tr>
<tr>
<td>- Inspiring a shared vision</td>
<td>High</td>
<td>26 86.7</td>
<td>30 100.0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>4 13.3</td>
<td>0 0.0</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>0 0.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td>- Challenging the process</td>
<td>High</td>
<td>20 66.7</td>
<td>30 100.0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>9 30.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 3.3</td>
<td>0 0.0</td>
</tr>
<tr>
<td>- Enabling others to act</td>
<td>High</td>
<td>20 66.7</td>
<td>27 90.0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>9 30.0</td>
<td>3 10.0</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 3.3</td>
<td>0 0.0</td>
</tr>
<tr>
<td>- Encouraging the heart</td>
<td>High</td>
<td>20 66.7</td>
<td>27 90.0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>9 30.0</td>
<td>3 10.0</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 3.3</td>
<td>0 0.0</td>
</tr>
<tr>
<td>Total Leadership practices</td>
<td>High</td>
<td>14 46.7</td>
<td>27 90.0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>15 50.0</td>
<td>3 10.0</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 3.3</td>
<td>0 0.0</td>
</tr>
</tbody>
</table>

Score: High ≥ 75 %, Moderate ≥ 50 % - < 75 %, Low < 50 %

P > 0.05 ⇒ Not significant, * ≤ 0.05 significant, ** ≤ 0.01 highly significant
Difference between first-line nurse managers and staff nurses’ perceptions for workgroup climate before program implementation, immediately after, and three months later.

Table 7 illustrates that there was a high significant difference between first-line nurse managers and staff nurses, immediately after the program, for the component "quality" ($\chi^2 = 0.004$); while a significant difference was found for the same time for the components "challenge" and total workgroup climate ($\chi^2 = 0.048$, 0.050), respectively. Moreover, a significant difference was found, before program implementation, for the components "clarity" and total workgroup climate ($\chi^2 = 0.018$, and 0.016), correspondingly. On the other hand, there were no significant difference for all components and total workgroup climate between first-line nurse managers and staff nurses for workgroup climate after three months of implementation.

Regarding "clarity", "support", and "challenge", the majority of first-line nurse managers had high scores before program implementation (83.3%, 70.0 %, 76.7 %), respectively. This is in line with staff nurses, who got high scores, before program, for "clarity", "support", and "challenge" (59.4 %, 52.4 %, and 66.5 %), correspondingly. As for immediately after the program implementation, all first-line nurse managers got high scores in "challenge" and total workgroup climate; while "clarity" and "support" had the same percentage and scored high (93.3 %), this last is in accordance with staff nurses, who got high scores for "clarity" and "support" (94.7 %, and 93.5 %), respectively. Moreover, all of them were high, after three months from program.
Table 7: Difference between first-line nurse managers and staff nurses’ perceptions for workgroup climate before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Components of workgroup climate</th>
<th>Before program implementation (B)</th>
<th>After program implementation (A)</th>
<th>After 3 months from program implementation (A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First-line nurse managers (N = 30)</td>
<td>Staff nurses (N = 170)</td>
<td>First-line nurse managers (N = 30)</td>
</tr>
<tr>
<td></td>
<td>No. %</td>
<td>No. %</td>
<td>Staff nurses (N = 170)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No. %</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No. %</td>
</tr>
<tr>
<td>- Workgroup climate – Clarity</td>
<td>High</td>
<td>25 83.3</td>
<td>28 93.3</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>4 13.3</td>
<td>2 6.7</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 3.3</td>
<td>0 0.0</td>
</tr>
<tr>
<td>- Workgroup climate – Support</td>
<td>High</td>
<td>21 70.0</td>
<td>28 93.3</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>8 26.7</td>
<td>2 6.7</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 3.3</td>
<td>0 0.0</td>
</tr>
<tr>
<td>- Workgroup climate – Challenge</td>
<td>High</td>
<td>23 76.7</td>
<td>30 100.0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>6 20.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 3.3</td>
<td>0 0.0</td>
</tr>
<tr>
<td>- Productivity</td>
<td>High</td>
<td>13 43.3</td>
<td>17 56.7</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>17 56.7</td>
<td>13 43.3</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>0 0.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td>- Quality</td>
<td>High</td>
<td>12 40.0</td>
<td>22 73.3</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>18 60.0</td>
<td>8 26.7</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>0 0.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td>Total Workgroup climate</td>
<td>High</td>
<td>22 73.3</td>
<td>30 100.0</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>7 23.3</td>
<td>0 0.0</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>1 3.3</td>
<td>0 0.0</td>
</tr>
</tbody>
</table>

Score: High ≥ 75 %, Moderate ≥ 50 % - < 75 %, Low < 50 %

P > 0.05 ↔ Not significant, * ≤ ↔ 0.05 significant, ** ≤ ↔ 0.01 highly significant
Difference between first-line nurse managers and staff nurses’ perceptions for leader’s performance before program implementation, immediately after, and three months later.

Table 8 indicates that there were significant differences between first-line nurse managers and staff nurses – before program implementation – for the components "problem solving" and "controlling" ($\chi^2 = 7.11$, and 6.261), respectively. Moreover, there was a significant difference between first-line nurse managers and staff nurses, immediately after program implementation, for "problem solving" ($\chi^2 = 5.968$). In addition to, a significant difference for "managing relationships" ($\chi^2 = 5.695$), after three months of program implementation. Conversely, there were no significant difference between first-line nurse managers and staff nurses for rest of the components of leader’s performance at the three times of program implementation.

In relation to before program implementation, the highest percentage of first-line nurse managers and staff nurses had moderate score in all components and total of leader’s performance. Contrary to immediately after and after three months of program implementation, which got the highest percent at the high score for first-line nurse managers and staff nurses in all components and total leader’s performance except for the item "problem solving" – immediately after program – which had moderate score for first-line nurse managers (53.3 %) and high score for staff nurses (68.8 %).
Table 8: Difference between first-line nurse managers and staff nurses’ perceptions for leader’s performance before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Components of Leader’s performance</th>
<th>Before program implementation</th>
<th>After program implementation</th>
<th>After 3 months from program implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(B) First-line nurse managers (N = 30)</td>
<td>Staff nurses (N = 170)</td>
<td>(A) First-line nurse managers (N = 30)</td>
</tr>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td><strong>- Problem solving</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>6</td>
<td>20.0</td>
<td>10</td>
</tr>
<tr>
<td>Moderate</td>
<td>21</td>
<td>70.0</td>
<td>145</td>
</tr>
<tr>
<td>Low</td>
<td>3</td>
<td>10.0</td>
<td>15</td>
</tr>
<tr>
<td><strong>- Planning</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>4</td>
<td>13.3</td>
<td>12</td>
</tr>
<tr>
<td>Moderate</td>
<td>22</td>
<td>73.3</td>
<td>141</td>
</tr>
<tr>
<td>Low</td>
<td>4</td>
<td>13.3</td>
<td>17</td>
</tr>
<tr>
<td><strong>- Controlling</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>12</td>
<td>40.0</td>
<td>35</td>
</tr>
<tr>
<td>Moderate</td>
<td>18</td>
<td>60.0</td>
<td>127</td>
</tr>
<tr>
<td>Low</td>
<td>0</td>
<td>0.0</td>
<td>8</td>
</tr>
<tr>
<td><strong>- Managing self</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>5</td>
<td>16.7</td>
<td>36</td>
</tr>
<tr>
<td>Moderate</td>
<td>22</td>
<td>73.3</td>
<td>125</td>
</tr>
<tr>
<td>Low</td>
<td>3</td>
<td>10.0</td>
<td>9</td>
</tr>
<tr>
<td><strong>- Managing relationships</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>11</td>
<td>36.7</td>
<td>34</td>
</tr>
<tr>
<td>Moderate</td>
<td>18</td>
<td>60.0</td>
<td>127</td>
</tr>
<tr>
<td>Low</td>
<td>1</td>
<td>3.3</td>
<td>9</td>
</tr>
<tr>
<td><strong>- Leading</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>11</td>
<td>36.7</td>
<td>51</td>
</tr>
<tr>
<td>Moderate</td>
<td>19</td>
<td>63.3</td>
<td>111</td>
</tr>
<tr>
<td>Low</td>
<td>0</td>
<td>0.0</td>
<td>8</td>
</tr>
<tr>
<td><strong>- Communicating</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>4</td>
<td>13.3</td>
<td>17</td>
</tr>
<tr>
<td>Moderate</td>
<td>23</td>
<td>76.7</td>
<td>139</td>
</tr>
<tr>
<td>Low</td>
<td>3</td>
<td>10.0</td>
<td>14</td>
</tr>
</tbody>
</table>

Note: * indicates significance at the 0.05 level.
Table 8: Cont.

<table>
<thead>
<tr>
<th>Components of Leader’s performance</th>
<th>Before program implementation</th>
<th></th>
<th>After program implementation</th>
<th></th>
<th>After 3 months from program implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(B)</td>
<td>(A)</td>
<td>(A3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>First-line nurse managers</td>
<td>Staff nurses</td>
<td>χ²</td>
<td>P</td>
<td>First-line nurse managers</td>
</tr>
<tr>
<td></td>
<td>(N = 30)</td>
<td>(N = 170)</td>
<td></td>
<td></td>
<td>(N = 30)</td>
</tr>
<tr>
<td>Total Leader’s performance</td>
<td>High</td>
<td>5</td>
<td>16.7</td>
<td>10</td>
<td>5.9</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>23</td>
<td>76.7</td>
<td>150</td>
<td>88.2</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>2</td>
<td>6.7</td>
<td>10</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Score: High ≥ 75 %, Moderate ≥ 50 % - < 75 %, Low < 50 %
P > 0.05 ⇔ Not significant, * ≤ 0.05 significant, ** ≤ 0.01 highly significant
Table 9 shows a significant difference between first-line nurse managers and staff nurses for staff nurses’ performance – before program implementation, and immediately after for some components. A high significant difference was found, before program implementation, for the component "clinical skills" ($\chi^2 = 0.006$), and a significant difference was found for the components of "education", and "professional development" – for the same time – ($\chi^2 = 0.039$, and 0.035), respectively. However, a significant difference was found – immediately after program – for the items "research", "professional development", and total staff nurses’ performance ($\chi^2 = 0.017$, 0.015, and 0.029), correspondingly. However, no significant difference was found for all the components and total staff nurses’ performance after three months of program implementation.

Regarding the components "research", "education", "professional development", "clinical skills", and total staff nurses’ performance, the highest percent of first-line nurse managers got moderate score and recorded 53.3 %, 66.7 %, 83.3 %, 73.3 %, and 83.3 %, respectively. This was in accordance with staff nurses, who recorded 53.5 % for "research", 82.9 % for "education", 92.4 % for "professional development, 90.6 % for "clinical skills" and 92.9 % for total staff nurses performance, for the same score.

As regard immediately after program implementation, the majority of first-line nurse managers and staff nurses had high score in all components and total staff nurses’ performance; while all first-line nurse managers and staff nurses – after three months from implementation – were classified as getting high scores.
Table 9: Difference between first-line nurse managers’ perceptions and staff nurses for staff nurses’ performance before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Components of staff nurses' performance</th>
<th>Before program implementation</th>
<th>After program implementation</th>
<th>After 3 months from program implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First-line nurse managers (N = 30)</td>
<td>Staff nurses (N = 170)</td>
<td>First-line nurse managers (N = 30)</td>
</tr>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>- Research</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>5</td>
<td>16.7</td>
<td>12</td>
</tr>
<tr>
<td>Moderate</td>
<td>16</td>
<td>53.3</td>
<td>91</td>
</tr>
<tr>
<td>Low</td>
<td>9</td>
<td>30.0</td>
<td>67</td>
</tr>
<tr>
<td>- Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>8</td>
<td>26.7</td>
<td>17</td>
</tr>
<tr>
<td>Moderate</td>
<td>20</td>
<td>66.7</td>
<td>141</td>
</tr>
<tr>
<td>Low</td>
<td>2</td>
<td>6.7</td>
<td>12</td>
</tr>
<tr>
<td>- Professional development</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>5</td>
<td>16.7</td>
<td>8</td>
</tr>
<tr>
<td>Moderate</td>
<td>25</td>
<td>83.3</td>
<td>157</td>
</tr>
<tr>
<td>Low</td>
<td>0</td>
<td>0.0</td>
<td>5</td>
</tr>
<tr>
<td>- Clinical skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>8</td>
<td>26.7</td>
<td>13</td>
</tr>
<tr>
<td>Moderate</td>
<td>22</td>
<td>73.3</td>
<td>154</td>
</tr>
<tr>
<td>Low</td>
<td>0</td>
<td>0.0</td>
<td>3</td>
</tr>
<tr>
<td>Total Staff nurses’ performance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>5</td>
<td>16.7</td>
<td>9</td>
</tr>
<tr>
<td>Moderate</td>
<td>25</td>
<td>83.3</td>
<td>158</td>
</tr>
<tr>
<td>Low</td>
<td>0</td>
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</tbody>
</table>

Score: High ≥ 75 %, Moderate ≥ 50 %, Low < 50 %

P > 0.05 ⇒ Not significant, * ≤ ⇒ 0.05 significant, ** ≤ ⇒ 0.01 highly significant
Relationship between first-line nurse managers leadership practices and socio-demographic characteristics before program implementation, immediately after, and three months later.

Table 10 illustrates that there were no relationships for first-line nurse managers between total leadership practices and socio-demographic characteristics.

Regarding the unit, 66.7% of them had high scores in medical units compared with the same percentage as moderate scores in surgical units, before program implementation; while, approximately all first-line nurse managers had high scores from the two units, immediately after program implementation and all of them had high scores, after three months from implementation.

As for age, half of the first-line nurse managers had moderate scores at the two age groups: from 30 to less than 40 and from 40 and above years old, before program implementation (42.8% and 66.7%), respectively; whereas, almost all of them had high scores at these same age groups, immediately after program (85.7% and 100.0%), correspondingly, also all got high scores, after three months from program implementation.

Regarding educational qualifications, half of first-line nurse managers got moderate scores – before program – compared with 90.0% as high scores immediately after program and with 100.0% after three months from program implementation.

According to nursing experience, half of first-line nurse managers – before program – had moderate scores; while approximately all of them got high scores – immediately after program – constituting 27 out of 30, having from 10 to 25 and above years of nursing experience; compared to 100.0% as high scores – after three months from program implementation – having the same years of nursing experience. As relating to experience as first-line nurse managers, the two groups of: from 5 to less than 10 years, and from 10 to less than 15 years of experience as first-line nurse managers – before program – got moderate scores and represented 5 out of 30 for each group; while, the majority – immediately after program – had high scores at different groups of years of experience; compared to all of them after three months of program implementation.

Concerning marital status, 52.2% of first-line nurse managers were married and had moderate scores of leadership practices (before program); compared with 91.3% (immediately after program) as high scores; and with 100.0% as high scores (after three months of program implementation). Whereas, before program, single first-line nurse managers represented 50.0% and got moderate scores; relative to 83.3% immediately after program as high scores; and to 100.0% as high scores after three months of program implementation.
Table 10a: Relationship between first-line nurse managers leadership practices and socio-demographic characteristics before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Socio-demographic characteristics</th>
<th>Before program implementation (B)</th>
<th>FET P</th>
<th>After program implementation (A)</th>
<th>FET P</th>
<th>After 3 months from program implementation (A3)</th>
<th>FET P</th>
</tr>
</thead>
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<tr>
<td></td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td><strong>Unit</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Medical</td>
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<td>66.7</td>
<td>5</td>
<td>33.3</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
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<td>26.7</td>
<td>10</td>
<td>66.7</td>
<td>1</td>
<td>6.6</td>
</tr>
<tr>
<td><strong>Age</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>&lt; 20</td>
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<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
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<td>0</td>
<td>0.0</td>
</tr>
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<td>30 - &lt; 40</td>
<td>11</td>
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<td>9</td>
<td>42.8</td>
<td>1</td>
<td>4.8</td>
</tr>
<tr>
<td>40 +</td>
<td>3</td>
<td>33.3</td>
<td>6</td>
<td>66.7</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Qualification</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma of Secondary Technical Nursing School</td>
<td>14</td>
<td>46.7</td>
<td>15</td>
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<td>1</td>
<td>3.3</td>
</tr>
<tr>
<td><strong>Nursing experience</strong></td>
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<td></td>
<td></td>
<td></td>
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<td>0.0</td>
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<td>5 - &lt; 10</td>
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<td>0.0</td>
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<td>2</td>
<td>33.3</td>
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<tr>
<td>15 - &lt; 20</td>
<td>6</td>
<td>42.9</td>
<td>7</td>
<td>50.0</td>
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<td>7.1</td>
</tr>
<tr>
<td>20 - &lt; 25</td>
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<td>2</td>
<td>40.0</td>
<td>0</td>
<td>0.0</td>
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<tr>
<td>Socio-demographic characteristics</td>
<td>Before program implementation</td>
<td>After program implementation</td>
<td>After 3 months from program implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------</td>
<td>-------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(B)</td>
<td>(A)</td>
<td>(A3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
<td>No.</td>
<td>%</td>
<td>High</td>
</tr>
<tr>
<td>25+</td>
<td>1</td>
<td>20.0</td>
<td>4</td>
<td>80.0</td>
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<td>0.0</td>
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<tr>
<td>- Experience as a First-line nurse manager</td>
<td></td>
<td>8.681</td>
<td>0.428</td>
<td>2.796</td>
<td>0.709</td>
<td></td>
</tr>
<tr>
<td>1 - &lt; 5</td>
<td>3</td>
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<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>5 - &lt; 10</td>
<td>4</td>
<td>40.0</td>
<td>5</td>
<td>50.0</td>
<td>1</td>
<td>10.0</td>
</tr>
<tr>
<td>10 - &lt; 15</td>
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<td>44.4</td>
<td>5</td>
<td>55.6</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>15 - &lt; 20</td>
<td>2</td>
<td>66.7</td>
<td>1</td>
<td>33.3</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>20 - &lt; 25</td>
<td>1</td>
<td>20.0</td>
<td>4</td>
<td>80.0</td>
<td>0</td>
<td>0.0</td>
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<tr>
<td>25+</td>
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<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
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<td>- Marital status</td>
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<td>0.325</td>
<td>1.582</td>
<td>0.564</td>
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<td>3</td>
<td>50.0</td>
<td>1</td>
<td>16.7</td>
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<td>0.0</td>
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<td>Divorced</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
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<td>100.0</td>
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<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Score: High ≥ 75 %, Moderate ≥ 50 % - < 75 %, Low < 50 %
P > 0.05 ⇔ Not significant, * ≤ ⇔ 0.05 significant, ** ≤ ⇔ 0.01 highly significant
Relationship between staff nurses' perceptions of first-line nurse manager's Leadership practices and socio-demographic characteristics before program implementation, immediately after, and three months later.

Table 10 b illustrates that there were no relationships for staff nurses’ perceptions between total leadership practices and socio-demographic characteristics. However, a significant relationship was found between the two units – before program implementation – (FET=6.971, 0.021).

Regarding the unit, 75.9% of them had moderate scores in surgical units compared with 57.5% as moderate scores in medical units, before program implementation; while, approximately all staff nurses got high scores from the two units, immediately after program implementation and all of them had high scores, after three months from implementation.

As for age, the majority of staff nurses got moderate scores at the different age groups, before program implementation; whereas, almost all of them had high scores at these same age groups, immediately after program, moreover all had high scores, after three months from program implementation. Regarding educational qualifications, the majority of staff nurses (66.5%) got moderate scores – before program – compared with 82.9% as high scores immediately after program and with 100.0% after three months from program implementation.

According to nursing experience, the highest percentage of staff nurses – before program – got moderate scores; while approximately all of them had high scores – immediately after program; compared to 100.0% as high scores – after three months from program implementation – having different years of nursing experience. As relating to experience with first-line nurse managers, the two years of experience groups: from 1 to less than 5 years, and from 5 to less than 10 years of experience with first-line nurse managers – before program – had moderate scores and represented 104 out of 170 for the two groups; while, the majority – immediately after program – got high scores from 1 to less than 20 years of experience; compared to all of them after three months of program implementation.

Concerning marital status, 65.8% of staff nurses were married and got moderate scores of leadership practices (before program); compared with 82.9% (immediately after program) as high scores; and with 100.0% (after three months of program implementation). Whereas, before program, single staff nurses represented 65.9% and had moderate scores; relative to 82.9% immediately after program as high scores; and to 100.0% as high scores after three months of program implementation.
Table 10 b: Relationship between staff nurses' perceptions of first-line nurse manager's Leadership practices and socio-demographic characteristics before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Leadership Practices</th>
<th>Before program implementation</th>
<th>FET</th>
<th>After program implementation</th>
<th>FET</th>
<th>After 3 months from program implementation</th>
<th>FET</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(B)</td>
<td></td>
<td>(A)</td>
<td></td>
<td>(A3)</td>
<td></td>
</tr>
<tr>
<td></td>
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<td>Moderate</td>
<td>Low</td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
</tr>
<tr>
<td>- Unit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Medical</td>
<td>35</td>
<td>40.2</td>
<td>50</td>
<td>57.5</td>
<td>2</td>
<td>2.3</td>
</tr>
<tr>
<td>- Surgical</td>
<td>18</td>
<td>21.7</td>
<td>63</td>
<td>75.9</td>
<td>2</td>
<td>2.4</td>
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<tr>
<td>- &lt; 20</td>
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<td>23.3</td>
<td>23</td>
<td>76.7</td>
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<td>0.0</td>
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<tr>
<td>- 20 - &lt; 30</td>
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<td>31.5</td>
<td>71</td>
<td>65.7</td>
<td>3</td>
<td>2.8</td>
</tr>
<tr>
<td>- 30 - &lt; 40</td>
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<td>34.5</td>
<td>18</td>
<td>62.1</td>
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<td>3.4</td>
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<tr>
<td>- 40 +</td>
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<td>66.7</td>
<td>1</td>
<td>33.3</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>- Qualification</td>
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<td></td>
<td></td>
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<tr>
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<td>113</td>
<td>66.5</td>
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<td>Technical Nursing School</td>
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<td></td>
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<td>- 1 - &lt; 5</td>
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<td>66.7</td>
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<td>2.4</td>
</tr>
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<td>- 5 - &lt; 10</td>
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<td>43.8</td>
<td>17</td>
<td>53.1</td>
<td>1</td>
<td>3.1</td>
</tr>
<tr>
<td>- 10 - &lt; 15</td>
<td>8</td>
<td>20.5</td>
<td>30</td>
<td>76.9</td>
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<td>2.6</td>
</tr>
<tr>
<td>- 15 - &lt; 20</td>
<td>4</td>
<td>28.6</td>
<td>10</td>
<td>71.4</td>
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</tr>
<tr>
<td>- 20 - &lt; 25</td>
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<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>- 25 +</td>
<td>1</td>
<td>100.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

FET P values: 6.971, 0.021*, 4.811, 0.566, 9.324, 0.349, 4.994, 0.290, 1.340, 0.309, 4.464, 0.194, 170.
## Table 10b: Cont.

<table>
<thead>
<tr>
<th>Socio-demographic characteristics</th>
<th>Before program implementation (B)</th>
<th>FET P</th>
<th>After program implementation (A)</th>
<th>FET P</th>
<th>After 3 months from program implementation (A3)</th>
<th>FET P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
<td>Moderate</td>
<td>Low</td>
<td>No</td>
<td>%</td>
<td>High</td>
</tr>
<tr>
<td><strong>- Experience with First-line nurse manager</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 1 - &lt; 5</td>
<td>36</td>
<td>32.1</td>
<td>72</td>
<td>64.3</td>
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<td>3.6</td>
</tr>
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<td>15</td>
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<td>32</td>
<td>68.1</td>
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<td>0</td>
<td>0.0</td>
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<td>0.0</td>
</tr>
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<td>• 20 - &lt; 25</td>
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<td>0.0</td>
</tr>
<tr>
<td>• 25+</td>
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<td>0.0</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>- Marital status</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Single</td>
<td>29</td>
<td>31.9</td>
<td>60</td>
<td>65.9</td>
<td>2</td>
<td>2.2</td>
</tr>
<tr>
<td>• Married</td>
<td>24</td>
<td>31.6</td>
<td>50</td>
<td>65.8</td>
<td>2</td>
<td>2.6</td>
</tr>
<tr>
<td>• Divorced</td>
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<td>0.0</td>
<td>2</td>
<td>100.0</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>• Widow</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
<td>100.0</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

Score: High ≥ 75 %, Moderate ≥ 50 % - < 75 %, Low < 50 %
P > 0.05 ⇒ Not significant, * ≤ 0.05 significant, ** ≤ 0.01 highly significant
First-line nurse managers' perceptions about their educational preparation on Leadership practices.

Table 11 shows that none of first-line nurse managers from surgical and medical units had adequate educational preparation regarding "concept of leadership", "goal setting", "action plan", "decision making", "vision", "innovation", "risk taking", "coaching", "setting priority", and "creativity". However, a minority from medical and surgical units stated that their educational preparation was adequate concerning "interpersonal communication skills", and "team building and teamwork" represented by 20.0 %, and 13.3 % of medical units, respectively; compared with 40.0 % and 33.3 % of surgical units, correspondingly. Moreover, the minority of first-line nurse managers from medical units (13.3 %, 13.3 %, and 6.7 %) reported that they had somewhat adequate preparation for "interpersonal communication skills", "problem solving", and "team building and teamwork"; compared with (6.7 %, and 13.3 %) of first-line nurse managers from surgical units who stated that they had somewhat adequate preparation on "interpersonal communication skills", and "team building and teamwork", respectively.
Table 11: First-line nurse managers' perceptions about their educational preparation on Leadership practices.

<table>
<thead>
<tr>
<th>Topics</th>
<th>Medical Units (N = 15)</th>
<th>Surgical Units (N = 15)</th>
<th>Total (N = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adequate</td>
<td>Somewhat adequate</td>
<td>Not adequate</td>
</tr>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
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<td>0.0</td>
<td>15</td>
</tr>
<tr>
<td>- Goal setting</td>
<td>0</td>
<td>0.0</td>
<td>15</td>
</tr>
<tr>
<td>- Action plan</td>
<td>0</td>
<td>0.0</td>
<td>15</td>
</tr>
<tr>
<td>- Decision making</td>
<td>0</td>
<td>0.0</td>
<td>15</td>
</tr>
<tr>
<td>- Vision</td>
<td>0</td>
<td>0.0</td>
<td>15</td>
</tr>
<tr>
<td>- Interpersonal communication skills</td>
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<tr>
<td></td>
<td>2</td>
<td>13.3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>18</td>
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<td></td>
</tr>
<tr>
<td>- Problem solving</td>
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<td>0.0</td>
<td>13</td>
</tr>
<tr>
<td>- Innovation</td>
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<td>0.0</td>
<td>15</td>
</tr>
<tr>
<td>- Risk taking</td>
<td>0</td>
<td>0.0</td>
<td>15</td>
</tr>
<tr>
<td>- Team building and teamwork</td>
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<td>13.3</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>6.7</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>66.7</td>
<td></td>
</tr>
<tr>
<td>- Coaching</td>
<td>0</td>
<td>0.0</td>
<td>15</td>
</tr>
<tr>
<td>- Setting priority</td>
<td>0</td>
<td>0.0</td>
<td>15</td>
</tr>
</tbody>
</table>

117
| - Creativity | 0   | 0.0 | 0   | 0.0 | 15  | 100.0 | 0   | 0.0 | 0   | 0.0 | 15  | 100.0 | 0   | 0.0 | 0   | 0.0 | 30  | 100.0 |
First-line nurse managers' perceptions about their previous and future in-service training programs.

Table 12 illustrates that 86.7% of medical first-line nurse managers and 60.0% of surgical first-line nurse managers did not attend any training programs. All first-line nurse managers from medical and surgical units stated that the attended programs did not include leadership development. Moreover, most of the participants mentioned that the training program was not regularly designed or attended because "the authority position was not concerned with first-line nurse managers' training and for shortage of time available for attending a training program" as mentioned by 86.7%, and 66.7% of those from medical units; and 53.3% and 80.0% of those from surgical units, respectively.

In addition to that, all first-line nurse managers, from medical and surgical units, stated that "the leadership development training program will increase their workgroup climate effectiveness and their performance, as well as those of their staff nurses. Furthermore, all of the participants were willing to attend the leadership development training program, as well as almost all of them (100.0% of medical units and 93.3% of surgical units) want to attend the training program to better perform in their jobs. Whereas, all of them from surgical units want to attend the training program to increase their knowledge and to provide quality of patients care; compared with 86.7% and 73.3% from medical units, respectively. Concerning topics to be included in the training program, all first-line nurse managers from medical units indicated that "action plan", "decision making", "interpersonal communication skills" should be included in the training program; compared with (80.0%, 60.0%, 100.0%, of surgical units, correspondingly. Moreover, most of the medical units wanted to include, in the training program, by (60.0%, 73.3%, 53.3%, 80.0%, 53.3%, 86.7%, 66.7%, 60.0%, 46.7%, and 66.7%), topics of "concept of leadership", "goal setting", "vision", "problem solving", "innovation", "risk taking", "team building and teamwork", "coaching", "setting priority", and "creativity", respectively; compared with, those of surgical units, (73.3%, 53.3%, 100.0%, 86.7%, 60.0%, 73.3%, 80.0%, 66.7%, 53.3%, and 60.0%), correspondingly.

Furthermore, all of the surgical first-line nurse managers and almost all medical first-line nurse managers (73.3%) reported that a period of one week is the most suitable for the training program; while only 26.7% of medical first-line nurse managers stated that two weeks is the most suitable period for the training program. However, almost all of medical (80.0%) and surgical (93.3%) first-line nurse managers indicated that the most preferred time for conducting the training program was from 10 am to 1 pm; whereas 20.0% of medical compared with 6.7% of surgical first-line nurse managers preferred the time from 11 am to 2 pm. Regarding suitable place for conducting the training program, all first-line nurse managers from medical and surgical units recommended that the program should be conducted in the hospital.
Table 12: First-line nurse managers' perceptions about their previous and future in-service training programs.

<table>
<thead>
<tr>
<th>Items</th>
<th>Medical Units (N = 15)</th>
<th>Surgical Units (N = 15)</th>
<th>Total (N = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Attendance of previous program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Yes</td>
<td>2</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>- No</td>
<td>13</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>2. The training program included leadership</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- No</td>
<td>15</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>3. Time of attending leadership development training program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 1 year ago</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- 2 years ago</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- More than 2 years ago</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4. Duration of leadership development training program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- One week</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Two weeks</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- More than two weeks</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Causes of irregularity in attending previous programs</td>
<td>10</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td>- Shortage of time</td>
<td>66.7</td>
<td>80.0</td>
<td>73.3</td>
</tr>
<tr>
<td>- No concern from responsible persons for training the nursing staff</td>
<td>13</td>
<td>8</td>
<td>13.3</td>
</tr>
<tr>
<td>- Lack of financial support</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Leadership development training program will increase workgroup climate and performance</td>
<td>15</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>- Yes</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>- No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7. Willingness to attend leadership development training program</td>
<td>15</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>- Yes</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>- No</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8. Reasons for attendance</td>
<td>13</td>
<td>15</td>
<td>28</td>
</tr>
<tr>
<td>- To increase knowledge</td>
<td>86.7</td>
<td>100.0</td>
<td>93.3</td>
</tr>
<tr>
<td>- To perform better job</td>
<td>15</td>
<td>100.0</td>
<td>96.7</td>
</tr>
<tr>
<td>- To provide quality of patient care</td>
<td>11</td>
<td>9</td>
<td>80.0</td>
</tr>
<tr>
<td>9. Topics to be included in the training program</td>
<td>9</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>- Goal setting</td>
<td>60.0</td>
<td>73.3</td>
<td>66.7</td>
</tr>
<tr>
<td>- Action plan</td>
<td>11</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>- Decision making</td>
<td>15</td>
<td>100.0</td>
<td>27</td>
</tr>
<tr>
<td>- Vision</td>
<td>8</td>
<td>9</td>
<td>24</td>
</tr>
<tr>
<td>- Interpersonal communication skills</td>
<td>15</td>
<td>100.0</td>
<td>23</td>
</tr>
</tbody>
</table>

Table 12: Cont.'
<table>
<thead>
<tr>
<th>Items</th>
<th>Medical Units (N = 15)</th>
<th>Surgical Units (N = 15)</th>
<th>Total (N = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>- Problem solving</td>
<td>12</td>
<td>80.0</td>
<td>13</td>
</tr>
<tr>
<td>- Innovation</td>
<td>8</td>
<td>53.3</td>
<td>9</td>
</tr>
<tr>
<td>- Risk taking</td>
<td>13</td>
<td>86.7</td>
<td>11</td>
</tr>
<tr>
<td>- Team building and teamwork</td>
<td>10</td>
<td>66.7</td>
<td>12</td>
</tr>
<tr>
<td>- Coaching</td>
<td>9</td>
<td>60.0</td>
<td>10</td>
</tr>
<tr>
<td>- Setting priority</td>
<td>7</td>
<td>46.7</td>
<td>8</td>
</tr>
<tr>
<td>- Creativity</td>
<td>10</td>
<td>66.7</td>
<td>9</td>
</tr>
</tbody>
</table>

10. The most suitable period for the program
- One week                                | 11         | 73.3| 15         | 100.0| 26         | 86.7|
- Two weeks                               | 4          | 26.7| 0          | 0.0  | 4          | 13.3|
- Three weeks and more                    | 0          | 0.0  | 0          | 0.0  | 0          | 0.0  |

11. The most suitable time for the program
- 10 AM – 1 PM                            | 12         | 80.0| 14         | 93.3| 26         | 86.7|
- 11 AM – 2 PM                            | 3          | 20.0| 1          | 6.7  | 4          | 13.3|

12. The most suitable place for conducting the educational session of the program
- Inside the hospital                     | 15         | 100.0| 15         | 100.0| 30         | 100.0|
- Outside the hospital (in a special training center) | 0          | 0.0  | 0          | 0.0  | 0          | 0.0  |
Assessment of first-line nurse managers' knowledge before program implementation, immediately after, and three months later.

Table 13 indicates that the first-line nurse managers' knowledge was highly significant differences between before program implementation and immediately after; and also between before and after three months from program implementation; except for the topic "setting priority", between before and after three months of program implementation, which was significant difference as \( P = 0.018 \). Whereas, no significant differences for their knowledge were found between immediately after and after three months from program implementation; except for "vision" and "creativity" which shows a high significant difference (\( P = 0.001 \), and 0.009), respectively.

Immediately after the program implementation, the knowledge of first-line nurse managers had developed; as follows: "vision" got the highest percentage (96.7 %); then "the concept of leadership", and "setting priority" (90.0 %, each); after this (86.7 %, and 83.3 %), respectively, for "interpersonal communication skills" and "goal setting"; then the other topics ranged from 60.0 % to 75 %; except for "innovation" which got 46.7 %.

After three months from program implementation, three topics were retained by (66.7 %), namely: "concept of leadership", "interpersonal communication skills", and "setting priority". Whereas, approximately half of first-line nurse managers (63.3 %, 60.0 %, 60.0 %, 53.3 %, and 53.3 %) had retention of knowledge about "problem solving", "goal setting", "vision", "decision making", and "team building and teamwork", correspondingly. However, less than half of first-line nurse managers (40.0 %, 40.0 %, 36.7 %, 33.3 %, and 30.0 %) retained knowledge about "risk taking", "coaching", "action plan", "innovation", and "creativity", respectively.
Table 13: Assessment of first-line nurse managers' knowledge before program implementation, immediately after, and three months later.

<table>
<thead>
<tr>
<th>Topics</th>
<th>No. with +ve grade before program implementation (B)</th>
<th>No. with +ve grade after program implementation (A)</th>
<th>No. with +ve grade after 3 months of program implementation (A3)</th>
<th>FET P (B &amp; A)</th>
<th>FET P (B &amp; A3)</th>
<th>FET P (A &amp; A3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Concept of leadership</td>
<td>3 10.0</td>
<td>27 90.0</td>
<td>20 66.7</td>
<td>0.000**</td>
<td>0.000**</td>
<td>0.057</td>
</tr>
<tr>
<td>- Goal setting</td>
<td>0 0.0</td>
<td>25 83.3</td>
<td>18 60.0</td>
<td>0.000**</td>
<td>0.000**</td>
<td>0.084</td>
</tr>
<tr>
<td>- Action plan</td>
<td>0 0.0</td>
<td>19 63.3</td>
<td>11 36.7</td>
<td>0.000**</td>
<td>0.000**</td>
<td>0.069</td>
</tr>
<tr>
<td>- Decision making</td>
<td>2 6.7</td>
<td>21 70.0</td>
<td>16 53.3</td>
<td>0.000**</td>
<td>0.000**</td>
<td>0.288</td>
</tr>
<tr>
<td>- Vision</td>
<td>0 0.0</td>
<td>29 96.7</td>
<td>18 60.0</td>
<td>0.000**</td>
<td>0.000**</td>
<td>0.001**</td>
</tr>
<tr>
<td>- Interpersonal communication skills</td>
<td>2 6.7</td>
<td>26 86.7</td>
<td>20 66.7</td>
<td>0.000**</td>
<td>0.000**</td>
<td>0.125</td>
</tr>
<tr>
<td>- Problem solving</td>
<td>1 3.3</td>
<td>22 73.3</td>
<td>19 63.3</td>
<td>0.000**</td>
<td>0.000**</td>
<td>0.579</td>
</tr>
<tr>
<td>- Innovation</td>
<td>0 0.0</td>
<td>14 46.7</td>
<td>10 33.3</td>
<td>0.000**</td>
<td>0.001**</td>
<td>0.429</td>
</tr>
<tr>
<td>- Risk taking</td>
<td>0 0.0</td>
<td>18 60.0</td>
<td>12 40.0</td>
<td>0.000**</td>
<td>0.000**</td>
<td>0.196</td>
</tr>
<tr>
<td>- Team building and teamwork</td>
<td>2 6.7</td>
<td>24 80.0</td>
<td>16 53.3</td>
<td>0.000**</td>
<td>0.000**</td>
<td>0.054</td>
</tr>
<tr>
<td>- Coaching</td>
<td>0 0.0</td>
<td>20 66.7</td>
<td>12 40.0</td>
<td>0.000**</td>
<td>0.000**</td>
<td>0.069</td>
</tr>
<tr>
<td>- Setting priority</td>
<td>3 10.0</td>
<td>27 90.0</td>
<td>20 66.7</td>
<td>0.000**</td>
<td>0.018*</td>
<td>0.057</td>
</tr>
<tr>
<td>- Creativity</td>
<td>0 0.0</td>
<td>19 63.3</td>
<td>9 30.0</td>
<td>0.000**</td>
<td>0.000**</td>
<td>0.009**</td>
</tr>
</tbody>
</table>

+ve grade \( \geq 70\% \) of total correct answers

\( P > 0.05 \) \( \Rightarrow \) Not significant, \( * \leq \Rightarrow 0.05 \) significant, \( ** \leq \Rightarrow 0.01 \) highly significant
First-line nurse managers' evaluation of the leadership development training program in medical and surgical units at Gamal Abd El Nasser Health Insurance Hospital.

It is concluded, from table 14, that all first-line nurse managers (from medical and surgical units) stated that "the program objectives" were clear, and that "the time allotted to the program" was adequate; as well as "program time schedule" which was suitable. Moreover, "the content of the program" was adequate and the program added new information. Furthermore, all first-line nurse managers indicated that "the educational climate" was comfortable and that "the teaching methods" were clear.

Regarding methods of teaching, all first-line nurse managers from medical units claimed that "small group work" and "lecture/discussion" methods were effective, compared with 86.7 %, and 93.3 %, respectively, from those of surgical units. However, 80.0 % of surgical first-line nurse managers stated that brainstorming was effective; compared with 73.3 % from medical units; whereas, 20.0 % from surgical units and 26.7 % from medical units viewed "brainstorming" as ineffective. In addition to that, all first-line nurse managers indicated that "audio-visual aids and media" were effective and adequate; with mentioning that "the presentation of the program's content" was interesting and they got chances for application of the knowledge gained from the program.

Concerning the constraints that prevent implementation of the knowledge gained, all medical first-line nurse managers viewed that "lack of authority in their own wards"; compared with 73.3 % for surgical first-line nurse managers, was one of the constraints that prevent the implementation of knowledge gained from the program. Moreover, "work overload" was the constraint accepted by all first-line nurse managers that prevents the knowledge gained from the program to be implemented; also, all surgical first-line nurse managers concluded that "shortage of personnel, facilities, equipments and supplies" was another constraint that prevent implementation of knowledge gained from the program; compared with 86.7 % from medical first-line nurse managers.

Furthermore, all medical first-line nurse managers suggested that they should be supported by administrative authority to help in implementing the knowledge gained; compared to 86.7 % of surgical units; whereas, 80.0 % of first-line nurse managers from surgical units and 66.7 % from medical units wanted to attend other in-service training programs on regular basis in order to achieve success for the program.
<table>
<thead>
<tr>
<th>Items</th>
<th>Medical units</th>
<th>Surgical units</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N = 15)</td>
<td>(N = 15)</td>
<td>(N = 30)</td>
</tr>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>1. Objectives of the leadership development training program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Clear</td>
<td>15</td>
<td>100.0</td>
<td>15</td>
</tr>
<tr>
<td>- Unclear</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>2. Time allotted to the program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Adequate</td>
<td>15</td>
<td>100.0</td>
<td>15</td>
</tr>
<tr>
<td>- Inadequate</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>3. Program time schedule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Suitable</td>
<td>15</td>
<td>100.0</td>
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</tr>
<tr>
<td>- Not suitable</td>
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<td>0</td>
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<tr>
<td>4. Content of the program</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Adequate</td>
<td>15</td>
<td>100.0</td>
<td>15</td>
</tr>
<tr>
<td>- Inadequate</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>5. The program added new information</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Yes</td>
<td>15</td>
<td>100.0</td>
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</tr>
<tr>
<td>- No</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
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<tr>
<td>6. The educational climate</td>
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<td></td>
</tr>
<tr>
<td>- Comfortable</td>
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<td>15</td>
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<tr>
<td>- Uncomfortable</td>
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<td>0.0</td>
<td>0</td>
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<td>7. Teaching methods</td>
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<tr>
<td>- Clear</td>
<td>15</td>
<td>100.0</td>
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<td>- Unclear</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
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<td>8. Teaching methods used</td>
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</tr>
<tr>
<td>a) Small group work</td>
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</tr>
<tr>
<td>- Effective</td>
<td>15</td>
<td>100.0</td>
<td>13</td>
</tr>
<tr>
<td>- Ineffective</td>
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<td>0.0</td>
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</tr>
<tr>
<td>b) Brainstorming</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>- Effective</td>
<td>11</td>
<td>73.3</td>
<td>12</td>
</tr>
<tr>
<td>- Ineffective</td>
<td>4</td>
<td>26.7</td>
<td>3</td>
</tr>
<tr>
<td>c) Lecture/discussion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Effective</td>
<td>15</td>
<td>100.0</td>
<td>14</td>
</tr>
<tr>
<td>- Ineffective</td>
<td>0</td>
<td>0.0</td>
<td>1</td>
</tr>
<tr>
<td>9. Audio-visual aids and handouts</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Effective</td>
<td>15</td>
<td>100.0</td>
<td>15</td>
</tr>
<tr>
<td>- Inadequate</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>10. Presentation of the program content</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Interesting</td>
<td>15</td>
<td>100.0</td>
<td>15</td>
</tr>
<tr>
<td>- Uninteresting</td>
<td>0</td>
<td>0.0</td>
<td>0</td>
</tr>
<tr>
<td>11. Chances for application of gained knowledge from program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Items</td>
<td>Medical units (N = 15)</td>
<td>Surgical units (N = 15)</td>
<td>Total (N = 30)</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>- Yes</td>
<td>15 100.0</td>
<td>15 100.0</td>
<td>30 100.0</td>
</tr>
<tr>
<td>- No</td>
<td>0 0.0</td>
<td>0 0.0</td>
<td>0 0.0</td>
</tr>
<tr>
<td>12. Constraints that prevents implementation of knowledge gained</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Lack of their authority in their own wards</td>
<td>15 100.0</td>
<td>11 73.3</td>
<td>26 86.7</td>
</tr>
<tr>
<td>- Work overload</td>
<td>15 100.0</td>
<td>15 100.0</td>
<td>30 100.0</td>
</tr>
<tr>
<td>- Shortage of personnel, facilities, equipment and supplies</td>
<td>13 86.7</td>
<td>15 100.0</td>
<td>28 93.3</td>
</tr>
<tr>
<td>13. Suggestion for the program to achieve success</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- First-line nurse managers should be supported by administrative</td>
<td>15 100.0</td>
<td>13 86.7</td>
<td>28 93.3</td>
</tr>
<tr>
<td>authority to help in implementing knowledge gained</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Attending other in-service training programs on regular basis</td>
<td>10 66.7</td>
<td>12 80.0</td>
<td>22 73.3</td>
</tr>
</tbody>
</table>
First-line nurse managers' evaluation of the subjects given in the leadership development training program in medical and surgical units at Gamal Abd El Nasser Health Insurance Hospital.

Table 15 illustrates that all medical first-line nurse managers found that "concept of leadership", "action plan", "vision", and "interpersonal communication skills" were very useful topics in the program; compared with (93.3 %, 80.0 %, 100.0 %, and 93.3 %), respectively of those from surgical units. In addition to that, the majority of medical first-line nurse managers (93.3 %, 93.3 %, 86.7 %, 80.0 %, 73.3 %, 73.3 %, 66.7 % and 60.0 %) found that "decision making", "team building and teamwork", "goal setting", "problem solving", "risk taking", "setting priority", "innovation" and "coaching" were very useful topics, correspondingly; compared to 6.7 %, 6.7 %, 13.3 %, 20.0 %, 26.7 %, 26.7 %, 33.3 %, and 40.0 %, respectively found these topics somewhat useful; as well as 46.7 % for "creativity".

Furthermore, 86.7 % of the surgical first-line nurse managers found that topics, such as "decision making", "risk taking", and "setting priority" were very useful; also all of them found that "teambuilding and teamwork" very useful, too; compared with 46.7 %, 33.3 %, 33.3 %, 26.7 %, and 26.7 % for "innovation", "goal setting", "creativity", "problem solving", and "coaching", correspondingly which were somewhat useful topics.
Table 15: First-line nurse managers' evaluation of the topics given at the leadership development training program in medical and surgical units at Gamal Abd El Nasser Health Insurance Hospital.

<table>
<thead>
<tr>
<th>Topics</th>
<th>Medical units (N = 15)</th>
<th>Surgical units (N = 15)</th>
<th>Total (N = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very useful</td>
<td>Somewhat useful</td>
<td>Not useful</td>
</tr>
<tr>
<td>- Concept of leadership</td>
<td>15</td>
<td>100.0</td>
<td>0</td>
</tr>
<tr>
<td>- Goal setting</td>
<td>13</td>
<td>86.7</td>
<td>2</td>
</tr>
<tr>
<td>- Action plan</td>
<td>15</td>
<td>100.0</td>
<td>0</td>
</tr>
<tr>
<td>- Decision making</td>
<td>14</td>
<td>93.3</td>
<td>1</td>
</tr>
<tr>
<td>- Vision</td>
<td>15</td>
<td>100.0</td>
<td>0</td>
</tr>
<tr>
<td>- Interpersonal communication skills</td>
<td>15</td>
<td>100.0</td>
<td>0</td>
</tr>
<tr>
<td>- Problem solving</td>
<td>12</td>
<td>80.0</td>
<td>3</td>
</tr>
<tr>
<td>- Innovation</td>
<td>10</td>
<td>66.7</td>
<td>5</td>
</tr>
<tr>
<td>- Risk taking</td>
<td>11</td>
<td>73.3</td>
<td>4</td>
</tr>
<tr>
<td>- Team building and teamwork</td>
<td>14</td>
<td>93.3</td>
<td>1</td>
</tr>
<tr>
<td>- Coaching</td>
<td>9</td>
<td>60.0</td>
<td>6</td>
</tr>
<tr>
<td>- Setting priority</td>
<td>11</td>
<td>73.3</td>
<td>4</td>
</tr>
<tr>
<td>- Creativity</td>
<td>8</td>
<td>53.3</td>
<td>7</td>
</tr>
</tbody>
</table>
DISCUSSION

The advent of the New Labour health reforms requires that nursing services has to be organized to provide effective nursing care and the requisite leadership (226). Change has been the one constant in healthcare for a number of countries throughout the 1990s and after the millennium. Although the pace and characteristics of change vary significantly, certain general patterns are emerging across the globe (227). Consequently, the field of healthcare has become increasingly complex and chaotic, requiring executive teams to manage and lead the various types of service provision so that they think and behave in a very different way (228).

In the Institute of Medicine (2000) report: “to err is human”, transformational leadership is identified as the best way to solve leadership problems within healthcare”. The dynamic demands of the twenty-first century and different types of workforce and work environment will produce a different type of leader than the twentieth century hierarchical, bureaucratic model, who will be less than effective in energizing and coordinating tomorrow's knowledge-workers. The Institute’s research reveals that such leadership is the essential precursor to patient safety, successful organizational change and an organization’s competitive position. As such, transformational leadership offers clear promise and direction for nursing leaders (229). De Groot (2005) affirms the Institute of Medicine’s view of transformational leadership, suggesting that such leadership involves organizational stewardship, decision making and vision translation through reasoned application or imperial evidence from management, leadership and patient care research (230).

Transformational leadership is proposed as empowering leadership style that better fits within today’s hospital and nursing environment (90, 231). Transformational leadership aims to empower the co-workers and to help them grow in their personal and professional development (232). Wong and Cummings (2007) recent review of studies examining the relationship between nursing leadership and patient outcomes reveals a positive relationship between transformational leadership and increased patient satisfaction and reduced patient adverse events and complications. The influence of staff performance on outcome will presumably mediate this relationship, suggesting an indirect and more complex relationship between leadership development and patient outcomes (233). Moreover, a recent review of literature (1999 – 2006) examining the relationship between leadership and nursing outcomes revealed that leadership development positively affects nursing teams in some ways (234 - 237). This is emphasized by the Management Sciences for Health (MSH) (2005), who viewed that the leading practices contribute to the creation of a positive work climate, and concluded that in order to build a strong work relationships and balance of challenge, clarity, and support, that is needed for a good work climate, a leader must communicate in ways that encourage understanding and learning; inspire the team; create opportunities for staff to share their knowledge and best practices; and organize a support network of senior manager (238).

This is also supported by Manion (2005) who stated that an organization’s success is directly correlated to its leaders’ strengths, and that the failure of an organization to develop leaders at all levels, relying instead on a few strong leaders at the top, results in dismal outcomes. Relying also on only formal managers for leadership, limits the tremendous possibilities that exist when leaders are differentiated from managers (239).
Across the health system, from public health organizations to every form of clinical delivery, nurses represent the largest investment in human capital requiring that nursing leaders at all levels have the requisite skills and expectations to lead. Many organizations are concerned with leadership inadequacies of their employees and are committed to education and training to develop managers’ skills, perspectives, and competencies. This is also recommended by Rafferty (1993) who undertook a review of nursing leadership approaches for the Kings Fund Center and found that “more attention needed to be paid to leadership training, management development and clinical leadership.”

This is emphasized by Marquis and Huston (2009) who mentioned that formal education and training required being apart of most management development programs; as well as a development of appropriate attitudes through social learning. Consequently, a proactive succession planning is the key to having new challenges and opportunities that will be presented to them in the future. This is based on the evidence that organizations that encourage and facilitate a culture of learning among employees in the work place out perform those that do not.

Nurses are pervasively positioned to play leadership roles, as their size of the profession relative to other health professional groups, and also they are dispersed in leadership roles vertically throughout every part of the care delivery system. Their responsibilities reach from the first level of management of the care giving process all the way to the leadership of strategic decisions made in the executive suite. With such breadth and depth of leadership roles, lately come a great variety of leadership development programs available to nurses. Correspondingly, the investment in the development of skills for nurses in such positions is a critical decision that impacts the skill set and competencies of individual nurse leaders and also contributes materially to the ability of any health-providing organization to deliver on its strategic goals and objectives. An underinvestment in the development of these skills tends to leave nurse leaders alienated from tasks they feel ill prepared to provide and the organization at risk of underperforming in an environment that is increasingly less forgiving of such failures. Therefore, Scott et al. (1999) concluded that developing transformational leadership is considered as an important strategy to improve the nurse work environment and to support hospitals as they progress in establishing magnet hospitals. Moreover, McNeese-Smith (1993) claimed that understanding the relationship between leadership behavior and employee performance is critical to the management of a nursing unit, as leaders frequently are unaware of how their behavior affects their employees. For this reason, Pashley (1998) estimated that nurse managers must employ transformational leadership styles to manage the complexities of the current health service; they must also foster key competencies and pursue training and development to enhance effective transformational leadership performance. This is the same as Reed (2007), who concluded that hospital leaders of tomorrow must connect with the hearts and minds of their workforce in a way that unleashes their full potential and maximizes productivity and performance.

**Leadership development program**

The result of the present study revealed that all first-line nurse managers did not attend any leadership development programs; and that some of the surgical first-line nurse managers attended only some in-service training programs related to their field of practice. For the previously mentioned result, there was a need for a leadership development, with the great emphasis for the Health Insurance organization, in order to be in line with the quality assurance and accreditation phase all over the country generally and at the health

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insurance organization specifically. The reasons for not attending any previous training program, as mentioned by the medical and surgical first-line nurse managers, were lack of concern from the authority and responsible persons for training the nursing staff, as well as shortage of time; while a minority of first-line nurse managers stated that lack of financial support was another reason for not attending any training program. This may be due to the fact that any training program requires administrative support, time and resources to conduct it. This was also indicated by Lam and White (1998), who stated that significant financial payoffs are found among organizations that emphasize training and development (250). This is also supported by O’Neil et al. (2008) who mentioned that a consistent issue with regard to the importance of quality training and development programming is needed. However, surprisingly, there was a little concern over the costs of programs. They also contended that more than 60% of the leadership and professional development programs for nurses primarily target only those working in the inpatient hospital setting, and just more than 50% of the programs were designed for nurses working at the executive level, and another 26% of the offerings examined target the mid-level, this supply the reality that matched the perceived shortage of programs for frontline leaders. Moreover, concerning barriers that prevented organizations from expanding leadership development programming for nurses, the release time was a paramount barrier, this was due to the inability to get time away from the work place to invest in the acquisition of new skills, and this barrier was followed by low budgets as another reason. They also concluded that greater investments in leadership development for all healthcare leaders, and that without a continued commitment to and investments in nursing leadership development – for executives, managers, and frontline staff – the future of healthcare organizations will be at risk (190). This is also consistent with Giber et al. (2000), who viewed that organizations that successfully develop their high-potential employees use structured leadership development systems. Leadership development is a systematic process that immerses the new nurse manager in the role through formal managerial education and informal learning, multirater (360-degree) feedback, exposure to executives, action learning, and mentoring programs (251). Moreover, Wicker (2008) concluded that without a pretest or direct observation for comparison, it can not be determined if there was a true improvement in self-reported leadership practices (i.e., outcome) or leadership competencies but feedback from study participants does support that nurse leaders gained new skills by completing the leadership training course (252).

Moreover, Burke and Day (1986) believed that organizations were unaware of the effectiveness of management training programs in improving job performance (253). This is also consistent with the result of this study which showed that all medical and surgical first-line nurse managers were willing to attend such program in order to acquaint new knowledge and skills to be able to deliver quality of care to the patients and to increase the level of their workgroup climate and performance. This is emphasized by Sellgren et al., (2008), who concluded the importance of leadership behavior for a creative work climate in the results of their study, and that there is a strong relationship between the two. This means that the manager in the leadership role is a key to nurse retention, also the manager’s role as a climate builder is very important and has great impact on nursing staff (154). In addition to that, Ekvall and Ryhammar (1998) clarified that the behavioural style of the manager affected organizational outcomes, such as creativity and productivity through influencing the creative work climate, and that the significant correlation between leadership behavior and organizational outcomes disappeared when the influence of the third variable “climate” was removed (254). This is also supported by Duffield and Franks (2001) who described a lack of formal preparation for the transition and development of
clinical nurses into management positions, and that many first-line nurse managers lack appropriate educational qualifications to do their job effectively (255).

Furthermore, Dierckx De Casterle et al. (2008) concluded that not only there is a positive impact of transformational leadership development on the leader and team members, but also that the first-line nurse managers became more effective in areas of self-awareness, communication skills, performance and vision; as well as the nursing team who benefited because more effective leadership promoted effective communication, greater responsibility, empowerment and job clarity (232). This is in line with O’Neil et al. (2008), who identified top competencies to be included in leadership development programs and were ranked as follows, by nurse leaders: building effective teams, translating vision into strategy, communicating, managing conflict, managing focus on patient and customer, and finally bringing creativity to vision and strategy formation (190). This is expressed in the present study’s results which illustrated that the majority of medical and surgical first-line nurse managers reported that they need all program topics: general introduction to leadership, goal setting, action plan, decision making, vision, interpersonal communication skills, problem solving, innovation, risk taking, team building and teamwork, coaching, setting priorities and creativity to be included in the training program.

First-line nurse managers and staff nurses’ perceptions of leadership practices

Peck et al. (2000) concluded that professional development should include the continuous acquisition of new knowledge, skills and attitudes to enable competent practice. Professional development thereby denotes a learning process and competence in the outcome of this process (256). O’Neil and Morjikian (2003) revealed that in order to respond to the growing challenges facing nursing both from within and from outside the profession, all dimensions of the profession – education, direct care and public health – must develop new ways of organizing and delivering their services and such transitions will require nurses to develop and deploy new leadership skills (257). Vitaska (2008) concluded that many United States are now mandating leadership assessment “as a lever to improve preparation programs and ongoing professional development and support” (258). Furthermore, Dalton (2004) emphasized the importance of effective leader preparation and the efforts of all stakeholders focused on learning (259). Petrie et al. (2000) stated that “good leaders in any field are not born, but are developed over time through hundreds, even thousands, of experiences dating from early childhood” (260).

This is in line with the results of this study which revealed a high significant difference for the five leadership practices between the three times of program evaluation (before, immediately after, and after three months); except for "challenging the process" which showed a significant difference. After three months got the highest mean score compared to the other two times of evaluation for both groups; “modeling the way” was higher at immediately after program implementation concerning the first-line nurse managers. This may be due to the fact that leadership development takes place overtime by being engaged with more practice. As for “modeling the way”, the first-line nurse managers supported their staff nurses and set an example for them when the program immediately ends; while they returned a little bit to their personal habits after a period of time (three months). Whereas, “challenging the process”, the first-line nurse managers are not faced with challenges which are resolved in a centralized manner by the director of nursing service; as well as being engaged in routine and secure tasks. This is in
accordance with Kouzes and Posner’s vision (1995) of how leaders challenge the process by being willing to take risks; to innovate and experiment; in order to find new ways of doing things. They also viewed that leaders model the way through personal example and dedicated execution (261). This is in line with the study conducted by Tourangeau et al. (2004) who concluded that both aspiring and established leaders self-reported improvements in all leadership practice areas from pre-test to posttest time periods. Observers also assessed established leaders as having improved their leadership practices in all five leadership practice areas at posttest time periods after the intervention of a 5-days residential leadership training program. They also found that peer observers reported statistically significant increases in participant use of all five leadership practice areas, though the final mean posttest assessment (15 months later) scores were lower than the first posttest mean (three months later) leadership practices scores. However, supervisors observers found that leaders had improved their leadership practices, between the pretest and last posttest, in all behaviors, except in two leadership practice areas: “modeling the way” and “encouraging the heart”. Furthermore, they suggested that a concentrated residential leadership development intervention can promote significant improvement in leadership practices by both established and aspiring leaders (262). This is also consistent with Brungardt (1996) who stated that a high significant difference was found for the leadership practices, by using pre and posttests as a result of collegiate leadership development program (263). This is also supported by Goldring et al. (2007) who concluded that establishing patterns of leadership behavior takes time and that the effects of leadership may not be seen immediately in performance (264).

The findings of this study revealed that "enabling others to act" was the most self-rated leadership practice by the first-line nurse managers before and after three months of program implementation, and also was the most perceived leadership practices by the staff nurses immediately after the program. This may be due to the nature of nursing profession as caring and giving; and the need for these leaders to provide a milieu that will enable their staff to deliver nursing care to patients and their loved ones. Moreover, staff nurses perceived the change immediately after the program, which may be due to their first-line nurse managers’ willingness to involve them in leadership development activities; and also they found what to transfer to their staff, including the information learned during the program. This is supported with the findings of Tourangeau et al. (2004), who stated that first-line nurse managers, in a focus group after attending a 5-days residential leadership development program, indicated that they influenced their staff nurses through grabbing teachable moments when others ask for change and found information summarized by presenters helpful and easy to use and realized the need to engage their staff in different leadership development activities (262). This is in line with Vitello-Cicciu (2001) who studied the leadership practices and emotional intelligence of nursing leaders and found that the most frequently self-reported leadership practices by all participants, was "enabling others to act" and that all participants articulated the need to work as a team, have respect for others on the team, and show sensitivity to others and the researcher concluded that "enabling others to act" was embedded in the other practices of "encouraging the heart" and "modeling the way" (106). This is emphasized by Kouzes and Posner (2003) who viewed that effective leaders must focus on relationships and must view people as the organizations most valuable resource, and stated that a great organization needs a great leader who is willing to recognize the value of relationships and team work (11). This is also supported by Kerfoot (1996) who stated that nursing is one service profession whose work is mostly in teams (265). Furthermore, Kouzes and Posner (1995) found that the effectiveness of any team is its ability to collaboratively work
together, promoting cooperative goals, having mutual trust, sharing power, developing competence, assigning critical tasks, and showing sensitivity to each other; all these are the basic underpinnings for this leadership practice and are crucial for nursing staff and nursing leaders to exhibit to be considered effective team members and team leaders. They also concluded that this leadership practice is vital for constituents too, a leader's ability to "enable others to act" is essential; in fact from the constituent's vantagepoint, this is the most significant of the five practices. Leadership is a relationship, founded on trust and confidence. Without trust and confidence, people don't take risks (261).

In addition to that, Kouzes and Posner (1995) found a statistical significant difference between the average mean scores from the leadership practices – observer in "enabling others to act", which is in accordance with the findings of the present study before the program implementation (261). Moreover, the present study revealed a high score for first-line nurse managers and a moderate score for staff nurses (before program implementation); whereas the two groups recorded high scores immediately after and after three months of program implementation. This may be due to the fact that when being trained and educated on concepts, such as team building and teamwork, as well as trust; the first-line nurse managers began to transmit what was learned to their working environment and consequently to their staff nurses. This is consistent with the finding of Cress (1996) who found that a difference was identified between the manager and subordinate group, and that the subordinates perceived a low level and the managers perceived a moderate level of leadership practice for "enabling others to act" and that this difference was identified as significant and also was consistent with the findings of Kouzes and Posner (1987); and also with related studies of Adams (1993) and Irurita (1994) who identified that first-line nurse managers most frequently engaged in the practices and behaviors associated with enabling others to act. They contended that this leadership practice tended to dominate the managers practice and positively impacted the effectiveness of the nursing leader. (105, 261, 266 - 267).

"Encouraging the heart" was the second rated leadership practice for all first-line nurse managers in this study, at immediately after and after three months of program implementation, and the one leadership practice that was found to be perceived as the first rank by staff nurses, at before and after three months of program implementation. This may be due to the fact that staff nurses perceived their first-line nurse managers to recognize their contributions and work together, hand by hand in order to better perform the nursing care needed.; also because first-line nurse managers believed that nursing shortage, faced in their units, would increase the workload; as a consequence they need to encourage their staff nurses continuously. This is inconsistent with the researches conducted by Kouzes and Posner (2003) and Etheridge (2009) who found that “encouraging the heart" was the fourth reported leadership practice (11, 268). This was partially supported by Vitello-Cicciu (2001) who found that encouraging the heart, was the third most frequently reported leadership practice for all the participants as evidenced by their ability to be sensitive to the feelings of others and to recognize the contribution of other members of the healthcare team (106). Furthermore, Kouzes and Posner (1995) stated that customer service managers also reported this practice as their fourth most practiced behavior (9). In this respect, Laschinger et al. (2000) concluded that encouraging nurses to participate in decision making and paying more attention to nurses’ opinions create a sense of trust among nurses and their leaders. Trust has been discussed as a measure of success and effectiveness of nurse leaders, it reinforces the significance of the leader’s role in
creating a work environment that supports autonomy and decision making participation (269).

Concerning the third and fourth most rated leadership practice, for all first-line nurse managers, in this study, it varied between the three times of program implementation, and also varied between two of the leadership practices “challenging the process” and “inspiring a shared vision”. However, the third perceived leadership practice for all staff nurses, in this study, was “inspiring a shared vision”; also the fourth perceived practice was “modeling the way”. “Challenging the process” was the third most rated practice by first-line nurse managers, after three months of program implementation; this is not an unexpected finding, as all nurse leaders search for opportunities to change the status quo and search for innovative ways to improve the organization; either by trying to increase staffing, or finding ways to decrease the emotional labor of their staff. The nurse leaders either take risks or are asked to take risks by executive management. This is supported by Kouzes and Posner (1995) who conveyed that customer service managers reported this practice as their third most frequently used behavior (9). In addition to that, Vitello-Cicciu (2001) concluded that challenging the process was the fourth most rated leadership practice and the most coded leadership practice for all nurse leaders (106). Furthermore, Porter-O’Grady (2003) argued that a good leader is always challenging the status quo: “in place of providing certainty to staff, the leader provides constancy, presence, support, insight and resources” (270). Moreover, Reay et al. (2003) mentioned that challenges for nurse leaders was to clarify the reallocation of tasks and to manage altered working relationships within the nursing team (271).

The fourth most rated leadership practice, by all first-line nurse managers, was “inspiring a shared vision”; whereas this same behavior was rated as third for staff nurses. This may be due to the fact that nurse leaders enlist others in their dreams and get people to see exciting possibilities for the future and create an ideal image of what the organization can become after the tremendous change provided by hospital administrators to embed the vision of the organization in their daily work. This is supported by Tourangeau et al. (2004), who found in their study that leadership practices had increased from pretest to the first posttest time periods (three months later), in the two leadership practice areas of “challenging the process” and “inspiring a shared vision”. Moreover, during their focus group, held after attending a leadership development program, the first-line nurse managers reported that they presented an overview of the leadership practices with staff nurses; and that they were trying to build support by enthusiastically sharing this model with them. They also stated that they have changed through participation in the program but the work environment/people have not changed (262). This is inconsistent with Vitello-Cicciu (2001) and Kouzes and Posner (1987) who concluded that inspiring a shared vision was the least frequent practice to be reported by their study’s participants and given that many of these nurse leaders were in middle management roles and not in senior management or top executive positions, as most of the organizational visions, especially in healthcare organizations, originate from senior management (106, 261). This is emphasized by Trofino (1995), in addressing visions, who identified that most people do not see themselves as sufficiently empowered and competent to be visionaries; thus impeding the ability to bring about necessary change (272).

The least rated practice to be reported, by all first-line nurse managers, was “modeling the way”, after three months from program implementation. This may be due to the fact that leaders generally establish principles concerning the way people should be
treated and the way goals should be pursued. Moreover, they create standards of excellence and, then set an example for others to follow. This is not applied by first-line nurse managers, as they get all the decisions and orders in a centralized manner by the director of nursing services, who prepare the entire work plan and, then first-line nurse managers execute it. They, also work with the same working condition as their staff nurses, as getting night shifts, being responsible of patients’ care,…etc. This is supported by Tourangeau et al. (2004) who viewed that leaders rated their partners as having decreased in all five leadership practices. Furthermore, the studied first-line nurse managers reported that they need to engage people at work the way they were engaged at the program and that they realized the necessity to make mentoring more accessible (262). This is not supported by Vitello-Cicciu (2001) and Cress (1996), who found that modeling the way was the second practice; and also by Molter (2001) and Kouzes and Posner (1995), who stated that it was the third practice; by giving the need for nursing leaders to “walk their talk” and role model the behaviors that they value. They must build a committed staff; in order to provide the care those patients and their loved ones have come to expect (106, 105, 273, 9).

The leadership practices mean scores for the first-line nurse managers group reflected that the managers and subordinates perceived a high level of leadership practice for the five practices, at immediately after and after three months of program implementation; while a moderate level was concluded, before program implementation, for “inspiring a shared vision” (for the two groups); for “enabling others to act” and “modeling the way” (for staff nurses only); while this difference was inconsistent with Cress (1996) who found a statistically significant difference between the manager and subordinate group, for “enabling others to act”; and that the managers perceived that they practiced “challenging the process”, “enabling others to act”, “modeling the way” and “encouraging the heart”, more frequently than what the subordinates perceived (105). While, Kouzes and Posner (1987) found that the manager group tended to have higher scores on all five leadership practices (261). In related studies of Smith (1993); Bennis (1989); and Peters and Waterman (1982), discovered that it was easy to talk about leadership, but difficult to practice (274 - 276).

The leadership practices mean scores as a whole, also revealed a slightly higher range of manager’s performance than that of their subordinates, as perceived by the self-assessment and the subordinate’s assessment of the leadership practices, before and immediately after the program; while there were approximately the same after three months of program implementation. The first-line nurse managers also tend to rate themselves higher in leadership practices to satisfy their self-esteem and fulfill their needs for recognition and self-actualization; whereas staff nurses perceived a change in their first-line nurse managers’ leadership practices after attending the program. This may be due to the fact that everyone perceived the leadership practices, individually and uniquely, based on age and experience. This is consistent with the findings of Etheridge (2009) who indicated that leaders rated themselves slightly higher on perceived leadership than did their subordinates (268). This is also supported by Hansen et al. (1995) who found a wide range of scores in their data on manager’s leadership behaviors as perceived by subordinates (277). This was the same as the findings of Cress (1996), who suggested similar conclusions as Hansen et al. (1995) (105, 277). In summary, the results of this study support the existence of a significant difference between self-assessment and the subordinate’s assessment, for “enabling others to act”, before program implementation;
whereas no difference was found for the others leadership practices at the three times of program implementation.

On the other hand, the study revealed no relation between leadership practices and socio-demographic characteristics, across the three times of program implementation; while a relation was found for the working unit – before program implementation – for staff nurses. This may be due to the nature of first-line nurse managers’ work, as being in a centralized environment, where the director of nursing services and hospital administrators has the upper hand in everything; thus inhibiting any self-awareness and development from first-line nurse managers to develop and practice the leadership skills and competencies needed in their unit. These characteristics would add innovative and creative ways in dealing with any situation; however, this seems inapplicable in this study, because the decision making’s authority is placed at the upper management levels in the organization, leading to decrease in innovation and creativity of the first-line nurse managers. This is consistent with the findings of Bettin and Fiedler (1984), who mentioned in their research, that experience contributes to effective interpersonal performance in any leadership situations (278). This is supported by Abdalla and Al-Homoud (2001) who found that the demographic characteristics have minimal effect on the respondents’ perceptions of leadership behaviors that facilitate or hinder leadership success. There were also no significant effects with all demographic characteristics, with the exception of age which had a significant direct negative impact on the value assigned to traditional leadership as a determinant of leadership success, as older respondents viewed traditional leadership as an inhibitors of leaders’ success (51). This is inconsistent with Armstrong (1998), who supported that age should be associated with experience, which in turn is associated with increased opportunities for performance in leader positions (279).

This is also contrary with the findings of Hansen et al. (1995) whose participants’ demographic data revealed a variety of experience, as well as maturity as related to age, and educational preparation; and they attributed the range in leadership scores to the variety of demographic characteristics. They also, concurred that experienced, mature individuals who pursued advanced education were successful leaders (277). In addition to that, Armstrong (1998) concluded that participation in organizations and becoming a leader increases steadily with increasing age. The same researcher indicated also that nursing studies of leaders indicate that positional leaders and managers tend to be older than average individual in the group which they lead, as in the 1970s the average age of nursing leaders was 55; while Scott (1985) studied female leaders in occupational therapy and found that the age of leaders ranged from 36 to 77 years (279 - 280).

As regards marital status, studies have shown that highly motivated, career-oriented women marry later and with less frequency than women who are not in leadership positions. Scott (1985) identified variables that contributed to leadership development among female and mentioned that leaders viewed themselves as leaders and viewed leadership as an appropriate activity for women and that leaders married less frequently (280). This is, also, emphasized by Ruffin (1989), who demonstrated similar findings in her study of black, professional women who married later in life (281). Moreover, Ferber and O’Farrell (1991) reported findings of studies of women and family in the workplace, and found that women with better job opportunities were less likely to marry and have children than women without these opportunities. These better job opportunities were described as positions that allowed for competitive salaries and upward mobility (282).
Concerning educational qualifications, formal educational attainment affects the level of leadership position a nurse might hold. Registered nurses with more formal education and advanced degrees tend to hold nursing leadership positions. This is not the case in the findings of this study, as all the first-line nurse managers were holding a diploma of nursing technical school degree, opposite to the American Nurses’ Association (ANA) (1988) which reported that registered nurses with a diploma or associate degree who did not have an advanced degree, were less likely to hold nursing leadership positions, and that among the advanced degrees held by nurse leaders were masters in nursing, masters in other disciplines, and the doctorate in nursing or other disciplines (127). Furthermore, the National League for Nurses (NLN) (1992) showed that nurses, who were doctorally prepared, were mainly in teaching or administrative positions (283). In this respect, Depp (1993) concluded that education was a contributing factor to the level of leadership self-efficacy (284). In a nutshell, Armstrong (1998) stated that formal educational attainment plays a major role in individual development and increases opportunity for career choices and are more able to perform and hold leadership positions within a community and organization (279).

First-line nurse managers and staff nurses’ perceptions of Workgroup Climate

The Management Sciences for Health (MSH) (2005) mentioned that climate is the “weather of the workplace”. Just as weather conditions can affect daily activities, work climate influences behavior at work. The (MSH) (2005) defined climate: “as the prevailing workplace atmosphere as experienced by employees. It is what it feels like to work in a group”. A good work climate can improve an individual’s work habits, while a poor one can erode good work habits (238). Moreover, Stringer (2002) found that a positive work climate leads to and sustains staff motivation and high performance (188).

Every health facility has a work climate. Some climates are positive and productive; while others tend to demotivate staff. Leadership behaviors enable leader to clarify purpose and priorities, communicate effectively, handle conflict, and motivate committed teams (238). Adding to that, Snow (2002) viewed climate as one of the most influential, yet, often overlooked variable that influences and shapes the employee’s behavior (285). This is emphasized by McMurry (2003) who concluded that climate distinguishes one organization from another (286). Some researchers indicated that work climate is a multidimensional construct, perception of their work environment with these perceptions influencing the employees’ behavior (287). In respect to these Farag et al. (2009), in their study, indicated that nurses reported that they perceived their unit climate as a moderately favorable atmosphere to work in, and that older nurses felt that their unit climate was characterized by administrative support; whereas younger nurses did not (288). In contrary to the previous study, Stuenkel et al. (2005) reported that as compared with older nurses, younger nurses significantly perceived their superiors to be supportive (289). This is in line with the results of the present study, which indicates that first-line nurse managers perceived “workgroup climate – support” higher than staff nurses did, across the three times of program implementation; and that “workgroup climate – support” got the highest mean score after three months of program implementation compared with the other two times of program evaluation, as perceived by first-line nurse managers and staff nurses; whereas there is no significant difference between first-line nurse managers and staff nurses at the three times of program implementation. This may be related to first-line
nurse managers, as they work closely with their staff nurses, almost all the times, in order to achieve work and help them; and, from their point of view; they support their subordinates, like they were in their families by virtue of age and position. The (MSH) (2005) stated that when people work in a supportive environment, they strive to produce results, such environment is called a positive work climate which is mainly emphasized and improved after attending leadership development programs (238).

Furthermore, the first-line nurse managers pointed to inefficient support by their superiors; thus, they did not want to let their staff nurses suffer and experience the same as they did. In this respect Ekvall et al. (1983) found that a creative work climate should maintain support for ideas (155). In addition to that, Beaman (1994) indicated that one of the responsibilities of the first-line nurse managers is to assure the availability of support services and to act as a resource to the staff (123). An emphasis is provided by (MSH) (2005) on supporting the workgroup by advocating for its work and its needs and by making the services performed and accomplished, visible to the wider organization and by securing or providing the resources needed to do the job. These include not only time, materials, and money, but also political and emotional support (238). This is emphasized by Memarian et al. (2008), who mentioned that Iranian nurses need a leader to be knowledgeable about professional needs and support and advocate on behalf of nurses’ needs to upper managers (3). While, Drach-Zahavy and Dragan (2002) found in their study that managers cared for patients instead of supporting staff members and they used, for example only 10 % of their working time to coach (290). However, Rosengren et al. (2007) commented that the staff’s view was that nursing leadership should be used to support their daily work, a finding well supported by other studies (120).

The results of the present study revealed that “workgroup climate – clarity” were highly significant for staff nurses; and first-line nurse managers, across the three times of program implementation. The first-line nurse managers perceived “workgroup climate – clarity” higher than staff nurses, before and after three months from program; while the contrary occurred immediately after the program. Moreover, “workgroup climate – clarity” got the highest mean score after three months of program implementation compared with the other two times for both groups. This may be due to the fact that first-line nurse managers work hand by hand with their staff nurses because of nursing shortage and that there may be only one nurse who is responsible of the unit for the working shift, acting as first-line nurse managers and staff nurses at the same time; therefore, her/his roles and responsibilities are usually clarified; in order to be prepared when working alone in the unit at any shift. Furthermore, first-line nurse managers, after attending the leadership development program made themselves and their organization and units’ goals clearer for their staff nurses. They also knew how to develop visions and work as teams in their units which was improved after three months of program implementation as it was related to practicing the leadership behaviors of “encouraging the heart”. This is consistent with Snow (2002) who found the “clarity” is one of the most important dimensions, with the greatest impact on work climate; and stated that in a highly rated unit, people should have a clear idea of what is expected of them and how they contribute to the mission through clarity which is the feeling that everyone knows what is expected from them; and that they understand how those expectations relate to the larger goals and objectives of the organization (285). This is also emphasized by Tourangeau et al. (2004) whose participants concluded that they tried to “encourage the heart” by teaching staff what they’ve learned in the leadership development program; by thinking to orient their staff on their roles and that of others; and by being more aware of their staff needs; in order to create a climate of
clarity within their workplace \(^{(262)}\). Moreover, this is supported by (MSH) (2005), who concluded that when each group member understands the roles and responsibilities of everyone in the group, then all members see how their roles contribute to the desired results of their group and ultimately of the organization which increase by the application of leadership development program. In order to clarify responsibilities for the staff, first-line nurse managers should talk about expectations of clients; as well as those of leader and make sure to point out the consequences of not meeting these expectations. Leader should inquire to see whether staff understand them and follow up with written documentation, to easily access this information \(^{(238)}\).

The results of the present study revealed that, for the “workgroup climate – challenge”, the highest mean score was three months later of program implementation, for both groups. However, a significant difference was found between first-line nurse managers and staff nurses, at immediately after the program. This result may be related to the working conditions found within the studied units, because of staff shortage and decrease in resources, which put them in challenging situations continuously. Also, this is in line with the leadership practice “challenging the process” which was also improved after three months of program implementation, as first-line nurse managers were taught how to take risks and to solve problem and how to be innovative in their working units. Consequently, these topics affected the “workgroup climate – challenge” at the studied units. This is emphasized by (MSH) (2005), who recommended for leaders, in order to challenge their staff, to offer assignments that stretch them beyond their current level of competence and confidence. Such assignments offer the possibility of doing something in a new way or starting something new. When staff members are not challenged, they do not grow or learn from mistakes, and they become bored; however, if challenged, staff members gain confidence in their ability to make the best possible decision at the time \(^{(238)}\).

In addition to that, Connor and Mackenzie-Smith (2003) commented that the challenge of being a leader at a time when towering organizations can come down overnight, is to bring into being new opportunities through sensing and discerning emerging patterns; and that by considering the challenge of work and individual capability to undertake this as two sides of the same coin, real insight can be gained into leadership; this can help meet the challenge of having the right people at the right time to lead organizations in turbulence \(^{(291)}\). Furthermore, Sherman et al. (2007) support the same idea, they concluded that outstanding leaders demonstrate self-confidence and are able to trust and empower others. They know how their communication and actions impact others and are sensitive to watching the cues in an environment, when things are not going well. Leaders make mistakes but are able to look at them, acknowledge them and learn from them \(^{(292)}\).

The findings of the present study revealed that “quality” got higher mean score at immediately after the program for first-line nurse managers, compared to after three months for staff nurses; and a significant difference was found between first-line nurse managers and staff nurses at immediately after program implementation. This may be due to the fact that first-line nurse managers, after attending the program, began to support their staff nurses in their daily work and also transmitted the information learned to them. Therefore, staff nurses perceived this change and conducted their work with quality despite working in stressful conditions, with scarce resources and in a centralized environment. This is inconsistent with Mrayyan (2009), who realized in his study, that the Jordanian healthcare system is centralized, which may indicate the non-supportive organizational
climates at hospitals and, in turn, may result in poor quality of nursing care. Therefore, the researcher concluded that positive perceptions of hospitals’ work climate, are the outcomes of quality of care, which is one of the major variables that influence hospitals’ work climate; and also argued that first-line nurse managers have to create supportive work climate that would encourage nurses to stay at their jobs to the end of their careers. This, in turn, would influence positively the quality of patient care (293). In this respect, Hwang and Chang (2009) stated that a cooperative climate can facilitate coordinated actions and provide the resources to achieve high-quality care; and they also concluded that such a work climate, focusing on high-quality nursing care for professional practice, may be critical for the provision of outstanding quality of patient care (294). Huston (2008) suggested that current quality problems are exacerbated by organizational cultures which focus on blame instead of identifying how and why such errors are made, and then addressing the processes which increase the likelihood of errors occurring (295). Moreover, White (2006) claimed that organization leaders in the 21st century will be those that lead in identifying and adopting innovative safety and quality improvement approaches (296). Furthermore, Urden and Monarch (2002) perceived quality care as an organizational priority; and nursing leaders were seen as responsible for developing an environment that fostered quality of care delivery; while staff nurses thought they were providing high quality care (297).

The present study, also, indicates that “productivity” got the highest mean score after three months of program implementation for both groups. This may be related to the dissatisfaction of the first-line nurse managers with any achievements done by their staff nurses and that they are, continuously, eager to improve and increase productivity regardless of human needs and working systems. Whereas, after attending the leadership development program, the first-line nurse managers make work easier for staff nurses through organizing work and applying learned leadership skills and thus leading to improve the group productivity. This is in line with Snow (2002), who concluded that “productivity” is high due to good planning and contrary if productivity suffers, people would not be sure what they are expected to do in the organization as mentioned by their study’s participants, who reported that “productivity” of their workgroup often suffers from lack of organization and planning (285). These results are also supported by Kouzes and Posner (1999), who mentioned that managers are the “human connectors” who make things happen (298). Buckingham and Coffman (1999) also found that the unit manager is the most critical player in building a strong work place (93). This is also supported by many researchers, who concluded that organizations with unhealthy work forces may have a cost burden from higher rates of absenteeism, presence at work but inadequate work performance, and loss of productivity (299 - 302).

First-line nurse managers and staff nurses’ perceptions of Performance

Regarding leader’s performance, the highest mean scores were found, after three months from program implementation, for all the leader’s behaviors components. The most rated behavior was “controlling” after three months of program implementation, for both groups; whereas “leading” was the second behavior, at immediately after and after three months of program implementation for first-line nurse managers; while it was the first at immediately after the program for staff nurses. This may be due to the fact that nurse leaders engaged in the previously mentioned behaviors as they acquire more knowledge and leadership skills while attending the training program as to promote performance. They, also, are willing and motivated to develop themselves and they were
looking forward to using all the new skills that was learnt; in order to satisfy their needs and those of their staff and to keep themselves abreast of the modern technologies and administration system within the organization. Moreover, almost all these topics were new to them, so they were keen to understand and apply the details given for these topics, which they listen to them in any of the meetings held at the organizational level; and therefore mastering them after application during a period of time. These findings are consistent with Wicker (2008), who, in his study, concluded that nurse leaders reported their competency level in leadership behaviors as having increased in many areas, after leadership training course, in particular, in leading, effective communication, building relationships (252). In this respect St-Pierre and Holms (2008); Vivar (2006); Peck (2006); Hutton (2006); and Baltimore (2006), concluded that there is a need for leaders and managers to decrease toxic workplaces by such means as role modeling, professional behaviors; validating assumptions and perceptions before drawing conclusions; using open communication; socializing new staff members; using conflict resolution; rewarding nurses for supporting each other; nurturing a culture of recognition and finally, having a policy of zero tolerance for violence (303 - 307). Moreover, Skytt et al. (2008) viewed that the first-line nurse managers; themselves had ambitions to work with long-term planning and the development of the services (308).

In addition to that, Wicker (2008) concluded that respondents reported a better understanding of management and leadership skills. Not only were skills learned such as communication, team building and running a meeting, but how to have better relationships with their employees and knowing when to manage them up or effectively supervise employee issues. Participants reported increased confidence in making decisions and leading others. Participants stated they were better at communicating with others because they could recognize not only their own style of leading, but also the styles of the individuals they are working with as well (252). Also, Marquis and Huston (2009) suggested that the most important strategy is to learn to “read the environment” through observation, listening, reading, detachment, and analysis. This allows nurse leader to understand relationships and communication within the organization (64). This is, also emphasized by Kotter (1990), who stated that nurse manager seeks to produce predictability and order by: establishing plans, solving problems, and controlling (309). In this respect, Rosengren et al. (2007) concluded that informants, in their study, considered communication skills as an important prerequisite of a leader in many situations in order to make him/herself clear in sending and receiving messages to their subordinates, and also they requested for professional acknowledgment from their managers (120). Communication is pointed out as an important part of the daily work of both ward managers and staff members (310 - 311). In addition to that, researchers mentioned that in order to facilitate professional acknowledgement, ward managers have to demonstrate human interest in each individual and build relationships as a result of their professional experiences and education in caring values (312 - 314). The results of the present study also revealed that the overall leader’s performance was highly significant after three months from program implementation. This may be due to the first-line nurse managers’ enthusiasm to apply what was learned during the leadership development program; in order to improve their performance, which also impacted their staff nurses’ perceptions. This is consistent with Long (2007) who found in his study that the overall leadership performance increased when comparing the pre leadership nurses’ perceptions. This is also emphasized by Holton III and Lynham (2000); as well as Rummler and Brache (1995) who stated that performance improvement is inferred, implied, and assumed as an outcome of leadership
and leadership development (316 - 317). Moreover, Collins (2001) mentioned that recent leadership development programs have begun to focus on enhancing performance over time (318).

Concerning the “relationships with subordinates”, this was identified by Kouzes and Posner (1999) as the number one success factor critical for positions in large organizations. They also documented that the highest performing managers show more warmth and affection towards others than do the bottom 25% and that effective leaders create relationships (298). In the same line is Stapleton et al. (2007), who concluded that nurse managers have a unique opportunity to invest in relationships with staff, because of the close daily interaction on a ward (319). Furthermore, Wolf et al. (2004) used strategic visioning and decision making assessment, building support structures, administration and evaluation to implement a transformational model of leadership (320). More to the point is Hardwood et al. (2003), who used mentoring, education, and support to help leaders change from exercising control to guiding and facilitating group decisions (321). Also, Dixon (1999) stated that those leaders admit and accept their own mistakes and consider them an opportunity to learn and further their personal and professional development (322). Kotter (1990) also stated that leadership seeks to produce necessary changes by developing a vision of the future and strategies to reach that vision. This includes communicating the vision and motivating and inspiring the staff to attain the vision (309). Yukl (2002) estimated that in modern organizations, success as a manager necessarily involves leading (323).

Pertaining to staff nurse’s performance, the findings of the present study revealed a high significant difference between the three times of program implementation for the first-line nurse managers and staff nurses, concerning subscales of “research”, “education”, “professional development”, “clinical skills” and total staff nurse performance; with its highest after three months from program implementation. Moreover, a significant difference was found between first-line nurse managers’ ratings and staff nurses’ ratings for staff nurses’ performance – before program implementation (for “education”, and “professional development”); and immediately after (for “research”, “professional development”, and total staff nurses’ performance); as well as, a high significant difference was found, before program implementation, for the component "clinical skills". These improvements may be related to the friendly atmosphere created by each first-line nurse manager at his/her unit, in order to overcome any deficiency for the other parts in nurses’ work such as payment, days off, and working schedule. Moreover, the first-line nurse managers, after attending the leadership program, encourage her/his staff and support them when asking for any information needed in the delivery of patient care or training by having confidence in their motivation, integrity, and ability; and consequently, they view them as better performing their work. This was supported by Espedal (2004) who found, in his study, that at the individual level, development was first related to training—a focus on developing skills connected to formal leader roles and on application of proven techniques and solutions to known problems. Development was second related to leader development—a focus on developing individual knowledge, skills, and abilities. They also concluded that “through leadership development, the capacity of managers can be expanded to engage effectively into leadership roles and processes.” Moreover, most of the respondents portrayed leadership development programs as a learning process where managers have opportunities to combine their own experience with the experience of others, to confront old experience with new experience, to acquire new knowledge, ideas, and so on. Such combinations could lead to incremental development from existing
knowledge or to more radical changes by developing novel ways of combining experience and ideas previously associated. In this way, the respondents looked at leadership development as production of actionable knowledge, which could help and empower managers, that is, the organizations used learning as a basis for developing and changing behavior and roles. Superiors should be responsible to develop and nurture their subordinates (324). Yammarino and Dansereau (2002) viewed that from the perspective of subordinates, subordinates perform in a satisfying manner for superiors based on their perceptions of the superiors who support his/her sense of self-worth, needs, feelings, and integrity. Subordinates provide satisfying performance for a superior according to their own perceptions of being supported by that superior (325). This way to measure individual performance is supported by many researchers, who compared self-rated performance with first-line nurse managers’ ratings. Most of these found a significant, though not high, correlation between self and supervisor rating (326 - 328). Also, other researchers included first-line nurse managers as key informants in their rating studies, as first-line nurse managers have observed subjects’ practice at close quarters and consequently may be considered to be a more reliable source of opinion (329 - 331). McDonald (1995) conducted a study to rate 52 nursing behaviors in relation to how often the behavior was performed, how well it was performed, and concluded that the subjects rated their nursing performance at a significant higher level, at posttest, than they had at a pretest (332). In this respect, Lockyer (2003) and Barnes et al. (1999) viewed that multisource feedback provides a rich assessment of performance from several perspectives, and also has a high educational impact and has been referenced as one of the better tools to provide feedback and guide future performance (333 - 334).

Regarding “professional development”, the results of the present study revealed that it was the first most rated staff nurses’ performance behavior by both groups at the three times of program evaluation. This may be related to the fact that first-line nurse managers transferred what was learned at the leadership training program to their staff nurses and enabled them to practice what they had learned from them. This is supported by Hart and Rotem (1995) who explored staff nurses’ perceptions of organizational and social factors associated with professional development in clinical settings and concluded that nurse leaders must focus on: peer support and opportunities for learning; role clarity; in order to support “professional development” in clinical settings (335). This is also in line with Samdal (2004), who indicated that nurse leaders were facilitators for staff nurses’ professional development (336). Moreover, this is consistent with Urden and Monarch (2002), who concluded that most successful hospital placed a significant emphasis on orientation, in-service education, continuing education, formal education and career development. They also found that personal and professional development was valued and there were opportunities for competency-based clinical advancement and resources to maintain competency (297). In this respect, Furaker (2003) commented that leaders consider competent, well-educated, motivated and interested staff as the most important factor to achieve the goals of nursing, and for this reason professional development was considered vital by nurse leaders (337). Furthermore, McClure et al. (2002) indicated that growth and development of nurses was emphasized to improve quality of nursing care. Nurses were expected to teach and were assisted in aspects of learning and teaching (338). In addition to that, Kuokkanen et al. (2007) and Skytt et al. (2007) concluded that staff nurses want empowerment, opportunities for education and development, access to information and opportunities for advancement (339 - 340). This is the same as Reed (2007) who commented that tomorrow’s healthcare leaders must focus on workforce development more than ever before, and that a hospital’s workforce – its caregivers and staff – play a critical role in
anything and everything to be accomplished, including the most important thing: providing the best care and service possible for patients in order to maximize healing and to unleash their full potential and to maximize productivity and performance (249).

The findings of this study showed that “clinical skills” was the second most rated behavior, for the three times of evaluation, for both groups. This may be due to that it was the main practice expected from staff nurses by first-line nurse managers in order to provide good nursing care. This is consistent with a study conducted by Mrayyan and Al-Faouri (2008), who concluded that nurses performed technical procedures, they taught families about their patients’ needs to be able to develop accurate plans of care and they promoted patients’ right to privacy; nurses also were willing to be involved, on their own time, in projects that would benefit patient care (341). In this respect, Sheldon and Parker (1997) found that a leader that successfully empowers staff, develops a climate of mutual trust, increases job satisfaction and fosters commitment to the organizational goals and culminates in the delivery of high quality patient care (342). Moreover, Moiden (2002) stressed that transformational leadership creates an empowering environment where quality in clinical care is salient, and that some strategies that continuously espouses to improve the quality of patient care included team building, personal and professional growth, risk management and patient satisfaction (343). In this respect, Jooste (2004); Snow (2001); Mahoney (2001); and Perra (2000) also assumed that leadership development influences the nursing team and that the nursing team in turn influences the care-giving process (90,344, 1, 345).

As for “education”, the findings of the present study revealed that “education” was the third most reported behavior by both groups at the three times of program implementation with its highest after three months from program implementation. This may be due to the fact that Diploma qualification prepare nurses to become a nurse practitioner rather than an educator, and also in their working organization, the top executive level did not deliver to them nursing education programs instead they provide them with practical training programs in their filed of specialty. Moreover, due to the nursing shortage, the staff nurses don’t have time to spend with their patients and families to teach them what is needed according to their conditions. Also, this had improved after three months of program implementation, as when first-line nurse managers attended the leadership development program; thus they disseminate the learned materials to their staff in order to improve their performance. In this respect is Wang et al. (2008) indicated that continuous education and training is a process of updating knowledge, developing skills, bringing about attitudinal changes and improving participants’ competency to perform their tasks efficiently and effectively (346). Moreover, O’Neil et al. (2008) mentioned that the healthcare organization has focused on continuing education to meet licensure requirements and to achieve advanced clinical practices (190). Education is also emphasized by Urden and Monarch (2002), who viewed nurses to be expected to incorporate teaching into all aspects of their practice and reported getting considerable professional satisfaction from the teaching (297). Furthermore, Lorentzon and Bryant (1997) mentioned that a better educated nursing workforce is likely to be a more assertive body of staff (347). Finally, this is highlighted by Schmalenberg et al. (2008) who support for education as one of the criteria for improving performance excellence; it is included as an aspect of the professional development; and it is identified by the American Organization of Nurse Executives as 1 of the 9 elements of a healthy work environment (348).
Regarding “research”, the findings of this study revealed that “research” was the least rated behavior for both groups. This may be due to the fact that all staff nurses do not possess the potential to conduct or to help in applying researches; as well as they found that, research, do waste their time which should be provided for nursing care according to their point of view. This is supported by Schmalenberg et al. (2008), who interviewed nurses on all units and noted that “planned and unplanned additional responsibilities” such as emergency admissions, orientation of new nurses, increased expectations of involvement in research and evidence-based practice teams, council activities, interdisciplinary meetings, would improve nurses’ performance (348). This is inconsistent with Albert and Siedlecki (2008), who in their study described the development and implementation of a nursing research team in a healthcare system to be very useful in improving staff nurses’ research abilities. They, also identified that nurses are able to generate and use nursing knowledge to improve practice, when there is a clear direction from leadership, access to nurse researchers that coach and mentor, infrastructure resources and leadership support (349). Moreover, Larkin et al. (2007) clarified the experience of the Massachusetts General Hospital, which reengineered the nursing research committee to overcome the barriers of insufficient time to access and implement research; lack of confidence to read, interpret, and understand research findings; and a lack of support to introduce research findings into practice; they added that the membership of the committee was open to all nurses in the hospital, and that members were self-selected into sub committees, and that those members provided a link between direct care providers and product lines (350). This is also emphasized by Rundall (2007), who identified the need for developing a questioning culture; training managers in evidence-informed decision making; establishing relationships with individual researchers, universities, research centers and other knowledge brokers (351). For all of the above, Larrabee et al. (2007) concluded that nursing leaders can improve attitudes about and participation in research utilization by internally marketing the support available for research-related activities (352).

Evaluation of first-line nurse managers’ knowledge and leadership development training program

Concerning first-line nurse managers’ knowledge assessment, the leadership program prove that the highest score in their knowledge was immediately after the program; followed by three months later when compared to before program implementation; for all the topics encompassed in the program: “general introduction to leadership”, “goal setting”, “action plan”, “decision making”, “vision”, “interpersonal communication skills”, “problem solving”, “innovation”, “risk taking”, “team building and teamwork”, “coaching”, “setting priority”, and finally “creativity”; whereas both “vision” and “creativity” were highly significant also after three months from implementation. This is consistent with Wang et al. (2008) who found that the overall leadership knowledge scores were increased significantly in the follow-up test compared with the pretest (346). Additionally, Knowles (1980) examined andragogy (the theory of adult learning) and noted that adult learners tend to be self-motivated and self-directed, build on a reservoir of knowledge and experience that has been accumulated over a lifetime, and have a problem-centered orientation that leads them to seek out the skills or knowledge they need to apply to the real-life problems they face. The role of the teacher is to function as a facilitator of learning and to serve as a resource to the student (353). These findings may be due to their educational preparation, as all the first-line nurse managers were holding Diploma of Technical Nursing School, where all these topics were not part of their educational curriculum or even if included, they were underestimated compared with the other subject.
area because the main concern of this qualification is to qualify a practical nurse. This is consistent with Sherman et al. (2007) who concluded that most nurse leaders have little formal leadership education and have learned on the job mostly through trial and error (354). This is also supported by Tourangeau (2003), Scoble and Russell (2003) and Noyes (2002) who recommended that leadership training for nurse managers should be formalized, and that each independently noted some common areas that call for competency development, including: the business of healthcare with financing and budgeting; leadership practices, behaviors, and skills; and the use of self in communication skills and personal effectiveness (355 - 357). This is also stressed by Duffield (1991), who indicated that nursing programs have prepared to be good clinicians, but not to be good managers. Therefore, Duffield (2005) and Heller et al. (2004) acknowledged the need of leadership education and training (358 - 359). Lorentzon and Bryant (1997), also, clarified that development programs as a means of leadership training are much discussed in current literature and that their nature and content vary greatly (347). This is also emphasized by Barnum and Kerfoot (1995) who stressed the need by first-line nurse managers for a “breath of education” which will enable them to become “renaissance persons”, having a broad knowledge base (360). Britt et al. (2006) who, in their study, found that participants, reporting higher engagement during the leadership course, were more likely to receive higher ratings of leadership when the course was over (361).

As regards first-line nurse managers’ evaluation of the leadership development training program, the findings of the present study revealed that all first-line nurse managers, from both studied units, mentioned the clearance of program objectives, and the adequacy of time allotted to the program, as well as the adequacy of the program’s content. They also indicated that the program added new information to them and it was delivered in a comfortable climate by using clear teaching methods. Moreover, the most effective teaching methods used, was lecture/discussion, followed by small group work and lastly by brainstorming, as stated by participants; and they also emphasized the adequacy and effectiveness of audio-visual aids, worksheets and handouts. This was due to the usage and application of most recent and updated knowledge; while developing the program, and the hospital’s facility which supported the program delivery as presence of conference hall and audio-visual devices; as well as the use of multi teaching methods and instructional strategies to help retain knowledge and gain the necessary leadership skills and practices. These were in line with Denning and Associates (2004) who surveyed nurse executives and nurse managers and found that, in order to prepare nurse leaders, almost all the nurse executives in the study reported that they prepared them with on-the-job training, more than four-fifths used workshops, and almost two-thirds used continuing education classes, while others used personal mentoring. Moreover, they wished to have more emphasis on leadership development and the transitioning from a clinical to a supervisory role, by including: curriculum-based study, in-class speakers, study guides and web-based programs (362). In this respect, Burke et al. (2006), and Barnett et al. (2005) viewed that the interactive training methods might be helpful in increasing the quality of the training and improving retention of knowledge through immediate reinforcement of learning (363 - 364).

In this respect, Management Sciences for Health (MSH) (1996) claimed that training organizations or training programs within a larger organization most commonly evaluate baseline knowledge, attitudes, and skills, and conduct input, process, and outcome evaluations. Needs assessments are done infrequently and are generally conducted for the purpose of designing a new course (365). Furthermore, Kitching (1993) indicated that the role of the ward leader is just as important today in influencing the ward learning climate
and that nursing needs to prepare its leaders and education is vital (366). This is also supported by Petticrew et al. (2007) and Vathsala (2006) who, in their studies, showed that continuous education and training is a process of updating knowledge, developing skills, bringing about attitudinal changes, and improving the emergency competency of participants to perform their tasks efficiently and effectively (367 - 368).

Finally, Antrobus and Kitson (1999) summarized that in order to influence both nursing practice and management; academic and political contexts will require leadership development programs that consider two key elements. Firstly, the skills repertoire of the future nurse leader. This repertoire is built around a central core that is concerned with developing nursing practice and explicating nursing knowledge. Secondly, equipping nurses with the knowledge and skills to operate successfully within the academic, management and political contexts (369). In a nutshell, Kouzes and Posner (2002) suggested that the true legacy of leaders is to create organizations and develop people who will adapt, grow, and change over time (370). Furthermore, Torstad and Bjork (2007) stated that nurse leaders who provided innovative work environments helped nurses develop and integrate their roles (371). In conclusion, Kanste et al. (2007) supported that leadership contributes to almost everything that happens in organizations; therefore, how nurse supervisors lead their subordinates is not insignificant. Nurse supervisors need tools to assess their own leadership behavior. There is, also, a need for evaluation of leadership behavior and active feedback, because supervisory behavior is related to subordinates’ performance and well-being at work as well as to the quality of care (372).
CONCLUSION & RECOMMENDATIONS

Nurse leadership is experiencing profound change, and nurse leaders need time together and with other health care workers to develop strategic approaches and reform in response to this change. There needs to be agreement about what improved patient care is, how corporate objectives can be realized and what investments needs to be made to meet the challenges such team face. The development program of this study provides a useful device for “unfreezing” views, ideas and opinions about leadership and, more importantly, for showing how the participants saw themselves as leaders. Leadership during these times of rapid change requires much opportunity for unfreezing if nursing is to meet the ongoing challenges and demands.

Consequently, the need for leadership and for developing leaders is universal, as leaders engage people in facing challenges, changing, and learning. In order to develop the abilities of managers who lead, organizations should be encouraged to conduct leadership development activities in a conscious and organized way. A well-designed leadership development program will institutionalize processes for the continual development of leaders at all organizational levels.

The results of the present study concluded that the leadership development in-service training program had positive effect on first-line nurse managers, as well as on staff nurses’ perceptions of leadership practices, workgroup climate, leader performance, and staff nurse performance; with their highest mean score after three months of program implementation which means that first-line nurse managers retained knowledge and leadership practices learned during the training program. The first-line nurse managers, in this study, exhibited the leadership practices; and the leadership development in-service program was effective for both groups; as first-line nurse managers retained the leadership practices, necessary to better performance and continue to practice them till the follow-up evaluation and this was highly impacted upon their staff nurses.

Based on the findings of the present study, more efforts is still needed for nurse administrators to be cognizant of these leadership practices and recognize that for extraordinary things to be accomplished in an organization, the five leadership practices must be exhibited consistently, as attention must be given to the current and emerging nurse manager’s growth as leaders, because the trajectory for the retirement of large
numbers of very experienced nurse managers could begin within the next three to five years.

The following recommendations are suggested and directed to different levels and disciplines of administrators within the health care organization:

1. First-line nurse managers should strive to continue professional development and self assessment to analyze personal growth. Leadership behavior in the areas of Model the Way, Inspire a Shared Vision, Challenge the Process, Encourage the Heart, and Enable Others to Act.

2. Nurse administrators would also do well to understand and value the concept of providing ongoing education within the organization, and incorporating these leadership practices into the ongoing educational programs for nursing leaders which is imperative for creating extraordinary leaders. Organization should devote a minimum of two weeks per year to leadership training and education. This may be internal or external programs.

3. To be more effective, hospital administrators should be encouraged to conduct leadership activities and development that should be aimed at managers early in their careers. A significant part of it needs to take place inside organizations during the course of daily work, as people try to achieve results through others.

4. Leadership development programs should use real organizational issues, such as declining funding, complex decentralization efforts or other health reform strategies; to provide challenges, feedback, and support. Leadership development programs also need to encourage self-awareness and empathy, since these are linked to leaders performance, as when leaders demonstrate emotional maturity, this create work climates in which information sharing, trust, healthy risk-taking, and learning flourish.

5. Deans of nursing faculties and hospital administrators should provide leadership development in-service training program for future generations of successful leaders is very beneficial in today’s turbulent environment that use research findings to develop curriculums responsive to the needs of both novice and expert nurse managers.

6. Hospital administrators have to create a conducive learning environment and more opportunities for nurse managers to be able to access leadership development resources through group discussion, library, periodic meetings and workshops.

7. Nursing administrators should encourage their first-line nurse managers to function in a decentralized manner and to be responsible of their units; in turn the first-line nurse managers should empower staff, foster commitment in them to the organizational goals and be a role model, through functioning in a supportive atmosphere with mutual trust; in order to improve the leadership practice “model the way”.

8. Hospital and nursing administrators should encourage first-line nurse managers to creatively solve their problems and take risks in their units; so as to increase the challenge and improve their workgroup climate. Moreover, they should provide support for their staff through improving their skills and motivating them by acting as a resource to them; also through clarifying purpose and priorities, communicating effectively, and finally handling conflict.

9. Hospital and nursing administrators should emphasis training for first-line nurse managers on planning activities and problem solving and should encourage them to present their overviews or solutions; in order to improve their performance.

10. Hospital and nursing administrators should establish a nursing research committee, with its members are selected voluntarily; and with the participation of interested academics nursing researchers; in order to increase participation of nursing workforce in researches and to provide a link between direct care providers and product lines.
11. Hospital and nursing administrators should support the introduction of research findings into practice through establishing relationships with individual researchers, universities, research centers and other knowledge brokers.

12. Hospital administrators should ensure that first-line nurse managers are not only promoted to that position based on their years of experience but also based on their educational preparation and leadership skills and leadership development in-service training programs’ attended.

13. Hospital and nursing administrators should assure that first-line nurse managers; as well as emerging or potential leaders are represented on committees and task forces, especially those that address personnel and work environment issues.

14. Hospital administrators should pay serious attention to the educational requirements for nurse leaders and recruitment to nursing leadership positions; in order to develop a competent nursing leadership.

15. Further study: it is extremely needed to examine the relationship between the five leadership practices and different patient outcomes to ensure quality of care provided to patients.

16. Moreover, replication studies are needed to further validate and examine study findings. Ongoing measurement of the five leadership practices for the first-line nurse managers in different settings through self and observer leadership practices assessment would provide valuable insight into the practices of the first-line nurse managers and allow for ongoing opportunities of growth and strengthening of the leadership practices.
SUMMARY

Leadership is often regarded as the most critical factor in the success or failure of an organization; it is a key for nursing as a profession. Transformational leadership promotes employee development, attends to needs and motives of followers, inspires through optimism, influences changes in perception, provides intellectual stimulation, and encourages follower creativity. The first-line nurse manager is a person who acts in hospital as a leader at a ward/unit; it is this nurse who translates the goals and objectives of the department into action. Opportunities for creating educational programs in leadership are extensive for nursing leaders, who will need to develop extraordinary leadership practices and behaviors through observing, role modeling, and participating in formal education, as Leadership development is a lifetime endeavor. Effective leaders seek or create continuing education opportunities to enhance their abilities to lead. The development program of this study provides a useful device for “unfreezing” views, ideas and opinions about leadership and, more importantly, for showing how the participants saw themselves as leaders. Leadership during these times of rapid change requires much opportunity for unfreezing if nursing is to meet the ongoing challenges and demands.

Consequently, the need for leadership and for developing leaders is universal, as leaders engage people in facing challenges, changing, and learning. In order to develop the abilities of managers who lead, organizations should be encouraged to conduct leadership development activities in a conscious and organized way. A well-designed leadership development program will institutionalize processes for the continual development of leaders at all organizational levels.

The study aims to determine the impact of first-line nurse managers' leadership development training program on: workgroup climate; first-line nurse managers' performance; and staff nurses' performance.

The study was conducted in all inpatient surgical and medical units and their specialties (general surgery A, general surgery B, general surgery C, general surgery – female, plastic surgery, ophthalmology surgery, urology surgery, ear, nose and throat surgery (ENT), obstetrics & gynecology surgery, orthopedics A, orthopedics B, orthopedics – female, neuro-surgery, surgery G1, surgery G2. Whereas the medical units included in the study were: general medical A1 (male), A2 (female), and A intermediate; general medical B1 (male), B2 (female), and B intermediate; general medical C1 (male), C2 (female), and C intermediate; neurology 1 (male), and intermediate; oncology; chest A (male) and B (female); and general medical G4), at Alexandria Gamal Abd El Nasser – Health Insurance Hospital. It comprised all first-line nurse managers and all staff nurses, available at the time of data collection. The number of first-line nurse managers = 30 and
staff nurses = 170; they were distributed as follows: all the first-line nurse managers in the previously mentioned units were included in the study (one / each unit). Staff nurses in surgical and medical units were distributed as follows: general surgery A (6 nurses), general surgery B (5 nurses), general surgery C (5 nurses), general surgery – female (5 nurses), plastic surgery (6 nurses), ophthalmology surgery (4 nurses), urology surgery (5 nurses), ear, nose and throat surgery (ENT) (5 nurses), obstetrics & gynecology surgery (6 nurses), orthopedics A (6 nurses), orthopedics B (7 nurses), orthopedics – female (6 nurses), neuro-surgery (6 nurses), surgery G1 (6 nurses), surgery G2 (5 nurses); general medical A1 (male) (5 nurses), A2 (female) (7 nurses), and A intermediate (6 nurses); general medical B1 (male) (5 nurses), B2 (female) (5 nurses), and B intermediate (5 nurses); general medical C1 (male) (6 nurses), C2 (female) (6 nurses), and C intermediate (5 nurses); neurology 1 (male) (6 nurses), and intermediate (8 nurses); oncology (6 nurses); chest A (male) (5 nurses), and B (female) (6 nurses); and general medical G4 (6 nurses).

**Tools of the study:**

I. **Exploratory phase tools:**

1. **Leadership Practices Inventory (LPI):** it was used to assess leadership behavior of nurse manager by herself and observers (staff nurses). It measures five leadership practices consistent with transformational leadership style, including behaviors associated with: modeling the way, inspiring a shared vision, challenging the process, enabling others to act, and encouraging the heart.

2. **Workgroup Climate Assessment (WCA):** it was used to measure change in assessment of workgroup climate. It includes two dimensions of perceptions, climate composed of clarity, support and challenge; productivity and quality perceptions.

3. **Performance Appraisal tool (Leader View 360):** it was used to assess performance effectiveness of leaders. It is consisted of seven job performance factors, namely: problem solving, planning, controlling, managing self, managing relationships, leading, and communicating.

4. **Staff Nurse Performance Questionnaire:** developed by the researcher based on their job description and review of related literature; in order to assess job performance behaviors of staff nurses. It consists of behaviors grouped into four performance dimensions, namely: research, education, professional development, and clinical skills.

II. **Planning, development and implementation of a first-line nurse managers leadership development training program tools:**

   a. **Content topics of the program were:**
      - **General introduction:** (Concept of leadership and leader, importance of leadership, principles of leadership, and differences between manager and leader);
      - **Model the way:** (Goal setting, action plan, and decision making);
      - **Inspire a shared vision:** (Vision and mission, and interpersonal communication skills);
      - **Challenging the process:** (Problem solving, innovation, and risk taking);
      - **Enabling others to act:** (Team building and teamwork, and coaching);
      - **Encouraging the heart:** (Setting priorities and creativity).

   b. **Needs assessment questionnaire:** was developed to assess first-line nurse managers' needs for leadership development training program and their educational preparation.
c. **Knowledge test (pre, post and retention test):** A questionnaire was developed based on review of current related literature to collect data related to first-line nurse managers' level of knowledge regarding leadership development at the beginning, end and after three months of the training program's implementation.

d. **Teaching sessions and time schedule:** which were developed.

III. **Evaluation of the first-line nurse managers' leadership development training program:**

   a. **Participants' reaction form:** A structured questionnaire form was developed based on review of current related literature to evaluate the outcome of the program from the first-line nurse managers' points of view. It included 12 questions that measure the strong and weak points of the objectives, time period, contents, time schedule of the program and methods of teaching used.

   b. **Knowledge test (post and retention test):** that was used before the program implementation, was used again at the end of the program and later after three months from program implementation.

   c. **The four tools that were used in the exploratory phase:** for the assessment of Leadership Practices, Workgroup Climate, Performance Appraisal tool for first-line nurse managers, and Staff Nurse Performance; were used twice – at the end of the training program and later after three months from program implementation – to validate the effect of the program mainly on the first-line nurse managers' leadership practices, workgroup climate, leader performance appraisal, and staff nurses performance.

**METHOD:**

1. The research tools were translated into Arabic; and tested by 5 experts in the field of study – from Faculty of Nursing, Alexandria University – for its content validity and translation, and accordingly, the necessary modifications were done based on their comments. They were one professor of psychiatric nursing and mental health, one professor of nursing education, one professor of emergency and critical care nursing, and two professors of medical and surgical nursing.

2. The developed questionnaire was tested for reliability using the cronbach’s alpha (internal consistency of the items). For testing stability over time, the adopted and developed tools were tested for reliability (test – retest method) using Spearman's correlation coefficient.

3. Informed consent was obtained from the subjects of the study for collecting needed data and program implementation.

4. A pilot study for the questionnaires was carried out on 3 first-line nurse managers; and 20 staff nurses (10 %) from Students' Health Insurance Hospital, who were not included in the study sample; in order to check and ensure the clarity of the questionnaires, identify obstacles and problems that may be encountered during data collection. Based on the findings of the pilot study, no modification was done.

5. **Data collection:**

   i. **Exploratory or Assessment phase:** Data were collected by the researcher after obtaining an official permission from the director of the Health Insurance North-West Delta Branch, and the hospital administrators to collect the necessary data.
Meeting with the director of nursing services was conducted by the researcher on an individual basis to explain the objectives of the study and to gain cooperation.

A. Individualized schedule interviews were conducted for first-line nurse managers and staff nurses included in the study to collect data concerning:
   a) The leadership behavior using Leadership Practices Inventory LPI – Self and Observer.
   b) Workgroup climate perception using Workgroup Climate Assessment (WCA).
   c) Performance appraisal of first-line nurse managers using Leader View 360.
   d) Staff nurse Performance appraisal using developed questionnaire.

II. Planning for staff development program:
1. Needs assessment questionnaire was distributed to first-line nurse managers before program implementation, to assess their needs for leadership development training program and their educational preparation.
2. The program was developed based on the result of the exploratory study; needs assessment; as well as review of related literature.
3. The objectives of the leadership development training program were developed as well as designing teaching plans and time plan.
4. Before application of the training program for first-line nurse managers, permission was secured through the hospital director, and the director of nursing services.

III. Implementation of the program:
1. A knowledge test was self-administered to first-line nurse managers at the beginning of the program to collect data related to their level of knowledge.
2. The program was implemented for first-line nurse managers in the training center of Gamal Abd El Nasser Health Insurance Hospital. The following teaching methods were utilized: lectures, discussions, brainstorming, role play, behavior modeling, reflective practice, group work; while computer-based resources (PowerPoint presentations), visual aids (chalk and white boards, and flip charts) and printed materials (handouts and worksheets) were used as teaching media and instructional resources. Daily sessions of 4 hours were given, each session varied from an hour and quarter to an hour and a half. The program in the hospital was carried out in a one week period for each group of first-line nurse managers, who were divided into two groups (medical and surgical).

IV. Evaluation of the leadership development training program: Evaluation of the program was carried out immediately after program implementation and after three months from implementation for first-line nurse managers using the following steps:
1. Participants' reaction questionnaire, that was distributed immediately after program implementation to reveal first-line nurse managers’ reactions to benefits gained from the program.
2. The knowledge test, which was used at the beginning of the program, was given again to first-line nurse managers at the end of the program; to evaluate the gained knowledge in comparison with the pre-test and, also, it was used after three months from program implementation to identify the participants' retention of knowledge.
3. Assessment tools (The Leadership Practices Inventory LPI – Self and Observer, Workgroup Climate Assessment (WCA), Performance appraisal of first-line nurse managers using Leader View 360, and Staff nurse Performance appraisal using
developed questionnaire), that were used in the exploratory phase of the study, were used immediately at the end of the program and after three months of the program implementation to reveal the changes in first-line nurse managers and staff nurses' behaviors and perceptions towards leadership practices, workgroup climate perception, performance appraisal of first-line nurse managers, and staff nurse performance appraisal.

All data were collected in eight months from November 2007 to July 2008

V. Statistical analysis:
Statistical analyses were conducted using the personal computer with the software SPSS V 13.0 (Statistical Package for the Social Sciences). Graphical presentations were done for data visualization by using Microsoft Excel.

The following were the most important results of the present study:
1. The majority of first-line nurse managers did not attend any training program prior to the present study. The reasons for not attending any program as clarified by most of them were no concern from responsible persons for training the nursing staff and shortage of time. Additionally, all first-line nurse managers mentioned that they wanted to attend the training program to perform better job, to increase knowledge, and to provide quality of patient care.
2. The leadership development training program had positive impact on first-line nurse managers as well as on staff nurses’ perceptions regarding leadership practices, workgroup climate, and performance.
3. Concerning leadership practices, all the components of leadership practices for first-line nurse managers were improved after the program and three months later. “Enabling others to act” was the most self-rated leadership practice by the first-line nurse managers before and after three months of program implementation, and also was the most observed leadership practices by the staff nurses immediately after the program; whereas “modeling the way” was the least rated leadership practice by first-line nurse managers. "Encouraging the heart" was the second most rated leadership practice for all first-line nurse managers and the one leadership practice that was found to be perceived as the first rank by staff nurses. “Challenging the process” was the third rated leadership practice for first-line nurse managers and the last leadership practice observed by staff nurses. “Inspiring a shared vision” was the fourth rated leadership practice for first-line nurse managers and the third leadership practice observed by staff nurses.
4. Regards to workgroup climate, approximately all first-line nurse managers rated their workgroup climate as high, as well as staff nurses. The two groups indicated that clarity, support, and challenge were highly scored before, after and after three months from program implementation. Whereas quality scored moderate for both groups – before program – and after program only for staff nurses and after three months, both groups scored high. However, productivity got a moderate score for the first-line nurse managers – before the program – and after the program for staff nurses, but a high score for the two groups at the other time of program implementation.
5. Regarding leader performance, the highest mean score was found for the components of “controlling” after three months of program implementation, for both groups; whereas “leading” was the second behavior, at immediately after and after three
months of program implementation for first-line nurse managers; while it was the first at immediately after the program for staff nurses. However, first-line nurse managers rated “planning” as the least behavior, before program implementation, the same as staff nurses, who also rated it the least after three months of program implementation. On the other hand, “problem solving was the least rated behavior, immediately after and after three months of program implementation, for first-line nurse managers; and immediately after the program for staff nurses.

6. Pertaining to staff nurse performance, the findings of the present study revealed a high significant difference between the three times of program implementation for the first-line nurse managers and staff nurses, concerning subscales of “research”, “education”, “professional development”, “clinical skills” and total staff nurse performance; with its highest at after three months from program implementation. Across the three times of program implementation, the most rated behavior was “professional development”; whereas the least rated behavior was “research” for both groups.

7. No relationship was found between leadership practices and socio-demographic characteristics of both first-line nurse managers and staff nurses; except for, the last group, the working unit (before program).

8. The knowledge and practices of first-line nurse managers had developed after implementing the training program and the majority of them had retained the knowledge and practices three months later from program implementation.

9. All first-line nurse managers mentioned the clearance of program’s objectives and teaching methods, the adequacy of time allotted to the program and program’s content, the suitability of the program’s time schedule, the adding of new information to the participants’ knowledge and the comfort of the educational climate.

10. Regarding constraints that put off the implementation of knowledge gained, all medical first-line nurse managers stated that it was due to lack of their authority in their own wards and work overload; whereas all the surgical first-line nurse managers indicated that it was related to work overload and shortage of personnel, facilities, equipment and supplies.

11. All medical first-line nurse managers found that "concept of leadership", "action plan", "vision", and "interpersonal communication skills" were very useful topics in the program; compared with approximately all those from surgical units. Moreover, the majority of medical first-line nurse managers found that "decision making", "team building and teamwork", "goal setting", "problem solving", "risk taking", "setting priority", "innovation" and "coaching" were very useful topics. Whereas, the majority of surgical first-line nurse managers found that topics, such as "decision making", "risk taking", and "setting priority" were very useful; also all of them found that "teambuilding and teamwork" were very useful; compared to a minority who viewed that "innovation", "goal setting", "creativity", "problem solving", and "coaching", were somewhat useful topics of the training program.

Recommendations were given, based on the findings of the present study to improve leadership practices/behaviors through increasing the availability of training and education program; providing opportunities to participate in decision-making, research, planning and implementation; continuous participation in professional development, and leadership development program; the use of real organizational issues; and finally encouraging first-line nurse managers to disseminate what was learnt to their staff nurses.
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