Coaching for Clinical Nurse Leaders:

A Mixed Methods Study

Lorraine Thompson

A thesis submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

School of Nursing and Midwifery

Central Queensland University

March 2016

Statement of Original Authorship

I declare that the work contained in this thesis is my own work and has not been submitted in any form for another degree at CQUniversity or other institute of tertiary education. To the best of my knowledge and belief, the material presented in this thesis is original except where due reference is made.

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Abstract

The current health care context is a fast paced dynamic environment with multiple dimensions and stakeholders, all working within fiscal constraints, fewer resources, increasing demands and a global shortage of healthcare staff, particularly nurses. Quality leadership has been shown to be a key factor in creating healthy work environments for nurses and promoting optimum levels of safety and high quality care for patients.

Contemporary health care requires strong leaders and positive role models who will provide leadership, motivate, support and encourage other staff to grow as professionals, assisting them to fully engage with their roles, despite this stressful work environment. To ensure the profession has a constant supply of quality nurse leaders, it is imperative that attention be paid to how individuals in clinical nurse leadership positions are prepared, developed and supported once in their complex roles. However, research paints a less than optimal work context for clinical nurse leaders, detailing a lack of support and professional development for both novice and experienced leaders. Despite the crucial role of clinical nurse leaders within the health care system, there has been very little attention paid to the processes of how clinical nurse leaders are supported and assisted in their development within their role.

This inquiry examined coaching as an approach for supporting and professionally developing clinical nurse leaders within their roles. An explanatory sequential mixed methods design was considered appropriate for this study consisting of a quantitative phase at the outset, followed by a qualitative phase.

The quantitative phase of this research was a pre and post-test study with an eight week coaching intervention. The sample included sixty clinical nurse leaders working in both

private and public organisations. The qualitative phase consisted of in-depth interviews with six clinical nurse leaders who had received the coaching intervention.

Results from the first phase of the inquiry showed that a coaching intervention significantly increased all aspects of clinical nurse leaders' work engagement levels. Additionally, results from using goal attainment scaling showed that all participants attained goals that matched either their best possible outcome (56%) or a better than expected outcome (41%). Clinical nurse leaders were highly satisfied with being coached, rating it as either good or excellent (94%) and most (96%) of the participants indicated that they would work with a coach again if provided the opportunity in the future. Unexpectedly, levels of burnout were also significantly increased.

The second phase of the study expanded on and contextualised the results gained from the first phase, using semi-structured interviews. An overarching theme of Coaching as Professional Development emerged from the data, along with three main themes: Professional Enrichment, Personal and Professional Growth and the Ripple Effect. Clinical nurse leaders enjoyed the safe space, tailored professional development and confidential professional support afforded by coaching. It also assisted them in setting and attaining their professional goals, reflect on their practice and their personal vision for the future. In addition, clinical nurse leaders felt they had attained some personal and professional growth, along with having a positive impact on their team and peers. Some participants experienced time pressures in accommodating the work of coaching into their busy work lives or stress in implementing their action plan. In contrast, others noted the experience to be entirely positive indicating that coaching reduced their stress.

Together the results from both phases of the study provide important insights into the beneficial effect coaching can have for supporting and developing clinical nurse leaders

within their roles. These findings are encouraging and infer that coaching can potentially add value to the profession by offering a tailored approach to professional development, which can provide confidential support and meet the learning needs of both novice and experienced clinical nurse leaders.

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Acknowledgements

I would like to acknowledge all the participants who took part in this study. Despite considerable workloads, they gave me their time and invited me into their personal and professional lives. For that I am truly grateful.

I am indebted to my previous supervisors Dr Kathy Ahern and Dr Mary McMahon at UQ for their supervision, support and guidance in the thesis. The many hours spent clarifying ideas, discussing issues and reading of drafts is much appreciated, as are the lessons I learned on our journey together before Dr Ahern retired.

Special appreciation and thanks go to my current supervisory team Associate Professor Tony Welch and Associate Professor Jennieffer Barr from CQU. I wish to express a deep sense of gratitude to you both, for assisting me in finishing this journey. Your constant support, enthusiasm, and sense of humour, assisted me in taking the necessary steps towards completion. I thank you from the bottom of my heart. You have been superb mentors for me.

I also wish to acknowledge Ingrid Kennedy for her professional services in formatting the finished thesis. This research higher degree candidature was supported by a Scholarship from the Australian Government's Research Training Program / Research Training Scheme. I gratefully acknowledge the financial support provided by the Australian Government.

A huge thank you also goes to those wise colleagues who shared the PhD experience, offered advice and provided some stimulating discussions during what seemed to be at times, an endless journey. To my friends, particularly Julie, I could not have completed this thesis without you. Your constant support and sense of humour helped me keep it all

in perspective. Your laughter and different points of view kept my spirits up and helped me believe I could do it. Thank you for being there and encouraging me when I needed it.

Finally I wish to thanks my family for their loving support throughout this long journey. To my son Gordon, thank you for all your thoughtful discussions, critiques and feedback on the work you read. Throughout my PhD you have grown into a wonderful young man and travelled on your own academic and life journey. I am immensely proud of you.

To my loving husband David. I dedicate this thesis to you. I could not have done this thesis without your constant support and love. You were there for me every step of the way; through every draft, every idea, every discussion, through all the agonies and the joys. You lived this PhD as much as I did. It is a shared achievement. Thank you from the bottom of my heart and for believing in me when I didn't believe in myself.

Definitions of Terms

AHPRA: Australian Health Practitioner Registration Authority.

Attention Control Group: The attention control group was only used in the pilot study. The attention control group received only social communication with the coach via telephone over the eight weeks of the pilot study.

Australian Nursing and Midwifery Competency Statements: Framework which guides professional practice within Nursing and Midwifery in Australia.

Burnout: Burnout is measured in this study by a score on the Maslach Burnout Inventory (MBI-HS). The MBI-HS consists of three sub scales that measure dimensions of burnout—emotional exhaustion (9 items), depersonalisation (5 items) and personal accomplishment (8 items). Items are scored on a seven point scale ranging from "never" (0) to "every day" (6). Statistical cut-off points were in line with the MBI-HS Manual (reference). High scores (≥ 27) on the emotional exhaustion and depersonalisation (≥ 13) subscales and low scores (≥ 39) on the personal accomplishment subscale were regarded as indicative of high levels of burnout.

Clinical Nurse Leader: For the purposes of this study, clinical nurse leaders are defined as registered nurses who are currently working in a clinical leadership role. Many different position descriptions expect clinical leadership from the individual in the role, and so the term clinical leader can include, but is not limited to nurses working in advanced practice roles.

Queensland Health (2014) have identified advanced level positions to include the following titles; Clinical Nurse Consultant, Nurse Unit Manager, Nurse Manager, Nurse

Educator, Nurse Researcher, Public Health Nurse and Nurse Practitioner. Definitions of each role are provided below.

Clinical Nurse Consultant (CNC)

A Clinical Nurse Consultant is a Registered Nurse who is accountable at an advanced practice level for the coordination of clinical practice delivered in a clinical specialty and who applies specialised nursing knowledge relevant to area of professional practice; demonstrates sound knowledge of contemporary nursing practice and theory; participates directly or indirectly in the delivery of clinical care to individuals/groups; ensures clinical practice is evidence based to facilitate positive patient outcomes; and has sound knowledge and the ability to apply relevant legislation, guidelines and standards (Queensland Health, 2014, p. 7).

Nurse Unit Manager (NUM)

A Nurse Unit Manager is a Registered Nurse who is accountable at an advanced practice level for the coordination of clinical practice and the provision of human and material resources in a specific patient/client area and who has ability to lead a nursing team in a multidisciplinary environment utilising the principles of contemporary human, material and financial resource management; demonstrates sound knowledge of contemporary nursing practice and theory; participates directly or indirectly in the delivery of clinical care to individuals/groups; ensures clinical practice is evidence based to facilitate positive patient outcomes; and has sound knowledge and the ability to apply relevant legislation, guidelines and standards (Queensland Health, 2014, p. 7).

Nurse Manager (NM)

A Nurse Manager is a Registered Nurse who is accountable at an advanced practice level for the provision of human and material resources either supporting

a division or a specific patient/client area or systems or service and who provides nursing expertise in a specialist area of nursing management (i.e. Patient Flow, Informatics, After Hours Nurse Management); demonstrates sound knowledge of contemporary nursing practice and theory; integrates the principles of contemporary human, material and financial resource management into service delivery; and has sound knowledge and the ability to apply relevant legislation, guidelines and standards (Queensland Health, 2014, p. 7).

Nurse Educator

A Nurse Educator is a Registered Nurse who is accountable at an advanced practice level for the design, implementation and assessment of nursing education programs, managing educational resources and provides nursing expertise relating to educational issues within a nursing service/division/facility/HHS and who integrates the principles of contemporary nurse education into nursing practice; demonstrates sound knowledge of contemporary nursing practice and theory; and has sound knowledge and the ability to apply relevant legislation, guidelines and standards (Queensland Health, 2014, p. 8).

Nurse Researcher

A Nurse Researcher is a Registered Nurse who is accountable at an advanced practice level for the development, coordination, implementation and evaluation of nursing research projects/programs to ensure clinical practice within the designated area is evidence based and who ensures the principles of contemporary research are integrated into nursing practice; demonstrates sound knowledge of contemporary nursing practice and theory; and has sound knowledge and the ability to apply relevant legislation, guidelines and standards (Queensland Health, 2014, p. 8).

Public Health Nurse

A Public Health Nurse is a Registered Nurse appointed to that position who is accountable at an advanced practice level for surveillance, prevention and control of communicable disease at a population level across multiple HHSs and who applies specialised nursing knowledge to the prevention and control of communicable diseases; participates directly and/or indirectly in the investigation, contact tracing and management of individuals and groups who have communicable disease or have had a potential exposure; participates in multidisciplinary, intersectorial teams to develop whole of population strategies to manage and contain disease outbreaks that are a threat to public health; provides education and advice to internal and external health service providers on prevention and control of communicable disease including immunisation; ensures practice is evidence based to facilitate positive outcomes for the individual, community and population; demonstrates sound knowledge of contemporary nursing practice and theory; and has sound knowledge and the ability to apply relevant legislation, guidelines and standards" (Queensland Health, 2014, p. 8).

Nurse Practitioner (NP)

A Nurse Practitioner is a Registered Nurse appointed to that position and who has been endorsed to practise as a Nurse Practitioner by the Queensland Nursing Council. A Nurse Practitioner is educated to function autonomously and collaboratively in an advanced and expanded (or extended) clinical role. The role includes assessment and management of clients using nursing knowledge and skills and may include, but is not limited to the direct referral of clients to other health care professionals; prescribing medications; and ordering diagnostic investigations (Queensland Health, 2014, p. 8).

Clinical Nurse

The Clinical Nurse/Midwife is a Registered Nurse/Midwife who has a broad developing knowledge in professional nursing issues and a sound specific knowledge-base in relation to a field of practice. A Clinical Nurse/Midwife is responsible for a specific client population, and is able to function in more complex situations while providing support and direction to a Registered Nurse and other non-registered nursing personnel. The Clinical Nurse/Midwife identifies, selects, implements and evaluates nursing interventions that have less predictable outcomes. The Clinical Nurse/Midwife is able to demonstrate the following; advanced level clinical skills and problem-solving skills; planning and coordination skills in the clinical management of patient care; ability to work without a collegiate/team structure; awareness of and involvement with quality; and contribution to professional practice related to area of expertise (Queensland Health, 2014, p. 6).

Coach: A person conducting the coaching who is familiar with the methods and strategies used in the process of coaching, and who has a recognised coaching qualification.

Coachee: Coachee, a recognised term in the coaching industry (Wilson, 2011) is for the purposes of this study, a clinical nurse leader, who is receiving coaching.

Coaching: The coaching intervention consists of up to eight weekly, one hour coaching sessions which focus on participants' progression towards achieving their stated professional goals. Coaching mode is by telephone with email support as required.

Control Group: The control group were clinical nurse leaders, randomly assigned to a group which did not receive the coaching intervention. This group completed the online

pre-test once enrolled in the study and then completed the online post-test eight weeks later. In this group, there was no contact with the researcher/coach over the eight weeks of the study.

Goals: Specific objectives set by participants during coaching, to achieve a desired level of professional practice within an eight-week time frame.

Goal Attainment Scaling: GAS is a method used to describe the attainment of goals. It is a descriptive measure of goal attainment that gives recognition to the fact that goal attainment can vary even within the same individual. The scale has five levels to provide specific reporting of progress towards goals, rather than a discreet reporting that the goal has either been attained or not. GAS has been widely used in health care, particularly in rehabilitation settings. The scale is detailed below.

0 = expected outcome

+1 = better than expected outcome

+2 = much better than expected outcome

-1 = less than expected outcome

-2 = much less than expected outcome

Goal Statement: A goal statement is a clearly defined description of the individual's goal. It describes the specific SMART elements of the goal.

GROW Coaching Model: The GROW model (Whitmore, 2002) is a framework which can be used to guide the coaching process. Goal, Reality, Options and Will, describe the steps used by the coach in identifying the coachee's goal, clarifying the reality of the

current situation, the options available to achieve the goal and the actions that the coachee will take to achieve the goal. The GROW acronym is a commonly used framework in coaching.

Intervention Group: The intervention group were clinical nurse leaders, randomly assigned to a group which received the coaching intervention. This group completed the online pre-test once enrolled in the study and then received weekly coaching via telephone with the coach/researcher for eight weeks of the study. Once coaching was finished at eight weeks, this group then completed the online post-test.

Model of Self-Regulation: The generic model of goal-directed self-regulation by Grant (2003, 2012a) is a visual representation of the various steps in the self-regulation cycle. It is a process whereby individuals identify the issue to work on, set a goal, develop an action plan and then take action on that plan. The model has processes where progress is monitored, and what is working/not working is evaluated. Plans are then changed to do more of those actions which are working and less of those actions that are not working.

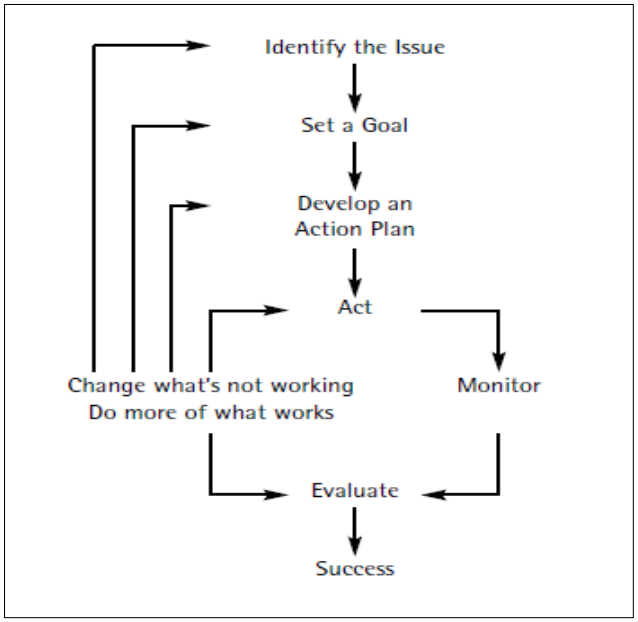

Figure 1: Generic Model of Goal-Directed Self-Regulation (Grant 2003, 2012a)

SMART: is an acronym that is composed of the various elements involved in setting a goal. According to the acronym, the goal must be Specific, Measurable, Agreed, Realistic, and Time bound. SMART is a widely-known acronym and it is widely used in business and coaching.

Self-Identified Work Related Topic: An area of professional practice that is chosen by participants for professional development purposes. Possible examples include, but are not limited to; time management, interpersonal relationships, clinical skills, education and team work

Social Communication: Social communication is a general work related conversation, which does not focus on goals, progress towards goals or professional development. The social communication occurs via telephone.

Work Engagement: Work engagement is measured in this study by a score on the 17 item Utrecht Work Engagement Scale which consists of three subscales that measure the dimensions of work engagement: Vigor (6 items), Dedication (5 items) and Absorption (6 items). The scale has seven points and scoring is classified from very low to very high. Cut-off scores are as per UWES Manual (Schaufeli and Bakker 2003) from very low (<1.93) to very high (>5.54). Scores between 3.07 and 4.66 were regarded as average work engagement.

Chapter 1.

Contextualising the Study

1.1 Introduction

Clinical nurse leaders are experiencing increasing demands within their role, which has the potential to impact negatively upon them, their staff and patient outcomes. This thesis argues that it is of pivotal importance to support clinical nurse leaders in their role, and that coaching is a valuable intervention to provide support and personal and professional development for individuals in these roles. This inquiry was implemented to determine the extent that coaching supports and develops clinical nurse leaders.

The purpose of this first chapter is to contextualise the study. This chapter commences by providing a picture of the current health care climate to illuminate the context within which contemporary health professionals operate. Firstly, the global shortage of nurses is addressed, followed by a discussion on the ageing workforce. This leads on to a discussion on the diminishing supply of new nurses and the increasing demands for services. The chapter moves on to discuss the departure of nurses from the profession and the loss of younger nurses from the workforce. The importance of leadership at the clinical level is then addressed, leading into a description of the research problem, the aim of the study and finishing with an overview of the structure of the thesis.

1.2 Background: The Current Health Care Climate

1.2.1 Global shortage of nurses. There is currently a global labour shortage. According to the McKinsey Global Institute (Dobbs et al., 2012), forces of demand and supply are shaping the global workforce. They report that mismatches between what employers require and what potential employees can offer, are causing imbalances in advanced economies and are likely to have similar effects in developing economies. In

this climate, it appears that many employers are experiencing difficulty in filling jobs due to a lack of available talent (ManpowerGroup, 2013).

The nursing profession is facing exceptional challenges with regards to the shortage of labour. The diminishing number of available nurses, is now a well-recognised global phenomenon (Buchan, Twigg, Dussault, Duffield, & Stone, 2015). According to the WHO, by 2035 there will be a global deficit of 12.9 million health care workers, including doctors, nurses and midwives (Campbell et al., 2013). Nurses are the largest group of health care professions (Australian Health Practitioner Regulation Agency [AHPRA], 2012; World Health Organisation [WHO], 2013) providing the majority of health care (up to 80%) in some countries (International Council of Nurses [ICN], 2007). As such, nursing shortages on such a scale can have immense implications on attaining global health targets (Campbell et al., 2013; World Health Organisation [WHO], 2006).

This worldwide trend of shortages is also reflected in the Australian nursing context, with future predictions regarding the nursing workforce considered to be dire. Health Workforce Australia (HWA) have provided supply and demand projections of the Australian nursing workforce modelled on a number of different scenarios. The nursing shortfalls will still be substantial in the year 2025, ranging from a low 14,770 to a high 147,250 depending on the modelling scenario chosen (Health Workforce Australia [HWA], 2012a, 2012b). In essence, there is a very real potential for the extensive nursing shortages to impact negatively on the quantity and quality of health care provision within society if they are not addressed urgently.

The nursing shortage is a complex situation, with an aggregation of multiple social and epidemiological factors, resulting in a health care context which has an ongoing diminishing supply of nurses and an increasing demand for services as the Australian

population increases and ages. Ageing results in additional health challenges and with the increasing number of those experiencing chronic illnesses rising demands on health services is related to an ageing population (Australian Institute of Health and Welfare [AIHW], 2014). Of major concern is the ageing nursing workforce.

1.2.2 The ageing workforce. As the baby boomer generation nears retirement age, the anticipated numbers leaving the nursing profession globally are projected to increase over the next 20 years. According to a United Kingdom Royal College of Nursing labour market survey (Buchan & Seccombe, 2011) one in three registered nurses in the UK is now aged 50 years or over, and it is estimated that approximately 180,000 UK nurses are due to retire in the next 10 years (European Federation of Nurses Associations, 2012). USA and Canada report similar statistics, with the largest group of nurses aged between 45-54 years and projected shortages to continue increasing for the next 10 years and beyond (Canadian Federation of Nurses Unions, 2013; Juraschek, Zhang, Ranganathan, & Lin, 2012).

A similar situation exists in Australia where the average age of the nursing and midwifery workforce is increasing. In 2012 the largest group of Australian nurses and midwives were aged between 45-54 years, with an average age of approximately 44 years (Australian Institute of Health and Welfare [AIHW], 2013). The proportion of older nurses in the current workforce has increased with 39.1% of the workforce now over 50 years of age and 44.6% aged 45 years and older, with the next largest group (42.3%) being 35 to 44 years of age (Australian Institute of Health and Welfare [AIHW], 2012). Data from Queensland also reflects these national trends, with more than half of the nursing workforce (50.4%) reported to be 45 years and older (Health Workforce Australia [HWA], 2012b). Many of these experienced nurses are also due to retire in the next ten

years making future workforce projections for Queensland and Australia, grim. Compounding this situation is the diminishing numbers of new nurses entering the profession.

1.2.3 The diminishing supply of new nurses. Workforce projections from the training pipeline analysis, to the year 2025, show that Australia requires approximately 15,000 to 23,000 newly qualified nurses per year to meet the growing demands (Health Workforce Australia [HWA], 2012a). However, higher education statistics consistently report below this level, with student completions for registration as a nurse recorded at 10,072 in 2011; 10,635 in 2012; 11,084 in 2013; and 11,640 in 2014 (Department of Education and Training, 2014, p. 19). Despite additional government funding to increase the volume of newly qualified nurses entering the workforce, consensus is, that increasing training capacity alone cannot be relied upon as the only strategy for addressing this shortage of nurses (Health Workforce Australia [HWA], 2012a).

This situation is further exacerbated by an increasing demand for services as the Australian population continues to increase in both size and diversity.

1.2.4 Increasing demands for services. The population of Australia is currently over 23 million and the annual growth rate for 2014 (1.6%) was above the world growth rate (1.1%) and projected to remain above 1% for the next 18 years (Australian Bureau of Statistics, 2014). As the population increases, so does the proportion of older adults and the subsequent demand for nursing services. In Australia, the population aged 65 years and over is projected to increase rapidly from 3.2 million (14% of the population) in 2012 to approximately 5.8 million (19.4% of the population) in 2031 (Australian Bureau of Statistics, 2014). Older adults are also living longer, with life expectancy

estimated at 84 and 87 years for males and females respectively (Government Statistician, 2013). As the projected numbers of people aged 85 years and over is expected to double within 20 years (Australian Bureau of Statistics, 2014), there will be increased demands for health service provision, as the elderly, particularly those over 85 years, are large consumers of health care services. One in five of those over 85 years of age have a severe disability and require assistance with activities of daily living (Australian Institute of Health and Welfare [AIHW], 2011) and total health expenditure per person is greatest for those aged 85 years and over (Australian Institute of Health and Welfare [AIHW], 2010). This increasing demand for services, compounds the diminishing supply of nurses, which is worsened by the premature exit of nurses from the profession, creating a situation that urgently needs to be addressed.

1.2.5 The departure of nurses from the profession. The premature departure of nurses from the profession has been identified as an issue and multiple studies have examined nurses' intentions to leave the profession (Flinkman, Laine, Leino-Kilpi, Hasselhorn, & Salanterä, 2008; Hasselhorn, Tackenberg, Müller, & NEXT study group, 2005; Parry, 2008; Zurmehly, Martin, & Fitzpatrick, 2009). One of the largest studies into this issue was a longitudinal study, the Nurses Exit Study (NEXT), across ten European countries which investigated the reasons, circumstances and consequences surrounding the premature departure of nurses from the profession (NEXT-Study Project Team, 2009). Multiple large studies (Flinkman et al., 2008; Gould, Fontenla, Anderson, Conway, & Hinds, 2003; Hasselhorn et al., 2005; Heinen et al., 2013; Simon, Müller, & Hasselhorn, 2010), were conducted by the NEXT researchers, providing strong evidence on the extent of the issue. For example, Heinen et al. (2013) in their study across 10 European countries found that overall, 9% of nurses intended to leave their profession early, varying from 5% to 17% between countries. Similarly, Simon et al. (2010) in their

study of 2,119 nurses across 16 hospitals in Germany, found that 18% (n=379) of the nurses in his study considered leaving the profession. In a similar vein, Hasselhorn et al. (2005) in their study across 10 countries and 39,689 nurses, revealed that the vast majority of nursing staff leave the profession prior to retirement. This is consistent with other studies that have reported nurses' intentions to exit the profession early (Borowski, Amann, Song, & Weiss, 2007; Boumans, De Jong, & Vanderlinden, 2008; Pike, Barker, Beveridge, & McIlroy, 2011).

Much research has also been conducted on nurses' intentions to leave their current employment (Bowles & Candela, 2005; Chan, Luk, Leong, Yeung, & Van, 2009; Ma, Lee, Yang, & Chang, 2009; Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2010) and their reasons for doing so. Studies reveal a myriad of reasons for leaving including a lack of job satisfaction (Applebaum, Fowler, Fiedler, Osinubi, & Robson, 2010; Ma et al., 2009; Zurmehly et al., 2009), excess workloads (Takase, Oba, & Yamashita, 2009), stress and burnout (Leiter & Maslach, 2009; Meeusen, Van Dam, Brown-Mahoney, Van Zundert, & Knape, 2011), interpersonal relationships (Moore, Leahy, Sublett, & Lanig, 2013; Tourangeau, Cranley, Laschinger, & Pachis, 2010), poor team work (Estryn-Behar et al., 2007; Gardner, Thomas-Hawkins, Fogg, & Latham, 2007), poor communication (Apker, Propp, & Zabava Ford, 2009), disillusionment (Eley, Eley, & Rogers-Clark, 2010), leadership style (Raup, 2008), low job control (Chiu, Chung, Wu, & Ho, 2009), the quality of patient care (Flinkman et al., 2008; Gardner et al., 2007) including delayed tasks (Duffield, Roche, O'Brien-Pallas, Catling-Paull, & King, 2009), insufficient resources (Tourangeau, Cummings, et al., 2010) and the psychosocial work environment (Li et al., 2010; Roche, Diers, Duffield, & Catling-Paull, 2010). Work/family problems and family needs also contribute to nurses' decisions to leave their jobs (Estryn-Behar, 2010). Given that the majority of nurses continue to be female (ABS, 2013) and that

women on average spend more time caring for young children (Baxter, 2013) and being primary carers of older family members (ABS, 2015), issues of child rearing and kinship responsibilities have also been shown to have an influence on intentions to leave. Personal factors such as these continue to be important for nurses in leadership positions, even at executive level (Moran, Duffiled, Donoghue, Stasa & Blay, 2011). In a report by the American College of Health Executives (2006), results showed that 31% of female executives were a primary caregiver compared to only 1% of male executives. Family-related variables and work-family conflict have been shown to be strong predictors of nurses' intentions to leave their organisation (Nei, Snyder & Littwiller, 2014; Yamaguchi, Inoue, Harada & Oike, 2016).

These studies provide a picture of a work context that has the capacity to leave many staff stressed and dissatisfied with their jobs, potentially culminating in burnout and exit from jobs or the profession. Of particular concern is the loss of younger nurses from the profession.

1.2.6 The loss of younger nurses from the profession. It is concerning that staff from the youngest generation of nurses, have considered leaving the profession. Flinkman et al. (2008) in their study of 147 RNs under the age of 30 years, found that 26% of young nurses had often thought of giving up nursing in the previous year. Hasselhorn et al. (2005) in their European study found that intention to leave the profession ranged from 6.8% to 36.2% across 10 countries, with nurses in the 25-35 age group being the largest group intending to leave the profession. Similarly, Barron and West (2005) found that younger nurses were more likely to leave the profession than older nurses. Also, Kuokkanen, Leino-Kilpi, and Katajisto (2003) reported that leaving the profession, had been considered more often by nurses in the 21-40 age group, than by those over 40 years.

The loss of staff from the profession particularly the younger generations is worrisome, particularly as the majority of the workforce ages and heads toward retirement. The nursing workforce is in danger of shrinking considerably over the next ten years, particularly if the dual trends of losing new graduates and the early exit of experienced nurses continues. Strong leadership is required in this demanding health care environment.

1.3 The Importance of Leadership

The current health care context requires strong leadership and positive role models who will motivate and support staff to remain and grow in their professional roles, despite this stressful work environment. Quality leadership at all organisational levels has been recognised as one of the essential elements in creating a healthy work environment for nurses (Kramer, Schmalenberg, & Maguire, 2010).

Creating a positive work environment is important for clinical nurse leaders as it has been linked to the quality of patient care (Kanste, Kyngäs, & Nikkilä, 2007). Research has also consistently related the quality of nurses' work environments to their job satisfaction (Coomber & Barriball, 2007; Cortese, 2007; Gardulf et al., 2008) and to staff turnover (Hauck, Quinn Griffin, & Fitzpatrick, 2011; Heinen et al., 2013; Li et al., 2010). In essence, the work environment clinical nurse leaders create plays an important role in the recruitment and retention of staff (Pearson et al., 2007).

Crucial elements needed for a positive work environment are personal working relationships and an individual leadership style that matches staff's needs. Leadership styles can also influence staff nurse job satisfaction (Larrabee et al., 2003; Malloy & Penprase, 2010). Transformational leadership styles, where the leader builds trust, demonstrates integrity, inspires others, encourages thinking and coaches their staff

(Avolio, 2011; Avolio & Bass, 2004) have been positively correlated with the psychosocial work environment for nurses (Malloy & Penprase, 2010). A predominant transformational style and a component of transactional style where leaders focus on rewarding achievement (contingent reward), have been negatively correlated with burnout (Kanste et al., 2007) and stress (Sabine Stordeur, D'hoore, & Vandenberghe, 2001). Cheng, Bartram, Karimi, and Leggat, (2016) studied transformational leadership and its impact on the team climate, intentions to leave, burnout and quality of patient care. Their results found that transformational leadership had a direct negative relationship with burnout and a direct positive relationship with team climate. Indirect relationships were also found between social identity and both turnover intentions and patient care. Essentially when leaders adopt a transformational leadership style they have the potential to positively influence the social climate, nurses' perceptions of care and turnover intentions. Results also show that show that teamwork was stronger and burnout was reduced when leaders adopted a transformational leadership style.

In contrast, the passive avoidant leadership styles where leaders focus on punishment or monitoring for mistakes (management by exception-passive) or where they avoid involvement completely (laissez-faire), have been positively correlated with burnout (Kanste et al., 2007). According to Avolio (2011; 2004) effective leaders most frequently display components of transformational leadership, followed by components of transactional (contingent reward, management by exception-active) and less frequently use passive avoidant styles (management by exception-passive, laissez-faire).

Research has demonstrated a relationship between transformational leadership and leadership effectiveness (Al-Mailam, 2004; Judge & Piccolo, 2004; Spinelli, 2006). The current health care context, requires strong leaders who are cognisant of their leadership

style and the professional relationships they are creating, as the relationship with one's direct supervisor has consistently been identified as one of the major reasons for nurses leaving their employment (Heinen et al., 2013; Tourangeau, Cummings et al., 2010).

Clinical nurse leaders who build trust, display integrity, inspire others, encourage thinking, and provide coaching (Avolio, 2011; Avolio & Bass, 2004; Avolio & Gardner, 2005) are likely to be more effective as leaders (Al-Mailam, 2004; Judge & Piccolo, 2004; Spinelli, 2006) and are more likely to be able to create a positive psychosocial work environment for their staff (Malloy & Penprase, 2010).

An important aspect of clinical leadership roles which have responsibilities for staff management is to act as an advocate for their team and patients. A strong leader can use research evidence to demonstrate that staff shortages can lead to poorer staff outcomes, including quality patient care. Quality patient care is important to nurses and it has been found to be an important predictor of job satisfaction for them (Chang, Ma, Chiu, Lin, & Lee, 2009; Kalisch, Tschanen, Lee, & Salsgiver, 2011; Leggat, Bartram, Casimir, & Stanton, 2010). Working with staffing levels perceived to be unsafe, is distressing for nurses (Zuzelo, 2007). Former nurses, when interviewed on the situations and factors that triggered their decision to leave the profession, described the distress they experienced when they were unable to deliver quality care for patients (Cheung, 2004). Similarly, Corley, Minick, Elswick, and Jacobs (2005) reported that over a quarter (25.5%) of nurses in their study, had left positions in the past because of moral distress. Moral distress is also negatively related to job satisfaction (Hamric & Blackhall, 2007) and positively associated with burnout (Corley et al., 2005; Hamric & Blackhall, 2007; Meltzer & Huckabay, 2004). In essence it seems that the way clinical nurse leaders

approach their role, can have either a positive or a negative impact on staff job satisfaction (Duffield et al., 2009; Upenieks, 2003) and ultimately staff retention.

To sum up, quality leadership is an important element in the retention of nurses within the profession (Beatrice, Karen van, & Hans Martin, 2009) and nurse leaders are in a key position to have a positive influence on staff job satisfaction and intentions to leave or stay by the way they perform their role. It is important then, that nursing has strong clinical leaders who are empowered and fully engaged with their roles, acting as powerful role models for their staff and advocates for both staff and patients.

It is against the background previously presented, that a brief description of the research problem is provided. For the purposes of transparency, the process by which the study evolved is now outlined briefly. The process can be sequentially followed throughout the thesis.

As the researcher contemplated the issues facing the nursing profession presented in the background section, the importance of leadership in the health care context became apparent. This led the researcher to consider the issues facing contemporary clinical nurse leaders and the problem for the study clarified. A review of the associated literature identified in greater depth, the specific challenges facing clinical nurse leaders and identified coaching as a promising intervention that could be researched. Following the review of literature, the broader aims of the study and the particular research questions were constructed. Although coaching as a workplace intervention appeared to have promise, the complexity involved when considering a workplace intervention for leaders in the current health care context, invited a pragmatic approach to inquiry. The lack of good quality studies on coaching within the workplace, particularly within nursing, identified the need to demonstrate the impact of coaching and influenced the choice of a

quantitative approach for the inquiry. Unanticipated results from the quantitative study led to subsequently adopting a mixed methods approach to the inquiry and the inclusion of a qualitative phase to explore the first phase results in greater depth. The pragmatics of "real-world practice oriented" inquiry and the argument that a mixed methods approach can provide the best of both worlds were pertinent to this study. Results from both phases of the study are integrated in the discussion chapter and inform the recommendations for education, research and practice. Limitations of the study are identified followed by a summary and conclusion. An overview of the study elements is included in Figure 1.

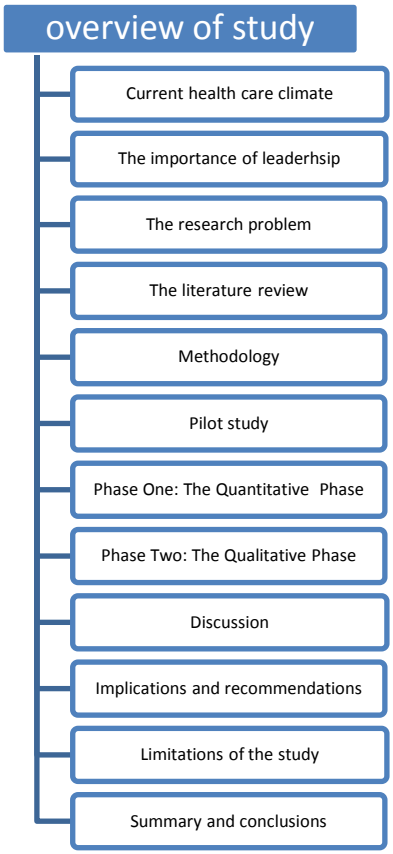

Figure 2*:* Overview of the Study

1.4 The Research Problem

Clinical nurse leaders are under increasing pressure and reports of stress and burnout are not uncommon in the literature (Browning, Ryan, Thomas, Greenberg, & Rolniak, 2007;

Kath, Stichler, & Ehrhart, 2012; Laschinger & Finegan, 2008; Shirey, Ebright, & McDaniel, 2008). However, chronic exposure to job stressors can also lead to burnout syndrome (Maslach & Leiter, 2005) which has been related to a variety of physical (Honkonen et al., 2006; Melamed, Shirom, Toker, Berliner, & Shapira, 2006; Shirom & Melamed, 2005) and psychological (Abdi Masooleh, Kaviani, Khaghanizade, & Momeni Araghi, 2007; Ahola et al., 2005; Peterson et al., 2008; Toppinen-Tanner, Ahola, Koskinen, & Väänänen, 2009) health problems. It has also been shown to have a negative impact on clinical nurse leaders' decision-making processes (Shirey, Ebright, & McDaniel, 2013). In addition to this, stress and burnout have both been related to a lack of job satisfaction and turnover intentions within the nursing profession (Flinkman et al., 2008; Laschinger, Wong, Grau, Read, & Pineau Stam, 2011; Leiter & Maslach, 2009; Meeusen et al., 2011), indicating that stressed nurse leaders are at risk of leaving not only their current positions, but also the profession.

One of the main problems facing clinical nurse leaders is the lack of preparation for their complex role, with nurse leaders reporting learning their role through trial and error or from reading leadership books (Fealy et al., 2011; Kitson et al., 2011; Paliadelis, 2005, 2008; Townsend et al., 2012). Compounding this situation, is the increasing complexity of nurse leadership roles, with multiple reports of role expansion and heavy workloads (Anthony et al., 2005; Duffield et al., 2001; Hutchison & Purcell, 2010; Paliadelis, 2008; Shirey et al., 2013; Wise, 2007). Particularly concerning is the lack of support for nurse leaders and the lack of ongoing leadership development once individuals are in these complex roles (Hutchison & Purcell, 2010; Lang, Patrician, & Steele, 2012; Paliadelis, Cruickshank, & Sheridan, 2007; Suzuki et al., 2009; Townsend et al., 2012). The risk of losing highly experienced, knowledgeable nurse leaders from the health care system remains high, as long as this situation continues to exist.

In addition to the circumstances previously described, is the pressing matter regarding the future supply of nurse leaders. Few of the current nurse leaders are less than 45 years of age (Laschinger & Finegan, 2008) and many are heading for retirement. The lack of current succession planning into leadership roles is concerning. There can be difficulties recruiting new staff into some clinical leadership positions, such as the nurse manager role (Wise, 2007) and reports of short tenure once individuals are in the job (Mackoff & Triolo, 2008a, 2008b). Additionally, there are diminishing numbers of younger staff applying for clinical leadership positions. In light of the urgent need to ensure a future supply of nurse leaders, new ways of preparing, professionally developing and providing support for individuals in clinical nurse leadership roles need to be examined.

Collectively, the research discussed in previous sections highlights the important role clinical nurse leaders play in ensuring quality patient care, staff job satisfaction and retention. However, the evidence presented also suggests there is an emerging crisis with regards to clinical nurse leadership, with stress (Kath et al., 2012; Paliadelis et al., 2007; Shirey et al., 2008; Shirey, McDaniel, Ebright, Fisher, & Doebbeling, 2010), burnout (Laschinger & Finegan, 2008; Suzuki et al., 2009) and intention to leave (Hewko, Brown, Fraser, Wong, & Cummings, 2015; Mullen, Gavin-Daley, Kilgannon, & Swift, 2011; Warshawsky & Havens, 2014) being reported by individuals in these roles. There are also reports of issues in relation to professional development and preparation for these demanding, complex leadership roles along with a lack of support once in the position. Such compelling evidence and a knowledge of coaching, has led this researcher to explore the situation in greater depth. A novel approach to providing support and professional development for clinical nurse leaders is proposed, using coaching to address some of the key issues.

1.5 Aim of the Study

The study aimed to examine coaching as an approach for providing professional development and support for clinical nurse leaders.

1.6 Research Questions

The overarching research question that guided this study was; *How suitable is a coaching approach for professionally developing and providing support for clinical nurse leaders*?

Specific research questions were;

1. To what extent does coaching have an effect on clinical nurse leaders' work engagement levels?
2. To what extent does coaching have an effect on clinical nurse leaders' burnout levels?
3. What is the effect of coaching on clinical nurse leaders' intentions to leave their position or the profession?
4. To what extent does coaching assist clinical nurse leaders to attain their professional goals?
5. What are clinical nurse leaders' perceptions of coaching?
6. To what extent does the qualitative phase of the study explain or enhance the interpretation of results from the quantitative phase of the study?
7. What do the quantitative and qualitative data together reveal about coaching as an approach for developing and supporting clinical nurse leaders?

1.7 Hypotheses

The following hypotheses were tested in this study.

Work Engagement

There will be no difference in the work engagement scores (Vigour, Dedication and Absorption) of clinical nurse leaders who have undergone coaching and those who have not.

Burnout

There will be no difference in the burnout scores (Emotional Exhaustion, Depersonalisation and Personal Accomplishment) of clinical nurse leaders who have undergone coaching and those who have not.

Nurse Retention

There will be no difference in intentions to leave (either their position or the profession) of clinical nurse leaders who have undergone coaching and those who have not.

1.8 Structure of the Thesis

Chapter One contextualises the study and illuminates the work context of contemporary health professionals. It goes on to highlight the challenges facing the nursing profession and in particular clinical nurse leaders. The research problem is then presented and the chapter ends by providing an outline of the thesis. Chapter Two, reviews the nursing literature to expand the discussion in chapter one about challenges facing the nursing profession. It examines the issues of stress and burnout in nursing, particularly for those in nurse leadership positions. The consequences of this continual stress for both organisations and individuals are briefly explored before examining the literature on work engagement, conceptually the opposite of burnout. The positive effects of fully engaged staff are explored both for individuals and organisations before strategies for promoting work engagement are explored. Finally, the chapter moves on to explore the literature on coaching, a common approach used in business and other professions, for professionally developing and supporting leaders. What follows is an examination of the literature on

coaching as a potential approach for providing support and professional development among nurse leaders in their roles.

Chapter Three presents the methodology used in both phases of this mixed methods research study. It provides the justification for using a mixed methods approach and discusses the research design framework. Epistemology relating to the inquiry is then followed by the methods used in phase one and phase two of the study, including participants, sample size, intervention and control groups, the coaching intervention and provides an overview of the coaching cycle. The instruments used for data collection are then discussed along with data analysis techniques. This section also includes the ethical considerations for the study.

Chapter Four provides an overview of the pilot study and includes a discussion on the psychometric properties of the three instruments used to evaluate the coaching intervention; the Maslach Burnout Inventory (MBI), the Utrecht Work Engagement Scale (UWES) and the Nurse Retention Index (NRI). This is then followed by pilot testing and development of the coaching intervention, describing in detail the various considerations undertaken when developing the coaching processes. Results of the pilot testing are then provided and information on how the results informed the development of the final version of the intervention.

Chapter Five presents phase one of the study which was the testing of the hypotheses. The chapter includes the results from the quantitative part of the study. In particular, it provides the results on burnout, work engagement and retention. This chapter also includes qualitative comments from the open questions on the questionnaires evaluating the coaching intervention.

Chapter Six presents phase two of the study which was the qualitative portion of the study conducted six months following the coaching intervention. The chapter includes the findings from the qualitative interviews and provides the participants' perspectives on the coaching they received. This chapter also serves to further examine unanticipated findings from the quantitative phase of the study.

Chapter Seven discusses the main findings from both phases of the research integrating them together to answer the research questions set out at the beginning of this inquiry. A synopsis of study findings is then included with a synthesis of existing and new knowledge, followed by an acknowledgement of the study limitations. The thesis then discusses implications and recommendations for education, practice and research, followed by a summary and conclusion.

Chapter 2.

The Literature Review

2.1 Introduction

Chapter two provides a review of the relevant literature pertinent to this study. Firstly, the important role that clinical nurse leaders play within the health system is discussed in relation to patient and staff outcomes. This is then followed by a discussion of the challenges facing clinical nurse leaders including role expansion, heavy workloads, role ambiguity, a lack of support and a lack of preparation for their roles. A definition of burnout precedes a discussion of research which shows how these challenges can turn into burnout for clinical nurse leaders. This is then followed by a discussion on the organisational impact of burnout and leads on to highlight research on intention to leave among clinical nurse leaders. In an attempt to uncover potential solutions to these issues, the literature on work engagement (conceptually the opposite of burnout) is considered. Following a discussion on the concept of work engagement, a brief overview of the attributes of engaged employees is provided. Next is a discussion of research that shows the organisational benefits of having engaged employees. This is then followed by a consideration of engaged clinical nurse leaders and the impact they can have on their staff, the work environment and their colleagues. Literature on the Job Demands Resources (JD-R) model is then discussed to provide insight into the antecedents of work engagement and the factors that can influence work related wellbeing for employees. The chapter concludes with an examination of the literature on coaching as an approach for professional development. The research on workplace coaching is discussed first, and this is followed by a discussion of the research on life coaching and health coaching. Studies on life and health coaching provide insight into coaching and goal attainment, assisting to build a picture of the potential usefulness of coaching as a professional

development activity. Next, the research on coaching within health is discussed, illuminating where coaching has been utilised for leadership professional development purposes, particularly within nursing. The need for coaching research within the nursing literature is described prior to the chapter completing with an outline of the research questions that guided this inquiry.

2.2 Leaders Play an Important Role within Health: Patient Outcomes

As has previously been stated in chapter one, leaders are important players in many aspects of contemporary health care and the way a leader chooses to perform their role can have a positive or negative impact on patients, staff and the work environment generally. The literature below describes a body of evidence that provides a clear connection between leadership approaches and positive outcomes for both patient and staff.

Leadership styles have been related to a variety of positive patient outcomes. For example, significant relationships have been found between patient satisfaction rates and leadership styles (Doran et al., 2004; Havig, Skogstad, Kjekshus, & Romøren, 2011; Kroposki & Alexander, 2006). Leadership styles have also been significantly related to lower patient mortality rates (Capuano, Bokovoy, Hitchings, & Houser, 2005; Cummings, Midodzi, Wong, & Estabrooks, 2010; Houser, 2003; Tourangeau et al., 2007).

Studies have also examined relationships between leadership styles and patient outcomes such as medication errors (Capuano et al. 2005; Houser, 2003; Paquet, Courcy, Lavoie-Tremblay, Gagnon, & Maillet, 2013; Vogus & Sutcliffe, 2011), falls and fractures (Capuano et al., 2005; Houser, 2003; Anderson et al., 2003), reduction of pressure ulcers (Castle and Decker, 2011), lower use of restraints (Anderson, Issel, & McDaniel, 2003;

Castle & Decker, 2011) and lower rates of urinary tract infections and pneumonia (Capuano et al., 2005; Houser, 2003). For example, Paquet et al. (2013), in their correlational study, examined relationships between the psychosocial work environment (work climate, social support, effort/reward imbalance) and quality indicators such as length of stay and medication errors. Results indicated a significant reduction in medication errors. Four perceptions of the work environment had an indirect effect on medication errors and length of stay; social support from supervisor, appreciation of the workload demands, pride in being part of one's work team and effort / reward balance. Similarly, Vogus and Sutcliffe (2011) completed a cross sectional survey of hospital staff (RNs n=1033 and Nurse Managers n=78) in order to examine how safety organising behaviours of RNs impacted patient safety. They analysed medication errors and linked these to survey data on trust in manager and use of standardised protocols (care pathways). Results showed that high levels of trust in the manager coupled with extensive use of care pathways and high levels of safety organising, resulted in significantly fewer reported medication errors. In studies by Capuano et al. (2005) and Houser (2003), both included medication errors in their structured equation modelling to evaluate the work environment (Capuano et al., 2005) and the context of nursing care delivery (Houser, 2003). Both studies reported significant reductions in a variety of patient outcomes including medication errors. Cheng, Bartram, Karimi & Leggat (2016) in their cross sectional study, found that if transformational leaders could positively influence the social identity of their staff, it could have a positive influence on the quality of patient care delivered by nurses.

Finally, Castle and Decker (2011) in their study on leadership style and quality of care, surveyed 3,867 Directors of Nursing and Nursing Home Administrators. Results showed significant associations between leadership and lower incidences of pressure ulcers

(Castle & Decker, 2011). They also showed signfiicantly lower levels in restraint use, patient pain levels and catheter insertion.

Overall these studies demonstrate a consensus that leaders can have a positive impact on patient outcomes. The majority of the studies in this area are quantitative, with only a few randomised controlled trials. The most common design used is correlation or cross sectional studies which cannot provide evidence of causation. Despite this, these studies are still of good quality with quality statistical analysis. The value of the research is that it contributes to our knowledge on the important part leaders play with regards to attaining positive patient outcomes.

2.3 Leaders Play an Important Role within Health: Staff Outcomes

The literature suggests that leaders play an important role with regard to the nursing workforce and an individual's leadership style can influence staff nurses' job satisfaction (Larrabee et al., 2003; Malloy & Penprase, 2010) and transformational leadership styles in particular, have been positively correlated with the psychosocial work environment for nurses (Malloy & Penprase, 2010). A considerable body of evidence exists showing how leadership styles can be a factor in either positively or negatively influencing staff outcomes.

Capuano et al., (2005) in their study of nurse staffing and patient outcomes used survey data and structural equation modelling to evaluate the work environment. Results indicated that strong leaders have more stable staff (lower turnover and vacancy rates) and higher levels of competent and proficient staff (using Benner's novice to expert model). Similarly, Cummings et al., (2010) conducted a systematic review of studies which examined relationships between leadership styles and outcomes relating to the

nursing workforce. Fifty three studies were included in the review which spanned twenty four years (1995-2009). The results of the review showed that nurses' job satisfaction levels were significantly higher when there were leadership styles that focused on people and relationships (Cummings, Hayduk, & Estabrooks, 2005; 2006; Lok, Westwood, & Crawford, 2005; McGillis Hall & Doran, 2007; Sellgren, Ekvall, & Tomson, 2008). Negative leadership styles such as management by exception or task orientated leadership, were significantly associated with lower levels of satisfaction (Cummings et al., 2005; Laschinger & Leiter, 2006; Lok et al., 2005; McGillis Hall & Doran, 2007).

The review results also showed that a positive leadership style has been significantly and positively associated with team effectiveness (Al-Hussami, 2008; Casida & Pinto-Zipp, 2008; Gil, Rico, Alcover, & Barrasa, 2005; Hendel, Fish, & Galon, 2005) enhancing staff wellbeing. Several of the studies showed a significant relationship between positive leadership styles and staff wellbeing including; decreased burnout, particularly emotional exhaustion (Leiter & Laschinger, 2006), decreased job tension (McGillis Hall & Doran, 2007), and significant increases in emotional health (Cummings et al., 2005). Conversely, Cummings et al. (2005) identified that negative leadership styles have shown significant increases in emotional exhaustion. The review by Cummings, MacGregor, et al. (2010) also showed that leadership styles were a major factor in staff turnover and staff nurses' organisational commitment. Conversely, studies have also showed that organisational commitment (Laschinger & Leiter, 2006; Lok et al., 2005; McGillis Hall & Doran, 2007) and decreased turnover (Capuano et al., 2005; Houser, 2003) were both significantly related to leadership styles.

In a similar vein to the above studies, a systematic review by Cowden, Cummings, and Profetto-McGrath (2011) examined the relationships between leadership practices and

staff nurses' intentions to stay. The review consisted of twenty-three studies from a variety of countries including Australia. The studies were assessed to contain either moderate or strong evidence. The results of the review highlighted eight leadership practices including leadership style; manager characteristics; supervisor support; leader power and influence; leader trust; and the leader's use of praise and recognition, which were all positively and significantly associated with nurses' intentions to stay. The majority of the studies, 21 out of the twenty-three, were quantitative studies with correlation designs. Other issues with regard to the studies were relating to a lack of random sampling or low response rates (<60%). However, valid and reliable instruments were used in all of the 23 studies in the review and thirteen studies conducted higher quality analysis using multiple regression, structural equation modelling or hierarchical linear modelling.

Although much of the focus for the studies mentioned above is on the nurse manager, charge nurse or front line manager roles, research by Mullen et al. (2011) concerning clinical nurse consultants indicated that clinical leadership roles other than the nurse manager can have staff reporting to them. Mullen et al. (2011) in their study reported that 64% (n=50) of the participants in the sample managed staff as part of their role as clinical leaders. Although there is little research on this specific aspect of other clinical leadership roles, clinical nurse leaders such as charge nurses, clinical nurse educators, advanced practice nurses, clinical practice leaders and team leaders remain important "go-to" patient safety resources for clinical staff (Tregunno et al., 2009), key roles that can influence factors related to nurse retention. For example, the quality of patient care (Flinkman et al., 2008; Gardner et al., 2007), interpersonal relationships (Moore et al., 2013; Tourangeau, Cummings, et al., 2010), poor team work (Estryn-Behar et al., 2007; Gardner et al., 2007), delayed tasks (Duffield et al., 2009) poor communication (Apker et

al., 2009) and the psychosocial work environment (Li et al., 2010; Roche et al., 2010) have all been related to nurses' intentions to leave.

Leadership has also been related to a climate of patient safety. A study by Thompson et al., (2011) demonstrated that staff perceptions of a safe climate differed significantly between units depending on the leadership style used. Results showed that leaders with high quality relationships were associated with positive staff perceptions of a safety climate. Similarly, Paquet et al. (2013) indirectly related social support from supervisor and other psychosocial factors in the work environment, to patient safety outcomes such as medication errors and length of stay. Vogus and Sutcliffe, (2011) in their cross sectional analysis of medication errors, found that the benefits of safety organising were enhanced when RNs highly trusted their manager, but benefits were significantly diminished when RN trust in their leader was low. The majority of research in this area is quantitative, with correlation or cross sectional studies the most common design used. The above designs are either concerned with providing a snapshot of a particular group or population in relation to the variables of interest, or are concerned with establishing the strengths of relationships between variables, rather than determining cause and effect. However the research studies are still of value as they are generally good quality and provide consistent evidence regarding nurse leaders and the important roles they play in staff outcomes.

Overall, research studies discussed in this section demonstrate that clinical nurse leaders are important and valuable players in the health care team, who assist in attaining positive outcomes for both patients and staff. However, research studies on the work context for clinical nurse leaders reveals a concerning picture with them consistently facing challenges in their roles and working with less than optimal circumstances. As early as

2001, Duffield et al. (2001) raised concerns about nurse managers and their expanding roles and workloads. Fourteen years later, these issues continue to exist, not only for nurse managers, but also for those in other clinical nurse leader roles. The next section reviews the literature, which examines the specific challenges faced by clinical nurse leaders and their current work circumstances.

2.4 Challenges Facing Clinical Nurse Leaders

2.4.1 Role expansion. There is general consensus in the nursing literature that the role of nurse leaders has expanded, diversified and often include multiple role responsibilities (Anthony et al., 2005; Duffield et al., 2001; Hutchison & Purcell, 2010; Meyer et al., 2011; Paliadelis, 2008; Suby, 2010). Evidence on expanding roles can be seen when studies on span of control are examined. Span of Control refers to the number of staff the nurse manager has reporting to them directly as part of their role. Large numbers of staff reporting directly to some nurse managers has been reported in the literature (Laschinger et al., 2008; Lucas, Laschinger, & Wong, 2008; McCutcheon, 2004; McCutcheon, Doran, Evans, Hall, & Pringle, 2009; Meyer et al., 2011). For example, Meyer et al. (2011) reported nurse managers being responsible for 29.0 to 174.3 direct reports, with one third of the managers responsible for 90 or more staff. Similarly, Suby (2010) in a benchmarking report, noted an increase of fifteen direct reports for some nurse managers in the space of one year. Concerns were raised regarding the potential implications of large spans of control as far back as 2001 by Duffield et al. (2001), who argued that expansion of these roles could risk them being ineffective. Since then, evidence to support such concerns has continued to build. For example, a study by Cathcart et al. (2004) found that as a manager's span of control increased, employee disengagement also increased. Higher spans of control have been show to negatively influence nurses' feelings of workplace empowerment (Lucas et al., 2008), job

satisfaction (McCutcheon et al., 2009), satisfaction with leader's supervision (Meyer et al., 2011) and perceptions of their manager's emotional intelligence (Lucas et al., 2008). Wider spans of control have also been associated with intentions to leave, hospital nurse turnover (Laschinger et al., 2008; McCutcheon et al., 2009) and decreased levels of patient satisfaction (McCutcheon et al., 2009).

2.4.2 Heavy workloads. Workloads and responsibilities have expanded considerably for some in clinical leadership roles (Suby, 2010) and scholars (Johnstone, 2003; Hutchison & Purcell, 2010; Wise, 2007) have reported nurse leaders feeling stretched and challenged to meet the requirements of their roles, resulting in them having to take work home to finish it in evenings or weekends (MacPhee, Wejr, Davis, Semeniuk, & Scarborough, 2009). The nurse manager position, in particular, appears to be a demanding, complex role and there have been criticisms that it is unrealistically configured (Shirey et al., 2008; Udod & Care, 2013) with managers having responsibility in areas where they also lack the power to make changes (Paliadelis, 2008). Nurse managers have also reported finding aspects of the job distressing or intolerable due to the political pressures placed on them (Johnstone, 2003).

Nurse managers are not the only clinical nurse leaders with expanding roles or heavy workloads. Clinical nurse consultants (Bloomer & Cross, 2011; O'Connor & Chapman, 2008; Vaughan, O'Baugh, Wilkes, & O'Donohue, 2005) and clinical nurse educators (MacPhee, 2008, 2009) have reported heavy workloads or roles that are too large with competing priorities (Lowe, Plummer, & Boyd, 2013). Coupled with the demands of heavy workloads, as role boundaries expand and new roles continue to be created, role ambiguity becomes an issue.

2.4.3 Role ambiguity. Role ambiguity was found to be one of the best predictors of stress for nurse leaders (Kath, Stichler, Ehrhart, & Schultze, 2013). Role conflict and role ambiguity has been reported for nurse managers (Hutchison & Purcell, 2010;) with concerns expressed that job descriptions differed from the realities of the position (McCallin & Frankson, 2010). Similarly, role ambiguity has also been reported for clinical nurse specialists such as diabetes nurses (Boström, Isaksson, Lundman, Sjölander, & Hörnsten, 2012), and clinical nurse consultants (Franks & Howarth, 2012; McSherry, Mudd, & Campbell, 2007; O'Baugh, Wilkes, Vaughan, & O'Donohue, 2007). Lack of role clarity has also been identified for Nurse Practitioners (Lowe, Plummer, O'Brien, & Boyd, 2012). Role ambiguity is an issue as increased levels of role ambiguity have been associated with higher turnover rates (O'Brien-Pallas, Murphy, Shamian, Li, & Hayes, 2010; Stordeur & D'Hoore, 2007). In addition to issues relating to role ambiguity, there has also been concern about the lack of support for nurses in their leadership roles.

2.4.4 Lack of support for nurse leaders in their role. Clinical nurse leaders play a key role in supporting and retaining staff (Chen, Chu, Wang, & Lin, 2008; Lacey et al., 2007; Lavoie-Tremblay, O'Brien-Pallas, Gelinas, Desforges, & Marchionni, 2008; Nedd, 2005; Sourdif, 2004; Tourangeau & Cranley, 2006), yet research suggests that they themselves lack essential support in their roles. Within Australia, Paliadelis et al. (2007) found that nurse unit managers did not feel supported by the wider organisation. Findings from a study by Townsend et al., (2012) support this and note that hospitals have not yet developed adequate career planning or training for the complex role of the nurse unit manager. Findings also show that while some nurses step into the manager role and require little formal support, others are left floundering. Similarly, Hutchison & Purcell, (2010) reported nurse managers feeling unsupported, isolated and neglected, with support lacking from both senior managers and HR. Similarly, Buchanan and Considine

(2002) reported nurses at all levels including nurse managers feeling unsupported in their roles. In the same vein, Suzuki et al. (2009) reported that from 172 Japanese nurse managers, only 69 reported receiving support from their manager while 103 reported that support from their manager was absent. Kitson et al. (2011) found that all the clinical nurse leaders in the study voiced concerns regarding the lack of consistent support from the organisation. Haycock-Stuart, Kean, and Baggaley (2010) in their qualitative study on emotional labour on community nurse leaders (n=12) in Scotland, reported a lack of emotional support, with leaders masking their emotions to maintain their professional demeanour, feeling unsupported and undermined by senior colleagues, with few having access to emotional support unless they were stressed or unwell. This lack of support is also reported by those in other nurse leadership roles, such as Clinical Nurse Consultants (Bloomer & Cross, 2011; Booth, 2006; Chan, Tam, Lung, Wong, & Chau, 2013; Mullen et al., 2011), Nurse Educators (Sayers, DiGiacomo, & Davisdson, 2011), Clinical Nurse Specialists and Nurse Practitioners (Lowe et al., 2013; Middleton, Gardner, Gardner, & Della, 2011). The evidence indicates that clinical nurse leaders, irrespective of their position or title, generally lack support in their complex roles (Suzuki et al., 2009). This is concerning given the links between a lack of support from management and burnout (Lang et al., 2012; Suzuki et al., 2009), which is discussed in a later section of this review.

2.4.5 Lack of preparation of nurse leaders for their role. For more than ten years, it has been acknowledged that nurses were not prepared well for leadership positions (Duffield et al., 2001). Duffield et al. (2001) compared the profile of nurse unit managers from 1989 and 1999. The majority of participants in both studies (54.6% in 1989 and 57.9% in 1999) reported that they had received no mentoring and fewer had completed formal management training in 1999 (60.9%) than ten years previously in 1989 (69.4%). More than 10 years since these studies, reports of nurses feeling

unprepared for these leadership roles are still evident in the literature (Fealy et al., 2011; Kitson et al., 2011; Paliadelis, 2005, 2008). For example, in a national survey in Ireland, Fealy et al., (2011) found that nearly two thirds of the 3,000 respondents had not received any leadership training for their role and that barriers to professional development existed. Fealy et al. (2011) also reported that participation in clinical leadership training was related to nurses' grade levels, with senior nurses being more likely to attend professional development sessions than lower grades of nurses, although nurses from all grades described experiencing barriers to leadership development. Kitson et al. (2011) also found that few clinical nurse leaders felt prepared for their leadership role and all voiced concerns regarding the lack of consistent support from the organisation. Similarly, Paliadelis (2005, 2008) found that nurse managers felt unprepared for their role, with few of them receiving any formal management training, learning their role through trial and error, reading management books in their spare time or asking for advice from more experienced nurse unit managers (Paliadelis, 2005).

Finally, Townsend (2012) interviewed fourteen nurse managers regarding their roles. Most indicated that they fell into the role accidentally and did not have an administrative or management career paths planned when they entered their role. Additionally, most nurse unit managers felt they were totally unprepared for their roles and were left unsupported to either "sink or swim" (Townsend, 2012).

Overall, the research on clinical nurse leaders paints a picture of a less than optimal work context for them. The expansion of roles and responsibilities, increasing spans of control, heavy workloads, role confusion, role ambiguity, lack of preparation for their role and a lack of support are all factors increasing demands on the individuals in these roles, which have been found to contribute to role stress and potentially to burnout (Maslach & Leiter,

1997). The next section provides a very brief outline on stress and burnout within health services, followed by an examination of the literature in relation to stress and burnout in clinical nurse leaders.

2.5 Definition of Burnout

Burnout, "a psychological syndrome ... experienced in response to chronic job stressors" (Day & Leiter, 2014), is a well-recognised phenomenon in health. Burnout was first described in the health literature in the United States of America (USA), where researchers (Freudenberger, 1974; Maslach, 1976) described symptoms of exhaustion and fatigue in health service staff. Since then burnout has been researched widely, indeed, Schaufeli, Leiter, and Maslach (2009) reviewed 35 years of burnout research and estimated that since the 1970s, more than 6,000 books, book chapters, journal articles and dissertations have been published on the subject. Early research on burnout in the 1970's focused on health service personnel as reflected in the initial definition of burnout as "a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people-work' of some kind" (Maslach & Jackson, 1981, p. 99).

Since then, research on stress and burnout has extended into other occupational groups including teachers, fire fighters, prison workers, engineers, financial dealers, emergency service personnel, oil rig labourers/drillers and entrepreneurs (Langan-Fox & Cooper, 2011) confirming that burnout is not solely related to health professionals. The wider application of the term "burnout" to other professions is reflected in a later definition as "... a state of exhaustion in which one is cynical about the value of one's occupation and doubtful of one's capacity to perform" (Maslach, Jackson, & Leiter, 1996, p. 20). The decades of research on burnout, within a variety of workplaces and professions confirm

that burnout is a well-recognised common phenomenon within the contemporary workplace.

2.6 When Challenges Turn into Burnout

Burnout is considered to be a reaction to chronic job stress (Salanova, Agut, & Peiro, 2005; Schaufeli & Taris, 2005). Clinical nurse leaders have consistently reported stress relating to their roles (Kath et al., 2012; Paliadelis et al., 2007; Shirey et al., 2008; Shirey et al., 2010; Udod & Care, 2013). Maslach and Leiter (1997) identified six areas or work life that can produce stress and subsequent burnout: excessive workloads, lack of control, insufficient rewards, lack of community, feelings of unfairness and conflict in values between the individual and the organisation. Clinical nurse leaders report many of these factors in their work environments, particularly heavy workloads (Bloomer & Cross, 2011; Lee & Cummings, 2008; O'Connor & Chapman, 2008; Vaughan et al., 2005) with reports of them feeling overwhelmed by the scope of their roles (Paliadelis, 2008). Role overload is commonly reported in these clinical leadership positions (Booth, 2006). A study by Kath et al. (2012) identified that role overload was the most important predictor of stress in nurse managers.A perceived lack of support from management has also been linked to emotional exhaustion, one of the main components of burnout (Lang et al., 2012). Similarly, Suzuki et al. (2009) studied burnout in 172 nurse managers in Japan and found significant differences between the burnout and non-burnout groups in relation to support from bosses, peers or social support. Laschinger and Finegan (2008) found that both personal and situational factors influenced nurse manager burnout over a one year time frame. Factors such as an effort reward imbalance and core self-evaluations were found to significantly contribute to nurse manager burnout. Interestingly in this study (n=134), at Time one, 50% of the nurse managers were in the severe burnout category and one year later at Time 2, 66% were in this category.

2.6.1 Organisational impact of burnout. There are organisational impacts of having employees who are suffering from chronic stress and burnout. Previous research has related burnout to a variety of organisational outcomes including high absenteeism levels (Ahola et al., 2008) chronic work disability (Ahola et al., 2008; Ahola, Toppinen-Tanner, Huuhtanen, Koskinen, & Väänänen, 2009) and future sickness absence due to mental health and musculo-skeletal disorders (Toppinen-Tanner, Ojajärvi, Väänänen, Kalimo, & Jäppinen, 2005). In Australia, it is estimated that stress related absenteeism directly costs Australian employers $3.48 billion per year and that total costs to the Australian economy are $5.12 billion a year (Medibank Private, 2008).

Burnout has also been related to other organisational outcomes such as poor job performance (Taris, 2006), low job satisfaction (Laschinger et al., 2011), and increased turnover intentions (Flinkman et al., 2008; Fochsen, Sjogren, Josephson, & Lagerstrom, 2005; Leiter & Maslach, 2009; Meeusen et al., 2011). Health care organisations' other priorities such as patient safety, has also been found to impact negatively by having stressed and burnt out staff (Cimiotti, Aiken, Sloane, & Wu, 2012; Halbesleben, Wakefield, Wakefield, & Cooper, 2008). Burnout in nurses has been associated with reduced patient safety (Halbesleben et al., 2008) and has been significantly associated with patient infections such as urinary tract infections (UTI) and surgical site infections (Cimiotti et al., 2012). In one study, hospitals where nurse burnout was reduced by 30% had a total of 6,239 fewer infections at a reduced cost with annual cost savings of $68 million (Cimiotti et al., 2012). Several studies (Garman, Corrigan, & Morris, 2002; McHugh, Kutney-Lee, Cimiotti, Sloane, & Aiken, 2011; Vahey, Aiken, Sloane, Clarke, & Vargas, 2004) have also shown that nurse burnout can have a negative impact on patients' satisfaction with their care. Patient satisfaction levels are lower in hospitals or units

which have more burnt out or dissatisfied nurses (McHugh et al., 2011; Vahey et al., 2004) or where team burnout exists (Garman et al., 2002).

The previously discussed research suggests that burnout can have multiple consequences for organisations. Yet there is a lack of research on specific strategies to reduce burnout, particularly relating to clinical nurse leaders. Evidence suggests that in the context of pervasive nursing shortages, the urgent need to retain staff and the documented links between burnout and staff turnover (Leiter & Maslach, 2009), organisations would benefit from investing in strategies to reduce levels of burnout, not only for their own interests as an organisation, but to facilitate quality care, patient satisfaction and reduce staff intentions to leave.

2.6.2 Intention to leave in clinical nurse leaders. Clinical nurse leaders in a variety of leadership roles have expressed their intentions to leave either their positions or the profession and there have been a variety of reasons for this intention to leave (De Milt, Fitzpatrick, & McNulty, 2011; Doran, Duffield, Rizk, Nahm, & Chu, 2014; Lamarche & Tullai-McGuinness, 2009; MacPhee et al., 2009; Skagert, Dellve, & Ahlborg, 2011; Skytt, Ljunggren, & Carlsson, 2007; Warshawsky & Havens, 2014). Stress and burnout have been reasons cited as reasons for clinical nurse leaders expressing intentions to leave their jobs. Nurse managers have consistently reported stress (Johansson, Sandahl, & Hasson, 2013a; Kath, Stichler, Ehrhart, & Schultze, 2013; Shirey et al., 2008; Shirey et al., 2013; Shirey et al., 2010) and burnout (Browning et al., 2007; Laschinger & Finegan, 2008; Suzuki et al., 2009; Warshawsky & Havens, 2014) in their roles, as have nurses in other leadership roles (MacPhee et al., 2009) like the Clinical Nurse Consultant (CNC) (Mullen et al., 2011).

Nurse managers have reported acting as shock absorbers for their staff within the hierarchy; however, to cope with their own stress within the role, they distanced themselves. The way they did this was to have a plan to exit from their position (Skagert, Dellve, Eklöf, Pousette, & Ahlborg Jr, 2008). A lack of job satisfaction has been reported by clinical nurse leaders and strong associations have been identified between job satisfaction and intentions to leave (AbuAlRub & Alghamdi, 2012; AbuAlRub, Omari, & Al-Zaru, 2009; Duffield et al., 2009; Kudo et al., 2006; Tourangeau & Cranley, 2006). Other reasons for nurse leaders to leave were because of reorganisation, personal reasons, and because of difficult relationships with, or a lack of support from their supervisor (Dawson, Stasa, Roche, Homer, & Duffield, 2014; Parsons & Stonestreet, 2003; Skytt et al., 2007). Nurse managers have also left because they found aspects of the job distressing or intolerable due to the political pressures placed on them (Johnstone, 2003).

Finally, there are links between a lack of support and intention to leave (van der Heijden et al., 2010). Nurse leaders have consistently reported a lack of support in their roles (Lang et al., 2012; Paliadelis et al., 2007; Suzuki et al., 2009). A lack of development opportunities for professional growth and limited scope for career advancement has also been identified as a factor in senior nurse leaders' intentions to leave (Dawson et al., 2014; Estryn-Behar, van der Heijden, Fry, & Hasselhorn, 2010).

A systematic review of thirteen studies from 1990 to 2008 (Brown, Fraser, Wong, Muise, & Cummings, 2013) examined intentions to stay and retention in nurse managers. Studies were arranged into organisational, role and personal factors, identifying factors such as job satisfaction, organisational commitment, values and culture of the organisation, a lack of feeling valued as an employee, lack of time to complete tasks and work-life imbalance, as reasons nurse managers left their role. From the thirteen studies

in the review, eight were a correlational design and five used qualitative methods. Quality of the studies in the review was rated moderate to high. Response rates (<60%) and sample sizes were issues reported with the quantitative studies and a lack of discussion on rigour in the qualitative studies was noted. However, the majority of the studies were guided by theory, conducted in more than one centre, were prospective and used valid instruments for their measurements. These studies provide good evidence that a variety of factors are involved in the retention of nurse managers and their intentions to stay.

There are suggestions that some front-line leadership roles, like the nurse manager role, have a short tenure. In one study, 40% of health care managers (n=216) had left after four years (Skagert et al., 2011). Similarly, other studies have reported nurse manager intentions to leave within the next two (25%, n=74) to five (37%, n=107) years (Warshawsky & Havens, 2014). Some CNCs (46%, n=36) intended to leave in next 4 years (Mullen et al., 2011).

A comprehensive understanding of factors relating to clinical nurse leader retention is important. Yet much of the research on intention to leave within nursing has focused broadly on nurses as a population group or specifically on nurse managers, resulting in minimal research in this area for those in other clinical nurse leader roles. It is possible that much of the research conducted does include nurses at senior levels, but failure to report the specific grades of nurse within the study populations, make it difficult to ascertain whether or not leaders were included. Some studies on intention to leave have included nurses with over ten years' experience (Dotson, Dave, Cazier, & Spaulding, 2014; Lindqvist et al., 2014; Zeytinoglu, Denton, & Plenderleith, 2011) and some have specified age ranges (Atinga, Domfeh, Kayi, Abuosi, & Dzansi, 2014; Dotson et al., 2014;

Lindqvist et al., 2014), all of which indicate the inclusion of experienced or senior staff. However, the positions of staff in these studies are not specified, resulting in minimal research that relates specifically to some clinical nurse leader roles and their intentions to leave. Consequently, there is still an incomplete picture of clinical nurse leaders' intentions to leave or remain in their positions, despite the important role they play in the current health care context.

The research that does exist, suggests that some clinical nurse leaders are at risk of leaving their positions or even the profession. In light of a predicted future nurse leader shortage, the potential loss of highly experienced knowledgeable staff from the workforce requires urgent attention. Despite clinical nurse leaders being a crucial part of the workforce, there has been little research attention paid to strategies for retaining this group of staff in the workforce. Consequently, strategies that are likely to be successful are not yet fully understood and calls for research to develop leadership retention strategies remain (Brown et al., 2013). A concept that is emerging as an important factor to consider in retention is that of work engagement.

2.6.3 Work Engagement and Clinical Nurse Leaders. Fully engaged leaders are confident, enthusiastic individuals, who are empowered and inspired in their role. In this next section, the concept of work engagement is examined in relation to the work context of clinical nurse leaders. First, the concept of work engagement is considered. Then the characteristics of engaged employees are examined along with the organisational benefits of having engaged employees. This is then followed by an exploration of the importance of having engaged clinical nurse leaders in the current health care context, particularly for staff and the work environment. Finally, the job demands resources model is considered as a framework for understanding the key drivers

of engagement and examines factors that could play a role in assisting clinical nurse leaders to maximise their engagement levels. Firstly, the concept of work engagement is examined.

2.6.4 The concept of work engagement The positive psychology movement in the last decade has seen the emergence of new concepts such as work engagement that have emerged from the organisational psychology and burnout literature. Although researchers have continued to sustain their interest in burnout, attention has shifted from negative aspects of the workplace such as stress and burnout, to newer concepts such as human flourishing (Seligman, 2012), workplace well-being (Robertson & Cooper, 2011), strengths (Linley, Willars, Biswas-Deiner, Garcea, & Stairs, 2010), flow (Csikszentmihalyi, 2014), and work engagement (Bakker, 2011; Bakker, Schaufeli, Leiter, & Taris, 2008; Schaufeli, Leiter, et al., 2009).

Work engagement has been described as the opposite of burnout (Bakker et al., 2008; Mauno, Kinnunen, & Ruokolainen, 2007) and defined as "an individual's sense of purpose and focused energy, evident to others in the display of personal initiative, adaptability, effort, and persistence directed toward organizational goals" (Macey, Schneider, Barbera, & Young, 2009, p. 7). The most widely used definition is that of Schaufeli, Salanova, González-romá, and Bakker (2002) who define work engagement as "a positive, fulfilling, work-related state of mind" (p. 74).

There are three components to work engagement; vigour, dedication and absorption (Schaufeli & Bakker, 2004; Schaufeli et al., 2002). Vigour is described as high levels of energy and mental resilience while working, the willingness to invest effort in one's work, and persistence in the face of work difficulties. The second component, dedication, is viewed as a sense of significance, enthusiasm, inspiration, pride and challenge in work.

Finally absorption is characterised as full concentration on and being engrossed in one's work, where time passes quickly and where individuals have difficulties in detaching from work. These three dimensions reflect the core aspects of work engagement and are well accepted in the literature (Bakker & Demerouti, 2008; Schaufeli & Bakker, 2010; Schaufeli, Bakker, & Salanova, 2006).

As with any new idea, there has been some debate in the field regarding the conceptualisation of work engagement. A lack of universal agreement on the meaning of work engagement has continued to date (Newman, Joseph, & Hulin, 2010). Some scholars have compared work engagement with other work related concepts such as job satisfaction, organisational commitment and workaholism, arguing that it is purely a repackaging of existing concepts and describing it as "old wine in new bottles" (Macey & Schneider, 2008, p. 6) or "same lady, different dress" (Schohat & Vigoda-Gadot, 2010, p. 98). Others agree, commenting that work engagement is not empirically distinct (Harter & Schmidt, 2008), a blend of other constructs (Newman & Harrison, 2008), a cocktail of constructs making it purely role specific (Saks, 2008), and an organisational rather than an individual construct (Pugh & Dietz, 2008).

In contrast, Bakker, Albrecht, and Leiter (2011) suggest that work engagement is not merely a realignment of old concepts, but a standalone construct. There is a growing body of literature supporting this argument (Hallberg & Schaufeli, 2006; Inceoglu & Fleck, 2010; Schaufeli, Taris, & Van Rhenen, 2008), and differentiating work engagement from other work related concepts such as job involvement or organisational commitment (Hallberg & Schaufeli, 2006), and workaholism (Schaufeli et al., 2008; Snir et al., 2013). This study aligns with the conceptualisation of work engagement as a standalone construct.

The notion of work related concepts such as engagement, irrespective of the debates in the field, can provide a vehicle for conceptualising, measuring and articulating the approach that clinical nurse leaders take to their work.

2.6.5 Attributes of engaged employees. Previous research has shown that individuals who are fully engaged in their job, take a characteristic approach to work. They are enthusiastic about the way they approach their role, they are energetic, and get so fully immersed in their work that time passes quickly (Bakker & Demerouti, 2008; May, Gilson, & Harter, 2004; Schaufeli & Bakker, 2004). Engaged employees enjoy their work, use their initiative, and exhibit extra role behaviours (Bakker, Demerouti, & Verbeke, 2004; Schaufeli, Taris, & Bakker, 2006; Xanthopoulou, Bakker, Heuven, Demerouti, & Schaufeli, 2008) going above and beyond their duties. They are also more likely to be innovative (Agarwal, Datta, Blake-Beard, & Bhargava, 2012; Bakker & Demerouti, 2007; Bakker, Hakanen, Demerouti, & Xanthopoulou, 2007; Hakanen, Perhoniemi, & Toppinen-Tanner, 2008). In a study by Engelbrecht (2006), midwives described engaged colleagues as individuals who were enthusiastic, passionate colleagues who were inspiring, knowledgeable, eager to share their knowledge, always open to learning, and proactive in investing time and effort in staying updated in their profession. Additionally, engaged colleagues cared for others in the team, displayed sensitivity to the needs of others and promoted a sense of community (Engelbrecht, 2006). Essentially, engaged staff find their work fun (Gorgievski, Bakker, & Schaufeli, 2010) and their characteristics as an employee would suggest that they are a desirable resource for employers.

2.6.6 Employee engagement and organisational benefits. There is evidence to suggest that engaged employees can be a beneficial asset within an

organisation. Recent research (Agarwal et al., 2012; Bakker & Bal, 2010; Demerouti & Cropanzano, 2010; Rongen, Robroek, Schaufeli, & Burdorf, 2014) has shown links between engaged employees and positive organisational outcomes. In the fast food, hotel and restaurant industries, work engagement has been positively associated with increased financial returns (Xanthopoulou, Bakker, Demerouti, & Schaufeli, 2009), improved service climate and increased customer loyalty (Salanova et al., 2005). Other organisational outcomes such as sick leave and absenteeism have been negatively associated with work engagement (Australian Institute of Management, 2006; Schaufeli, Bakker, & Van Rhenen, 2009). One of the benefits of engaged employees is that they have an increased commitment to the organisation (Halbesleben, 2010; Hallberg & Schaufeli, 2006; Schaufeli & Bakker, 2004). Another benefit is that engaged staff demonstrate increased job performance as individuals (Bakker & Bal, 2010; Demerouti & Cropanzano, 2010; Halbesleben & Wheeler, 2008; Xanthopoulou et al., 2009), and in groups (Salanova, Llorens, Cifre, Martínez, & Schaufeli, 2003) compared to those who are not engaged.

Additional research that supports the view of engaged employees being attractive to organisations, is related to employee satisfaction, turnover and sickness levels (Agarwal et al., 2012; Halbesleben, 2010; Rongen et al., 2014; Schaufeli, Bakker, et al., 2009; Simpson, 2009b).

Engaged employees report higher levels of job satisfaction (Simpson, 2009a) and tend to remain in their jobs, as evidenced by the strong negative relationships found between work engagement and turnover intentions (Halbesleben 2010, Saks 2006, Agarwal 2012). With regards to health, engaged staff contrast markedly from staff who are stressed or who burn out, as they enjoy good mental health (Hallberg & Schaufeli, 2006; Schaufeli et

al., 2008), have fewer psychosomatic health complaints (Demerouti, Bakker, de Jonge, Janssen, & Schaufeli, 2001; Schaufeli & Bakker, 2004) and take fewer sick days (Australian Institute of Management, 2006; Schaufeli, Bakker, et al., 2009). Work engagement has also been examined in relation to work ability and long term sickness absence (10 or more days). Work ability is defined as the "self-perceived capability to fulfil the mental and physical demands of the job" (Rongen et al., 2014). Results show that staff who were low on engagement, were also more likely to have a low work ability and report long term sickness absence (Rongen et al., 2014). Work engagement has also been a negative predictor of depressive symptoms (Hakanen & Schaufeli, 2012; Innstrand, Langballe, & Falkum, 2012).

The research previously discussed in this section suggests that for organisations, having engaged employees is beneficial and can be clearly related to positive organisational outcomes, including financial ones. Thus, indicating an engaged workforce could be a valuable resource for any organisation. In the current health workplace context, the research evidence suggests that focusing on activities to promote work engagement in staff would be a worthwhile investment for organisations. The next section considers how an engaged clinical nurse leader can influence others in practice.

2.6.7 Engaged clinical nurse leaders. An engaged clinical nurse leader can have a considerable influence on their colleagues and their team. Research on emotional contagion provides evidence that leaders' behaviour and attitudes can directly affect the people they work with. Emotional contagion or emotional crossover has been defined as "an inter-individual dyadic process where stress and strain experienced by an individual generate similar reactions in another individual" (Westman, 2001, p. 718). Essentially it describes a process where an individual's reactions to an experience, either positive or

negative, can be transferred to another person. In other words, followers can share their leaders' emotions (Bono & Ilies, 2006; Eberly & Fong, 2013; Gooty, Connelly, Griffith, & Gupta, 2010). This means that positive leaders can positively affect their staff (Bono & Ilies, 2006; Eberly & Fong, 2013; Gooty et al., 2010). However, emotional contagion also works conversely; negative leaders can have a negative effect on their staff (Glasø & Einarsen, 2006). For example, in nursing, negative supervisors affected nurses' intentions to help other colleagues in the team (Chang, Teng, Chu, Chang, & Hsu, 2012). Groups and group processes can also be affected by the leader's emotions, and results have shown that those groups with a positive leader have a more positive affective tone, have more coordination and expend less effort than those groups with a negative leader (Sy, Côté, & Saavedra, 2005).

Research studies have also shown that a leader's emotions can affect their peer group, as working with engaged (or burned out) colleagues in a team, can positively (or negatively) affect the others in the group. The crossover of engagement within teams has been established (Bakker, van Emmerik, & Euwema, 2006), with team level work engagement and burnout being positively related to individual levels of work engagement and burnout (Bakker et al., 2006). In other words, individuals who worked in a team with engaged (or burned out) colleagues also reported high individual levels of engagement (or burnout). There is also evidence that the contagion effect may also spill over from work into a leader's personal life, creating a potential situation where work factors continue to affect the individual even when they are not in the work context (Bakker, Demerouti, & Schaufeli, 2005). Research on the contagion effect provides evidence that a leader's personal approach to their job, can influence their staff. These research studies draw attention to the importance of developing self-awareness in clinical nurse leaders and

provides the evidence to support the inclusion of personal aspects in leadership development activities.

The presence of positive role models in nursing leadership is a key factor in attracting junior staff into leadership positions. Previous research has shown that exposure to positive individuals who are enthusiastic about the role, can make front line leadership positions attractive to the next generation of nurse leaders (Carey, Philippon, & Cummings, 2011; Mass, Brunke, Thorne, & Parslow, 2006; Wong et al., 2012). Individuals in current leadership posts have reported that their previous leaders were an influencing factor in the decision to enter into a leadership role (Bondas, 2006). Perceptions of the role can also affect interest in leadership roles (Rognstad & Aasland, 2007; Sherman, Bishop, Eggenberger, & Karden, 2007) and negative perceptions can discourage nurses from even considering such roles (Laschinger et al., 2012). An engaged leader is positioned well to reframe how the clinical leadership role is perceived by junior staff (Wong et al., 2012); and to promote interest in the role (Rognstad & Aasland, 2007; Sherman et al., 2007). The above research suggests that potential nurse leaders are influenced by those currently in leadership roles. In the light of potential nurse leader shortages and difficulty in recruiting into these roles, the evidence provides support for promoting self-awareness and work engagement in current leaders, so they are confident, fully engaged and personally aware of how they are portraying the role.

The way a clinical nurse leader engages with their role can positively (or negatively) influence the work environment for their staff. Quality leadership at all organisational levels has been shown to be the number one factor in creating a healthy work environment for nurses (Kramer et al., 2010; Leiter & Laschinger, 2006). This is important as quality work environments for staff have been related to nurse's job

satisfaction and intentions to stay (Choi, Cheung, & Pang, 2013). Conversely, a negative working atmosphere can strongly influence nurses' intentions to leave (Tummers, Groeneveld, & Lankhaar, 2013).

Engaged leaders can bring a positive influence into practice by the way they use their communication skills. Research has indicated that nurses want leaders who are skilled in communication, approachable, and safe to speak to (Kramer et al., 2010). They also want leaders to hold staff accountable for their decisions, to resolve conflicts constructively, to regularly provide them with feedback and to promote teamwork (Kramer et al., 2010). Essentially, the evidence indicates that nurses want effective leaders with highly developed soft skills. Soft skills have been defined as the "interpersonal skills, communication skills, persuasion skills, political savvy and emotional abilities used by leaders" (Rao, 2010, p. 4). Yet nurses in practice and leaders commonly report interpersonal relationship issues, conflict and communication difficulties (Coelho Amestoy et al., 2014; Ennis, Happell, Broadbent, & Reid-Searl, 2013; Hendel et al., 2005; Wittenberg, Goldsmith, & Neiman, 2015). Previous research has shown that communication exchanges between employees and their immediate supervisors can influence job satisfaction, work engagement and intentions to leave (Agarwal et al., 2012; Galletta, Portoghese, Battistelli, & Leiter, 2013; Han & Jekel, 2011; Shacklock, Brunetto, Teo, & Farr-Wharton, 2014). Authenticity in communication is also influential. When a leader is perceived to be authentic, staff have higher levels of work engagement (Bamford, Wong, & Laschinger, 2013; Wong, Laschinger, & Cummings, 2010), lower levels of burnout (Laschinger, Wong, & Grau, 2013) and report greater levels of trust in the leader. Conversely, perceptions of workplace politics are associated with a high intention to leave and can negatively affect levels of job satisfaction, commitment and work performance in nurses (Atinga et al., 2014). These research studies show that the way

leaders communicate can have a powerful influence on colleagues and staff, having either positive or negative effects on job satisfaction and intention to leave. They also highlight the importance of good communication skills in leaders and provide support for leadership development activities that focus on not just the technical aspects of a leader's role, but also the personal aspects of being a leader.

In summary, a leader's personal approach to their work does not take place in isolation. The research on contagion indicates that leaders who are anxious, stressed or burnt out, are at risk of promoting these feelings in their teams, colleagues or subordinates. In contrast to this, engaged leaders who bring their enthusiasm, energy and vision to the way they communicate with others, can create a positive working environment for their staff and colleagues. In addition, the research has shown links between a positive working environment, staff job satisfaction and retention. Research has reported that nurses want a safe supportive positive work environment from their leaders (Kramer et al., 2010). However, that requires leaders to be prepared well for their roles and highly engaged once in their roles. Yet there has been very little attention paid to how clinical nurse leaders develop or maintain an engaged approach to their role. The Job Demands-Resources (JD-R) Model provides a framework for evaluating work engagement in clinical nurse leaders.

2.6.8 The Job Demands Resources (JD-R) model. The Job Demands-Resources (JD-R) model (Bakker & Demerouti, 2007; Demerouti, Bakker, Nachreiner, & Schaufeli, 2001) is a useful conceptual framework through which to examine work engagement in clinical nurse leaders. This model proposes that irrespective of the type of job or the profession, working conditions can be divided into the distinct categories of job demands and job resources. The combination of job demands and job resources can result in either a health impairment process leading to burnout or a motivational process

leading to engagement (Bakker & Demerouti, 2007; Demerouti, Bakker, Nachreiner, et al., 2001).

According to the JD-R model, the health impairment process occurs when extreme job demands exist, leading to constant strain and overtaxing of the individual, ultimately resulting in exhaustion, one of the elements of burnout (Bakker & Demerouti, 2007; Demerouti, Bakker, Nachreiner, et al., 2001). When job demands are high and at the same time there are limited job resources, the situation is exacerbated, leading to a downward spiral of withdrawal behaviours, disengagement from work and exhaustion, the two core components of burnout (Bakker & Demerouti, 2007; Demerouti, Bakker, Nachreiner, et al., 2001).

Conversely, a motivational process occurs when the individual has sufficient job resources. This then leads to a greater investment in work and increased engagement. Job resources are important in their own right and they also buffer the negative effect of job demands (Bakker et al., 2007).

In the JD-R model, job demands have been identified as role overload, time pressures, role conflict and role ambiguity (Hakanen & Roodt, 2010). Multiple factors have been identified in clinical nurse leaders' roles that could act as job demands including; role overload (Bloomer & Cross, 2011; Johansson, Sandahl, & Hasson, 2013b; Meyer et al., 2011; Paliadelis, 2008), time pressure (Johansson et al., 2013b; Mullen et al., 2011; Shirey et al., 2010), role conflicts (Kath, Stichler, Ehrhart, & Sievers, 2013) and role ambiguity (Bloomer & Cross, 2011; McCallin & Frankson, 2010; Mullen et al., 2011; Hutchison & Purcell, 2010). A recent review on the antecedents of job stress for nurses, using the job Demands-Resources model provides further support for the job stresses and demands on nurses (McVicar 2016).

Job resources on the other hand have been described as “those physical, psychological, social or organisational aspects of the job that a) reduce job demands and the associated physiological and psychological costs, b) are functional in achieving work goals, or c) simulate personal growth, learning and development” (Bakker & Demerouti, 2007, p. 275). Job resources have been identified as support, job autonomy, job control, performance feedback, supervisory coaching and opportunities to learn and grow (Bakker et al., 2004; Hakanen, Bakker, & Schaufeli, 2006; Halbesleben, 2010). Yet factors that could be acting as job resources have been identified as lacking for clinical nurse leaders. Examples are the lack of support from supervisors (Johansson et al., 2013b; Lang et al., 2012; Paliadelis et al., 2007), the lack of feedback on performance, the lack of opportunities to grow and develop (Lang et al., 2012; Paliadelis et al., 2007; Suzuki et al., 2009). Additionally, the lack of physical resources such as office space (Paliadelis, 2013) or staff shortages have also been well reported in the literature (Queensland Nurses’ Union, 2011). A recent review of the research relating to job resources also supports these findings (McVicar, 2016).

Job resources are valuable because they act as buffers, offsetting the negative effects of high job demands and boosting work engagement levels (Bakker et al., 2007; Xanthopoulou, Bakker, Demerouti, & Schaufeli, 2007). According to Halbesleben (2010), developing employee resources is one of the best strategies for organisations to consider when focusing on interventions aimed at increasing employee engagement. In promoting work engagement for clinical nurse leaders, increasing job resources is a more useful approach than attempting to reduce workplace demands, as aspects such as workload, time pressure or role conflicts are contextual and specific to the organisation, and are therefore not as easily altered.

The combination of high job demands and low job resources that clinical nurse leaders experience, highlights the need for job resources that will support and develop them in their role. The strong empirical evidence that links job resources positively with work engagement (Halbesleben, 2010; Mauno et al., 2007) and with intentions to leave (Wendsche, Hacker, Leggat & Rudolf, 2016) also lends support for the development of such resources. A recent review in this area has also identified the need for raising job resources and increasing personal resources (McVicar, 2016).

According to the JD-R model, the provision of opportunities for learning, growing and development, social support, and activities that can promote the attainment of work related goals, can all be considered job resources. Professional development activities could be a potential mechanism for the delivery of such job resources to clinical nurse leaders and indeed, it has been suggested that coaching may be a useful strategy for promoting engaged productive workforces (Xanthopoulou et al., 2009). The next section examines the literature in relation to coaching as a potential intervention that could act as a job resource for clinical nurse leaders, proposing it as a way to professionally develop and support them, while they also engage fully with their roles.

2.7 Coaching as an Approach for Professional Development

In recent years there has been an increasing interest in coaching. Grant (2011), in a review of the peer reviewed behavioural scientific literature and identified two hundred and thirty-four outcome studies published on coaching since the year 2000. Out of this total number however, only a small number (25) were between subject studies (where two or more groups are compared), fourteen of which were randomised. The remainder were case studies (131) and within-subject studies (77). The review found studies on workplace coaching across a variety of areas, studies on life coaching, health coaching for

patients and executive coaching. Grant concluded his review by commenting that the knowledge base relating to coaching is continuing to grow substantially each year.

In order to establish the evidence base in relation to the use of coaching as an approach for professionally developing nurse leaders, a search was conducted of electronic databases (CINAHL, PsychInfo, Medline, PubMed, Academic Search Complete, Health Source Nursing Academic, SocINDEX, Health Business Elite, Cochrane database of Systematic Reviews, Joanna Briggs Institute EBP Database) from 2005-2015. Once the titles and abstracts were screened for relevance and duplicates removed, 34 research results remained. Table 1 provides the results of the searches conducted.

Database	Search Terms/Process					
	"Coaching" (KW) **"Executive coaching" (KW)** **"Leadership Coaching" (KW)**	**"Leadership" (MM)** **"Leaders+" (MM)** **"Nursing leaders" (MM)**	**Combined**	**Limits** **Dates 2005-2015, Peer reviewed, English, Academic journals, Research**	**Relevance to Study**	**Remove Duplicates**
CINAHL	1,976	24,018	107	28	17	17
PsychINFO	2,543	20,217	209	51	23	5
Medline	3,481	15,750	146	89	16	5
ACADEMIC SEARCH COMPLETE	1,174	527	254	47	6	1
HEALTH SOURCE NURSING ACADEMIC	102	147	220	72	12	6
SocINDEX	1,182	7,866	54	29	0	0
Health Business Elite	1,326	1,280	1,838	0	0	0
Cochrane Database of Systematic Reviews	13	12	24	12	0	0
Joanna Briggs Institute EBP Database	9	5	0	0	0	0
			TOTAL	**505**	**74**	**34**
					TOTAL	**34**

The professional support and development of clinical nurse leaders is a major area of interest within the nursing profession. Of continuing concern is the lack of studies focusing on identifying effective ways to provide that support and professional development. The following section reviews literature found in the above search of the databases, relating to the use of coaching as a professional development activity.

2.7.1 Workplace coaching

Coaching as a method for professional development has been predominantly used within the business arena, and most often with senior leaders and executives. A small number of good quality, between groups studies exist where coaching has been used as an intervention (Duijts, Kant, van den Brandt, & Swaen, 2008; Franklin & Doran, 2009; Grant, 2014b; Grant, Curtayne, & Burton, 2009; Grant, Green, & Rynsaardt, 2010; Moen & Federici, 2012). An example is the study by Grant et al., (2009), where they randomly allocated forty-one public health executives to either a waitlist control group or to receive four coaching sessions over a ten-week period. Results showed that compared to those in the control group, coaching enhanced goal attainment, resilience, workplace wellbeing and reduced depression and stress. Qualitative findings reported that participants found coaching helped increase their self-confidence, personal insight, build management skills, and helped them deal with organisational change. Similarly, in a randomised study by Grant (2014b), thirty-one executives and managers from a global engineering company were coached during organisational change. Results confirmed that coaching was associated with increased goal attainment, enhanced solution focussed thinking and an increased ability to deal with change. Coaching was also associated with increased leadership self-efficacy, resilience, and a decrease in depression. Along the same lines, Moen and Federici (2012) studied 144 leaders from a Norwegian fortune 500 company. Senior executives and middle managers were randomly assigned to either a coaching

group (n=70) or a control group (n=74). The intervention group completed a one year business coaching program with individual and group coaching sessions. Post testing for all groups was completed following completion of the program. Results found that goal setting and leadership self-efficacy were increased in the coaching group compared with the control group.

Duijts et al. (2008) conducted a randomised controlled study on Dutch employees who received a six-month course of individual coaching in relation to sickness absence. The coaching group received the preventive coaching program and the control group received usual care. Results showed that in comparison to the control group, the coaching group had statistically significant improvements in health, life satisfaction, burnout, psychological wellbeing, but not in relation to sickness absence. Similarly, in a randomised study of high school teachers (Grant et al., 2010), participants received ten individual coaching sessions as an intervention. Results showed that participation in coaching was associated with the teachers attaining their goals, stress reduction, along with enhanced resilience and workplace wellbeing.

Rarely are double blind studies conducted in coaching as it is difficult to blind participants to a coaching intervention. However, Franklin and Doran (2009) conducted a double blind randomised controlled trial on first year university students, allocated to a Preparation Action Adaptive Learning (PAAL) coaching group (n=27) (peer coaching using the PAAL framework), a self-regulation co coaching group (n=25) (peer coaching using a self-regulation framework) or a no treatment condition (n=2103) (no coaching at all). Both groups in the coaching groups performed better than those in the no coaching condition. Those who received the co-coaching (peer coaching) had significant increases in self-efficacy and resilience. However, those in the PAAL group performed

significantly better in other areas such as decisional balance, hope, self-compassion and academic performance.

These randomised studies provide good quality evidence on the effects of coaching as a professional development intervention. However, randomised studies on coaching are few, and the remaining studies found in the literature review provide evidence from quasi experimental studies, within group studies, case studies and qualitative studies. For example, Gyllensten and Palmer (2005a) conducted a quasi-experimental study on 31 leaders from a UK finance organisation. Anxiety and stress decreased more in the coaching group compared to the control group. Similarly, Evers, Brouwers, and Tomic (2006) conducted a quasi-experimental study on 60 federal government managers, where one group followed a four-month coaching program and the other did not. Pre- and post-testing was completed for both groups, with the coaching group scoring significantly higher on outcome expectancies and self-efficacy beliefs to set own goals.

In a within group study, Grant and Hartley (2014) examined the transfer of training in their study of the Commonwealth bank "Leader as Coach" coaching programme. The 373 senior managers underwent a two-day coaching workshop and created a personal case study, in which they identified their goals, potential solutions and rated how close they were to solving that issue and how long it had been a problem for them. At the end of the two-day workshop, participants re-rated themselves and how their level of confidence had changed in relation to solving this problem. Results showed a significant increase in goal attainment following the coaching workshop and an increase in confidence that they were able to address the issue. Participants generated on average 5.33 action steps that would assist them in solving their problems which had existed for 1.36 (*SD*=2.42) years, and included issues such as dealing with negative co-workers,

conflict, delegation, and disengaged employees. Results also showed a 55.8% increase in leaders feeling they held more effective coaching conversations, with a 56.5% increase in leaders recognising when to coach and when to delegate, and a 45.2% increase in their work engagement levels. Finally, Ladegard and Gjerde (2014) conducted a six month non-randomised coaching intervention on thirty middle and senior managers regarding coaching and leadership role efficacy. Results from the study show that leader role efficacy and trust in subordinates increased in the coaching group but not the control group. The authors concluded that coaching is a promising leadership development tool.

Although these studies provide some interesting results, limitations are that there is the potential for a risk of selection bias associated with the non-random allocation of participants to the intervention and control groups. It is possible that contextual factors relating to specific particular organisations may have contributed towards the results reported in these studies. In addition, the use of self-reports or non-validated measures rather than validated objective instruments, also could be a factor influencing bias. The results therefore need to be interpreted with caution.

Qualitative studies of course provide no direct evidence of the efficacy of coaching as an intervention, but provide insight into how business leaders perceive coaching. Smith (2015) completed a grounded theory study on eight senior leaders in public and private organisations to examine the impact of coaching on their resilience. Participants perceived that coaching had positively influenced their resilience. Although the study focused on resilience, the participants also reported that coaching helped them reclaim their self-belief, contributed to their learning and helped them see the wider perspective. Similarly, Reynolds (2011) in a phenomenological study of six senior executives who had recently transitioned into new positions, reported participants found the coaching helped

them overcome vulnerability in the face of complex challenges, and develop new personal, social and cognitive capacities. Timson (2015) in the qualitative element of the study interviewed six managers from a public-sector organisation in UK with regards to the impact of a coaching program on their individual resilience. Findings from interviews identified five themes; tools and techniques used during coaching, pressured working environment, time and space for thinking and reflection, moving forward and coaches. Participants appreciated the supportive role of the coach and found that coaching helped them to step back and stayed focussed.

There were several case studies in the review of literature, which also report positively on coaching interventions for leaders and executives (Berg & Karlsen, 2012; Perkins, 2009; Simpson, 2010; Wallis, 2010). Case studies provide information on how coaching worked for specific individuals, and are useful as they provide insight into the application of coaching. For example, Berg and Karlsen (2012) found coaching to be a helpful training process to learn about and to develop new management behaviours. Furthermore, the authors comment that coaching and other leadership training should be based on the specific work challenges that the managers experience at their workplace. Similarly, Perkins (2009) commented that more productive meeting behaviours can be promoted by coaching and providing feedback for executives. Similarly, Simpson (2010) concluded that coaching is making a positive contribution to leadership recruitment and retention and is particularly valuable at career transition points. Similarly, Cortvriend, Harris, and Alexander (2008) participants perceived coaching had made a difference to their individual performance as a leader. They found coaching gave them space and time for reflection, work-life balance and stress reduction. They also used the coach as a sounding board, and felt they had increased their self-confidence and changed their leadership style so they were more strategic. Finally, Wallis (2010) commented that coaching and

training sessions in a leadership development programme had led to sustained change for six months beyond the end of the programme. These studies, although not providing strong evidence of effectiveness of coaching, provide insight into how coaching is utilised and viewed as a professional development activity by other professionals.

2.7.2 Life coaching. Another area of coaching that can provide insight into the usefulness of coaching as a professional development activity, is life coaching. These coaching studies, although small in number, use cognitive behavioural approaches, and can therefore provide insight into the personal outcomes that leaders could potentially gain from engaging in coaching. For example, Green, Oades, and Grant (2006) conducted a solution focussed cognitive based life coaching program with 56 adults. Participants were randomised to receive group coaching or to a waitlist control group. Results showed that coaching increased goal attainment, wellbeing and hope. Follow up at 30 weeks after the coaching found that the results had been maintained. Similarly, Green, Grant, and Rynsaardt (2007) randomised 56 female high school students to a solution focussed cognitive behavioural life coaching program over ten weeks. Coaching increased cognitive hardiness, mental health and hope. In the same vein, Spence and Grant (2007) randomised sixty-three adults to a life coaching program with a peer coach, a professional coach, or a waitlist control group. Results showed that professional coaching was more effective in promoting goal commitment, goal attainment, and environmental mastery. Similarly, Spence, Cavanagh, and Grant (2008) randomised forty-five adults to receive mindfulness based health coaching over eight weeks. Compared to the control group, goal attainment was greater for those in the coaching groups. These studies provide good quality evidence with regards to life coaching and personal outcomes. The randomisation, the use of a control group and the use of validated instruments to measure the outcomes, all add strength to the quality of evidence

these studies provide and indicate the usefulness of a cognitive behavioural approach in coaching. They also reinforce the links between coaching and goal attainment, which does have relevance for coaching health professionals.

2.7.3 Health coaching. Coaching is a new concept within health and over the past five years there has been a considerable increase in the literature on coaching. Much of the interest has focused on health coaching, provided by nurses or other health professionals, for patients' as a health and wellbeing intervention. A few high-quality studies have now reported coaching as a positive approach for supporting patients to reach their health goals, including those with cardiac problems (Jelinek, Santamaria, Thompson, & Vale, 2012), asthma (Garbutt, Yan, Highstein, & Strunk, 2015), diabetes (González-Guajardo, Salinas-Martínez, Botello-García, & Mathiew-Quiros, 2015) and stroke (Spassova, Vittore, Droste, & Rösch, 2016). These studies provide further support for coaching as an intervention that can assist individuals in reaching their goals.

2.7.4 Workplace coaching within health. In relation to coaching as a professional development activity within the health field, a good quality study was found where coaching was used as a professional development intervention for General Practitioners (GPs). Gattellari et al. (2005) conducted a randomised controlled study on 227 GPs in relation to them making informed decisions about prostate-specific antigen (PSA) screening with their male patients. The intervention group received two peer based coaching sessions integrated with educational resources, while the control group received only summaries of guidelines for PSA testing. Results found that compared to the control group, the coaching group gained significantly greater knowledge about PSA screening and related information (Mean intervention group=6.1, control =4.8. $P<0.001$), they had lower levels of decisional conflict (Mean 25.4, control group=27.4. $P<0.0002$) and

perceived less medico legal risk (OR=0.31; 95% CI=0.19-0.51) and less likely to agree that patients remain passive in decisions about screening (OR=0.11; 95% CI=0.04-0.31; P<0.001). These results show that coaching as a professional development intervention increased the GP's ability to make informed decisions about PSA screening. This study gives some insight into the use of coaching as a professional development activity, indicating that it can be used to develop and support leaders attain positive outcomes. As such it has promise for clinical nurse leaders in their roles.

There are a small number of studies which have used coaching with clinical nurse leaders and reported on the nurse leaders' performances in their role (Brinkert, 2011; Godfrey, Andersson-Gare, Nelson, Nilsson, & Ahlstrom, 2014; McNally & Lukens, 2006; McNamara et al., 2014; Patton et al., 2013; Yu, Collins, & Cavanagh, 2008). For example, McNally and Lukens (2006) described an evaluation of a six-month leadership coaching program, where an executive coach provided individual and group coaching for 64 clinical leaders. Participants perceived they were more competent and confident in their roles and more than 50% stated they were more likely to stay in their position. Similarly, Yu et al. (2008) conducted a six-month workplace coaching program for 17 nurse managers within an Australian teaching hospital. This pre- and post-test study included workshops, group and also individual coaching sessions over the six month period. Results showed that the leaders had significantly enhanced their proactivity, their core performance, goal attainment and autonomy. However, the lack of a control group and use of self-report measures act as limitations reducing the strength of this evidence. Similar results have been found by Cilliers and Terblanche (2010) whose participants found that coaching helped them perform their roles with more self-authorisation and McNamara et al. (2014), whose leaders were coached to develop two out of seven

leadership competencies (self-awareness, advocacy and empowerment, decision-making, communication, quality and safety, teamwork and clinical excellence).

A few studies reported on teamwork or on skill development for leaders. Brinkert (2011) trained twenty nurse managers as conflict coaches. Results show that coaching was a useful method for developing nurse managers' conflict handling skills and as a way of supporting them during the application of these skills in their practice. Patton et al. (2013) also reported development of new skills, improved communication skills and improved team working. In a two-day workshop that coached nurse managers to use coaching skills with their staff, attitudes and intentions to use coaching behaviours increased significantly, despite leaders facing challenges in implementing these skills in practice (Cummings et al., 2014).

Team coaching was only reported by one study, in which inter professional health care teams were coached (Godfrey et al., 2014). The main findings were that coaching was perceived to positively support practice improvement processes, however the study measured coach performance and coaching activities rather than specific predetermined outcomes from coaching. Interestingly, leaders in nursing perceive more value is obtained from individual coaching sessions than from group coaching sessions (McNally & Lukens, 2006).

Personal aspects of leaders' development have been reported. For example coaching has been associated with significant increases in self-insight, motivation and positive affect (Yu 2008). Cilliers and Terblanche (2010) found that coaching created a reflective space for leaders to develop personal and leadership awareness and it also helped them manage their personal and organisational boundaries. Others have found similar results, where participants also reported self-awareness, self-reflection, developing new insights, skills

or having a different perspective on themselves or others (McNamara et al., 2014; Patton et al., 2013).

Leaders who have been coached have also reported improvements in their relationships. Karsten, Baggot, Brown, and Cahill (2010) conducted a pilot study on nurse leaders, where one on one coaching was provided. Relationships with immediate supervisors and direct reports were perceived to be stronger as a result of the coaching. They also reported improved job satisfaction; however, only 12 respondents were included in this study and the questionnaire used was not a validated instrument, reducing the quality of evidence from this study.

Overall within nursing, perceptions of the coaching experience are positive (Godfrey et al., 2014; McNamara et al., 2014) and in one particular study by McNally and Lukens (2006) the organisational investment for coaching was perceived to be money well spent, given they had retained staff who had intended to leave. Similarly, Fielden, Davidson, and Sutherland (2009) examined perceptions of coaching and mentoring in a longitudinal study which had a six-month coaching program and repeat measures at three time points, T1 = baseline, T2 = four months and T3 = nine months. Differences and similarities between the coaching and mentoring processes were examined following a six-month coaching/mentoring program. Mentoring was perceived to be “support” while coaching was perceived to be “action” although the descriptions of processes and content were similar. Both the coaching group (n=15) and the mentoring group (n=15) reported significant development in relation to career development, leadership skills and capabilities. Budhoo and Spurgeon (2012) also identified coaching as a supportive approach for professionally developing clinical nurse leaders and although numbers in this study were small (n=22), participants felt that coaching would improve leadership

skills. Participants also voiced concerns regarding coaching; preferring a coach who was external to the organisation for confidentiality reasons; being matched with the right coach and finding time for coaching (Budhoo & Spurgeon, 2012).

Mackenzie (2007) in her phenomenological study interviewed eight nurse managers who had recently completed the UK RCN Clinical leadership development Programme. The main theme suggested that participants viewed coaching as an opportunity for "stepping off the treadmill". Categories were "in and out the comfort zone", "mirror mirror", "unconditional positive regard", "creative conversations", "ripple effect" and "I'm OK you're OK". The author concludes that coaching is an important component of the leadership programme, enabling a transfer of learning. She calls for further research into the acceptability of coaching as a way of building clinical leadership capability and capacity. Similarly, Ponte, Gross, Galante, and Glazer (2006) in a study of four nurse executives who were coached, found that nurse leaders engaged a coach to help them think through a challenging work situation or environment, or work through issues related to complex relationships or roles. They also reported using a coach when considering career transitions, and when they required confidential assistance in exploring their decisions regarding a move. Ponte et al. (2006) also found that nurse executives initiated coaching to address performance challenges in relationships where they held a key role. The executives also identified the need for a coach who was external to the organisation, to provide authentic, feedback about their performance, organisational dynamics or relationships. Ponte et al. (2006) concluded that coaching offers tremendous benefits to nurse leaders.

The quality of studies determining the efficacy of coaching with nursing leaders is an issue. Research focusing on efficacy to provide evidence that coaching does make a

change as a personal and professional intervention requires key components like control groups, validated instruments and an appropriate sample size (Shields & Watson, 2013). To achieve this quantitative studies are required, specifically randomised controlled trails or good quality experimental students with control groups and large numbers in the sample who are exposed to the intervention of coaching. Although good quality studies are increasing within coaching, there still remains a lack of experimental studies, with large sample sizes which use control groups, randomisation and validated instruments. There are also few long-term studies which study the effects of coaching over longer periods of time. There were only three studies which measured the effects of coaching over six months or longer (Fielden et al., 2009; McNally & Lukens, 2006; Yu et al., 2008). There was only one study identified (Godfrey et al., 2014) that used a mixed methods approach to evaluate team coaching. However, the study focussed on evaluating the coaches' performance, the activities they used with the teams (from questionnaires) and gathered perceptions of coaching (from interviews) rather than measuring specific outcomes from the coaching.

Several of the quantitative studies had small sample sizes (McNally 2006, n=58, Karsten 2010, n=12; Budhoo 2012, n=22, Yu 2008, n=17, Cummings 2014, n=21) although one study (Godfrey et al., 2014) (n=382) had 382 coachees. Only one quantitative study reported randomisation (Budhoo & Spurgeon, 2012) but provided no further details on how this randomisation was conducted. Although some of the studies had a questionnaire component, few used instruments with established validity and reliability and some only used the questionnaire to obtain feedback on the coaching experience (McNally & Lukens, 2006) rather than to measure variables. Overall, the studies in this area provide an incomplete picture of the effectiveness of coaching as an approach for developing or supporting clinical nurse leaders.

Qualitative studies have their place to gain understanding of the experience of providing and receiving coaching as well as other important explanations about coaching in a natural setting. A few studies adopted a qualitative approach (Mackenzie, 2007; McNamara et al., 2014; Ponte et al., 2006) using phenomenology (Mackenzie, 2007), a systems psychodynamic approach (Cilliers & Terblanche, 2010) and others used a pluralistic approach to data collection including focus groups, group interviews, individual interviews and written feedback (McNamara et al., 2014; Patton et al., 2013; Ponte et al., 2006). The use of focus groups rather than separate interviews is acknowledged in one study by McNamara et al. (2014) as a limitation, noting that this approach may not have fully captured the essence of the coaching experience for individuals.

2.7.5 The need for studies on coaching. The issues facing clinical nurse leaders, is an area of ongoing concern within the nursing profession. Studies in this literature review have shown they are stressed, receive little support or development either in preparation for their roles or once in their roles. We have an urgent agenda to develop and support clinical nurse leaders, given they are in key positions to influence the workplace environment, quality of patient care delivery and the retention of front line staff.

Up to now, much of the research on leaders has focussed on describing specific leadership roles, styles and behaviours, or examining the extent to which the issues they face are having an impact on themselves or their staff. Far too little attention has been paid to finding solutions for their issues and researching interventions that will effectively provide support and professional development for these leaders.

The literature reviewed above indicates that coaching has potential as an intervention and may be an innovative way to provide both support and professional development for clinical nurse leaders. Several scholars have called for the use of coaching with nursing leaders (Griffith, 2012; Haycock-Stuart et al., 2010; McNamara et al., 2014) and Haycock-Stuart et al. (2010) in their study on emotional labour of community nursing leaders, recommended coaching as a mechanism for supporting clinical nurse leaders in their roles. Similarly, Griffith (2012) in her review of literature, recommended that coaching be incorporated into succession planning for potential leaders. In relation to work engagement, Xanthopoulou et al. (2009) suggested that coaching may be a useful strategy for promoting engaged productive workforces and Karsten et al. (2010) purported that the effectiveness of coaching for nursing leaders should be assessed by including outcomes focussing on employee engagement and turnover.

Despite comments regarding the potential value of coaching for nursing leaders, there are few nursing studies which examine and measure how effective coaching is as a specific intervention with regards to leadership development or support. There are also few mixed method studies that capture both quantitative and qualitative elements of the coaching experience in nursing, to provide an overall picture of how coaching can contribute to real world health services. Finally, there are no studies at all which provide information on providing coaching as an approach to professional development for clinical nurse leaders. This study therefore responds to the multiple calls for coaching to be examined as an intervention to support and develop clinical nurse leaders in their roles. The questions this study addresses are listed below.

2.8 Research Questions

The research sought to answer the following questions:

2.8.1 Overarching research question.

How suitable is a coaching approach for professionally developing and providing support for clinical nurse leaders?

2.8.2 Research questions.

1. To what extent does coaching have an effect on clinical nurse leaders' work engagement levels?
2. To what extent does coaching have an effect on clinical nurse leaders' burnout levels?
3. What is the effect of coaching on clinical nurse leaders' intentions to leave their position or the profession?
4. To what extent does coaching assist clinical nurse leaders to attain their professional goals?
5. What are clinical nurse leaders' perceptions of coaching?
6. To what extent does the qualitative phase of the study explain or enhance the interpretation of results from the quantitative phase of the study?
7. What do the quantitative and qualitative data together reveal about coaching as an approach for developing and supporting clinical nurse leaders?

Chapter 3.

Methodology

3.1 Introduction

This chapter begins with a reiteration of the research problem addressed in this thesis and the aim of the study. The overarching research question and the other research questions that guided this inquiry are next. This is then followed by a justification for choosing a mixed methods approach for the study and a discussion on the related epistemology. The research design framework is then discussed, followed by a description of the methods used in phase one and then phase two of the study. The chapter is then complete with a discussion on the ethical considerations for both phases of the study.

3.2 Problem Statement

Clinical nurse leaders face immense challenges in their roles and are under a great deal of stress, with some experiencing burnout and reporting intentions to leave. There is often little preparation for these roles, and there is frequently a lack of support or development for individuals once in the role. A need exists for a practical way to provide both support and professional development for clinical nurse leaders as they work in these complex roles within the practice setting. It is not known if coaching is a suitable means for providing this support or for the professional development of clinical nurse leaders. Therefore, the aim of this study was to examine coaching as an approach for providing professional development and support for clinical nurse leaders.

3.3 Overarching Research Question

How suitable is a coaching approach for professionally developing and providing support for clinical nurse leaders?

3.4 Research Questions

As discussed previously, the main research questions were:

1. To what extent does coaching have an effect on clinical nurse leaders' work engagement levels?
2. To what extent does coaching have an effect on clinical nurse leaders' burnout levels?
3. What is the effect of coaching on clinical nurse leaders' intention to leave their position or the profession?
4. To what extent does coaching assist clinical nurse leaders attain their professional goals?
5. What are clinical nurse leaders' perceptions of coaching?
6. To what extent does the qualitative phase of the study explain or enhance the interpretation of results from the quantitative phase of the study?
7. What do the quantitative and qualitative data together reveal about coaching as an approach for developing and supporting clinical nurse leaders?

3.5 Justification of Choosing Mixed Methods

Reflection on the literature and the inquiry process, led the researcher to the key purpose of the study, which was to understand if coaching was a suitable approach for professionally developing and supporting clinical nurse leaders. The initial design for this inquiry was an eight week coaching intervention, with pre and post testing, collecting data via an online survey. The quantitative study was planned and executed, however, some of the results obtained from this phase of the study were unanticipated and required to be explored in greater depth. This changed situation invited the addition of a qualitative phase to the study to examine these results further, and it seemed that a quantitative approach alone would be insufficient to provide an overall answer to the

research questions. Proponents of mixed methodology approaches, note that it is appropriate to use mixed methods when one method alone is insufficient to gain an understanding of the problem (Creswell, 2015; Plano Clark & Badiee, 2010; Teddlie & Tashakkori, 2010). A mixed methods design was deemed an appropriate way to progress the inquiry. According to Creswell (2015), it is common for the design to emerge rather than being pre-planned in a mixed methods study. He defined mixed methods as:

> an approach to research ... in which the investigator gathers both quantitative (closed-ended) and qualitative (open-ended) data, and integrates the two, and then draws interpretations based on the combined strengths of both sets of data to understand research problems. (Creswell, 2015, p. 124)

One of the core features of mixed methods approach is that it contains both the collection and analysis of quantitative and qualitative data in order to answer research questions (Creswell, 2015). The assumption is that the combination of both quantitative and qualitative data provides a better understanding of the research problem than either element would provide on its own (Creswell, 2015). Although quantitative studies can provide evidence on relationships between variables, statistical significances, confidence intervals and effect sizes, if the results are unanticipated, such as in this study, it is unknown how the findings occurred (Creswell, 2015). In such a case, a qualitative phase in the study can be utilised to inform the interpretation of such statistical results. Mixed methods designs can have the qualitative and quantitative elements of the study play a more or less prominent role in the overall inquiry, depending on the design utilised.

The use of both qualitative and quantitative data allows for different perspectives within the inquiry and can provide a more comprehensive view of the problem. Ultimately, using both types of data can also provide for potentially stronger, more valid inferences to

be made from the results of the study (Creswell & Plano Clark, 2011; Teddlie & Tashakkori, 2009). An additional key justification of using mixed methods is that using principles from two alternate paradigms (positivism and constructivism) means that the work provides complementary strengths from each paradigm (Johnson & Onwuegbuzie, 2004). Alternatively, weaknesses of the different paradigms when used alone are minimised through a mixed method approach. The next section considers the epistemology related to mixed methods.

3.6 Epistemology Related to Mixed Methods Research

This section outlines the philosophical foundations that underpin this study. According to Creswell (2014, p. 6) there are four popular "world views" or paradigms researchers can take including, post positivism, constructivism, transformative and pragmatism. Pragmatism as a philosophy is focussed on actions and on "solving practical problems in the real world" (Feilzer, 2010, p. 8). Pragmatism has four elements: it is "problem-centred", is "real-world practice oriented", it is "pluralistic" and it focuses on the "consequences of actions" (Creswell, 2014, p. 6). Pragmatists believe that research occurs in social, historical, political and other contexts and as such is likely to need different philosophical considerations of how to analyse the data (Creswell, 2015). According to Morgan (2014), the much focussed on "how to" and "problem solving" aspects of pragmatism focussed on by Mixed Methods Researchers (MMR), only partially encompass the paradigm, and does not embrace the larger philosophical aspects of the approach. However, John Dewey's work (Dewey, 2008) provides a strong philosophical base for pragmatism. Dewey's philosophy was that knowledge was the result of a continual cyclical process of interactions between beliefs and actions (Dewey, 2008). His model of inquiry supported this continual interaction, where our beliefs continually influenced our actions and our actions continually influenced our beliefs. He claimed that

warranted assertions (or knowledge) was due to this continual interaction of beliefs, actions and reflection (Dewey, 2008). Morgan (2014) commenting on Dewey's warranted assertions, explains that this view perceives knowledge to be the result of "using a belief in practice, in which knowing cannot be separated from doing ... [where] the knower and the known are inseparable, bound together in a process of inquiry" (p. 4). Essentially knowledge comes from our unique experiences in the world, where actions have consequences, which in turn inform future more purposeful actions (Tebes, 2012). Tebes (2012) and other scholars (Biesta, 2010; Morgan, 2007), point out that if all knowledge is dependent upon how we as individuals engage with the world, and each of our interactions are unique, then a diverse approach to knowledge generation, using different research methods is justified (p. 17). Similarly, Greene and Hall (2010, p. 132) point out that pragmatism does not adhere to any particular research method for generating knowledge, noting that "pragmatic inquirers may select any method based on its appropriateness to the situation at hand".

According to Creswell and Plano Clark (2007, p. 102) paradigms can shift in a research study. Although a debate in the literature continues about how to move between paradigms in a rigorous manner (Giddings, 2006; Giddings & Grant, 2007; Taylor & Francis, 2013), mixed methods scholars such as Morgan (2014), reject the subjectivism-objectivism dichotomy, viewing the distinctions between post positivism and constructivism as "two sides of the one coin" (p. 4) with each providing important information about the human experience. The argument that a mixed methods approach provides the best of both worlds is thus pertinent to this inquiry, as it adheres to pragmatism allowing for inquiries to answer questions immediately applicable to the "real world" (Taylor & Francis, 2013). In summary, this research was guided by pragmatism; the world view that research sometimes needs more than one philosophical approach.

3.7 Research Design Framework

The framework that guided this mixed methods study was Creswell (Creswell, 2015). According to Creswell (2015, pp. 35-40) there are six mixed methods designs: a) the convergent parallel design, b) the explanatory sequential design, c) the exploratory sequential design, d) the intervention design e) the social justice design and f) the multistage evaluation design. The design of this study is the explanatory sequential design detailed in Figure 2.

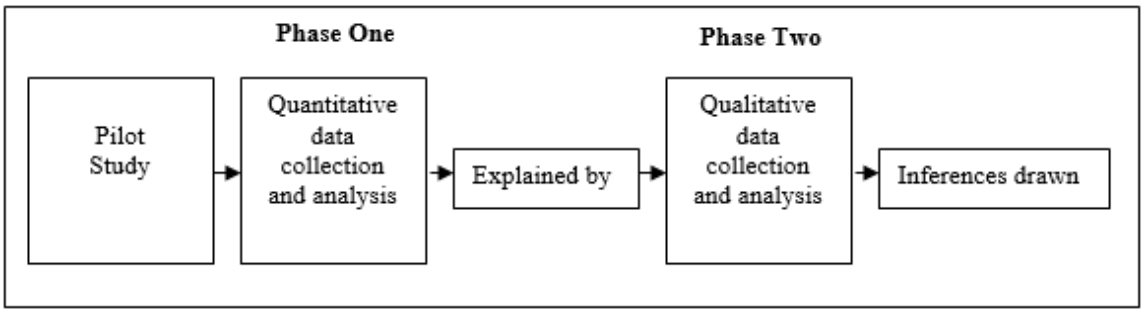

Figure 3: The Explanatory Sequential Design

This design of this inquiry is a two-phase study which has a quantitative phase at the outset followed by a qualitative phase to assist in explaining the results obtained from the first phase. In phase one quantitative research questions were constructed, an intervention was delivered and pre- and post-tests were conducted. Hypotheses were tested using validated instruments. Data analysis was performed using statistical testing and results were analysed using statistical software SPSS (SPSS Inc, 2009).

The results from phase one of the research informed the second phase of the research, the qualitative element. In the second phase, qualitative questions were constructed and individual interviews were conducted with participants who had completed the coaching intervention. Once qualitative data collection and analysis were complete using content

analysis as a framework, inferences were then drawn about how the qualitative results helped to explain the quantitative data (Creswell, 2015).

Creswell notes that mixed methods researchers have four key decisions to make regarding their study designs; 1) the level of interaction between the phases 2) the relative priority of the phases 3) the timing of the phases and 4) the procedures for mixing the phases. In this study, the level of interaction is independent. That is, the two phases are separate from each other with different research questions, data collection and data analysis procedures. The different phases are only mixed when integrating the quantitative and qualitative data, and drawing conclusions at the end of the research study.

In regards to the relative priority of the different phases for the research reported in this thesis, greater emphasis was placed on the quantitative phase and the qualitative phase was used in a secondary role. The timing of the two phases was sequential, with the collection and analysis of data in the first quantitative phase being completed prior to the qualitative phase being commenced.

Regarding the procedures for mixing the two phases, the data analysis from the first phase provided clarification regarding the issues to be explored in the second phase of the study.

The point of interface for the two phases in the study was at interpretation, where there was consideration of the extent to which the qualitative study added insight to and helped explain the quantitative results. Consideration was also given to what was learned in response to the overall purpose of the study.

In conclusion, the principles used to direct this inquiry as according to Creswell's framework included:

- both quantitative and qualitative data were collected and analysed;

- the collection and analysis of both types of data were systematically and rigorously undertaken using the core principles of the specific paradigm (e.g. quantitative and qualitative paradigms);
- both data were integrated to form an explanation which answers the research question for this inquiry; and
- specific to the particular research design used in this inquiry, that of explanatory sequential design (Cresswell 2015) the quantitative research phase was undertaken first and then the qualitative phase with the purpose of the qualitative data explaining the meaning of the findings from the quantitative phase.

3.8 Methods for Phase One of the Study

Phase one of the research study was a quantitative study, a coaching intervention with pre- and post testing. The purpose of this phase of the study was to examine whether coaching is an effective intervention for assisting clinical nurse leaders to attain their professional development goals, increase their levels of work engagement, their levels of retention and reduce their levels of burnout.

3.8.1 Participants. The population of interest was registered nurses in Queensland, who worked either at the point of care in a clinical leadership role or who led a team of health care professionals that worked at the point of care. Inclusion criteria were:

1 Current registration to practice with the Nursing and Midwifery Board of Australia.

2 Willing to commit to the coaching process by setting and working towards their own professional development goals.

3 Willing to complete the pre- and post-test questionnaires.

4 Employed for more than 48 hours per fortnight and either:

a whose major role was working at the point of care in a clinical leadership role

or

b whose major role was to lead a team that worked at the point of care.

Leadership expectations exist across a wide variety of roles within clinical practice and are often not limited to a particular position. Therefore, to access a wide range of leaders, participation was invited from but not limited to those in the following clinical leadership positions; Clinical Nurses, Nurse Unit Managers, Clinical Nurse Consultants, Clinical Nurse Educators and Nurse Practitioners. Those who were excluded from the study were included below in Table 2.

Table 1: Study Exclusion Criteria

Excluded	Rationale for exclusion
Those in nursing leadership positions who had purely executive roles and functions or those whose major work was leading non-clinical teams	Excluded because the study required only nurses whose major role was working at the point of care in a clinical leadership role or those who led a team of health care professionals who worked at the point of care
Student nurses, new graduates or level one nurses	Excluded because the study required only nurses who were in a clinical leadership role
RNs whose major role entailed working in either the tertiary or other non-clinical settings	Excluded because the study required only nurses whose major role was working at the point of care in a clinical leadership role or those who led a team of health care professionals who worked at the point of care

3.8.2 Recruitment. Recruitment involved the following process. Participants were sought from a hospital and health service, which had two regional and two rural hospitals, five community health services and a residential aged care facility. Participants were also sought from two private health care institutions (one urban, one regional). Recruitment into the study was via flyers and information sessions conducted throughout these organisations, in professional seminars and study days. The information sessions gave a brief outline of the study and provided an opportunity for potential participants to speak directly to the researcher regarding any questions about the study. Participants who responded to the initial invitation were subsequently provided with written information on the study. The researcher was also available via telephone or email to clarify any issues, answer any questions or respond to any participant concerns. Individuals who wished to participate in this study were given information sheets (Appendix A) and a consent form to sign (Appendix B).

3.8.3 Sampling method. All participants who provided signed informed consent were randomly allocated to either the control or intervention group. Random allocation occurred through a coin toss approach (Shields & Watson, 2013). This meant that as each participant enrolled in the study, a coin was tossed to decide which group they were allocated to: heads = intervention group, tails = control group. Once participants were enrolled in the study, they were sent an email link to the online pre-test questionnaire. Blinding of researcher and participants regarding enrolment in the intervention group was not possible because the coaching intervention was provided by the researcher.

3.8.4 Sample size. In order to determine an appropriate sample size, a power analysis was conducted for this study. Statistical power is described as the probability

that a researcher will reject a false null hypothesis and avoid a type II error (Gillis & Jackson, 2002). A level of 0.80 is generally accepted as providing an acceptable level for power to detect an effect in the variables (Schneider, Whitehead, & Elliott, 2007). Based on an alpha of 0.05 and a power level of 0.80, the calculation revealed that 64 participants were required to detect a moderate effect size (0.30, Faul, Erdfelder, Lang, & Buchner, 2007).

3.8.5 Intervention and control groups. Participants in the intervention group received weekly telephone coaching sessions of 45minutes to one hour in length, over a period of eight weeks. The control group did not receive any coaching during the eight weeks of the intervention period and during that time, participated in their usual professional and development activities.

3.8.6 The coaching intervention. The coaching focused purely on goals that were related to the individual's professional activities as a leader. Each participant had to identify an area of their professional practice they wished to focus on during the coaching. Goals such as losing weight or resolving marriage or financial issues were not appropriate for this type of coaching. This was not life coaching, counselling, or any other type of therapy. For the participants, there was still considerable scope with regards to the content of the coaching as long as the goals were related to their professional activities and development as a leader.

To ensure a degree of consistency regarding the coaching processes followed, the researcher utilised a coaching protocol based on the GROW coaching model (Landsberg, 2015) which provided a broad structure for the coaching session. There was only one person conducting the coaching intervention—the researcher.

The coaching intervention was informed by the nursing and coaching professional frameworks and regulations. The International Coach Federation's (ICF) Code of Ethics (ICF, 2008a), ICF Professional Charter for Coaching and Mentoring (EMCC & ICF, 2011), and the ICF Coaching Core Competencies (ICF, 2008b) informed the content and process of the coaching program. In addition, the coaching was within the context of nursing practice and as such was bound by the Nursing and Midwifery Board of Australia, and the regulatory body AHPRA (Australian Health Practitioner Regulation Agency), along with the Code of Conduct, and Code of Ethics.

The coaching intervention was also informed by theory as a cognitive behavioural, solution focussed approach was used in the coaching sessions. The cognitive behavioural approach was utilised because of the effectiveness of cognitive behavioural therapy and the close alignment it has with the intentions of coaching (Grant, 2012b; Palmer & Gyllensten, 2008). Cognitive behavioural therapy is a short term focussed approach that assists individuals to identify unhelpful thoughts and behaviours, and to learn or relearn healthier skills or habits (Australian Association for Cognitive Behavioural Therapy, 2015). Cognitive Behavioural Coaching guides the individual receiving the coaching to find their own solutions or answers and aims to help them develop self-awareness. It is usually time limited and goal directed (Palmer & Gyllensten, 2008).

The solution focussed approach developed by Steve De Shazer and Insoo Kim Berg (De Shazer, 1984, 1985, 1991, 1994), also underpinned the approach taken in the coaching sessions. The solution focussed approach emphasises solutions rather than problems, centring on possibilities and the future rather than the past. It concentrates on eliciting the individual's strengths and resources, recognising previous successes and emphasises working collaboratively in identifying goals and constructing solutions.

Although the solution focus approach initially started off as a family therapy, its techniques are now widely used outside the therapy context in areas such as Education (Daki & Savage, 2010; C. Franklin, Moore, & Hopson, 2008; Kvarme et al., 2010) and Business (Jackson & McKergow, 2002; Macdonald, 2011). It has also been used successfully in the coaching setting (Green et al., 2007; Green et al., 2006; Jane Greene & Grant, 2003; McKergow, Oglethorpe, & Faulkner, 2012). Techniques such as scaling questions, focusing on past successes, exceptions, the miracle question and goal setting are all tools from solution focussed therapy that are useful in the coaching setting.

3.8.7 Delivery of the coaching intervention. The coaching intervention was delivered via the telephone. An extensive review of the literature identified that telephone coaching had not previously been studied as a means of professional development for clinical nurse leaders. Given the reports of nurse leaders having difficulty in accessing professional development (Courtney, Yacopetti, James, Walsh, & Finlayson, 2002; Courtney, Yacopetti, James, Walsh, & Montgomery, 2002; Paliadelis, 2005), professional development via telephone or Skype could be a potentially cost-effective way to overcome some of these barriers.

Based on the coaching research literature it was concluded that eight weekly coaching sessions was a reasonable timeframe for participants to meet their goals (see for example Hovell et al., 2011; Iles, Taylor, Davidson, & O'Halloran, 2011; MacLean et al., 2012; Terry, Seaverson, Grossmeier, & Anderson, 2011; Vale et al., 2003). Given that there were no clear guidelines in the literature regarding number or duration of calls it was essential that telephone sessions did not place an onerous burden on the already time poor nurse leaders. The work of key scholars in the field (Grant, Green, et al., 2010; Gyllensten & Palmer, 2005a, 2005b, 2006; Passmore & Brown, 2009) was used to guide

call duration and frequency, and the coaching intervention was developed to consist of one 45-60 minute call per week over a period of eight weeks. The timing of the calls was flexible to fit in around contextual demands of the participants and the workload demands of their workplaces.

3.8.8 Flexibility of the coaching intervention. In the context of clinical practice, circumstances can change quickly. It was essential that the coaching program was designed with sufficient flexibility to accommodate last minute unforeseen emergencies. Scheduling of weekly coaching sessions had to be flexible and it was important that the coach could be contacted if the planned session for that week had to be rescheduled. Dates and times for the coaching sessions could not be planned in advance, as all participants did not enter the study at the same time. In addition, each individual participant would have different time preferences for the coaching session depending on the context of their work environment. Mutually agreed times that were suitable for both parties guided the dates and timing of the coaching sessions.

3.8.9 Coaching contract. In establishing a coaching relationship, there is usually a formal agreement or a coaching contract signed between the coach, coachee and other stakeholders such as the employer or institution paying for the coaching (Bluckert, 2006 p. 11; Grant, 2006 p. 103). Because no money changed hands, no contract was signed for this coaching other than the research consent form.

3.8.10 Costs. In usual coaching circumstances, there are costs associated with being coached. As this was a research study, there were no costs associated with the coaching for the participants. All costs of the coaching calls were borne by the researcher. Also, no payment was received by the coach researcher for the coaching services provided.

3.8.11 The coaching cycle. The eight-week coaching cycle was based on the generic model of self-regulation (Grant, 2003, 2012a) presented in Figure 3.

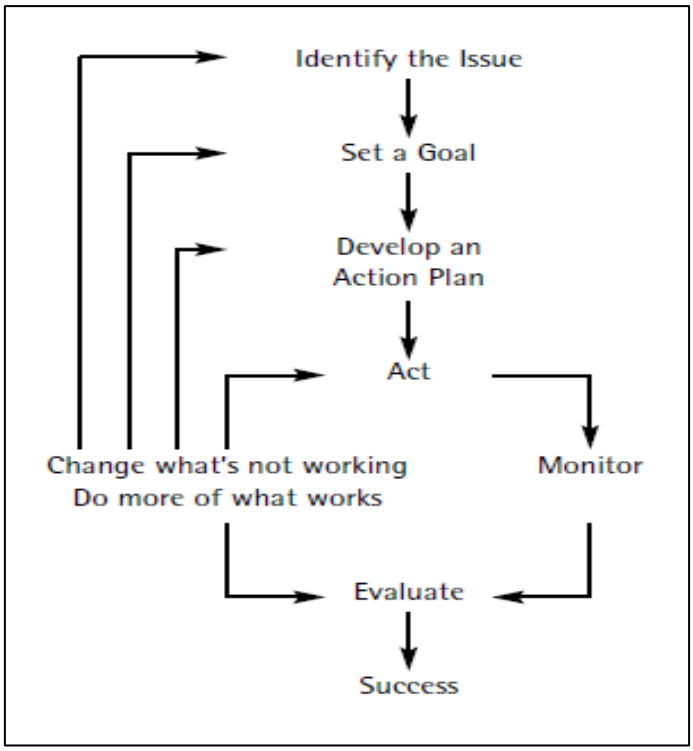

Figure 4: The Generic Model of Goal-directed Self-regulation (Grant, 2003, 2012a)

Identifying the issue and goal setting

The early steps in the self-regulation model focuses on identifying the issue and setting a goal. In coaching, the first session is used to start building the important relationship that exists between the coach and coachee. The session commenced with a brief introduction to professional coaching and an explanation of how the coaching sessions would be structured. Conversation then focussed on identifying the issue. Discussion centred around the individual's current professional context, the professional issues they currently faced, along with their vision for how they would like it to be. Once the issues they faced as a professional were identified, they were then asked to choose a focus for the coaching and set an initial goal. It is recognised that there is value in spending time early in the

coaching process, exploring the coachee's vision (Greene & Grant, 2003, p. 128) for themselves and for the coaching, to ensure the goals are personally meaningful to the coachee. This was an important step in ensuring commitment from participants in attaining their goal. To ensure the goals set were attainable within the eight-week timeframe, there was time allocated at the beginning of the coaching period for the coach to work closely with the participants in constructing their goals, although there was also flexibility built in to refine their goals in later sessions as clarity and focus developed for them. This is consistent with the coaching literature which suggests that defining goals too early can be problematic, as often clarity comes during the coaching process, and those topics discussed early may not be the "real" issue of concern (Greene & Grant, 2003, p. 128).

All goals identified by the coachees in this study were related to their professional activities and development as clinical leaders. Participants were asked to identify an area of their professional practice they would like to develop further and write a goal to attain during the coaching using the SMART acronym (Specific, Measurable, Attainable, Relevant, Timely). They were also asked to construct a goal statement for each of the five levels in the Goal Attainment Scale so their goal attainment could be assessed. If participants were unsure of an area for their focus, they were referred to the National Competency Standards for the Registered Nurse (ANMAC, 2005) for guidance in choosing their topic area, as these are part of the regulatory framework governing delivery of competent nursing care. These guidelines are also viewed as a benchmark to assess competence across a range of settings and are regularly used by individual nurses to self asses their own performance (ANMAC, 2005). In addition, because this coaching was developed specifically for nursing leaders, the leadership competencies from the Nursing Leadership Institute (Sherman et al., 2007), the ICN Nursing HR Planning and

Management Competency Framework (ICN, 2010) and the NHS Leadership framework (NHS Leadership Academy, 2013) were also used as resources to assist coachees in identifying a relevant professional practice issue to work on. After developing their SMART goal, and they then engaged in the weekly coaching sessions.

Action, plan and act During each coaching session, the program required that a specific, mutually agreed action plan was set for the following week. Criteria for the action plan included achievable steps within a realistic time frame, and that strategies accommodated individual work and personal contexts. The time between weekly coaching appointments was when the participants implemented the strategies from their action plan. This step between coaching appointments can be challenging for coachees, so additional contact was made possible for the participants if they required clarification of issues or needed to contact the coach urgently. No participants utilised this option.

Monitor, evaluate and modify Monitoring and evaluating progress was built into each session. Each session commenced with a review of weekly progress, and ensuing discussion centred on any issues that had occurred. The coaching interventions took the form of an iterative review on strategies that were working and changing those that were not. These ongoing evaluations were an essential component of the coaching program because it kept coachees motivated and on track with their goals. The action plan was modified after each session and the newly refined plan was then put into action for that coming week.

During the coaching conversations, open ended questions were used to assist the participants reflect, maintain focus and keep momentum. The coach/researcher maintained a non-judgemental approach and listened for issues that were raised and for any signs of resistance or fear that would need to be addressed in order to further goal

attainment. Successes, large and small, were celebrated throughout the coaching process as these were important motivators for coachees. The coach encouraged individuals to identify ways in which they would celebrate their own personal successes, no matter how small. Recognising achievements and celebrating successes are important aspects of coaching (Bluckert, 2006, p. 32) and are a well-recognised part of the coaching process.

3.8.12 Structure of the individual coaching sessions. The coaching session is often an iterative unpredictable process, making it difficult to predetermine or prescribe the next steps (Cavanagh & Grant, 2006 Pg 155). Despite this, the literature is replete with coaching models or formats for guiding coaching sessions. Nevertheless, coaches are cautioned to ensure that they use these models only as a guide and not as a mechanistic tool which could limit the intervention and reduce its chances of success (Cavanagh & Grant, 2006, p. 155).

The coaching conversations in this study, although focused on the professional development of the clinical nurse leaders, each developed in a unique way, as the individual leaders had different professional development goals, and each time they spoke with the coach, they had different coaching issues to discuss. Although the coachee's particular agenda for the session and their unique responses to the coach's questions, did inform the direction of the coaching session, the GROW model was used to guide or add an overall broad structure to each coaching conversation. In order to provide an overall structure to the individual coaching sessions and to ensure consistency in the approach used across all participants in the program, a protocol based on the popular GROW model (Landsberg, 2015) was utilised to guide the individual coaching sessions. See Appendix C.

3.8.13 Phase One study outcomes. The primary outcomes for this part of the study were the clinical nurse leader's levels of work engagement, their levels of burnout,

and their intention to remain in either their current position or the profession. Coaching is a goal focussed activity (Grant, 2003; Grant et al., 2009; International Coach Federation (ICF), 2008b; Passmore & Gibbes, 2007), and as such, necessitated the inclusion of goal attainment as one of the outcome measures. Participants' satisfaction with the coaching intervention was evaluated and the survey also included a section containing some open ended questions to evaluate participants' perspectives immediately following the coaching.

3.8.14 Data collection instruments. Data collection was via an online survey form which contained the Utrecht Work Engagement Scale (UWES), the Maslach Burnout Inventory Health Services Survey (MBI-HSS), the Nurse Retention Index (NRI), and a Goal Attainment Scale.

3.8.14.1 The Utrecht Work Engagement Scale. The Utrecht Work Engagement Scale has 17 items and consists of three subscales that measure the dimensions of work engagement: 1) Vigor (VI; six items), 2) Dedication (DE; five items), and 3) Absorption (AB; six items). Items are scored on a seven-point scale ranging from zero (never) to six (always). The UWES Manual (Schaufeli & Bakker, 2003) classifies scores as very low, low, average, high and very high. Statistical cut-off points in this current study were applied as per the UWES Manual (Schaufeli & Bakker, 2003) and scores ≤3.06 were accepted as having low work engagement. Very low work engagement scores were ≤ 1.93. Scores ≥ 4.67 and ≥ 5.54 were regarded as high or very high work engagement respectively. A score between 3.07 and 4.66 indicated average work engagement. Internal consistency for the UWES is high, rated at .80 -.90 (Schaufeli & Bakker, 2004). (Te Brake, Bouman, Gorter, Hoogstraten, & Eijkman, 2007) reported

reliability coefficients 0.94. A level of 0.70 or higher is considered to be an acceptable level of reliability for an instrument (LoBiondo-Wood & Haber, 2002).

3.8.14.2 The Maslach Burnout Inventory (MBI-HSS). Burnout is measured by the Maslach Burnout Inventory (MBI-HS). The MBI is generally recognised as a leading measure of burnout and has been used worldwide for over twenty years, particularly within the nursing profession (Kanste, Miettunen, & Kyngas, 2006; Le Blanc, de Jonge, de Rijk, & Schaufeli, 2001). The MBI consists of three scales – emotional exhaustion (EE; nine items), depersonalisation (DP: five items) and personal accomplishment (PA; eight items). Reliability coefficients for the subscales are reported as .90 for Emotional Exhaustion, .79 for Depersonalisation, and .71 for Personal Accomplishment. Items are scored on a seven point scale ranging from "never" (0) to "every day" (6). High scores on the emotional exhaustion and depersonalisation scales, and low scores on personal accomplishment scale are indicative of burnout. As per the MBI manual (Maslach et al., 1996), High scores (≥ 27) on the emotional exhaustion and depersonalisation (≥ 13) subscales and low scores (≥ 39) on the personal accomplishment subscale were regarded as indicative of high levels of burnout.***The Nurse Retention Index (NRI).*** The Nurse Retention Index (NRI) is designed to measure nurses' intention of remaining in the nursing profession. There are six items in the scale, with a balance of negatively and positively worded items. An eight-point Likert scale is used to guide responses from 1 (definitely false) to 8 (definitely true). The higher the scores on the NRI, the higher their intention to remain in the profession. Reliability for the scale has been reported as Chronbach's alpha .97 .95 and .94. (Cowin, 2002; Cowin & Hengstberger-Sims, 2006; Cowin, Johnson, Craven, & Marsh, 2008; Hart, 2005).

3.8.14.4 Goal attainment. The literature on coaching indicated that coaching interventions were associated with coachees attaining their goals. Measuring

goal attainment was considered to be an important factor in answering question five on the extent to which coaching could assist clinical nurse leaders in attaining their professional development goals.

Goal Attainment Scaling (GAS) is an individualised criterion based measure of change, which captures meaningful progress towards goals and provides a systematic way of comparing goal progress across a group. It was originally used in the mental health field (Kiresuk, Smith, & Cardillo, 1994) and has been subsequently used in a variety of other fields including occupational therapy (Meyers, 2010), elderly care (Klosec, 2007), long term care (Bravo, Dubois, & Roy, 2005), amputee rehabilitation (Rushton & Miller, 2002) and brain injury (Ertzgaard, Ward, Wissel, & Borg, 2011) to measure progress towards goals. Goal Attainment Scaling (GAS) (Kiresuk & Sherman, 1968) is viewed as a valuable outcome measure in coaching (Grant, Passmore, Cavanagh, & Parker, 2010; Greif, 2007; Spence, 2007) and for this study was considered to be an appropriate measure for providing a complete picture of participants' goal attainment. In evaluating the degree to which clinical nurse leaders attained their goals, a dichotomous yes/no response would provide very little information, particularly for those individuals who made very good progress towards their goals, but didn't attain their end goal. Dichotomous responses in such a situation would provide a distorted view of the situation, implying that no progress had been made at all. It was decided to use a more pragmatic measure of goal attainment that would demonstrate progress towards the goal and provide a more comprehensive picture of goal attainment.

In the first coaching session participants worked with the coach to identify how they would assess their goal achievement. Once their goal statement was constructed from their SMART goal, coachees were asked to use the Goal Attainment Scaling (GAS)

describe their hypothetical 1) expected outcome, 2) a better than expected outcome, 3) a much better than expected outcome, 4) a less than expected outcome and 5) a much less than expected outcome for their goal. At the end of the coaching session, these definitions were applied to determine the coachee's degree Goal Attainment Scaling was used to measure the coachee's degree of goal attainment at the end of the study. An example of the goal attainment scale used in this study can be seen in Figure 4.

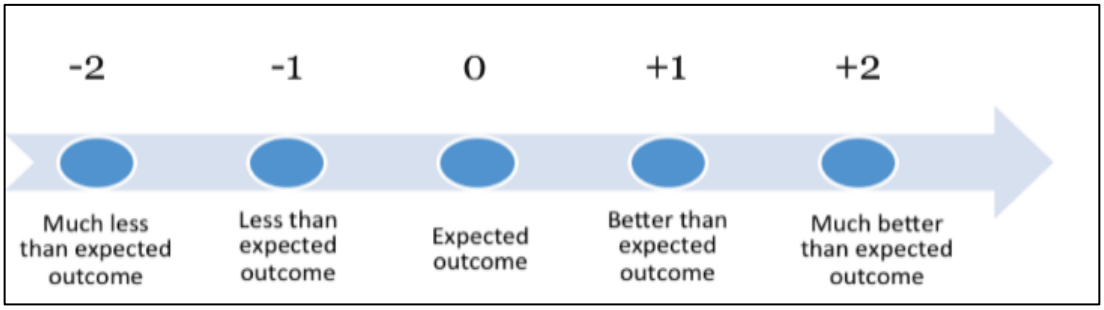

Figure 5: Goal Attainment Scale

3.8.14.5 Participant satisfaction with the coaching. Data was collected on the survey form regarding participants' satisfaction with the coaching. Satisfaction was measured on a five point Likert scale with ratings of poor, fair, good, very good or excellent.

3.8.15 Data collection phase one. Data collection occurred before the implementation of the coaching intervention (pre-test). In this pre-test survey all instruments described above were included in the questionnaire as well as demographics. Demographics were useful to determine the characteristics of those clinical nurse leaders volunteering to participate in coaching.

The second quantitative data collection of phase one was the post-test survey, which was sent out immediately following the completion of the coaching intervention at eight weeks. The control group also received their post-test eight weeks following enrolment

in the study. All instruments included in the pre-test survey were included in the post-test survey so that comparisons could be achieved during data analysis. Each participant was asked to provide a pseudonym to record and trace the data collection between the pre- and post-test data collection.

3.8.16 Data analysis. Data was analysed using SPSS software package. Data were checked and cleaned prior to analysis, with decisions about outliers made on a case by case basis. The extent to which data met the assumptions for specific statistical tests was also assessed. Mean differences of work engagement, burnout, and intention to leave of the control and intervention groups was compared using general linear modelling. Parametric tests were used for the data that was normally distributed, such as the MBI PA subscale and non-parametric tests were used for data that were not normally distributed, such as the EE and DP subscales.

3.9 Methods for Phase Two of the Study

Phase two implemented a qualitative inquiry to expand on and contextualise the results gained from phase one. This adheres to the mixed method approach of explanatory sequential design (Creswell 2015). The methods will now be explained.

The principles that guided this phase of the inquiry were:

1. Ensuring transparency of the research process by adhering to the criteria set out by Guba and Lincoln (1989);
2. Maintaining a rigorous approach to inquiry by utilising Schreier's framework for content analysis (Schreier, 2012, 2014) and
3. Ensuring that the processes of data gathering and analysis explicate the experiences of the participants.

3.9.1 Sampling. A purposive sampling strategy was utilised in Phase two of this study. All of the participants who had received the coaching intervention were emailed an invitation to participate in an interview, approximately six months following their last coaching session. Seven participants' contact details had changed completely and the initial emails came back undelivered. These participants also could not be contacted via telephone. A second email was sent to non-responders two weeks following the initial email, and a final follow up reminder two weeks later. There were thirteen non-responders and enquiries revealed that some participants had changed employers, retired from the workforce, gone on sick leave, study leave or long service leave. From the twelve participants who did respond to the initial invitation, only six participants were able to successfully schedule a time to be interviewed. Reasons for non-participation in the interviews were a lack of time due to current workloads, impending deadlines for their projects, annual leave, maternity leave, or heading overseas for work or conference. This resulted in six participants being available to participate in the qualitative phase of the study.

3.9.2 Data collection. Telephone interviews were scheduled for a date and time suitable for the six participants who agreed to be interviewed. During the interviews, open questions were used to elicit in depth responses from participants and used phrases such as "Can you comment on ..."; "Can you tell me about ...". Prompts such as "Can you give me an example of ...", "Could you expand on that?" were used to encourage the participants to expand on the points being made and provide more in depth information. A copy of the interview schedule is attached in Appendix H. The interviews were recorded and transcribed verbatim.

3.9.3 Data analysis. Data from the interviews was analysed using an inductive approach to qualitative content analysis. Schreier (2012, p. 1) defined content analysis as "a method for describing the meaning of qualitative material in a systematic way". According to Schreier (Schreier, 2012, 2014), content analysis is characterised by three features; it reduces data, it is systematic and it is flexible. Qualitative content analysis can be conducted inductively or deductively and essentially commenced as a method in communication research for systematically quantifying or classifying oral or written content (Cho & Lee, 2014; Moretti et al., 2011). Mayring proposed a step model for content analysis that could be utilised with either inductive or deductive content analysis with some small step differences between the two types of analysis (Mayring, 2001). In relation to qualitative content analysis, he proposed the steps of determining the unit of analysis; conduct open coding; formulate preliminary codes; coding the main data; revising of codes; and developing categories and themes along with retesting of new statements to ensure categories are mutually exclusive. Similarly, Schreier (2012) composed a framework of eight steps to guide content analysis. This included:

1. Decide on the research question
2. Select your material
3. Building a coding frame
4. Dividing your material into units of coding
5. Trying out your coding frame
6. Evaluating and modifying your coding frame
7. Main analysis
8. Interpreting and presenting your findings.

Schreier's framework (Schreier, 2012) is what guided the content analysis in this study. Interview transcripts were the unit of analysis. All transcripts were read and re read

several times and pertinent words or phrases were highlighted and notes taken in the margins. Open coding continued like this for two or three transcripts as preliminary codes were identified. Detailed coding then began using the preliminary codes. The entire data set was then coded systematically, line by line and the data was organised into meaningful units. Initial codes were descriptive in nature often using the participants' own words or phrases and new codes were added as required. As the analysis progressed, similar codes were then collated into broader higher order categories or themes. Analysis was an iterative process where codes and themes were constantly reviewed and checked against the data. Ongoing analysis of the specifics within each theme and a movement from description to a higher level of abstraction and interpretation, led to refinement of the early descriptive material into the final story that reflected the participants' reality. The findings, themes and categories from that analysis are discussed in Chapter Six.

To ensure that qualitative findings accurately represent the data in a research study, trustworthiness required to be established. According to Lincoln and Guba (Lincoln & Guba, 1985) this involves establishing credibility, dependability, transferability and confirmability. Credibility in this study was established through peer debriefing, where several other researchers discussed the analysis to help uncover assumptions and taken for granted biases (Lincoln & Guba, 1985). Dependability was also established using a panel of researchers to examine the processes followed during the study and the findings from the inquiry. Transferability was established through providing "thick" detailed description of the participants' accounts and confirmability was established through triangulation of multiple data sources and methods used in this mixed methods study. Data analysis was facilitated by the use of QSR International's NVivo 9 data analysis software (QSR International Pty Ltd, 2010).

3.10 Ethics for both Phases of the Study

Ethics approval for this study was obtained from the Behavioural and Social Sciences Ethical Review Committee, University of Queensland, approval 2008000838. An explanation of participants' rights was included in the information sheet, which stated that participation in the study was entirely voluntary and participants had the right to withdraw from the study at any time without fear of penalty, discrimination or reprisal. Information from those who withdraw from the study would be destroyed and not used for the research. The Participant Information Sheet contained the contact number of the researcher and a contact number for a member of the Human Research Ethics Committee if further information was required. A copy of the participant information sheet, the consent form and ethics approval notifications are provided in the appendices.

Data collection for this study was through online questionnaires on a secure website, hosted by SurveyMonkey (SurveyMonkey). Only the research team and authorised members from SurveyMonkey.com had access to the research data. The researcher was the only one who had access to the full participant details. The list of participant details was kept in a locked filing cabinet. This list and data from the study will be kept for at least fifteen years following the last action, in a secure location and then destroyed. This is in accordance with the University Sector Retention and Disposal Schedule QDAN601v3 (Queensland Govt, 2014) which is a policy set in place for research data management within Queensland public universities.

The data collection instruments were on a website hosted by SurveyMonkey.com in a secure environment, protected by firewall and intrusion prevention software. SurveyMonkey has a security policy and a privacy policy regarding storage and usage of data. The policy specifies that the server which is used to store the data is also in a secure

locked environment, with digital surveillance equipment and restricted entry to authorised staff via passcard and biometric recognition. Further details on how SurveyMonkey keep data secure are available on their website at http://surveymonkey.com/HelpCenter/Answer.aspx?HelpID=42

Steps were also taken to ensure that SSL (Secure Sockets Layer) was enabled so that the survey link and the survey pages were encrypted as they were returned from the participants. This ensured that the data was collected in a totally encrypted, safe environment. Participants' privacy was also maintained by ensuring that the data collection instruments did not have any record of their names or any other identifying information. Participants were sent the web URL address once enrolled in the study, and they were asked to use code names rather than their real names on the pre- and post-test questionnaires.

Although this phase of the study was conducted online, participants were reassured that employers did not have access to any of the data from the research, or were even aware of any one individual's contribution to the study. The participants were not required to pay for coaching phone calls, as all the calls were made by the coach to the telephone number supplied by the participant. There were no conflicts of interest that arose from this study and there were no payments direct or indirect, or any "in kind' support provided to the researcher for this study or for providing the coaching.

The coaching was conducted by the researcher in accordance with the standards and guidelines set out by the International Coach Federation (ICF), in particular the ICF Code of Ethics (International Coach Federation (ICF), 2008a), ICF Coaching Core Competencies (International Coach Federation (ICF), 2008b), and the ICF Professional Charter for Coaching and Mentoring (EMCC & ICF, 2011), which set out clear

parameters for practicing coaches. The coach was a member of the international coach federation and as such was bound by the code of ethics and the code of conduct described on their website.

The coaching provided in this study was within the context of nursing practice, and as such was governed by the Australian Health Practitioners Regulation Agency (AHPRA) and specifically by the Nursing and Midwifery Board of Australia. Nurses are bound by their professional code of conduct (Nursing and Midwifery Board of Australia, 2008b) and a code of ethics (Nursing and Midwifery Board of Australia, 2008a). There are also other guidelines which provide a framework for their practice, including the competency standards (Nursing and Midwifery Board of Australia, 2006), the delegation and decision making frameworks (Nursing and Midwifery Board of Australia, 2010a), the guidelines on professional boundaries (Nursing and Midwifery Board of Australia, 2010b) and the Professional Practice Guidelines (Nursing and Midwifery Board of Australia, 2010c). All of these codes and guidelines provided a regulatory framework within which the coaching processes took place and which guided the practice of the coach and those being coached in the study.

To encourage the control group participants to return their post-test questionnaires after eight weeks of being enrolled in the study, these participants were offered a complimentary coaching session on receipt of their post-test questionnaire, once all the data collection from the quantitative phase of the study was collated. Twenty-four individuals from the control group accepted the offer of a complimentary coaching session. These coaching sessions occurred anywhere from 10 weeks to six months after the participants had returned their surveys.

Following Phase One, further ethical approval was sought and obtained from the Behavioural and Social Sciences Ethical Review Committee, University of Queensland, approval no 2008000838 (Amendment). See Appendix E All the previous ethical considerations regarding data collection and storage previously discussed were also applicable to the second qualitative phase of the study.

Chapter 4.

Phase One—The Pilot Study

4.1 Introduction

Gerrish and Lathlean (2015) advise nurse researchers to always consider conducting a pilot study prior to collecting data for the research. The purpose of the pilot is to act as a "dummy run" where data collection instruments can be tested and processes run to check if they work (Gerrish & Lathlean, 2015, p. 26). In this quantitative phase of the study, a pilot test was conducted on the instruments used and the coaching processes that were planned. The following section describes the participants involved and then moves on to describe the pilot testing of the data collection instruments and the psychometric properties of the instruments utilised. Pilot testing of the coaching processes are described next along with the results of that testing. Recommendations from the pilot study results are then provided.

4.2 Pilot Study Participants

Participants for the pilot study were identified through the researcher's existing professional networks. Clinical colleagues were approached directly via email or telephone call, regarding their willingness to participate in a pilot study to test the psychometric properties of the study instruments. A total of 12 clinical nurse leaders agreed to participate in the pilot study. Two of the participants failed to return their questionnaire at Time two, the post-test, giving a good response rate of 88% (Polit & Beck, 2008). The data from these two participants was then excluded from the analysis. All participants were female.

The majority of participants in the pilot study (n=10) were experienced clinical nurse leaders with 90% (n=9) of participants being qualified for eight years or more and only 10%

(1) having four to five years' experience in their leadership position. Eighty percent (n=8) of the nurses were full time (defined as more than 48 hours per fortnight) and 20% (n=2) worked part time. Most (90%) of the nurses who participated in the pilot study were working in urban/regional areas with only 10% working in a rural area. Eighty percent (n=8) of them were working in hospitals with only 20% working in the community. Half (n=5) of the clinical nurse leaders in the pilot study were working in private health care industry with the other 50% working in public sector. Table 3 indicates the demographic characteristics of the pilot participants.

Table 2: Demographic Characteristics of the Pilot Study Participants

Variable	Frequency	%
Hours Worked		
Full Time	8	80%
Part Time	2	20%
Geographic Location		
Urban/Regional	9	90%
Rural	1	10%
Employee location		
Hospital	8	80%
Community	2	20%
Institution		
Private	5	50%
Public	5	50%
Years Qualified		
4-5 years	1	10%
8 years or more	9	90%

As can be seen in Table 3 the majority of nurses in the pilot study were experienced clinical nurse leaders, who worked full time in urban/regional hospitals. There was an equal spread of nurses who worked for private and public institutions.

4.3 Pilot Testing the Data Collection Instruments

Previous studies on coaching indicate that it has the capacity to build on each individual's previous experience, yet also meet each leader's unique learning needs. Previous studies in coaching have reported increases in self confidence, self efficacy, perceptions of feeling supported and increases in motivation for those being coached. If being coached could provide a supportive, positive learning experience for clinical nurse leaders, then it is possible that it could also have a positive impact on the way they experience their challenging work situations. As there were no validated tools that specifically measured the outcomes from coaching, measuring work engagement levels, levels of burnout and intention to remain in post, seemed to be important secondary measures to determine the effect of coaching on clinical nurse leaders in practice. The Maslach Burnout Inventory (MBI), The Utrecht Work Engagement Survey (UWES) and the Nurse Retention Index (NRI) were chosen as appropriate validated measures to utilise in this study.

4.3.1 Psychometric properties of the instruments. Test retest is the classic test of stability (Wood & Ross-Kerr, 2006) and was performed on the instruments in this study. Links to the online pre-test questionnaire (Appendix F) were emailed to participants to complete (Time 1; T1) and ten days later the link to the post-test questionnaire (Appendix F) was emailed a second time to the same participants (Time 2; T2). Pearson's correlation co-efficient was then calculated for each of the three instruments used in the study; the Maslach Burnout Inventory (MBI), the Utrecht Work Engagement Survey (UWES) and the Nurse Retention Index (NRI).

4.3.1.1 Maslach Burnout Inventory (MBI-HSS). The MBI-HSS has 22 items and three subscales: Emotional Exhaustion, Depersonalisation and Personal Accomplishment, which were calculated as follows. The subscale of Emotional Exhaustion (EE) was

calculated as the sum of variables 1, 2, 3, 6, 8, 13, 14, 16, and 20; the subscale of Depersonalisation (DP) was calculated as the sum of variables 5, 10, 11, 15 and 22; and the subscale of Personal Accomplishment (PA) was calculated as the sum of variables 4, 7, 9, 12, 17, 18, 19, and 21. A summary of the descriptive results for all three subscales in the MBI-HSS for Time 1 and Time 2 are represented in Table 4.2.

Table 3: Time 1 and Time 2 Pilot Study Results—Maslach Burnout Inventory—Health Services Survey (MBI-HSS)

	Time 1				Time 2		
Variable	**M**	**SD**	**Range**		**M**	**SD**	**Range**
Emotional Exhaustion	24.80	16.20	40 (8-48)		22.30	14.90	42 (6-48)
Depersonalisation	6.90	5.25	15 (0-15)		6.50	4.80	12 (0-12)
Personal Accomplishment	34.20	7.80	24 (22-46)		35.20	7.40	21 (25-46)

As can be seen in Table 4 the mean scores for all three subscales were very similar for the two measurement points, indicating high test-retest reliability for the three subscales.

Table 4: Pilot Study Test-Retest Correlations for Maslach Burnout Inventory—Health Services Survey (MBI-HSS)

Variable	Correlation
Emotional Exhaustion (EE)	.87 ($p<.01$)
Depersonalisation (DP)	.84 ($p<.01$)
Personal Accomplishment (PA)	.78 ($p<.01$)

Test re-test correlations for the Maslach Burnout Inventory (MBI-HS) were high with levels of .87 for Emotional exhaustion (EE) ($p< .01$), .84 for Depersonalisation (DP) ($p<.01$) and .78 for Personal Accomplishment (PA) (sig at .007). These results demonstrate the stability of the MBI and are similar to reliability coefficients previously

reported for this instrument (.82 for EE, .60 for DP, and .80 for PA) significant at .001 (Maslach et al., 1996).

4.3.1.2 Utrecht Work Engagement Survey (UWES). The UWES has 17 items in total and three subscales which measure the dimensions of work engagement: Vigour, Dedication and Absorption. The three subscales of the UWES were calculated as follows. The subscale of Vigour (VI) was calculated as the sum of variables 1, 4, 8, 12, 15, and 17; The subscale of Dedication (DE) was calculated as the sum of variables 2, 5, 7, 10, and 13; and the subscale of Absorption (AB) was calculated as the sum of variables 3, 6, 9, 11, 14, and 16. Descriptive results for all three subscales in the UWES for T1 and T2 are represented in Table 6.

Table 5: Time 1 and Time 2 Pilot Study Results—Utrecht Work Engagement Survey (UWES)

	Time 1				Time 2		
Variable	**M**	**SD**	**Range**		**M**	**SD**	**Range**
Vigour	28.80	8.00	22 (20-42)		30.10	7.40	20 (21-24)
Dedication	25.40	6.23	18 (17-35)		26.50	5.30	14 (21-35)
Absorption	26.00	8.36	22 (17-39)		28.40	8.80	23 (19-42)

As can be seen in Table 6 the mean scores for all three subscales were very similar for the two measurement points, indicating high test-retest reliability for the three subscales.

Table 6: Pilot Study Test-Retest Correlations for Utrecht Work Engagement Survey (UWES)

Variable	Correlation
Vigour (VI)	.97 (p<.01)
Dedication (DE)	.93 (p<.01)
Absorption (AB)	.91 (p<.01)

As can be seen in Table 7 Pearson Correlations of the test re-test scores for the Utrecht Work Engagement Survey (UWES) were very high. These results demonstrate the stability of the instrument over time and are consistent with previous reports in the literature. Reliability coefficients for the whole scale are reported as 0.94 (Te Brake et al., 2007) and 0.92 (Schaufeli & Bakker, 2003).

4.3.1.3 Nurse Retention Index. The Nurse Retention Index has six items in total which measure nurses' intention of staying in nursing or their intention of leaving the profession to find other work. The mean for this scale was calculated as the sum of variables NRI Questions 1-6. The means for T1 was 26.4 (sd 4.92) compared to 25.4 (sd 5.16) for T 2, with a correlation of .79 or higher for each item ($p<.01$). These results demonstrate the stability of the instrument and are consistent with other reports in the literature (Cowin, 2002; Cowin & Hengstberger-Sims, 2006; Cowin et al., 2008; Hart, 2005).

The above results on the Maslach Burnout Inventory (MBI-HSS), the Utrecht Work Engagement Scale (UWES) and the Nurse Retention Index (NRI) demonstrate that the instruments selected for use in the main study have acceptable test-retest reliability for use in the main study.

4.3.1.4 Participant feedback on the questionnaire. All three instruments were collated into one survey form and feedback was sought from the piloted participants regarding the ease of use. One item at the end of the piloted survey form asked participants to estimate the time it took to complete the questionnaire. Initial estimated completion times (five to ten minutes) for the questionnaires were supported by feedback from these participants, with 90% of participants taking less than 10 minutes to complete the whole questionnaire. Over half (60%) found it took them less than five minutes to

complete the questionnaire. Only one participant found it took her more than 10 minutes to complete the questionnaire. All the participants reported that the instructions in the questionnaire were clear and easy to follow.

The majority of nurses who participated in this pilot were experienced nurses with eight years or more clinical experience. No novice clinical nurse leaders took part in the pilot study despite repeated invitations to novice Nurse Unit Managers or novice Clinical Nurses to participate in the pilot study. To assess if coaching had potential for being used as a professional development option more widely within nursing, it was considered useful to find out if this approach could be utilised for both novices and experienced clinical nurse leaders in a variety of settings. As a result of this, it was decided that for the main study, the inclusion criteria should be extended to include a wider range of staff. It is recommended that the inclusion criteria for the main study be altered to include not only clinical nurses, but to also encompass nurses in other clinical leadership positions, such as clinical nurse educators, clinical nurse consultants and or other senior clinical nursing roles across both hospital and community settings. Inclusion criteria regarding the requirement to be currently practicing in a clinical role or managing a clinical team remained unchanged.

4.4 Pilot Testing the Coaching Processes

In order to pilot test the coaching processes, six participants from the twelve agreed to participate in pilot testing for the coaching processes. Participants were randomly allocated to groups and those in the intervention group were put through an eight-week coaching process, while those participants in the control group received no coaching. Woolfe et al. (2007) raised concerns regarding control groups in psychological research, pointing out that it is not as simple as assuming that a control group is a “no treatment”

group. If participants are told they are to be allocated to either a treatment group or a non-treatment group and subsequently find out they are in the non-treatment control group, it can lead to feelings of disappointment or of being "rejected." Such feelings may subsequently stimulate the individual to actively seek out further information, support or treatments related to the study outcomes (Woolfe et al., 2007), which introduces a potential source of bias. Similar concerns have been raised by other researchers (Lindquist, Wyman, Talley, Findorff, & Gross, 2007) who noted that participants who are attracted to a study because of their interest in the intervention, might feel resentful once they realise they are in the control group and may subsequently withdraw from the study. In an attempt to promote retention numbers in the main study, an assumption was made that a complimentary coaching session would encourage participants not in the intervention group to remain for the eight weeks in the study. This assumption was confirmed in the pilot. All pilot group participants not in the intervention group accepted this offer and remained in the pilot for the eight weeks of the cycle.

In order to distinguish between the effects of the coaching intervention and the effects of non-specific factors such as social contact, support or attention which may have been provided by the weekly coaching calls, an attention control group was added to the pilot. The attention control group received weekly social contact telephone calls from the researcher/coach during the intervention time period of eight weeks. This was in comparison to the intervention group who received the same frequency of phone calls, but instead of a social conversation, they received the intervention—eight focussed coaching sessions over a period of eight weeks.

This would assist in ruling out the possibility of any Hawthorne effects (Polit & Beck, 2008) created by weekly contact with a coach and would assist in isolating the specific

effects of the coaching intervention. Both the attention control group and the intervention group received weekly telephone contact from the researcher, although only the intervention group received coaching during the call. The number of telephone calls and the frequency of the calls were controlled as each participant in the attention control group received the same number of calls on a weekly basis over eight weeks as those in the coaching group. Further, the content of the calls was delimited. The intervention group had calls which focussed on their professional leadership activities and attainment of their professional goals, whereas the call that each person received who were in the attention control group had a more general focus which did not include discussions of goals, goal setting, professional development or their leadership activities. The remaining control group had no contact with the researcher during the pilot test study other than at pre- and post-testing.

Overall, the pilot testing lasted eight weeks. All participants in the pilot went through an individual eight-week cycle, irrespective of the date they were recruited into the study. Pre-testing occurred at the beginning of the eight week cycle and post testing occurred at the end of the eight week cycle. A separate survey for the pilot testing was set up using Survey Monkey. Those in the intervention group and the attention control group received weekly calls over the eight-week cycle of the pilot test.

Finally, it has been argued that provision of information about the aims of a study may unintentionally contribute to the study outcomes (Lindquist et al., 2007). This was particularly relevant in this study where the outcomes of burnout, work engagement and achievement of work related goals were being measured. To control for this effect, the title of the pilot study on the participant information sheet and the consent form did not

directly specify outcomes being measured and only indicated the broad area of leadership. A summary of the processes followed in this pilot study are outlined for in Figure 5.

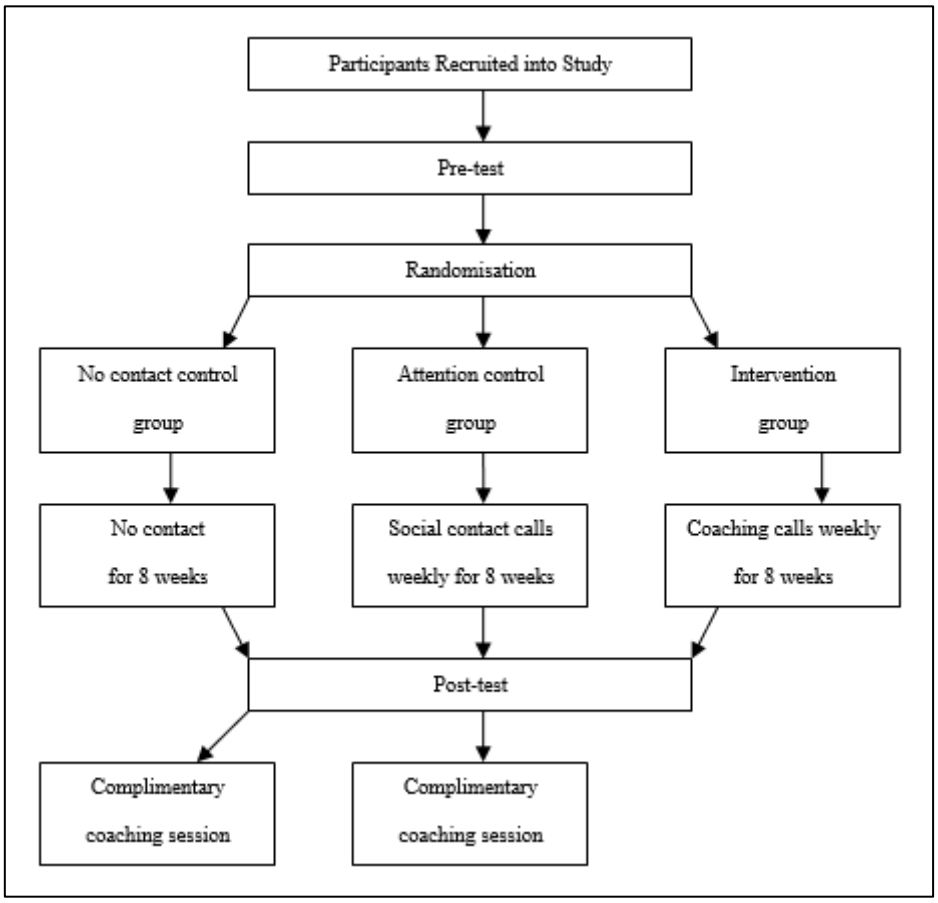

Figure 6: Flow Diagram of Coaching in Pilot Study

4.4.1 Results from pilot testing the coaching processes. During the pilot test, it became clear that there were difficulties with the attention control group, who were allocated to have only social contact telephone calls. The conversations which were intended to be only social, were perceived by the participants as coaching. The participants wanted some benefit from the conversations and it quickly became clear that telephone calls were at risk of turning into coaching calls. From the coach's perspective, it was difficult to maintain social conversations for the designated time period (45-60 minutes) without engaging in a professional development conversation. The attention control group participants were busy professionals and feedback indicated a lack of

motivation to spend time on the phone for a conversation where there would be no coaching involved. The investigator also had concerns regarding the difficulties in ensuring the content of the calls was purely social, along with the difficulties in ensuring the time equivalence of phone calls. These aspects informed the decision to discard the attention control group from the main study. Thus, the study design now consisted of only two groups: an intervention group and a control (non-contact) group. Figure 6. shows a summary of the revised flow diagram of the coaching study.

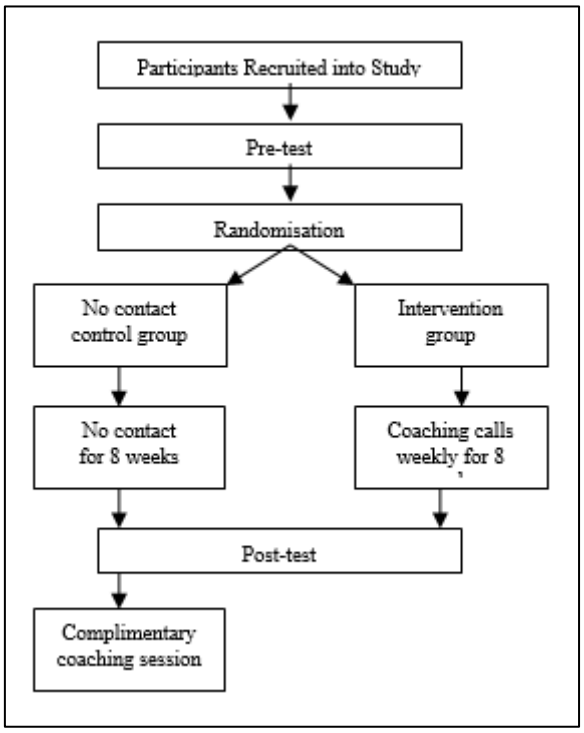

Figure 7*:* Revised Flow Diagram of Coaching in Pilot Study

Participants in the intervention group had a 45-60 phone call from the coach each week, where progress towards goals was discussed and any setbacks reviewed. The coaching process provided support for the participants as they progressed through their action plan towards their goal. All the participants in the pilot study attained their pre-set goal within the eight weeks of the program.

Participants found the coaching intervention to be a valuable process in their professional development and requested a way to provide further qualitative comments on the experience. It was decided to include some open-ended questions in the questionnaire that would capture qualitative comments from the group that received the coaching intervention.

4.5 Recommendations from Pilot Study Results

As a result of the analysis of the pilot study, the following decisions were made regarding the main study:

1. The inclusion criteria for the study was extended to include a wider range of nursing staff, incorporating senior clinical nursing staff in a variety of clinical leadership positions, but all in clinical leadership roles.
2. The selected instruments were retained because they had high test-retest reliability.
3. The questionnaire was retained in its current layout as it took no longer than 15 minutes to complete and pilot participants did not report any difficulties in completing it.
4. The attention control group was unwieldy and created difficulty in maintaining the element of control in the study without any perceived benefits. As a result, it was excluded from the study.
5. The cognitive behavioural, solution-focussed approach to conducting the coaching was appropriate in content and format for use as an intervention in the study.

A variety of open ended and some closed questions were added in the post-test questionnaire, to allow the intervention group to provide a more comprehensive

evaluation of the coaching intervention. Kirkpatrick's framework on program evaluation was used to guide the questions for the evaluation (Kirkpatrick & Kirkpatrick, 2007).

Chapter 5.

Phase One—The Quantitative Study

5.1 Introduction

This chapter was informed by the pilot test discussed in Chapter Four, and presents the data collected from Phase One the quantitative element of the study, and also includes information from the qualitative questions at the end of the questionnaires. First the chapter begins with discussing how data was prepared and cleaned. An overview of the sample is then provided with demographic characteristics and a description of the intervention and control group. This is then followed by a section on subscale analyses and the results of the hypothesis testing. Results from the evaluation of the coaching experience are presented next and the chapter concludes with an analysis of the comments from the open ended questions on the questionnaire.

5.2 Section One: Data Preparation

This section describes the preparation of data prior to the commencement of data analysis. All of the eight Items in the Personal Accomplishment (PA) subscale of the MBI were reversed for analysis (Table 8) as per the Maslach Burnout Inventory Manual (Maslach et al., 1996). The Utrecht Work Engagement Scale (UWES) had no reversed items and The Nurse Retention Index (NRI) had two of its six items reversed (Table 9).

Table 7: Reversed Items of the PA Subscale*

Item	
Item 4	I can easily understand how my recipients feel about things
Item 7	I deal very effectively with the problems of my recipients
Item 9	I feel I'm positively influencing other people's lives through my work
Item 12	I feel very energetic
Item 17	I can easily create a relaxed atmosphere with my recipients
Item 18	I feel exhilarated after working closely with my recipients
Item 19	I have accomplished many worthwhile things in this job
Item 21	In my work, I deal with emotional problems very calmly

The scoring for the PA subscale is opposite from that of other subscales of the MBI-HSS. In this subscale, the lower the score, the less the participant experiences positive outcomes in their work.

Table 8: Nurse Retention Index—Reversed Items

Items	
Item 3	As soon as it is convenient for me I plan to leave the nursing profession.
Item 6	I would like to find other employment by leaving nursing

The scoring of these two items from the NRI are opposite from that of the other four items in the scale. In the NRI scale the lower the score the greater the participants' intentions to leave their nursing job.

5.3 Data Screening and Cleaning

Data collected from the study sample were coded and entered into SPSS Statistical Package for Social Sciences (version 17). Frequency analyses were conducted to check

for data entry errors and missing data. Results indicated that there were three variables that had out of range results. Upon investigation, these turned out to be data entry errors which were corrected. Twenty one cases were identified with missing data due to item non response. However, no data were lost due to participant attrition from the study (Schlomer, Bauman, & Card, 2010). Further examination of the missing data revealed 11 missing values from the pre-test and ten from the post-test data. The missing data in this study were random with no discernible pattern. The missing values were checked against the original questionnaire, which identified a further four data entry errors. These errors were subsequently corrected, leaving 17 missing values in total, less than 1% of the total data.

5.3.1 Missing data. According to Schlomer (2010) multiple imputation is a preferred strategy for handling missing data. The first step in the process was to identify the missing variables. In order to obtain specific information on where exactly the missing variables were located, dummy variables were created, and case summaries computed to identify missing values. Table 9 provides a summary of the missing values for all the subscales of the MBI-HSS.

Table 9: Missing Data for Items in MBI-HSS

MBI-HSS Items	Pre-test Intervention	Pre-test Controls	Post-test Intervention	Post-test Controls
Item 6: Working with people all day is really a strain for me		Participant 43		
Item 4: I can easily understand how my recipients feel about things			Participant 10	
Item 7: I deal very effectively with the problems of my recipients			Participant 10	
Item 9: I feel I'm positively influencing other people's lives		Participant 43		

MBI-HSS Items	Pre-test Intervention	Pre-test Controls	Post-test Intervention	Post-test Controls
Item 11: I worry that this job is hardening me emotionally		Participants 43 and 55		
Item 14: I feel I'm working too hard on my job	Participant 2			
Item 17: I can easily create a relaxed atmosphere	Participant 11			
Item 19: I have accomplished many worthwhile things in this job		Participant 55		
Item 15: I don't' really care about what happens to some recipients				Participant 58 Participant 60
Totals	**2**	**5**	**2**	**2**

Eleven values were identified as missing from the MBI. Each case that had missing values was inspected to identify variables that might have been related to item non-response. Demographic variables such as years of experience, place of work (hospital or community, private or public, rural or urban) and whether participants worked full time or part time, were considered to be possible influences in item non-response.

Therefore, for example, if a participant worked full time and did not respond to an item, the mean of all other participants who also worked full time was calculated. This process was repeated for other demographic variables pertinent to the participant who had a missing value. Once mean responses for missing the item were calculated for other demographic variables, these were then averaged and this average (imputed) response to the item was entered as the missing value.

Treatment of a missing response for item 11 by case 43 provides an example of the multiple imputation process. Case (participant) 43 had been qualified for eight years or

more, and worked full time in an urban community setting within the private sector. The mean responses for a) participants who had been qualified for eight or more years, b) participants who worked full time, c) participants in urban settings, d) participants working in the private sector and e) participants working in the community were calculated. Table 11 provides a summary of the mean scores for the missing data in item 11 of the MBI-HSS of these variables.

Table 10: Calculation of mean scores for missing values in MBI-HSS Item 11 Participant 43

Demographic	Participant 43	Mean for all participants	SD for all participants
Years' since qualification	8+ years	1.19	1.58
Work status	Full time	1.27	1.55
Location	Urban	1.22	1.51
Sector	Private	0.97	1.24
Specialty	Community	1.37	1.73
	Sum of means	**6.02**	
	Average (imputed) mean score	**1.20**	

The imputed mean score was then used to replace the missing value for participant 43 in item 11. An analysis identical to the one just described was used to replace each of the other missing values.

5.3.2 Outliers. Outliers were assessed by examining the box plots, histograms, Q-Q plots and the extreme values table. Extreme outliers were identified and compared with the raw data for accuracy. Three data entry errors were found and corrected. The 5% trimmed mean for the remaining outliers was then compared with the original mean scores to check if any extreme responses were having an influence on the mean. Scores

which were three standard deviations above or below the mean were considered to be outliers (Norman & Streiner, 2008; Petrie & Sabin, 2005). Repeat analyses were conducted both with and without the outlying values in order to ascertain the influence of the outliers. According to Petrie and Sabin (2005) if the results are similar it can be concluded that the outlier is having a minimal influence on the analysis. Results of this set of analyses are discussed later on in this chapter in the description of processes applied in dealing with outliers in the individual subscales.

5.4 Overview of Sample

Eighty nine nurses initially responded to the invitation to participate in the study. Twenty three failed to return consent forms, despite follow up emails and phone calls. Six participants withdrew following enrolment, leaving a total of 60 nurses in the study (n=32 intervention; n=28 control). The majority (92%) of participants were female and held positions where they worked in a clinical leadership capacity, either in practice themselves or leading a team who worked in clinical practice. Of the 60 participants, over 90% (91.7%) had been qualified for eight or more years. Approximately half the participants (51.7%) worked for private health organisations and the remainder worked in the public sector (48.3%), with 5% being self-employed. The majority of participants were based in an urban/regional setting (88.3%) with over three quarters (76.7%) employed on a full-time basis. Just under two thirds of the participants were hospital based and one third of participants were community based (33.3%). Table 12 gives details of participant demographics.

Table 11: Demographic Data for Participants

Categories	Intervention (n=32)	Control (n=28)	Total %
Years Qualified			
8 yrs or more	30 (93.7%)	25 (89.2%)	91.6%
6-7	1 (3.12%)	2 (7.14%)	5%
2-3 yrs	1 (3.12%)	1 (3.57%)	3.3%
Hours Worked			
Full Time	23 (71.8%)	23 (82.1%)	76.6%
Part Time	9 (28.1%)	5 (17.8%)	23.3%
Geographic Location			
Urban/Regional	28 (87.5%)	25 (89.2%)	88.3%
Rural	4 (12.5%)	3 (10.7%)	11.6%
Institution			
Public	22 (68.75%)	9 (32.1%)	48.3%
Private	12 (37.5%)	19 (67.8%)	51.6%
Setting			
Hospital	19 (59.3%)	18 (64.2%)	61.6%
Community	11 (34.3%)	9 (32.1%)	33.3%
Other	2 (6.25%)	1 (3.5%)	5%

5.4.1 The control group. A total of 28 participants were randomly assigned to the control group. Twenty five had been qualified for eight years or more, two had been qualified for 6-7 years and one had been qualified for 2-3 years. The majority (89.3%) of participants in the control group worked in the urban/regional setting and only three worked in a rural setting. Twenty three participants (82%) worked on a full time basis and five worked part time. Nineteen participants (67%) were employed in the private sector and only nine were employed in the public sector, the majority (64%) of whom worked in hospital settings and 32% who worked in the community. One participant in the control group worked in a private education setting.

5.4.2 The intervention group. A total of 32 nurses, were randomly assigned to the intervention group, the majority of whom (93%) had been qualified for eight years or more. One participant had been qualified for 6-7 years and one had been qualified for 2-3 years. Eighty seven percent of participants in the intervention group worked in the urban setting with only four (12%) who worked in the rural setting. Twenty three participants (71%) worked on a full time basis with nine (28%) who worked part time. Twelve of the participants (37%) worked in the private sector and 22 (68%) were employed in the public sector. Nineteen (53%) participants worked in a hospital setting and 11 (34%) worked in the community, with two participants who worked in other settings such as education and alternative health.

5.5 Hypothesis Testing

This section describes the investigations pertaining to data cleaning and tests for assumptions of analysis for each of the subscales: Vigour (VI), Dedication (DE), Absorption (AB), Emotional Exhaustion (EE), Depersonalisation (DP), Personal Accomplishment (PA); and the NRI scale. Prior to presentation of the findings, a brief description of testing of assumptions for the analysis is provided for each subscale.

5.5.1 Work engagement: vigour, dedication and absorption. The intervention and control groups were compared on their responses to the Utrecht Work Engagement Vigour (VI) subscales of vigour, dedication and absorption.

5.5.1.1 Vigour subscale. The two sample Kolmogorov-Smirnov test was used to compare the distributions of the intervention and control groups at both pre and post testing. The Kolmogorov-Smirnov test is a non-parametric test used to determine if two datasets differ significantly in their distribution. At pre-test, the vigour scores for both groups (Table 13) were normally distributed (intervention K-S z = .09, *df* = 32, p = .20;

control K-S z = .11, df = 28, p = .20), and there was no significant difference between the groups (intervention *M* = 5.12, *SD* = .81; control *M* = 5.02, *SD* = 1.09) t(58)= .39, p= .69).

Table 12: Overview of Vigour Subscale at Pre-Test

Item	Intervention (n= 32)			Control (n= 28)		
	Mean	**SD**	**Median**	**Mean**	**SD**	**Median**
At my work, I feel bursting with energy	4.54	1.11	4.00	4.43	1.45	4.00
At my job, I feel strong and vigorous	4.84	1.08	5.00	4.86	1.53	5.00
When I get up in the morning, I feel like going to work	4.91	1.25	5.00	4.96	1.47	5.00
I can continue working for very long periods at a time	5.25	1.70	6.00	5.07	1.60	5.00
At my job, I am very resilient, mentally	5.25	1.27	6.00	5.18	1.12	5.00
At my work, I always persevere, even when things do not go well	5.94	.98	6.00	5.64	1.22	5.50

5.5.1.2 Null hypothesis 1a: Vigour. There will be no difference in the work engagement scores (Vigour, Dedication and Absorption) of clinical nurse leaders who have undergone coaching and those who have not.

Results of the Kolmogorov-Smirnov two sample test, indicated that post-test data for the two groups was normally distributed for both groups (intervention K-S z = .13, *df* = 32, p = .14; control K-S z = .14, df = 28, p = .12). Table 14 provides details of individual items in the Vigour subscale.

Table 13: Vigour Subscale at Post-Test

Item	Intervention (n= 32)			Control (n= 28)		
	Mean	SD	Median	Mean	SD	Median
At my work, I feel bursting with energy	5.22	.97	5.50	4.64	1.36	4.00
At my job, I feel strong and vigorous	5.16	1.13	5.00	4.96	1.34	5.00
When I get up in the morning, I feel like going to work	5.26	1.21	6.00	5.32	1.38	6.00
I can continue working for very long periods at a time	5.66	1.23	6.00	5.21	1.47	5.50
At my job, I am very resilient, mentally	5.59	1.07	6.00	5.46	1.13	6.00
At my work, I always persevere, even when things do not go well	5.97	1.12	6.00	5.89	1.22	6.00

5.5.1.3 Results. The mean for the intervention group at post-test was 5.47 (*SD* = .72) compared to 5.25 (*SD* = 1.09) for the control group. There was no significant change in the pre and post scores of the control group but the intervention group had a significant increase in scores from pre-test (*M* = 5.12, *SD* = .81) to post-test (*M* = 5.47, *SD* = .72, t(31)= -3.56, P =.001). These results indicate that the nurses who received the coaching scored significantly higher on the Vigour subscale than those who did not receive coaching. The null hypothesis was therefore rejected.

5.5.1.4 Dedication subscale. In the Dedication subscale, results of the Kolmogorov-Smirnov two sample test indicated that the intervention and control groups were normally distributed and with similar means at pre-test (K-S z = .14, *df* = 32, p = .07 and K-S z = .10, *df* = 28, p = .20 respectively). The mean for the intervention group was 5.40 and for the control group was 5.59 (See Table 15 for individual item scores).

Table 14: Overview of Dedication Subscale at Pre-Test

Item	Intervention (n= 32)			Control (n= 28)		
	Mean	SD	Median	Mean	SD	Median
I find the work that I do full of meaning and purpose	5.41	1.24	6.00	5.64	1.16	6.00
I am enthusiastic about my job	5.25	1.10	5.00	5.43	1.16	6.00
My job inspires me	4.94	1.36	5.00	5.07	1.35	5.00
I am proud of the work that I do	6.00	.98	6.00	5.85	1.00	6.00
To me my job is challenging	5.44	1.68	6.00	5.95	1.20	6.00

5.5.1.5 Null hypothesis 1b: Dedication. There will be no difference in the work engagement scores (Vigour, Dedication and Absorption) of clinical nurse leaders who have undergone coaching and those who have not.

At post-test, the Kolmogorov-Smirnov two sample test indicated that data for the control group (K-S z = .13, df = 28, p = .20) were normally distributed, but the data for the intervention group (K-S z = .18, *df* = 32, p = .00) were not. Graphical analysis revealed one outlier in the intervention group which could have skewed the distribution of the intervention group. Analysis of z scores revealed that participant 29 had four data points which were three standard deviations below the mean. Analysis was conducted both with and without these outliers (Petrie & Sabin, 2005). Removal of this participant from the analysis resulted in a normal distribution for the intervention group (K-S z = .15, *df* = 31, p = .07) and a decision was made to eliminate this participant from further analysis on the dedication subscale and use the more powerful parametric statistic to compare groups. Table 16 provides details of specific items.

Table 15: Overview of Dedication Subscale at Post-Test

Item	Intervention (n= 32)			Control (n= 28)		
	Mean	SD	Median	Mean	SD	Median
I find the work that I do full of meaning and purpose	6.00	1.03	6.00	5.46	1.13	6.00
I am enthusiastic about my job	5.94	.96	6.00	5.50	1.26	6.00
My job inspires me	5.60	1.08	6.00	5.25	1.32	5.50
I am proud of the work that I do	6.48	.50	6.00	6.00	.98	6.00
To me my job is challenging	5.49	1.03	6.00	5.82	.81	6.00

5.5.1.6 Results. There was no significant change in the control group between pre-test (*M* = 5.59, *SD* = .98) to post-test (*M* = 5.60, *SD* = .92 t(27)= .12, P =.90), but the intervention group had a significant increase in scores (pre-test *M* = 5.40, *SD* = 1.03l post-test *M* = 5.99, *SD* = .72, t(30)= 3.36, P =.002). The results from this subscale indicate that nurses who received the coaching had a significant increase in their Dedication scores compared with those who did not have the coaching and the null hypothesis was rejected.

5.5.1.7 Absorption subscale. At pre-test, the absorption scores for both groups (Table 17) were normally distributed for both the intervention group (K-S z = .13, *df* = 32, P = .17) and for the control group (K-S z = .12, *df* = 28, P = .20). There were no significant differences between the groups (intervention *M* = 5.07, *SD* = 1.10; control *M* = 4.95, *SD* = 1.20) with the variance of the two groups being similar (F = .55, p = .46). The scores for individual items of the Absorption subscale are provided in Table 17.

Table 16: Overview of Absorption Subscale at Pre-Test

Item	Intervention (n= 32)			Control (n= 28)		
	Mean	SD	Median	Mean	SD	Median
Time flies when I'm working	6.09	1.11	6.50	5.79	1.47	6.00
When I am working, I forget everything else around me	4.75	1.52	5.00	5.00	1.65	5.00
I feel happy when I am working intensely	5.03	1.17	5.00	5.11	1.44	5.00
I am immersed in my work	5.56	1.26	6.00	5.36	1.44	6.00
I get carried away when I'm working	4.72	1.68	5.00	4.89	1.61	4.50
It is difficult to detach myself from my job	4.31	1.89	4.00	3.61	1.57	4.00

5.5.1.8 Null hypothesis 1c: Absorption. There will be no difference in the work engagement scores (Vigour, Dedication and Absorption) of clinical nurse leaders who have undergone coaching and those who have not.

Post-test, the Kolmogorov-Smirnov two-sample test indicated that data for the control group (K-S z = .11, df = 28, p = .20) were normally distributed, but data for the intervention group (K-S z = .24, *df* = 32, p = .00) were not. Graphical analysis revealed several outliers, so analysis was conducted both with (nonparametric analysis) and without these outliers (Petrie & Sabin, 2005). Both analyses yielded similar results, so a decision was made to eliminate these six outliers from any further analysis on this scale and conduct a student's *t* test. The independent samples *t* test (student's *t* test) was deemed useful as it tests for a difference between group means in two unrelated groups.

Table 17: Overview of Absorption Subscale at Post-Test

Item	Intervention (n= 32)			Control (n= 28)		
	Mean	SD	Median	Mean	SD	Median
Time flies when I'm working	6.58	.57	7.00	5.79	1.16	6.00
When I am working, I forget everything else around me	5.85	1.08	6.00	4.93	1.53	5.00
I feel happy when I am working intensely	5.92	.68	6.00	5.11	1.34	5.00
I am immersed in my work	6.10	.59	6.00	5.32	1.24	6.00
I get carried away when I'm working	6.04	.66	6.00	4.54	1.68	5.00
It is difficult to detach myself from my job	4.65	1.32	5.00	3.82	1.78	3.50

5.5.1.9 Results. The results from this analysis showed that the intervention group had a significant increase in scores from pre-test (M = 5.37, SD = .88) to post-test (M = 5.85, SD = .38, t(25)= 3.06, p =.00). By comparison, there was no significant change in the control group from pre-test (M = 4.95, SD = 1.20) to post-test (M = 4.91, SD = 1.14 t(27)= -.22, p =.82). This subscale analysis indicated that nurses who received the coaching had a significant increase in their Absorption scores compared with those who did not have the coaching. The null hypothesis which stated there would be no difference in scores was therefore rejected.

5.5.2 Burnout: emotional exhaustion, depersonalisation and personal accomplishment. Both the intervention and the control groups were compared on their responses to the Maslach Burnout Inventory subscales of Emotional Exhaustion (EE), Depersonalisation (DP) and Personal Accomplishment (PA).

5.5.2.1 Emotional exhaustion subscale. Despite minor differences in the skewness and kurtosis of the distribution of the intervention and control group, results of

the Kolmogorov-Smirnov Test indicate that both the intervention group (K-S z= .13, *df* = 32, P = .12) and control group (K-S z= .14, *df* = 28, p = .13) were normally distributed at pre-test. The seven items of the EE subscale were examined individually. Table 19 provides details of each item in the EE subscale for both the intervention and control group.

Table 18: Overview of Emotional Exhaustion Subscale at Pre-Test

	Intervention (n= 32)				Control (n= 28)		
Item	**Mean**	**SD**	**Median**		**Mean**	**SD**	**Median**
I feel emotionally drained from my work	3.25	1.54	3.00		3.21	1.64	3.00
I feel used up at the end of the workday	3.38	1.66	3.50		3.36	1.61	3.00
I feel fatigued when I get up in the morning	2.84	1.70	3.00		2.64	1.87	2.00
I feel burned out from my work	2.41	1.73	2.00		2.39	1.52	2.00
I feel frustrated by my job	3.75	1.83	4.00		3.07	1.84	3.00
I feel I'm working too hard on my job	3.73	1.79	3.00		3.14	1.91	3.00
I feel like I'm at the end of my rope	1.94	1.70	1.00		1.71	1.63	1.00

The mean for the EE subscale for the intervention group was 3.04 (SD, 1.45) compared to 2.79 (SD 1.37) for the control group. There was no significant difference between the total mean scores of the intervention (*M*=3.04, *SD* =1.45) and control group (*M*= 2.79, *SD* = 1.37) t(58)=.68, p = .49) at the beginning of the study. In addition, there were no differences in any of the scores for the nine individual EE items between the intervention and control groups at pre-test.

5.5.2.2 Null hypothesis 2a: Emotional exhaustion. There will be no difference in the burnout scores (Emotional Exhaustion, Depersonalisation and Personal

Accomplishment) of clinical nurse leaders who have undergone coaching and those who have not.

Post-test, the Kolmogorov-Smirnov two sample test indicated that EE subscale data for the intervention (K-S z= .17, *df* = 32, P = .01) was not normally distributed, but the control group (K-S z= .13, *df* = 28, p = .18) was. An analysis of the above scores revealed that the last item ("I feel like I'm at the end of my rope") had very low mean scores in comparison to the other items in the scale. A box plot for this particular item is shown in Figure 7.

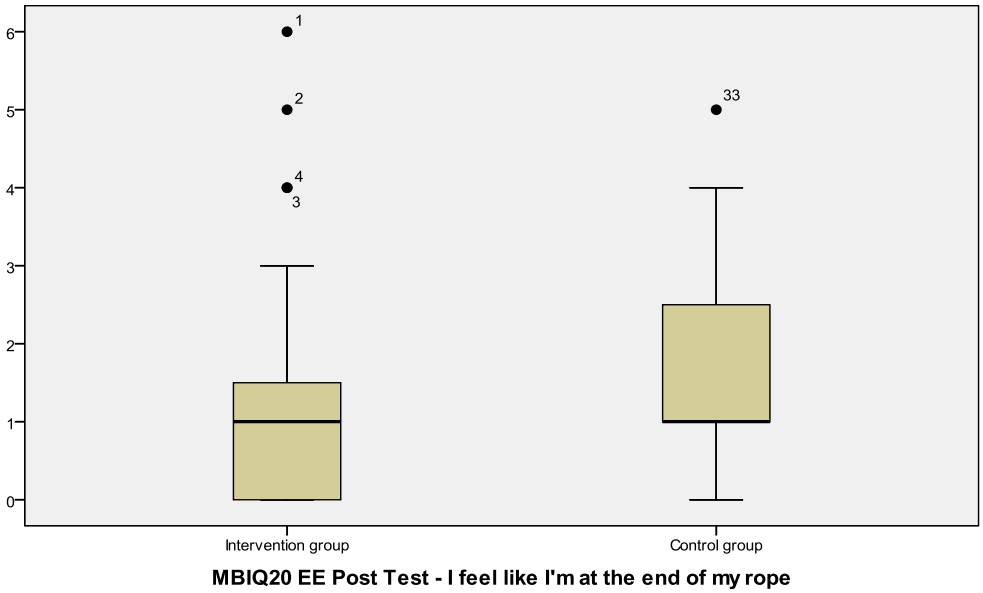

Figure 8*:* "I feel like I'm at the end of my rope"

As can be seen in Figure 7. five outliers on this particular item could have skewed the mean scores. Calculation of z scores for this item also revealed that one data point was more than three standard deviations above the mean and were originally deleted from the analysis. However, the results continued to show a non-normal distribution for the intervention group (K-S z= .17, *df* = 28, P = .03), so it was decided to include the five

outliers in the data analysis as they appeared not to have an undue impact on the distribution of the data.

5.5.2.3 Results. Post-test results show that the mean for the EE subscale for the intervention group was 2.59 (*SD* = 1.32) compared to 2.67 (*SD* = 1.38) for the control group. As the post-test data was not normally distributed, the Wilcoxon Signed Ranks test was utilised to identify differences between the groups. The Wilcoxon Signed Ranks test is a non-parametric test which matches, pairs and ranks the values from each group. The difference between group values can then be compared.

Results from the Wilcoxon Signed Ranks Test indicated that the intervention scores increased significantly from pre-test (*Mean Rank* = 13.89, *Sum of Ranks* = 125.00) to post-test (*Mean Rank* = 16.19, *Sum of Ranks* = 340.00, Z = -2.21, *P* =.02). In contrast, the control group scores at pre-test (*Mean Ranks* = 8.82, *Sum of Ranks* = 97.00) did not significantly increase at post-test (*Mean Rank* = 12.56, *Sum of Ranks* = 113.00, Z = -2.99, *P* =.76). These results indicate that there was a significant increase in the Emotional Exhaustion scores of the intervention group, but not in the control group. This indicates that Emotional Exhaustion increased following the intervention, and as a result, the null hypothesis, which stated that there would be no difference in scores between the groups, was rejected.

5.5.2.4 Depersonalisation subscale. Pre-test, the Kolmogorov-Smirnov two sample test indicated that data pertaining to the DP scale were not normally distributed for both the intervention (K-S z = .25, *df* = 32, p = .00) and control groups (K-S z = .16, *df* = 28, p = .04). The Wilcoxon Rank Sum test was utilised to compare the intervention and control groups on the Depersonalisation (DP) subscale (Table 21) which measures burnout.

Table 19: Overview of DP Subscale at Pre-Test

Item	Intervention (n= 32)			Control (n= 28)		
	Mean	SD	Median	Mean	SD	Median
I feel I treat some recipients as if they were impersonal objects	1.00	1.39	.50	.64	.98	0.00
Working with people all day is really a strain for me	1.78	1.56	1.00	1.74	1.37	1.43
I've become more callous towards people since I took this job	1.38	1.51	1.00	1.14	1.50	.00
I worry that this job is hardening me emotionally	1.47	1.68	1.00	.94	1.30	.00
I don't really care about what happens to some recipients	.56	1.16	.00	.50	.74	.00
Working with people directly puts too much stress on me	1.69	1.59	1.00	1.68	1.27	1.00
I feel recipients blame me for some of their problems	2.72	1.85	3.00	2.14	1.60	1.50

Although the mean and median scores for the DP subscale was higher in the intervention group (*Mean Rank* =32.64, *Sum of Ranks* = 1044.50) than in the control group, (*Mean Rank* = 28.05, *Sum of Ranks* 785.50) this difference was not significant (U= 379.50, *Sig* =.30), indicating the burnout scores were comparable in the intervention and control group. In addition, there were no significant differences between the groups on the responses to the individual items in the subscale at pre-test.

5.5.2.5 Null hypothesis 2b: Depersonalisation. There will be no difference in the burnout scores (Emotional Exhaustion, Depersonalisation and Personal Accomplishment) of clinical nurse leaders who have undergone coaching and those who have not.At post-test, the Kolmogorov-Smirnov two sample test indicated that, like the pre-test, the data were not normally distributed (intervention K-S z = .18, *df* = 32, p = .00; control K-S z

= .22, df = 28, p = .00 respectively). An overview of the items of the DP post-test subscale is provided in Table 22.

Table 20: Overview of DP Subscale at Post-Test

Item	Intervention (n= 32)			Control (n= 28)		
	Mean	SD	Median	Mean	SD	Median
I feel I treat some recipients as if they were impersonal objects	.63	.90	.00	.71	1.04	.00
Working with people all day is really a strain for me	1.56	1.36	1.00	1.64	1.39	1.00
I've become more callous towards people since I took this job	.75	1.16	.00	1.00	1.33	.00
I worry that this job is hardening me emotionally	.72	1.17	.00	1.07	1.43	.00
I don't really care about what happens to some recipients	.25	1.07	.00	.08	.26	.00
Working with people directly puts too much stress on me	1.47	1.45	1.00	1.71	1.46	1.00
I feel recipients blame me for some of their problems	2.13	1.60	1.00	2.25	1.99	1.00

5.5.2.6 Results. The intervention group's mean rank increased significantly at post-test (*Mean Rank pre-test* = 9.83, *Sum of Ranks* = 88.50; *post-test Mean Rank* = 16.08, *Sum of Ranks* = 289.50, *P* = .01). In contrast the control group's pre and post scores did not change significantly (*pre-test Mean Rank* = 12.05, *Sum of Ranks* = 132.50; *post-test Mean Rank* = 12.88, *Sum of Ranks* = 167.50, *P* = .61). As with the scores in the EE subscale, Depersonalisation increased significantly following the intervention and the hypothesis stating there would be no difference in scores between the groups, was therefore rejected.

5.5.2.7 Personal Accomplishment subscale. The personal accomplishment subscale is a reversed scale, where a higher degree of burnout is reflected in lower

personal accomplishment scores. Results from the Kolmogorov-Smirnov two sample test indicate that at pre-test, both groups were normally distributed (intervention group K-S z = .11, *df* = 32, p = .20; control group K-S z = .11, df = 28, p = .20). An overview of the PA items at pre-test is provided in Table 23.

Table 21: Overview of PA Subscale at Pre-Test

	Intervention (n= 32)				Control (n= 28)		
Item	**Mean**	**SD**	**Median**		**Mean**	**SD**	**Median**
I can easily understand how my recipients feel about things	.65	.97	.00		.78	1.42	.00
I deal very effectively with the problems of my recipients	.68	.78	1.00		.75	.70	1.00
I feel I'm positively influencing other peoples' lives through my work	1.28	1.08	1.00		1.03	1.07	1.00
I feel very energetic	2.09	1.32	2.00		2.00	1.56	1.50
I can easily create a relaxed atmosphere with my recipients	1.25	1.21	1.00		1.00	1.08	1.00
I feel exhilarated after working closely with my recipients	1.87	1.47	2.00		1.96	1.66	1.50
I have accomplished many worthwhile things in this job	1.93	1.54	1.00		1.53	1.26	1.50
In my work, I deal with emotional problems very calmly	.84	.84	1.00		1.50	1.52	1.00

An independent samples t test on the individual items in the subscale, indicated that one item ("In my work I deal with emotional problems very calmly"), did not have equal variances between the intervention and control groups (F = 17.46, Sig = .00), but did not affect the overall distribution of the subscale. Independent samples t test on the PA subscale indicated no significant differences between the intervention group (M =1 .32, SD = .70) and the control group (M = 1.32, SD = .818) t(58)=.03, P = .97) at the start of the study.

5.5.2.8 Null hypothesis 2c: Personal Accomplishment. There will be no difference in the burnout scores (Emotional Exhaustion, Depersonalisation and Personal Accomplishment) of clinical nurse leaders who have undergone coaching and those who have not.

At post-test, the Kolmogorov-Smirnov two sample test indicated there were no significant differences in the distributions of the intervention group (K-S z = .14, *df* = 32, p = .08) and the control group (K-S z = .13, df = 28, p = .18), both of which were normally distributed. An overview of the individual items for the PA subscale for is provided in Table 24.

Table 22: Overview of PA Subscale at Post-Test

	Intervention (n= 32)			Control (n= 28)		
Item	**Mean**	**SD**	**Median**	**Mean**	**SD**	**Median**
I can easily understand how my recipients feel about things	.65	1.03	.00	.96	1.20	.50
I deal very effectively with the problems of my recipients	.71	1.11	1.00	.75	.96	.00
I feel I'm positively influencing other peoples' lives through my work	.90	1.02	1.00	.78	.73	1.00
I feel very energetic	1.46	1.01	1.00	2.14	1.60	2.00
I can easily create a relaxed atmosphere with my recipients	.62	.65	1.00	.85	1.04	.50
I feel exhilarated after working closely with my recipients	1.31	.99	1.00	1.75	1.35	1.50
I have accomplished many worthwhile things in this job	1.43	1.47	1.00	1.46	1.17	1.00
In my work, I deal with emotional problems very calmly	.844	.88	1.00	1.39	1.31	1.00

5.5.2.9 Results. Results on the PA subscale indicated that there was a significant decrease in scores from pre-test (*M* = 1.32, *SD* = .70) to post-test (*M* = .99, *SD* = .58, t(31)=2.73, P =.01) for the intervention group. In contrast, a small decrease in the control group scores was not significant (t(27)=.55, P =.58). The results indicated that nurses who had undergone coaching significantly decreased in the Personal Accomplishment scores, compared to nurses who did not have the coaching. The null hypothesis was therefore rejected.

5.5.3 Nurse retention. At pre-test, the Kolmogorov-Smirnov two sample test indicated that the control group (K-S z = .12, df = 28, p = .20) was normally distributed and that the intervention group was not (K-S z = .18, *df* = 32, p = .00).

Table 23: Overview of NRI at Pre-Test

	Intervention (n= 32)				Control (n= 28)		
Item	**Mean**	**SD**	**Median**		**Mean**	**SD**	**Median**
It is my intention to continue with my nursing career	6.78	1.53	7.00		5.89	2.18	6.00
I would like to stay in nursing as long as possible	6.16	1.98	7.00		5.61	2.36	6.00
As soon as it is convenient for me, I plan to leave the nursing profession	5.81	2.32	7.00		5.14	2.36	5.50
I expect I will keep working as a nurse	6.72	1.39	7.00		5.57	2.18	6.00
My plan is to remain with my nursing career as long as able	6.00	2.18	7.00		5.64	2.32	6.00
I would like to find other employment by leaving nursing	5.87	2.49	7.00		5.17	2.49	6.00

Scores for the NRI subscale were higher in the intervention (*Mean Rank* =33.41, *Sum of Ranks* = 1069.00) than in the control group, (*Mean Rank* = 27.18, *Sum of Ranks* 761.00) although this difference was not significant (U=-1.38, *Sig* =.16). In addition, there were

no significant differences between the groups on the responses to the individual items in the subscale at pre-test.

5.5.3.1 Null hypothesis 3: Nurse Retention. There will be no difference in the intention to leave of clinical nurse leaders who have undergone coaching and those who have not.

At post-test (Table 26), the Kolmogorov-Smirnov two sample test indicated that the intervention group (K-S z = .18, *df* = 32, p = .00) was not normally distributed, so the more conservative non parametric analysis was most appropriate (Field, 2009).

Table 24: Overview of NRI Subscale at Post-Test

	Intervention (n= 32)				Control (n= 28)		
Item	**Mean**	**SD**	**Median**		**Mean**	**SD**	**Median**
It is my intention to continue with my nursing career	6.88	1.66	8.00		6.04	2.34	7.00
I would like to stay in nursing as long as possible	6.44	2.10	7.50		5.61	2.51	6.00
As soon as it is convenient for me, I plan to leave the nursing profession	6.40	2.06	7.00		5.57	2.41	7.00
I expect I will keep working as a nurse	6.53	1.91	7.00		5.89	2.34	6.00
My plan is to remain with my nursing career as long as I am able	6.34	2.23	7.00		5.61	2.51	6.05
I would like to find other employment by leaving nursing	6.15	2.47	7.00		5.25	2.73	6.50

5.5.3.2 Results. The control group pre-test scores (*Mean Rank* = 7.83, *Sum of Ranks* = 47.00) were not significantly different from the scores at post-test (*Mean Rank* = 7.25, *Sum of Ranks* = 58.00, Z=-.34, *P* = .73). Similarly, the intervention pre-test scores (*Mean Rank* = 14.85, *Sum of Rank s*= 193.00) were not significantly different from the

scores at post-test (*Mean Rank* = 9.73, *Sum of Ranks* = 107.00, Z= -1.230, *P* =.219). These results indicate that there were no significant differences between the intervention and control groups. The null hypothesis which stated there would be no difference in the intention to leave between those Clinical Nurse Leaders who received the coaching and those who had not, was therefore accepted.

5.5.4 Summary of hypotheses testing. In summary, data were checked for data entry errors, missing data and outliers. Once these issues had been addressed, separate analyses for the various subscales were conducted. This included assessing normality of the intervention and control groups at pre-test and post-test. Finally inferential statistics were used to compare outcomes of the coaching intervention.

The analyses show that the intervention group and control group were similar for all measures at pre-test. At post-test, results indicated that there was a significant increase in the Emotional Exhaustion scores of the intervention group, but not in the control group. As with the EE results, the Depersonalisation mean score increased significantly for the intervention group while the control group did not change significantly at post-test. The Personal Accomplishment subscale results indicated that there was a significant decrease in scores for the intervention group but not for the control group. This is a reversed scale and the direction of the scores, like the other MBI-HSS subscales were in opposition to what was anticipated. The results on all of these subscales indicated an increase in all the elements of burnout following the coaching intervention.

Results relating to the UWES Vigour subscale show that at post-test, there was a significant increase in the Vigour scores of the intervention group, but not the control group. This was also the case for the Dedication and for the Absorption subscales, whose scores increased for the intervention groups but not for the controls. The results on the

Utrecht Work Engagement Scale indicated that coaching increased all elements of nurses work engagement.

Results relating to the NRI show at post-test, there were no significant differences between the total mean scores of the intervention group and the control group. The results meant that the null hypothesis was accepted and led to conclude that coaching did not have the anticipated effect of reducing nurses' intention to leave their jobs.

5.6 Evaluation of the Coaching Experience

Participants in the intervention group completed an online questionnaire evaluation of their experience following the coaching intervention (See Appendix G). The evaluation questionnaire consisted of nine items, which included closed questions, multiple response questions and questions which had space for open comments. Two items (question two and nine) had a rating scale. One item (question eight), "Would you work with a coach again?" was a "yes/no" forced response item which also had space for participant comments. Other items (questions three and four) reflected the literature on perceived benefits of coaching, and participants could select more than one response.

Quantitative results from the evaluation of the coaching experience are discussed in this next section followed by a section on the qualitative comments from the open ended questions.

In relation to professional growth and development, the majority of participants (91%) felt that the coaching had assisted them in the achievement of their professional goals and more than two-thirds (69%) indicated that it had helped them motivate themselves. More than half (59%) felt coaching helped them with their decision making skills and half (50%)

with career planning. Figure 8. provides details of responses related to professional growth and development.

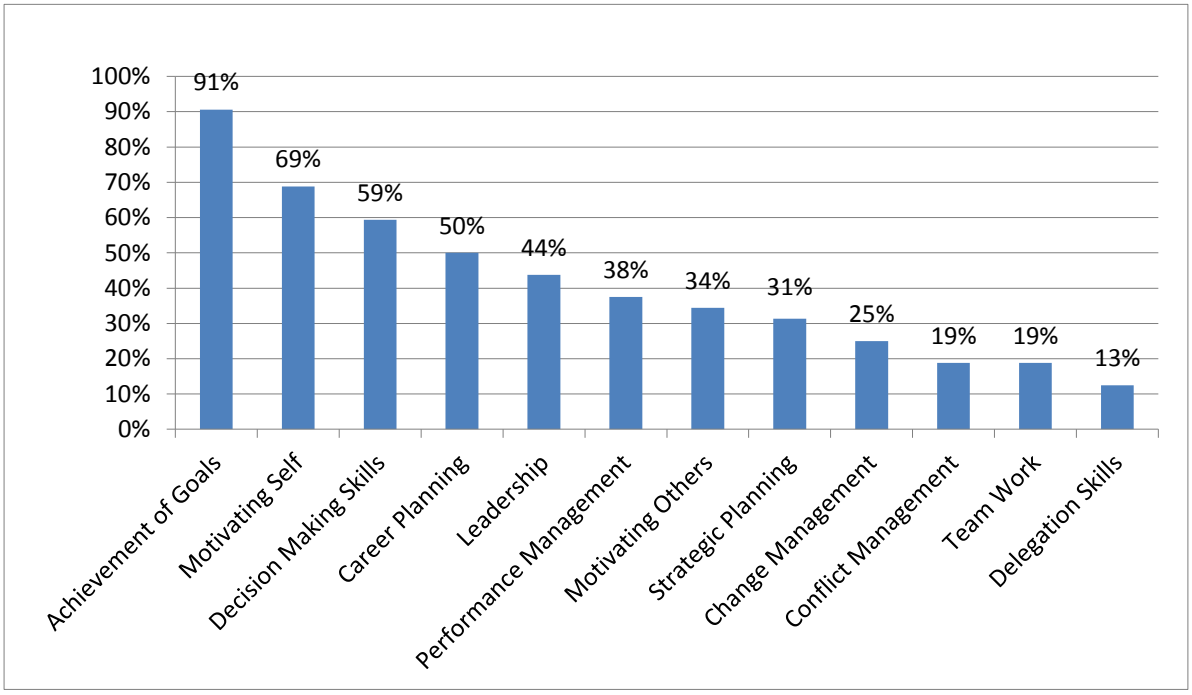

Figure 9*:* Professional Growth and Development

In relation to personal growth and development, approximately three quarters of the participants felt that the coaching had assisted them to increase their focus (78.1%) and motivation (75%). Slightly more than two thirds indicated that coaching had increased their self-awareness (69%) and empowered them to act (69%). The only response where fewer than half of participants indicated personal growth was in the clarification of their career direction (47%). Figure 9. provides details of participants' responses related to personal growth and development.

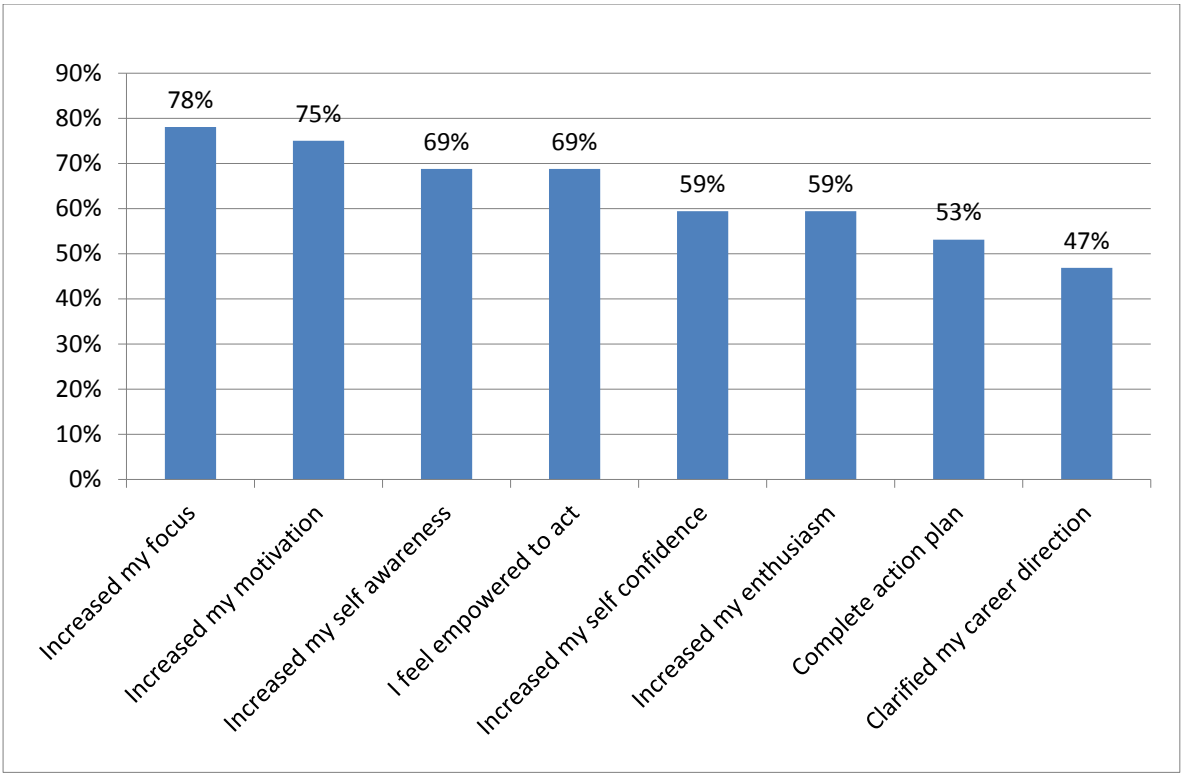

Figure 10*:* Personal Growth and Development

Participants rated attainment of their goals and their satisfaction with the coaching experience. Findings related to goal attainment are discussed first followed by participants' satisfaction ratings.

At pre-test, the intervention group participants were asked to describe their goals in specific terms according to the goal attainment scale categories of expected outcome, better than expected outcome, much better than expected outcome, less than expected outcome, and much less than expected outcome. Following the coaching intervention, participants were asked to rate how well they felt they had attained their goals using these categories. Ninety-seven percent felt they had achieved either a much better than expected outcome, or a better than expected outcome as depicted in Figure 10.

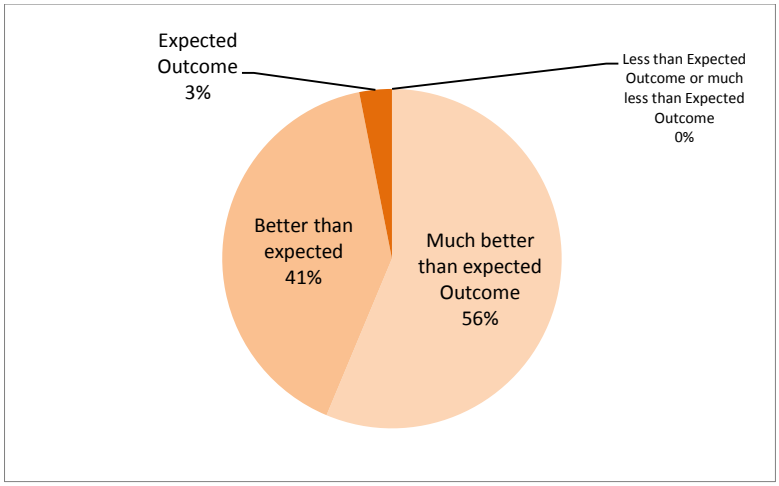

Figure 11: Goal Attainment Scale Ratings

When asked about overall satisfaction with the coaching intervention, 94% of participants rated it as very good or excellent. Figure 11. provides details of the satisfaction ratings for the coaching intervention.

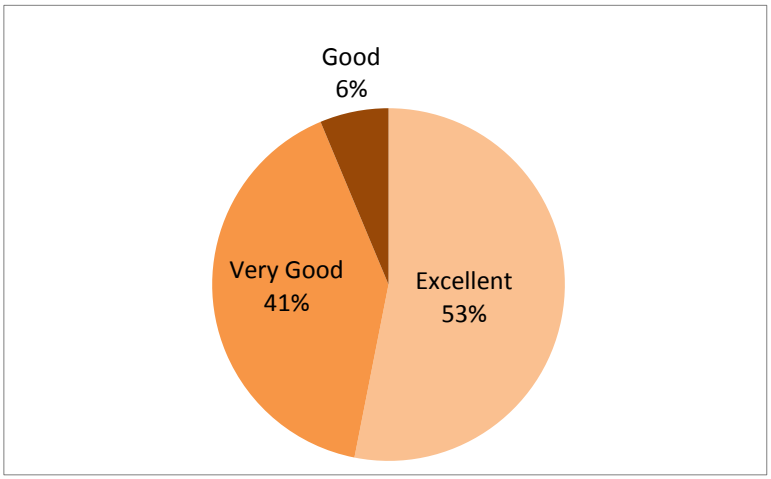

Figure 12: Satisfaction Ratings for the Coaching Intervention

One item asked if the participants would work with a coach again and 96.9% (31) responded "yes" and two responded "no". Further investigation revealed that one of the two participants who would not work with a coach again had already commenced their own small business while still working as a nurse, and responses on the Nurse Retention Index indicated that this participant was not intending to continue with their nursing

career and planned to leave nursing as soon as it was convenient. The second person who reported that she would not have a coach again ticked both the Yes and No responses on the questionnaire. However in her other questions she responded positively about the coaching, giving it an excellent rating on the goal attainment scaling. There was also space included in this item for participants to add an extended response if they wished. Twenty three (71.8%) participants chose to comment further in the space provided, and these responses are discussed with the other open ended responses in the next section.

5.6.1 Qualitative comments. This section provides an analysis of the qualitative responses from the open ended questions on the questionnaire. The responses were analysed using Kirkpatrick's four levels of program evaluation to identify "a priori" themes (Bernard & Ryan, 2010; Miles & Huberman, 1994; Reis & Judd, 2000) for the analysis. Kirkpatrick's model was chosen as it provides a more in depth picture of the value provided by training and educational programs. It was decided that the use of Kirkpatrick's model would provide a greater depth to any feedback obtained from participants on the questionnaires and therefore provide greater insight into the use of coaching within the context of nursing. It was anticipated that the four levels would provide information on participants reactions to the coaching (Level 1–Reaction), information on what they learned during the coaching (Level 2–Learning), information on how they applied that learning back in the workplace (Level 3–Behaviour) and provide information on any organisational or individual outcomes obtained (Level 4–Results). Figure 12. provides details of Kirkpatrick's four levels used in this analysis.

Level 4: Results	The degree to which targeted outcomes occur as a result of the training and the support and accountability package
Level 3: Behaviour	The degree to which participants apply what they learned during training when they are back on the job
Level 2: Learning	The degree to which participants acquire the intended knowledge, skills, attitude, confidence and commitment based on their participation in the training
Level 1: Reaction	The degree to which participants find the training favourable, engaging and relevant to their jobs

Figure 13*:* Kirkpatrick's Four Levels of Program Evaluation

5.6.1.1 Results. Comments from the open ended questions were analysed using a priori codes from Kirkpatrick's four levels of program evaluation and deductive analysis. The themes and categories from the responses to the open questions are summarised in Figure 13.

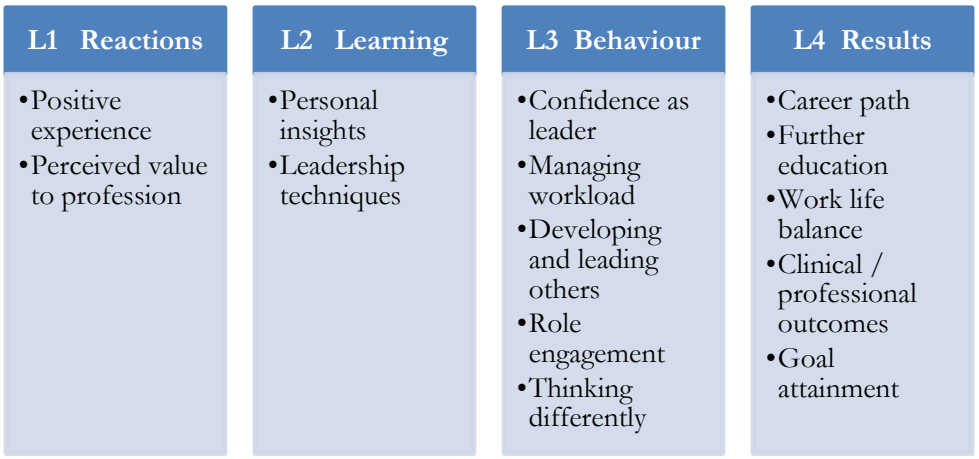

Figure 14: Summary of Responses to Open Questions

Findings under each heading are now presented in Table 27 starting with participants responses in Level 1 Reaction. This is then followed by responses in L2 Learning, then L3 Behaviour and finishes with L4 Results.

Table 25: Themes and Categories from Responses to Open-ended Questions

Reactions
The first "*a priori*" theme, Reactions, focused on assessing the participants' feelings regarding the coaching. Data related to this theme was collected from a closed-ended question asking participants about their intentions to undertake coaching again. There was a space for participants to make comments. Twenty three participants (71.8%) chose to expand on their answer. Open responses were analysed and two categories were identified: Positive Experience and Value to the Profession.
Positive Experience
Ten participants responded in this category. Overall participants' reactions to the coaching were very positive as reflected in the comments below: **Participant 10** *I have found this experience to be extremely dynamic, profound, enlightening and has 'Kick Started' the next chapter in my very varied life. I truly want to live my passion & do 'What Makes My Heart Sing'. I believe coaching is the way of the future & extremely invaluable.* **Participant 6** *… quite exhilarating really …* **Participant 21** *I cannot overstate the benefits of coaching … I found coaching a very enjoyable process and looked forward to the sessions.* **Participant 13** *… it has given me new energy and direction to continue in my Nursing Career.*
Value to the Profession
Twelve participants responded in the category, Value to the Profession. This category reflects the participants' responses on the value of coaching to them and to the profession as a whole. On an individual basis many participants described their experience as "valuable" (P26). However, several commented on coaching from an organisational or professional perspective. **Participant 7** *I think there should be one coach per 30 staff in high positions - that way each*

person would be working to the best of their ability and [employer's name] would get higher productivity… In my opinion coaching is very underutilised and would greatly benefit [employer's name].

Participant 11

It would be wonderful to have CNE points applied upon the successful completion of these sessions.

I would definitely promote this method of coaching to busy RNs within any workplace for the development of skills required within their role.

Participant 21

I did not previously have a good understanding of the role [coaching] but now believe it is something that everyone would benefit from.

Participant 3

I have recommended coaching to sooo many people now.

Participant 26

I would recommend coaching to everyone who feels lost in the in the direction they are going.

In summary, the comments from this first theme, Reaction, indicate that the participants' reactions to the coaching intervention were very positive. They perceived it as a valuable professional experience which they would recommend to others. This is consistent with the data from the forced choice items in the questionnaire regarding working with a coach again and satisfaction ratings with the coaching intervention.

Learning

The second *"a priori"* theme related to Level two of Kirkpatrick's model of evaluation (Kirkpatrick & Kirkpatrick, 2007) was Learning. It focussed on assessing the skills and knowledge the participants' felt they had gained from the experience. Participants were invited to comment on what they learned during the coaching intervention. Thirty one participants (96.8%) did so. Two categories emerged from this level regarding what the participants felt they learned from the coaching intervention; Personal Insight and Leadership Techniques.

Personal Insight

The Personal Insight category reflects participants' perceptions of the coaching

experience and its positive impact on their self-awareness. Ten participants chose to respond in this category and their comments reflect the notion of coaching offering a space for personal learning:

Participant 6

> *… [the coach's] gentle questioning around some of the issues raised, increased my awareness of certain beliefs and values under pinning my approach to responding to these issues.*

Participant 21

> *The coaching provided guidance and clarity in self-reflection and self-understanding. Having this clarity and understanding, especially around strengths, allowed me to take an objective view of myself, my career and my work practice.*

Leadership Techniques

Leadership Techniques, the second category in the learning theme, reflects participants' views that they learned some valuable leadership techniques through the coaching experience. Eighteen participants chose to respond in this category.

Participant 10

> *I have learned about committing to achieving [my goals] by identifying the action required & following through with that action in a specified timeframe in order to maintain momentum.*

Participant 28

> *I learned to be more assertive with people who I found to be intimidating. I am 100% certifiably assertive. Since the coaching, I have continued to employ my simple strategies and the payoff has been wonderful.*

Participant 11

> *We had experienced a period of unrest in the workplace and I needed extra skills to address issues that remained unresolved … I learnt the skills to address the areas of concern [such as] conflict resolution.*

Participant 7

> *… learned lots of strategies that are simple but effective.*
>
> *… able to develop organisational skills and prioritization skills.*

In summary, the comments from this second theme Learning and it's categories, indicate that the participants' perceived they had learned worthwhile leadership skills or techniques that would assist them in their professional roles. The personal insights gained were also perceived as valuable learning to these professionals.

Behaviour

The third "a priori" theme, Behaviour, relates to Kirkpatrick's third level of evaluation (Kirkpatrick & Kirkpatrick, 2007). Participants were invited to comment on how they have applied in practice, what they learned in coaching. Thirty one (96.8%) participants answered this question. Five main categories were identified in this theme: Confidence as a Leader, Managing Workload, Developing and Leading Others, Role Engagement and Thinking Differently.

Confidence as a Leader

Confidence as a leader emerged as one of the categories in this theme. Eleven participants chose to respond in this category. Participants perceived an increase in their self-confidence generally as a result of being coached and felt more able to be confident in their practice as a result. Others commented more specifically on their confidence gain.

Participant 11

> *I gained confidence in myself as leader of the team.*

Participant 3

> *I have in a short period of time reinvented myself. Prior to coaching I think I was just slipping further and further into a feeling of helplessness. I couldn't seem to get on top of anything and staff issues simmered but I couldn't manage them. Staff refused to report them. I didn't think I could even get through the issues that surrounded me. I didn't realise that I was struggling I couldn't even explain what sort of leader I was. That was before [the coaching]". Following coaching "my hands were no longer tied. I actually have the confidence myself to say "bring it on". I have taken back control of my Unit and can confidently say I'm actually loving my job more. I have been given the skills to now manage upwards. It has empowered me to place meetings into my manager's diary to follow-up, and perhaps understand that it is within my scope to do something about my manager's lack of support. I now don't complain, I action, record my issues and*

keep trying. Before coaching I was drowning feeling like I was to blame for all my unit's issues as I was a poor manager. I now have a positive focus and I feel I'm functioning well as a NUM now. I'm not going to leave!

Participant 24

I found the feedback from a third party who was not involved gave me confidence in my own ability to make good judgements of situations.

Participant 21

I now have more confidence and practical strategies for stepping outside fears and complacency and into my potential.

Managing Workload

Managing workload was another category in this theme, where participants felt that they could apply in practice what they experienced during the coaching. Eighteen participants chose to comment in this category. Some participants felt they now had better personal organisational skills as acknowledged by this comment:

Participant 7

I now utilise a daily planner on a more efficient basis (Coach showed me a good grid to use).

… prioritising and … saying NO now and then".

Participant 11

I have learned to address difficult tasks positively, to focus and see them completed, rather than procrastinating and putting them off until after the eleventh hour, then rushing through them. As a result, I now have the satisfaction of seeing my ' in tray' empty much more frequently, and have the added satisfaction of a ' job well done' as I have been able to quietly apply myself to the task at hand.

Participant 24

The goal setting strategy [coach's name] gave me, I now use regularly.

… not getting caught up in reactive problem solving all the time.

Participant 16

Since the coaching has ceased I have continued to use regular timelines and the skills learned in setting longer term goals. I am very good at daily/weekly

prioritising but frequently risk getting bogged down in the minutiae of the workplace grind and lose sight of the bigger picture.

Participant 7

[I now] plan using a goal centred approach at the beginning of the week–spending time doing this saves time in the long run. Reviewing these goals at the end of the week provides satisfaction and rationales as to why some of them weren't able to be met–increasing my ability to set realistic goals.

Developing and Leading Others

Developing and leading others is the third category in the theme of Behaviour. Thirteen participants chose to respond in this category. This category relates to participants applying the leadership skills or strategies addressed during the coaching intervention, in leading or developing others. Several participants referred to how the coaching had supported them sufficiently that they could then go into the workplace and provide that support to others.

Participant 25

The coaching supported me to empower others to take the lead in their roles to meet outcomes … Supporting and empowering key stake holders created a ripple effect that has allowed for professional and educational growth for all members of my team.

Participant 3

Coaching has enabled me to focus on my expectations of my senior staff. My staff now act more responsibly and are accountable. Through setting guidelines about what were my expectations as a Nurse Unit manager I have achieved amazing things after being coached to understand what I needed/wanted to achieve. A staff member resigned when she came to understand I wasn't going to tolerate unprofessional behaviour. This nurse quickly realised I had taken away her ability to undermine so she left. Although this had never been my intention through managing these difficult conversations I have shown staff that I support them. More staff are now coming up to me with the confidence that I will manage issues on the unit.

Participant 11

I now actively promote staff suggestions for solutions to issues raised, with the resulting empowering of my staff to be part of the solutions, not merely the

reporters of problems.

The coaching provided an environment that was conducive to leaders being open regarding their skills and fears of dealing with some of the challenges they faced. Using the coaching space to gain clarity on the issues and discussing potential solutions assisted them in being able to apply those strategies in practice.

Role Engagement

Role Engagement is a category which describes the participants' feelings of being more engaged with their work. Six participants chose to respond in this category. Several participants commented on how the coaching experience promoted their ability to perform in their role and meet their outcomes. Encouraging people to focus on their strengths is a core activity in coaching.

Participant 21

> *Through understanding my strengths I now have a clearer understanding of the best ways I can develop in my role and also have improved acceptance/understanding of the areas I need assistance with either in my own learning or through outsourcing information.*

Participant 28

> *This [learning to be assertive] has been very positive and powerful and makes me feel more comfortable fulfilling my role. [Coach's name] has helped me to re-prioritise… which has helped me to refocus and get more enjoyment out of my position.*

Participant 3

> *Prior to these coaching sessions I had contemplated leaving my job…. and [I] can confidently say I'm actually loving my job more. I'm not going to leave!*

These comments regarding coaching and work engagement are consistent with the quantitative results which show that the coaching intervention significantly increased the work engagement of the participants.

Thinking Differently

The final category in the Behaviour theme is Thinking Differently. Nine participants chose to respond in this category. Participants' comments reflect the perception that coaching assisted them to think differently. Several participants felt that working with the

coach assisted them to see their professional situations from a different viewpoint and consider options they had not previously considered.

Participant 24

> *I found this coaching experience very positive. It has started me asking a lot of questions of myself.*

Participant 16

> *… now prepared to think outside of the square.*
>
> *… to seek alternative solutions outside the box.*
>
> *[coach's name] was able to ask me questions that challenged my thought processes and activities in my role.*

Participant 3

> *Coaching has enabled me to look at my position in a different way, to be comfortable in feedback and not take anything personally.*

Participant 21

> *… step outside of fears and complacency and into my potential.*

In summary, the comments from this third theme Behaviour and its categories show that participants felt they were able to apply what they learned in coaching to their clinical practice. They were able to apply the skills they learned in coaching to the workplace as evidence by their goal setting and ability to manage their activities differently. The coaching provided a ripple effect in staff development. Once the leaders gained clarity and focus on how they would deal with their challenging issues, they were then able to support others and address the professional issues that faced them. They became more engaged in their roles and more able to think outside of the box.

Results

The final "*a priori*" theme was Results. This theme represents the quantifiable outcomes that participants obtained from the coaching and relates to Kirkpatrick's fourth level of evaluation (Kirkpatrick & Kirkpatrick, 2007). The participants were invited to relate any quantifiable outcomes that may have resulted from their coaching. Twenty seven participants (84.3%) responded to this question. The categories from this theme were: Career Path, Further Education, Work Life Balance, Clinical Professional Outcomes and Goal Attainment.

Career Path
The category Career Path reflects the career orientated outcomes participants obtained at the end of the coaching intervention. Nine participants chose to respond in this category. **Participant 9** *Identified different career paths within nursing.* **Participant 23** *… think with an increased vision about options/possibilities.* **Participant 26** *It has helped me to clarify the direction I would like to move in my career. It has helped me to see myself more clearly and has given me a goal to work towards* **Participant 7** *… career goals and how they could be realistically achieved.* *… written 5 year career plan.* **Participant 9** *I have found a different job within nursing which meets all of the criteria of a job that I enjoy. The coaching sessions were pivotal in clarifying what is important to me about nursing. The end result has meant that I have changed jobs within the nursing profession.*
Further Education
Several participants chose to use the coaching to assist them reach their goals in furthering their education. Eight participants responded in this category. One participant was working with university staff to complete a proposal to accompany their application for entry into higher degrees program: **Participant 29** *I have started working with university staff to fast track into a PhD program.* **Participant 9** *… commenced university studies in clinical education.* **Participant 26** *… started online study …* **Participant 13**

… enrolled in a Small Business Management Course which was one of my goals.

Participant 23

I completed both my training to use the [name] Program and have completed the 2 day course as a master trainer of this program.

Participant 27

My best possible outcome was to complete an assessor module from the [course name]–that I did.

Work Life Balance

Work life balance emerged as a category. Some participants set goals to attain an approach to work that provided them with an appropriate work life balance for them. This is evident as one participant reflected:

Participant 28

I learned to prioritise the needs of not only my job but myself. I was getting snowed under trying to make everyone else pleased, that my needs were falling to the bottom of the list. [Coach's name] has helped me to re-prioritise to ensure that my job and life has a better balance, which has helped me to refocus and get more enjoyment out of my position.

Participant 24

… "clarify" the issues that were "personally important to gain a work/life balance".

Participant 21

By identifying what work/life balance really is, I was able to apply a measurement to each component which clearly demonstrated improvements and the eventual achievement of a work/life balance that worked for me.

Clinical Professional Outcomes

The category of Clinical Professional Outcomes refers to the clinical outcomes that participants had attained by the end of the coaching intervention. Thirteen participants responded in this category. Health professionals are frequently required to give clinical practice analysis or case conference presentations to other staff. Some participants focused their goal on developing their skills in this area and delivering their presentation:

Participant 9

This [coaching] resulted in me meeting the objective of giving a presentation to a large group of people.

Participant 16

The conference paper was completed well ahead of schedule.

Participant 20

My goal was to have 100% of staff complete 1–3 mandatory training activities within a given time frame. This was achieved and recorded in TREND.

Participant 31

The staff survey is now complete, results analysed and plan implemented.

Participant 11

With [coach's name] guidance, prompting and enthusiasm, I have been able to develop a 6 hour workshop for staff members–something I would not have been able to do prior to undertaking the coaching sessions.

Goal Attainment

The final category in the Results theme was Goal Attainment. Seven participants chose to respond in this category. Participants responses reflected that they had attained their goals. The majority of the comments are summed up by the comments of two participants:

Participant 3

I can honestly say I more than achieved my goals I set in the beginning.

Participant 18

I have achieved what I set out to do by successfully completing the projects I commenced.

The outcomes described by these participants are supported by the results from the goal attainment scaling, which was discussed in a previous section and showed that all the participants attained the goals they set during the coaching intervention, and that the majority of the participants attained their goal at a level which they deemed was better that expected or their best possible outcomes.

In summary, the comments from the five categories in this Results theme show that participants were able to achieve quantifiable outcomes from the coaching they received. This ranged from constructing a 5 year career plan to finding a new job. Some enrolled in

a new university course while others completed an existing course. Other participants achieved a work life balance that was suitable for them. Many of the participants achieved clinical focused outcomes such as giving a clinical presentation, or developing a clinical audit, survey or workshop. Others developed their papers and presented at conference. In summary, all participants attained their goals and attained a better than expected outcome.

5.6.2 Summary of the coaching evaluation. In summary, the evaluation of the coaching program indicated that coaching is a positive professional development experience that many of the participants would want to repeat. The majority (97%) said they would work with a coach again, rating the coaching as excellent (53.1%) or very good (40.6%). All of the participants attained the goals they set at the beginning of the study, with the majority (56%) achieving their best possible outcome and 41% rating their goal attainment as better than expected.

The qualitative comments from the questionnaire indicated that while participants enjoyed the program (Kirkpatrick's level 1), they also felt they had gained some professional learning from it (Kirkpatrick's level 2), were able to apply their learning to their practice situation (Kirkpatrick's level 3), and perceived that they attained some discernible results (Kirkpatrick's level 4), from their coaching experience.

5.7 Chapter Summary

This chapter outlined Phase One—The Quantitative Study. Results from the evaluation of the coaching program were positive. Participants reported personal growth in relation to focus, self-awareness and self-confidence. They also reported professional growth relating to motivation and decision making. In addition to this, all participants attained their professional development goals set prior to the coaching and the majority reported

high levels of satisfaction with the coaching. As mentioned in the previous section, participants reported positively on all Kirkpatrick's four levels. However, inferential analysis showed mixed results. There was a significant increase in all aspects of participants work engagement levels, including vigour, dedication and absorption. In contrast to this, hypothesis testing revealed a significant increase in the dimensions of emotional exhaustion, depersonalisation and a significant decrease in personal accomplishment. Discussion of these results is explored in the context of the extant literature in Chapter Seven.

Chapter 6.

Phase Two - The Qualitative Study

6.1 Introduction

This chapter pertains to Phase Two of the mixed methods study. This phase was conducted approximately six months after the coaching intervention (Phase One) was completed. The chapter commences by outlining a profile of the participants involved in this phase and then progresses to discussing findings from the individual participant interviews. A thematic analysis of the data is presented, outlining the three main themes; Professional Enrichment, Personal and Professional Growth, and The Ripple Effect. The related subthemes are discussed under each main theme and the chapter concludes with a summary of the key findings from Phase Two of the study. Pseudonyms have been used in the reporting of the findings to protect the identity of the participants.

6.2 Profiles of Participants

In order to contextualise the qualitative data analysis, a brief profile of each of the participants who engaged in the qualitative phase of the study is presented.

6.2.1 Sandy. Sandy was an experienced nurse unit manager who was in charge of a ward in a large general public hospital. She had replaced the previous nurse unit manager and had "inherited" a ward that had a poor reputation. As a result, it was difficult to recruit and retain staff. The ward staff were unsure of Sandy, very loyal to their previous manager, and as a result of this, were bypassing Sandy when they experienced issues in the ward. Sandy had walked into a ward culture where there was secrecy, staff conflict and low morale.

6.2.2 Joanne. Joanne had been in leadership posts for more than eight years and now held a senior leadership post which was responsible for care delivery across a variety of different hospital areas. Joanne was confident in her role and had a clear vision of where she wanted to take her team and the goals she wanted to achieve. She had some aspects of her role which she wanted to focus on and develop greater skills in these areas.

6.2.3 Angie. Angie was new to her leadership role. She had been asked to step into a role that had an increased teaching component. Although experienced in practice, she was new to the education role, and experienced doubt about whether she had made the right step with this new role. Angie worked in the community. She was in the process of completing a distance education course.

6.2.4 Laura. Laura was an experienced clinical nurse leader. She had recently been appointed to a more senior clinical role within a busy major hospital and was aware that people were watching her performance as the new leader. She had a vision of how she wanted her area to be, but was both excited and apprehensive regarding the changes. She knew there would be resistance from certain quarters and she was questioning whether she could successfully manage the change process in this busy practice area.

6.2.5 Shauna. Shauna had been in her role as a manager of a medical facility for several years. She managed a large staff which worked over several wards and smaller units within the hospital. Shauna had successfully implemented some changes at work and had an abstract on her project accepted for a major international conference. She had never presented her work before such a large audience and felt intimidated by the internationally renowned speakers who would be present in the audience. Her rising anxiety had led her to procrastinate regarding preparing the presentation and she was now

questioning the importance of her results and her ability to deliver the information successfully.

6.2.6 Constance. Constance was an experienced leader who was new to her role in hospital and community settings. She carried a large workload, running several large projects concurrently, while also completing postgraduate studies at university. She found herself working very long hours and used her days off to catch up, leading to a considerable work-life imbalance. She procrastinated excessively over her studies and was losing motivation. Parts of her new role were challenging for her and she was questioning whether she had the skills to get the outcomes the role demanded.

6.3 Findings

Three main themes emerged from the qualitative interviews: *Professional Enrichment, Personal and Professional Growth* and *The Ripple Effect.* Figure 14. presents a diagrammatic representation of these themes.

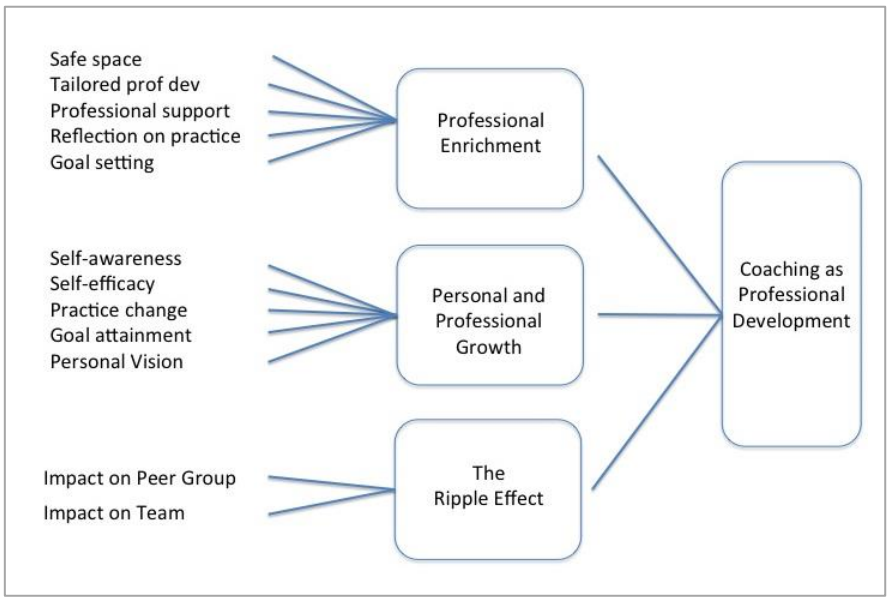

Figure 15*:* Themes from Qualitative Analysis

This figure illustrates all the main themes and sub themes from the qualitative analysis of the data.

6.3.1 Theme 1 - Professional enrichment

The first major theme to emerge from the qualitative component of this study was: Professional Enrichment as demonstrated in Figure 15.

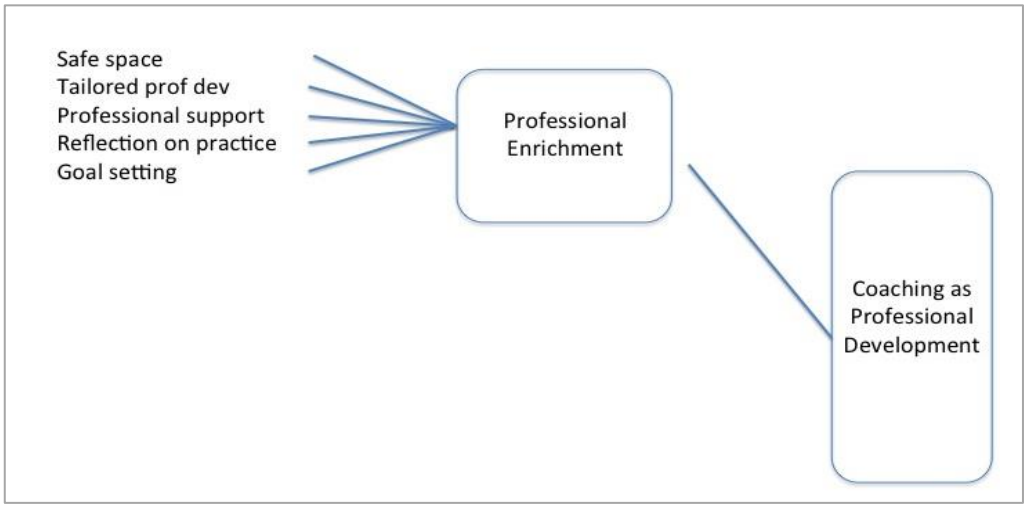

Figure 16: Major Theme - Professional Enrichment

Coaching as a form of professional development was new for all of the participants in this study and the theme of *Professional Enrichment* describes how participants experienced the nature of the professional dialogue within the coaching context. Five sub themes contributed to this theme: *Safe Space, Tailored Professional Development, Professional Support, Reflection on Practice* and *Goal Setting*.

6.3.1.1 Safe Space. One of the sub themes that emerged from the main theme of Professional Enrichment was the notion of safe space. All participants who were interviewed commented on how the coaching interactions (staff with coach) provided a "safe space" for them, in which they could explore professional practice issues, instilling a sense of confidence that overflowed into their daily professional practice. In reflecting

on their coaching conversations, participants referred to three different aspects of having a safe space; confidentiality, authenticity and learning.

Safe space for many of the participants was around the issue of confidentiality. The majority (four out of six) of participants reported feeling that conversations were safe because they were confidential as evidenced by Sandy who remarked "I knew it was confidential, so I could open up". A crucial aspect of this confidentiality, mentioned by all participants, was that the coach was external to the organisation. Joanne felt "very safe to talk to the coach as an external person". It was clear from their comments, that all participants felt confidentiality could not to be assured in their work environments as Joanne explained: "*because you are never sure in the organisation who is giving information to who ... confidentiality is not always there*". Further, participants felt that by having "*someone external to the workplace ... someone who is independent ... it's confidential*" (Sandy) allowed them to be more open. By way of explanation, Joanne recounted that having a coach who was external to the organisation was:

> *a critical factor in the success of my outcomes with the coaching. I think if the coach had been part of the organisation I could not have been so frank, because a lot of the challenges are inherently part of the organisational culture. So because the coach was an outsider, it allowed me to be really open and reflective.*

Similar sentiments on using an external coach were expressed by Laura who explained "*if it [coaching] was with somebody that knew my work environment and those I worked with ... I probably would not have shared as much nor got as much benefit out of it*". In addition to the importance of confidentiality as contributing to a safe space, authenticity was also considered important for the participants.

Authenticity, related to participants feeling safe enough to be themselves in the coaching sessions. Five out of the six participants used the word "*honesty*" and other phrases that

expressed authenticity, such as "*I could be clear and honest" (Laura), or "... you could be really honest ... I could open up*" (Sandy). Participants felt they could reveal how they truly felt about the issues and challenges they were facing in practice. In effect they could be authentic. For example, Constance revealed authenticity in her comment when she spoke of her "*comfort zone ... you can get that under the table stuff, the stuff that you really want to hide ... you can actually allow that to come out*" as did Shauna who said "*the onus was on me to be honest*". Sandy also felt she could "*be really honest with the coach ... and lay it on the line*" and Laura felt she was able to "*clearly and comfortably speak about some of the concerns that I [she] had within my [her] work environment*".

Participants also felt safe to share their true feelings and thoughts about their own professional performance as they explored the issues confronting them. They described the coaching as a process of "*opening me up*" (Constance) and helping them to "*be open and transparent" (Laura), to be "open and reflective*" (Joanne), and to *"be honest with myself*" (Sandy) about my [their] practice[s]. Sandy elaborated by noting that coaching provided the opportunity for her to "*reflect and say out loud that I was doing it wrong ... to say yes that's right I'm not doing that so well … but I can*". Joanne summarised by saying "*the collegial conversations ... I think it was really valuable for me to have conversations at that level*".

The comments relating to authenticity reveal that participants felt the coaching provided a valuable opportunity for them to have professional conversations about their practice and to reflect honestly on their own practice. Such conversations appeared not to be commonplace in practice as according to Constance "*it's not terribly often you get to have nice little sessions and talk about yourself and your professional life*". Two other participants commented on the difficulty of having such conversations in their practice

environments. According to Joanne, when individuals are "*in a position of leadership, it's sometimes hard to have those conversations with others in the organisation*". Sandy agreed and commented more fully that:

> *I don't think you get the opportunity to say 'I handled that situation really poorly' or 'I have spoken out of line' ... it's very difficult to go to another nurse unit manager ... it's difficult to broach it and bring it up ... its seen as a failure.*

In essence, the Safe Space provided by the coaching afforded the clinical leaders the opportunity to be authentic about their challenges, their issues and their professional practices as leaders. It also provided them with conditions within which they felt they could learn and develop as leaders safely. The third and final aspect of the sub theme Safe Space was related to learning.

Learning related to participants viewing the coaching interactions as a safe space for them to learn and rehearse aspects of their leadership roles. All the participants made comments on coaching creating a space for them to either learn specific skills relating to their role or a space where they could in relation to exploring options and rehearsing how to deal with difficult situations they would face in their role. Sandy recalled exploring options where "*the coach actually gave me feedback ... 'well did you try this?' or 'have you thought about that?' I was shown some concepts and things to try out to see whether they worked out*". Constance similarly explored options explaining *"... this is what I am looking at doing and the coach would go 'well what are your options?' ... 'what will happen if you do this? ... what will happen if you do that?'* ". Similarly, Angie recalled rehearsing how to provide feedback to a staff member regarding poor performance "*I felt uncomfortable doing that [providing feedback]. I remember one day the coach helped me with some words ... because I didn't know how I was going to approach this situation*". Sandy also recalled rehearsing "*how to have some of those difficult conversations ... and*

pull people into account". Constance also commented on this rehearsal aspect, viewing it as a useful risk management strategy for leaders dealing with difficult situations:

> *if you don't have someone who can coach you through that [difficult] situation ... I think for the organisation, that's an awful big risk ... whereas with the coaching you can work through the whole thing with someone and actually process it before the time, so you are much less at risk when you actually come to resolving the issue.*

Five out of the six participants mentioned coaching in relation to safety and learning. Coaching was viewed by Joanne as *"a safe place ... for us as leaders to grow and learn*". Constance similarly mentioned safety in relation to learning, saying:

> *... the beauty of one on one learning, is that it's a very safe place ... people can ask the questions that they might not ask in a group of 20 ... having that safety is really good sound learning ... coaching very much facilitates that process.*

Angie saw coaching as "*... promoting learning ... coaches help people to develop and grow their skills and their performance*". This was confirmed by Laura who felt the coaching "*really helped with my [her] leadership skills*" whereas Shauna felt the coaching had an impact on her learning style making her "*much more of an independent learner*". Joanne summed this aspect up by saying *"... I have just learned so much*".

6.3.1.2 Tailored professional development. The second subtheme within the main theme of Professional Enrichment is Tailored Professional Development. This subtheme refers to the individualised nature of coaching and describes a personalised, tailored approach to professional development. Participants enjoyed the individualised nature of coaching and the unique tailored approach to professional development that it provided. Five out of the six participants remarked on this. For example, Constance commented: *"... what's lovely about coaching is it's very personalised and very tailored to the individual".* This tailored approach provided an opportunity for the participants to work one on one

with the coach. It meant they could "*sit and choose much more meaningful goals ... selectively choose something I [they] really need to concentrate on"* (Shauna). The opportunity to take time out was valued by the participants. Shauna went on to explain further "*I really enjoyed the opportunity to take time out and just think about my bigger goals rather than the everyday timeline stuff you have to get done*". Joanne commented similarly: *"Having that time for me ... that allocated time with someone who was willing to listen and to engage".* In the same vein, Constance said *"I actually really enjoyed it ... to have someone put it all into such a positive light for you and help you and support you ... oh it's a treat".* Participants enjoyed this tailored approach to their professional development as they felt it built on their existing skills. Sandy reflected *"I probably had some of the skills there ... coaching gives you the skills that consolidate what you probably already know".* Constance commented similarly: *"I think that I probably had some of those skills but they were probably enhanced through the coaching process ...".*

One of the key aspects of coaching as a professional development method is that it can be constructed to take account of the individual's current workplace context and the unique demands on them. For example, four of the participants mentioned the coaching in relation to themselves or others transitioning into a new role. Sandy reflected "*I wish that I'd actually had the opportunity to do some coaching when I first became a nurse unit manager ... because I think it would have helped me when I stepped into the new role*". Angie agreed saying "*Yes I definitely believe that if there was coaching for individuals doing this role, it would have made it a lot easier [for me] in the beginning*". Laura explained: "*It was extremely timely to have the coaching, especially when I was stepping into a new role ... so for me that was excellent*". Constance was also new to her role. She described: "*I think when I did the coaching I was reasonably new in my job, so it was really quite timely*". Angie was quite clear that for new staff transitioning into a new role

"*it can be quite daunting ... coaching definitely should be used because it nurtures new people ...*" (Angie).

Five out of the six participants, including those who were already established in their roles, saw coaching as "*a credible way of supporting leaders*" (Joanne) and "*really the only way we could seriously do succession planning into management*" (Constance). Coaching was seen as valuable, "*particularly if we could get it to nurses who are coming up ... our clinical nurses who are stepping up to be Nurse Unit Managers*". Sandy elaborated further "*not many people want the manager's role because we get dumped on from all angles, but there is probably a lot of nurses out there, who with some coaching, could do really well*". Constance agreed with this sentiment and explains the situation further by saying:

> *When you have got a nurse ... [acting] into the manager's role ... it is a totally different skill set to being a clinician ... and a lot of intelligent, experienced people come into it [manager's role] and really struggle ... you know that [having people struggle] doesn't work for anyone, having a coach or a mentor to coach you through that process, is really the way to go.*

Reflecting on coaching as a way to help leaders transition into roles or to do succession planning led four out of the six participants to compare the tailored approach that coaching offers with their current professional development activities. Sandy reflected and said:

> *... so it doesn't meet our needs ... professional development activities are kind of ad hoc ... you will say ... 'I didn't know how to handle that HR problem so I will run off and do that course' or 'there is an issue here so I'll run off and do that course' ... I had been to all of these courses but no one had sort of put it all together for me ... I had the skills and I didn't really know how to apply them ... the coach kind of gave me permission to try them.*

Shauna also commented similarly on her professional development activities when she explained:

> *… it's kind of like ... stop gap stuff, it is not really meeting the need, because it doesn't make you stop and think ... ' well is this really what I need to do?' If you do a few workshops over a year, you don't even remember doing them let alone the content ... it's a bandaid ... Yeah, I think there is a very big difference between that which we are used to and professional coaching.*

Constance remarked on the leadership and management workshops provided by her organisation. She said:

> *It's a great idea, except that if I do it in April this year but I don't actually step into a manager's position until October, it's really not going to be of much benefit to me ... certainly you can learn some principles etc. on a course ... sure I think you can get qualifications and you can learn the theory, but actually being able to manage the job and all the threads of it, I think the coaching model or mentoring model is ideal for that ... you're not going to learn the job any other way ... there is certainly a place for coaching in nursing.*

In summary, the participants enjoyed the tailored approach to professional development that coaching offered. They liked the personalised approach and the way coaching met their needs by focussing on their individual goals and building on their existing skills. The differences between coaching and existing leadership workshops or courses were noted and it was felt that coaching held very clear benefits for those transitioning into new roles. Coaching was also viewed as a viable way to do succession planning for potential leaders and a useful professional development activity for those already in leadership roles.

6.3.1.3 Professional support. The third sub theme contributing to the main theme of Professional Enrichment was Professional Support. The relationship between coach and coachee is a key factor in the coaching process (Palmer, 2010). All of the

participants mentioned the coaching relationship in a positive manner. Half of the participants referred to a trusted relationship between themselves and the coach. For example Shauna explained "*There is a trust goes on between the coach and coachee and it is about your professional development*". Constance also spoke of the "*trusted relationship that can facilitate growth*" as did Sandy who said "i*t's someone who is independent ... someone you can trust*".

The concept of support was referred to by all of the participants as a central component of coaching, in contradiction to their roles which they viewed as very stressful and lacking in support. For example, Constance bemoaned the lack of supportive relationships in nursing generally. She said:

> *I think there is a need for a lot of support for nurses which they don't get really ... I guess in my thirty years of nursing, the whole lack of communication and empathy and relationship building has been my ongoing frustration ...*

Other comments from the participants also reflected a general lack of support for them in their roles. For example Angie commented on the need to " *... just have someone there to be supportive ... nursing is such a stressful place to work at times let alone trying to learn [a new role] as you go*". She also spoke of "*that terrible feeling of what happens when you are overwhelmed*". Constance also commented about the lack of support when moving into a new role, saying "*it can be quite overwhelming ... it's like take a leap of faith and have a go and hope you don't drown*". Shauna in relation to her role mentioned "*all those competing priorities*" and "*playing catch up on lots and lots of paperwork". She finished with a resigned comment of "and so yea that's the stress of the role ... what can you do*?" In a similar vein, feelings of isolation are evident in Sandy's comment as she reflected on the lack of support she received in her role as a manager. As she explained:

> *I really felt my director of nursing was failing me and wasn't providing me with support or direction ... I wasn't feeling like I was supported ... I kind of came in to my role and then I was just drowning ... I was getting a lot of issues coming up on the floor and I was just at my wits end about how to manage those without support from anyone ...*

It was clear from comments all the participants made, that coaching provided much needed support for them. For example, Angie noted that "*the coach was there and supported me throughout*" as did Laura who said "*it gave me some support you know ... having someone there*". Sandy was very clear in saying that "*by being coached, it actually opened my eyes to the fact that I wasn't alone*". Others also commented on coaching being "*a kind of supportive role*" (Constance) or saying that "*coaching is all about a sense of support*" (Shauna). Laura provided some insight into how the coaching supported her when she said:

> *It [coaching] gave me confidence, ... because I was new in the role, I felt overwhelmed with so many things to do and the coaching actually gave me some clear processes to think about ... and to be able to structure my busy day in a way that was not quite so stressful.*

Sandy reflected similarly

> *I started the coaching ... [it was] really support and debriefing … and each week just trying new things that were just simple ... but I was blown away by how it worked.*

When asked about stress relating to the coaching experience, four out of the six participants mentioned issues they faced during the coaching.

Sandy described her feelings of anxiety as she started to implement some of the changes discussed in coaching. Sandy reflected that:

> *… it actually became a bit overwhelming a little while after I started it ... and I 'thought oh my goodness what have I done' … suddenly everyone [staff were] was*

telling me everything and the flood gates opened ... it was like oh my goodness ... how can I cope with this, where is [coach's name].

For three participants the challenge to be organised in completing their weekly action plan in preparation for the coach's call was at times stressful. For example, Angie said:

... I felt a little bit of pressure when I knew that the coach was calling ... trying to be organised for the phone call ... although it was only stressful because I wasn't organised and I left it to the last minute.

Joanne also felt the pressure to be prepared for her coaching call, but differentiated between quiet apprehension and stress. She commented:

No stress ... I think there was definitely that tension around what I think of as creative tension or motivational tension that any sort of goal or deadline brings ... the fact that we had a goal, we had a time commitment, we had a date set in the diary ... that was a motivating factor ... so some might see that as negative because it's a bit of time pressure, but it's that sort of positive tension really.

Laura expressed similar sentiments to those of Joanne in stating: "*I would have to say no stress ... however in my busy role I did at times feel a little bit of pressure around having to be prepared for an additional discussion with the coach*". Two participants made comment on the lack of stress for them during the coaching. Shauna explained "*Absolutely no stress ... quite the reverse actually ... I think it has reduced my stress levels ... I think it has been very helpful and there hasn't been any negatives*". Constance also commented on this, saying "*I didn't feel as if there was any stress or anything. I saw it as 100% positive and beneficial*". Although it seems for some participants, there was some anxiety in relation to implementing changes in the workplace and some time pressures for others in completing the weekly action plan and being prepared for the coach's call, participants also found the coaching motivating as Angie recalled "*after our conversations I always felt motivated to go on*". Laura agreed saying *"... I would literally get off the phone to the coach and comment to others 'I have just had a fantastic coaching*

session ... and I am going to do this and I'm going to do that' ... and it would go on like that".

All the participants described the coaching as a positive experience for them. Sandy said "*it was so positive ... when I look back now ... it was just one of those life changing things*" ... Joanne was similar in her view "*It was just a really positive experience for me ... I think the coaching has just been really great*". Shauna repeated the sentiment "*I've thoroughly enjoyed it ... It was such a positive experience for me ... so thank you*". Laura found the coaching to be "*really beneficial*" and Constance said "*I actually really enjoyed it*". Angie enjoyed it so much she expressed an interest in engaging in coaching again " *... and now I am thinking that I would like coaching again*" as did Joanne "*and given the opportunity I would engage in it again*". Sandy also expressed a wish to work with a coach again "*I've been thinking that I might go looking for more coaching now ... I think that it was so positive ... perhaps is there something else a coach could help me with ... help develop me further in some aspect*".

In essence participants appear to have enjoyed the professional support that coaching provided. They commented on the trusted relationship with the coach and the support provided for them during coaching. The stressful nature of their roles and lack of support in their workplace was evident in their comments, using words such as "overwhelm", "drowning" and "stressful" when describing their current work circumstances. Although one participant made comment regarding stress in the initial stages of implementing her action plan, others differentiated between stress and the tension they felt with regard to time pressure and being prepared for the coaching call, in addition to their heavy workloads. In contrast others noted the experience was entirely positive or that coaching reduced their stress. Having a supportive professional relationship was a positive factor

leading to professional enrichment for the participants. It also provided them with the opportunity to reflect on their practice.

6.3.1.4 Reflection on practice. The fourth sub theme contributing to the main theme of Professional Enrichment was Reflection on Practice. Five participants mentioned reflection in relation to the coaching they had received. Reflection is a key component of contemporary practice (Jasper, 2006), yet despite this, participants were challenged to find the time for reflection in their busy work schedules. Joanne commented "*I was always too busy to reflect ... because it's just a really busy job and I wasn't really getting around to reflect on those areas of my practice that needed work*". Similarly when speaking about reflection Sandy said "*I never used to do that ... I honestly never used to do that ... I can honestly say to you I just went to work and struggled through my day*". Shauna reported that the coaching experience "has *really helped me to reflect more ... to slow down my thinking*".

The coaching sessions were focussed on professional practice and as such invited reflection on the professional individual issues raised. Angie spoke about reflecting back on "*things I have learned*" whereas Laura felt it was "*very worthwhile ... just reflecting on my own personal experiences*". For Joanne, coaching provided "*an opportunity to be able to explore those interpersonal issues around the job ... you know just reflecting on my personality and other people's personality and the way they [and I] manage*". The challenges inherent in such reflection were not lost on Sandy "*sometimes that self reflection ... sometimes you are going to see some things that you don't want to see ... but that will make you a better manager*". Joanne enjoyed "*just having specific allocated time to reflect on my practice ... that was very important ... that's really what the coaching did I guess it gave me the ability to stop and pause*".

An insightful commentary is provided from Sandy on her own practice of reflection after a challenging day at work. As she said:

> *You can go home and have a glass of wine and think god that was a bad day ... but you don't always reflect on what made it a bad day ... I am more likely now [after the coaching] to go now what has made today a bad day and what could I have done differently and tomorrow what am I going to do about it.*

In summary, the coaching experience provided participants with the opportunity to reflect on their own practice and the professional issues they faced. Participants were challenged to find the time to reflect regularly on their practice and found that coaching provided the opportunity to do that. There was acceptance that reflection is not always easy but it was recognised as a valuable activity for their practice, particularly as they planned for the future. The last aspect of coaching that contributed towards their professional enrichment was related to setting goals.

6.3.1.5 Goal setting. The fifth sub theme contributing to the main theme of Professional Enrichment was Goal Setting. Coaching is a goal centred activity (Green, Oades, & Grant, 2006). All participants referred to goal setting in relation to their coaching experience. Participants commented on various aspects of the goal setting process. The coaching experience clarified the goal setting process for two individuals. Constance commented "*I think I got more of an idea now about setting goals ... from talking with the coach ... I think that has been a good help*". Shauna also felt it was "*very helpful to have somebody help you set goals*". The coaching provided an opportunity for the participants to prioritize their own professional growth. All the participants used the word focus in relation to their coaching and goal setting. Sandy indicated that coaching "*enabled me to focus*" and Shauna reported that it helped her to "*sit down and focus completely ... focus a great deal on my goal*". Laura also commented on this, saying "*I*

think coaching is great for being able to focus on setting goals". Coaching was viewed as a good process for helping individuals "*concentrate on what you need to do, rather than ... you know ... just worry about it all*" (Shauna).

A key part of the goal setting process was ensuring that realistic goals were set. Four participants referred to the process of breaking the goals down into realistic components. Sandy commented "*Yeah I wanted that big goal and that big vision ... but I really needed to start small ... and I think that's the thing*". Joanne also reflected on her larger vision "*it just seemed all too big and overwhelming and daunting*". Shauna agreed "*you need to be able to pick bits off that you know you can achieve in a realistic time frame ... to make the goals realistic was really important to me because I tend to be big picture ... it helped me break down the problem into workable pieces. That was the most helpful thing for me*". Constance also referred to "*being able to break it down Yeah ... to break something down and make it achievable through small steps*". Laura also found it helpful to have smaller steps "*I had clearly defined some goals ... I now had some very clear steps and plans around what I was going to do*".

A degree of professional growth for the individual is always expected in coaching and setting goals that are attainable but which also provide a degree of challenge (Locke & Latham, 1990), is part of the process. Two participants described how they would not have stretched themselves professionally if they had not been in the coaching situation. Angie elaborated:

> *I wouldn't have done all of that course if I hadn't had contact with the coach ... I would just have done parts of it and I certainly wouldn't have taken on doing the more complex module ... I would have just pushed that to the side and picked out bits [of the course] that were simple ... so for me to take that on ... that was a good stretch for me.*

Laura made a similar comment:

> *I don't know if I would have done it without having the coaching ... I was definitely outside my comfort zone.*

Regular contact with the coach encouraged momentum towards goals. A degree of accountability for moving towards their goals was noted in four participants' comments. Angie felt the commitment "*to sit down and make sure I [she] had it all complete*" as did Shauna. As Shauna explained:

> *It was like having your homework ... you have got to get your homework done, it was a mutual agreement between us at the end of each session, that by the following week or so that I would have whatever we agreed done ... there was that onus on me.*

The regular meetings kept Angie on a path towards her goals, she explained that "*by the coach calling me on those regular intervals ... it kept me on track ... I know I wouldn't have completed my goal without the coaching*". Laura was also motivated "*knowing that I [she] had some time frames to achieve things*". Coaching also helped Shauna "*set realistic timeframes and keep on track with timelines*". Joanne provided a final comment on the whole goal setting process when she stated:

> *Coaching is about making a commitment to action and then seeing it through ... setting the goal, creating those steps to achieve the goal, and working to complete the steps and get the outcomes.*

Overall the main theme of Professional Enrichment showed that participants felt that coaching provided them with a safe, confidential professional space, where they could honestly reflect on their practice with a coach who was exterior to the organisation. The professional support provided during coaching, provided them with a time and space where they could focus on their own professional development, set their individual professional development goals and receive tailored coaching in the areas they wished to

develop further. The following section will now discuss the second main theme, Personal and Professional Growth.

6.3.2 Theme 2 - Personal and professional growth. The second of the three major themes was Personal and Professional Growth as shown in Figure 16.

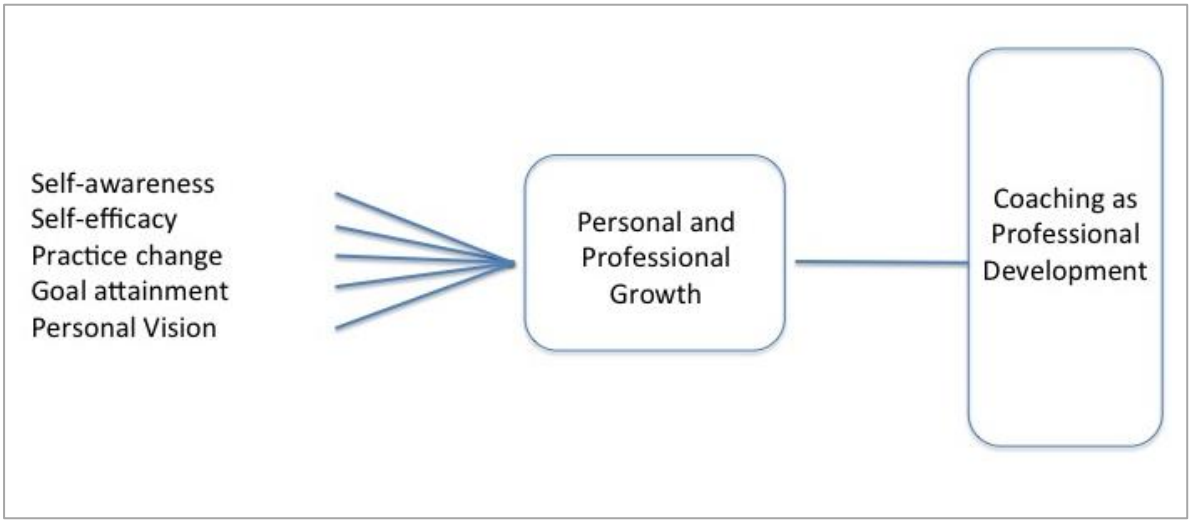

Figure 17. Major Theme - Personal and Professional Growth

All participants reported that they had attained some degree of both personal and professional growth from the coaching. This main theme had five subthemes, Self Awareness, Self Efficacy, Practice Change, Goal Attainment and Personal Vision. The first two subthemes are related to personal growth and development. These subthemes represent participants' perceptions that coaching contributed to aspects of their personal growth. All participants reported some aspects of personal growth and their stories relate to an increase in self awareness and an increased self efficacy and confidence as a practitioner. The remaining three subthemes are related to aspects of professional growth and development. These subthemes represent participants' perceptions that coaching had a positive impact on their professional growth. All participants reported some aspects of professional growth and their stories relate to changes in their practice, attaining their goals and creating a personal or professional vision for the future.

6.3.2.1 Self awareness. One of the sub themes that emerged from the major theme of Personal and Professional Growth was Self Awareness. Four participants mentioned an increased self awareness in relation to coaching. During coaching, participants engaged in reflection on their own attitudes, behaviours and feelings towards the issues they were facing. This led to them articulating some self knowledge regarding their professional strengths, skills or usual patterns of behaviour. Constance demonstrated some self awareness when she said "*I think what I achieved was basically a better understanding of my personal strengths and a better understanding of me in a bigger picture ...I think there were benefits in that ...*". Sandy found the coaching helped her uncover her skills "*I needed to see them ... my skills ... to be brought out and see them in the light ... and as I said bring it all together*". Some of the participants displayed insight into their usual patterns of reaction and felt that coaching had helped. Joanne commented:

> *... so the coaching might just make me be a little less ... a little bit less inclined to fall into my normal habits ... that was my personal weakness ... I used to get so frustrated and lose sleep ... I guess it [coaching] just gave me the ability to stop and pause.*

Sandy commented similarly "*I felt I* ***can*** *[emphasis] do this ... if I don't overwhelm myself with where I want to be*". Angie also commented on this point "*so I do believe that having that nurturing from the coach, throughout the time when I was doing that course ... helped me keep it all in perspective*". Constance spoke of how the coaching "*helped me develop an acceptance of the fact that ... that's who I am and that I'll develop these other skills as I go along ... but I already bring a lot to this situation*".

6.3.2.2 Self efficacy A second sub theme to emerge from the main theme of Personal and Professional Growth was Self Efficacy. Bandura (2000) defined self efficacy as "people's beliefs in their capability to perform in ways that give them control

over events that affect their lives" (p. 212). In other words self efficacy is the belief in yourself that you can succeed in specific situations. Coaching had a positive impact on the participants' beliefs in their ability to accomplish certain aspects of their roles. Five participants expressed comments that demonstrated an increase in self efficacy regarding specific situations in their role. For example Laura felt more able to handle difficult conversations with senior staff or peers. She explained:

> *I had physical anxiety symptoms around having those difficult conversations and by the end of the eight weeks of coaching I felt more confident ... Probably before the coaching I would have avoided the conversation ... now I feel a lot more comfortable and confident in having those difficult conversations.*

In a similar vein Sandy felt more able to manage staff performance issues in her ward after working on this with the coach. She shared:

> *I think now it has given me the skills that I can recognise very quickly ...if there has been some bad behaviour ... I remember thinking that she was my first gold star ... I called her to account and told her outright that she didn't meet any of the (performance) expectations ... I wished now I'd confronted her when I first started there ... if only I'd known how.*

Shauna, another nurse unit manager, demonstrated increased self efficacy as she described her positive change in attitude towards giving an international conference presentation when she said:

> *I don't feel so daunted by it ... local presentations are easy to do in your own comfort zone at your own workplace ... but when you are talking to peers or people who have a great deal more knowledge than you (at conference) ... it takes a great deal more confidence ... so yes I have grown in that respect ... definitely.*

Self efficacy was also demonstrated by comments that revealed a change in belief about their ability to now succeed in this role. Sandy explained:

> *… when I started [coaching] I was ready to give up ... I was thinking this is hopeless, I am a poor manager, I can't do this … but over the period of time I think ... it gave me the confidence that actually, I am doing the right thing.*

Laura was also in a new role, saying:

> *when we first started our coaching, I was feeling excited about being in my new job, but I was also feeling extremely overwhelmed and a bit vulnerable ... as to whether or not I could actually perform ... where I fit now is I am extremely comfortable in my position ... I am extremely confident.*

Angie commented similarly:

> *I was feeling quite negative and I didn't have a lot of confidence taking on the position ... it was a big step up to take on this position ... my confidence was near my boots and I didn't think I could actually do the job properly ... After talking to the coach, I felt lifted ... like the weight was gone ... the coach lifted my burden ... I certainly believe that the coaching helped me.*

Others made more general comments that revealed a change in their belief about their own ability to succeed. For example Constance reflected:

> *… and so you get past this horrible factor of … oh I'm not good at this or I'm not good at that ... I guess in a sense it gave me more confidence.*

Shauna agreed that:

> *It has given me a lot more confidence.*

Joanne commented similarly:

> *I think apart from the actual goal, a lot of the other things that came out of the coaching, were probably more important to me ... the confidence of going through the process.*

Ongoing personal growth and development is an essential element of being a health professional and Constance summed this up beautifully with a final comment for this section when she said:

> *It's about developing yourself personally and professionally, as well as clinically ... and I guess at the end of the day it is all about the patient or the client, and if we don't have our own house in order and our own development happening, we are really not in a great space to give to others.*

In summary, the two subthemes relating to personal growth show that participants felt coaching promoted aspects of their personal growth and development. Their comments reflected changes in their beliefs regarding their ability to succeed in various aspects of their role and also demonstrated an increase in self awareness. The remaining three sub themes within this main theme of *Personal and Professional Growth* are related to aspects of professional growth and development.

6.3.2.3 Practice change. The third sub theme to emerge from the main theme of Personal and Professional Growth was Practice Change. This sub theme represents the areas of practice development reported by the participants. All six of the participants reported an area where they felt their practice had changed since the coaching. In particular, participants described how their practices had changed in relation to communication. Three participants commented on a change in their communication skills. Angie said:

> *The coaching discussions did help to improve my communication skills.* commenting *I'm a little more assertive now.*

Laura also noted there was:

> *... definitely an improvement in the confidence of my [her] own communication* particularly *when it came to the difficult conversations.*

Laura went on to explain further*:*

> *... with some of the strategies that the coach shared with me, I now feel more comfortable about preparing myself and then redirecting the conversation so that I can try and get a win-win situation.*

Laura also added that she:

> *… could now have conversations with a more strategic focus … I probably didn't do that so well [before the coaching] ... I have certainly improved on that.*

Communicating in professional forums like conferences and meetings were mentioned by three participants. Shauna spoke of an improvement in her:

> *... skills and my [her] ability to prepare a presentation and to be able to deliver it professionally and get good feedback.*

Laura spoke of:

> *… following up on conversations, especially when somebody made a verbal commitment to you.*

She went on to explain that:

> *… before the coaching I probably didn't have the skills to think about how I would follow up on that ... but I certainly follow up on those now.*

Joanna also explained how her communications in meetings had changed since the coaching:

> *Sometimes in a forum where I felt that decisions were being influenced by either a hidden agenda or politics that weren't on the table ... I thought I was selling my soul ... after the coaching I just systematically tried to see things from a more global point of view, a political point of view.*

In essence these examples of participants' comments reveal that coaching played a part in changing practice for these professionals, particularly relating to communication skills. Practice was also changed in relation to how the participants worked with their staff and in relation to the coaching processes they adopted in their daily activities.

One participant, Sandy, faced challenging staff performance issues that had been ongoing for more than a year. She described how her approach to these situations had changed:

... say for example I know that nurse is being rude ... I now bring her in and say 'this is what I expect from you ... and I'm not going to tolerate that'...

She went on to comment*:*

I have really made them accountable [now] and some of them just didn't like being accountable [and] they are the ones that have left.

Sandy reflected on the changes she made to her practice and commented:

... really I should have made them accountable a lot earlier than I did.

Laura also spoke of working differently with her staff following the coaching. She shared her new understanding when she said:

... I feel that the coaching has given me some skills around getting the staff to take some responsibility for whatever their concern might be ... once upon a time I probably would have tried to take it all on board myself ... having developed my leadership skills that bit further, I now tend to get the individual to actually take the ownership and responsibility around doing something about it ...

Sandy also described a change in her practice with regard to how she dealt with new staff since her coaching. Before the coaching when:

new staff started ... I gave them an orientation package and I said there's your preceptor off you go.

She then goes on to say:

... the change to me is, I [now] bring them into my office and I say 'this is my expectation' ... when any new staff come in, it's now one of the first things I do ... and I didn't do that originally before the coaching.

Some participants changed their practice to include some of the processes they experienced during the coaching. For example, three participants now use goal setting in their regular work activities. Constance said:

> *I went on and used that process ... breaking it down into small steps and putting it together ... even though I knew that intellectually, I don't know that I actually did it [before the coaching].*

Similarly, Laura commented:

> *I do now clearly set goals about what I want to achieve ... and how I am going to get the staff to work with me and the rest of the team to achieve the goal ... that was really beneficial.*

Joanne also indicated that she now:

> *... continues setting goals in everyday practice.*

Two participants referred to now using a coaching approach as a part of their everyday practice. Laura explained:

> *with succession planning for the nurses, I do now pick up some coaching ... in essence around how to help themselves professionally.*

Angie also commented on this saying:

> *coaching has put me in the mindset ... I've removed myself from saying 'this is how you should do it' ... the coaching has made me step back ... I now say, 'let's look at different techniques'.*

In summary, comments in this sub theme of Practice Change provide a picture of how participants changed aspects of their practice following coaching particularly with regards to their communication skills, the new processes they adopted or in relation to how they worked with their staff.

6.3.2.4 Goal attainment. The fourth sub theme to emerge from the main theme of Personal and Professional Growth was Goal Attainment. Coaching is a goal directed activity and as such the focus is on supporting participants in their journey towards their goal attainment. All participants attained their goals and made comments in relation to that. For example, Angie said:

... I really used the opportunity to be coached to help me achieve completing that module ... which I did.

Sandy also commented on her goal:

I wanted to develop skills in how to deal with some of those difficult behaviours ... which I did, I took back control and re-established myself ... in my own ward.

Constance also commented on attaining her goal.

One of the things that we talked about in the coaching was an aspect of my job ... I went on and did the project ... I was really happy with it.

Joanne spoke of her goal of writing a paper for publication:

... we focussed on publication... well the paper is written ... it isn't published yet but it has been written. We decided to go with a proper peer reviewed journal so that is where it's at.

Laura's goal was in relation to establishing some new roles and an organisational framework into her place of work.

I was trying to embed a framework as well as my own role ... and three new roles into the area. There were no clear guidelines ... in the end I did it.

Finally Shauna spoke of her goal:

... to get my [her] conference presentation prepared and to deliver it at conference ... and I achieved that ... it all went really, really well ... and I've done two or three other presentations since then and they have also gone very well.

6.3.2.5 Personal vision. The fifth sub theme to emerge from the main theme of Personal and Professional Growth was Personal Vision. This sub theme represents participant's comments in relation to their personal vision for their professional future. Five participants made comments on their personal future or career when discussing their coaching. Sandy's comment shows her considering her next leadership challenge:

> *It has got to a point now where maybe I am ready to move on now ... only because I am looking at bigger and better challenges and that perhaps it's time for me to get more experience ... to go up higher in nursing.*

Laura also commented on her next step within the profession:

> *Coaching has helped me set some foundations for the rest of my career pathway. I have had my performance review since the coaching and they said I have done an exceptional job ... they passed comment on my excellent leadership skills and highlighted the need for me to consider stepping into higher level positions. I have just taken that step of putting an expression of interest together for a higher level position.*

Some participants have considered doing more education. For example Shauna said:

> *I have certainly gone and met with different people and talked about the possibilities of doing a PhD ...*

Angie commented similarly,

> *I'm now going to do some further education at university ... I am enrolled to start in July this year ... so that is an opportunity to start a different direction for me.*

Constance found that the coaching gave her:

> *... some more clarity around where I [she] was going and what I [she] was doing professionally.*

Shauna agreed with this sentiment saying that:

> *... coaching just keeps people fresh ... it keeps them forward focussed in their careers.*

Not all participants spoke of their next steps in their career, some spoke of transferrable skills they felt they had gained. From their comments it seems that participants have been able to take what they gained from the coaching and transfer it to different environments or situations. Joanne's comment provided an example:

So definitely those skills were transferable and I have used them many many times, in situations where I have been in ... I guess in political situations where I felt a little bit out of my depth ... so there has been lots of times where the stuff I learned through the coaching process was applicable and particularly in my role as manager ... that's where it's been most useful.

Laura also felt that the coaching has given her:

a lot of additional tools of the trade ...

She had confidence that she would be able to transfer those skills and use them to assist her in future challenges. She went on to explain:

in the future when I get the opportunity to challenge myself at a higher level ... I feel like I have got through the coaching, the under pinning skills to be able to work through how I am going to manage those situations at a different level now.

Laura also commented on her being able to transfer the skills she learned into her personal environment. She explained:

... outside of the work environment I do use it in my personal environment ... I have had a lot of personal trauma in the last few months with some deaths in the family ... one of my family members in relation to that, is very negative, very angry bitter person ... so I have been able to make use of those more advanced strategies ... to guide them into some better decision making.

There was one comment on the broader intangible aspects of coaching. For example when speaking about what she gained from the coaching, Constance said:

I don't think I could say I have learned something this year and I don't have it with me anymore ... I think you take it all on board and it all contributes to ongoing enrichment.

To sum up, participants commented on their personal visions for their futures and the transferrable skills they felt they had gained through participating in the coaching. However they also made comments in relation to the nursing profession and provided commentary on the use of coaching as a professional development activity.

Three participants felt that coaching should be more widely used within the profession. Joanne commented:

> *... coaching is really important ... without a doubt, it definitely contributes to professional development and I would love to see every nurse offered it ... it's been far reaching.*

Shauna suggested that:

> *the new grads would quite welcome it ... the younger staff coming though, would be comfortable with the whole concept of professional coaching.*

Constance felt that coaches could work with staff in relation to personal growth:

> *I do see there is a place for coaching in nursing ... there is a need for nurses to be encouraged to grow personally and professionally* … however, she is not confident it will happen ... *unfortunately if the higher levels don't understand the whole personal growth thing ... it is probably not going to be acknowledged and filtered down to the lower levels which is really what nursing needs".*

Half of the participants felt that if coaching were to be adopted into nursing, it should be integrated into the professional development framework and allocated professional development points. Joanne commented:

> *I do think that it would make sense for coaching to be part of the professional development of all nurses ... and give it credibility by applying points.*

Laura agreed by saying:

> *I really think that coaching as such should be considered as part of your continuing education points especially if you are looking at succession planning into leadership roles or management positions.*

Shauna also made a comment on coaching being allocated professional development points:

> *... for the registration points each year ... they are asking for active participation ... this is the perfect way to do it ... everyone is running off to do lots of one day*

workshops to try to keep their points up ... whereas something like this coaching, would really lend itself. I don't know how you would work out the evaluation of the points, that would be something the registration body would determine or the Royal College of Nursing.

Joanne provided some further comments on integrating coaching into nursing and suggested:

at a political level, building it into conversations with the Queensland Nurses Union and around enterprise bargaining.

She also felt:

… it is just as beneficial as clinical supervision and there is no reason why it couldn't be built into a similar framework, where every nurse could be entitled to an hour of coaching a month or a fortnight ... the way supervision is built in ... it could follow a similar structure.

Joanne makes a final comment saying:

I think it's probably just a matter of exposing more nurses to coaching.

6.3.2.6 Summary of personal and professional growth. Overall the subtheme of *Personal and Professional Growth* showed that participants felt there had been both personal and professional growth and development during the coaching. Throughout this section participant's comments provided examples of increases in self awareness and self efficacy. All participants attained their professional development goals and there were reports of practice change, particularly in relation to communication skills and how they worked with their staff. Consideration was also given to their vision for the future on both a personal and professional level with some commentary on the use of coaching as a professional development activity. The following section will now discuss the last main theme, The Ripple Effect.

6.3.3 Theme 3—The ripple effect. The third of the three major themes was The Ripple Effect as shown in Figure 17.

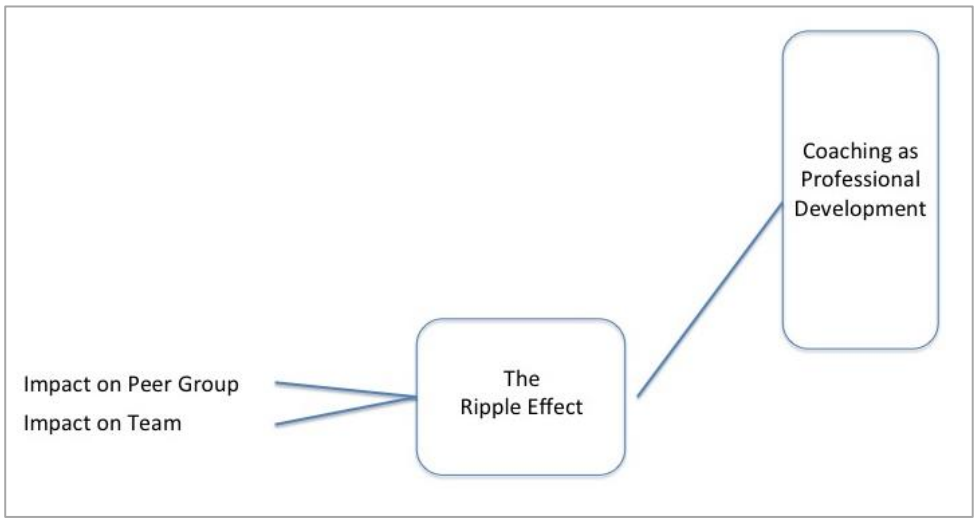

Figure 18*:* Major Theme—The Ripple Effect

The ripple effect pertains to the wider impact that coaching had beyond the actual goals of the coaching. Although the ripple effect is discussed here in greater detail, it is also evident in comments made within other themes previously discussed. The majority of participants reported a ripple effect. Joanne described the ripple effect clearly*:*

> *You know, I think there are lots of spin offs from coaching ... it's a bit like when you throw the pebble into the water ... you never really know where the ripples end up.*

As the participants continued to apply their new skills, behaviours or attitudes in the practice arena, over time there was a flow on effect to those who worked closely with them. In particular, the "Ripple Effect" of the coaching extended to the subthemes of peer group and teams.

6.3.3.1 Impact on peer group. The first sub theme to emerge from the main theme of The Ripple Effect was Impact on Peer Group. The impact of the coaching appears to have rippled out as the participants shared their coaching experience with their colleagues.

Four participants mention sharing what was learned in coaching with others. Sandy commented:

> *Interestingly I have found myself giving advice to one of my colleagues ... who was having the same issue ... my colleague has got the same manager and was having the same problems ... and I know that she is now doing a similar thing.*

Joanne also made the same point about sharing:

> *…the team talked about the coaching ... so as the coach was supporting individuals to learn about themselves and to reflect, develop and reach their goals, they were automatically sharing that learning with each other.*

She went on to explain, that by sharing the experiences they had with the coach, it kept some of the peers on track:

> *... and so we talked about how valuable that [coaching] was and sometimes if somebody was getting off track they would remind each other ... 'what was the process you used when you were working with the coach?'...*

Constance also reported sharing what she learned and the resources she used with others:

> *I'm now actually able to pass on some of that in one way or another ... spread the love so to speak ... I'm able to direct them in how to find their own strengths.*

Laura reported that she openly shared all of her coaching experiences with others:

> *I have spoken ... quite openly and honestly about the coaching ... and some of the goals and the strategies that I put in place with that.*

She felt this was a useful strategy as then:

> *… they themselves could see the benefit of the coaching because of the way I have worked with them ...*

The above comments indicate a ripple effect out to others who were not involved in the coaching as the participants shared their coaching experiences, information and resources with their colleagues.

6.3.3.2 Impact on team. The second sub theme to emerge from the main theme of The Ripple Effect was Impact on Team. The Ripple Effect appeared to have had an impact on how teams now worked. Half of the participants discussed specific examples of how their teams were now working differently since the coaching. Laura provided an example of the ripple effect as she described how a change in her own practice had impacted her team's practices with regards to the provision of feedback on poor performance:

> *I will now often say ... 'well did you discuss with so and so what they did or didn't do?' and they say 'oh no I haven't done that, I am just telling you' ... and I then say 'the better way to deal with this would be ...'*

Laura went on to say:

> *following on from those discussions, people will then go on and speak to the other person and do it in a really constructive manner.*

She also related how a change in her practice helped her team to support each other and recognise good practice:

> *I have had people come and tell me what a wonderful job somebody else has done and I have asked them ... 'have you shared that with the other person? ... and they go oh no' ... and I encourage them to go back and tell the other person ... and they then come back and share with me how it made them feel really good and that the other person received it really well.*

Sandy's comments revealed the ripple effect as she reflected on the impact of dealing with the conflict in her ward and making her staff accountable. Sandy provided an example of where a change in her own behaviour had a clear ripple effect on her team's attitudes and behaviours. Once Sandy asserted herself, exhibited clear leadership and in her own words "*took back control"*, the performance issues started to diminish. As Sandy said:

... as I got people in to my office ... more and more were reflecting ... 'gee that was bad behaviour' ... it was interesting when I started to do that, how many of them then started to fess up ... they came in and reflected on their own bad behaviour and so I didn't have to ...

Once Sandy's confidence as a leader increased, it had a further ripple effect of pulling the team together. She comments:

I spoke to the whole team and used what we rehearsed in coaching ... that was one of the best things I ever did. my staff were trusting me ... and that was something I hadn't had before ... they realised I could help them.

Once her team knew they had a leader who would confidently manage the conflict and bullying behaviours, it had a cohesive effect on the way they worked together. Sandy commented on how her team are now:

...all working really well together ... they want to be a team, they are proud of their work and only had praise for each other ... whether I'm there or not they are going to continue ....

Joanne's comments also revealed a ripple effect onto her team. As Joanne worked with the coach in relation to her goal of publishing, she in turn worked with her team regarding publishing their work. Subsequently, Joanne's team have presented their work at conferences and have published. She also commented on how her team now has:

... a commitment to publishing.

She went on to explain that:

... now we have regular meetings around it, we talk about it ... in fact this afternoon [name] and [name] are working on a publication, it just part of our regular work now ... so I think that is significant".

Two final examples of The Ripple Effect are related to ward culture. Two participants mentioned a change in their ward culture following a change in their behaviour as leader. Laura commented*:*

> *I know from the written evaluations and the verbal feedback that I continuously get from the team of 120 nursing staff, that the culture of education and learning has changed significantly in the unit for the better ... so at the end of the day I love going to work.*

Similarly, Sandy commented:

> *I guess the whole workplace changed and it probably yeah ... took six months ... the ward used to have a really bad reputation ... well its losing that bad reputation and it's actually a place people want to work.*

Sandy went on to demonstrate how the culture in her ward had changed by providing a contrast

> *... last time I'd come back [from holiday] and found that a couple of the staff had been fighting ... it was a nightmare to come back to.*

She went on to describe how the situation has changed following her coaching and the subsequent change in her leadership approach:

> *You know, I actually took holidays for the first time in a long time and I took nine weeks off ... and I can tell you as a manager not many managers take nine weeks off ... I felt I could step out of it and go have a holiday and not worry about what was going to be the bad behaviour when I wasn't there ...*

6.3.3.3 Summary of the ripple effect. In summary, participants' comments reflected a ripple effect, where the coaching had an impact wider than the actual goals of the coaching and beyond the individuals being coached. As the participants changed themselves and their practices through the coaching process, they felt it had had a flow on effect to their peer groups and teams.

6.3.4 Chapter Summary. This chapter outlined Phase Two—The Qualitative Study. Results from the qualitative study revealed three main themes, Professional Enrichment, Personal and Professional Growth and The Ripple Effect. The coaching

provided an enriched professional space where professionals could feel safe to reflect on their practice and spend time focussing on their professional goals. The supportive professional relationship with an external coach provided confidentiality, the space for them to be authentic about their practice and the environment in which they could identify their learning needs as a leader. Participants reported both personal and professional growth and all reported attaining their goals set prior to the coaching. Participants commented that their practice had changed, along with perceived changes in their self efficacy, self awareness and their considerations of their future careers as professionals. Discussion of these results will be explored in the context of the extant literature in the next chapter, Chapter Seven.

Chapter 7.

Discussion

This chapter provides a discussion of the findings of this study. The chapter begins with a presentation of a brief synopsis of the findings from this study followed by a discussion of the results within the context of the current literature. A brief synthesis of existing knowledge and new knowledge from this study is then provided. A discussion of the implications of these results and recommendations for education, practice and research is then presented. Limitations of the research are then discussed along with suggestions for future research in this area. The chapter then concludes with a summary and conclusions.

7.1 Introduction

The purpose of this study was to examine coaching as an approach for developing and supporting clinical nurse leaders. The study was an explanatory sequential design (Creswell, 2015) with the quantitative phase of the thesis being undertaken first, followed by the qualitative phase. The first phase consisted of a pilot study and then pre- and post testing on an eight week coaching intervention for clinical nurse leaders. The second phase consisted of qualitative interviews with clinical nurse leaders who had received the coaching intervention. In the explanatory sequential design, the second phase of the design was intended to examine the results obtained from the first phase in greater depth.

7.1.1 Synopsis of study findings. This study found that Clinical Nurse Leaders who engaged with professional development coaching, significantly increased their levels of work engagement. It also assisted them in attaining their professional goals in addition to providing professional enrichment, personal and professional growth, all of which had a ripple effect on colleagues and peers with whom they worked.

Engaging with professional coaching made no difference to their intention to remain in their role or the profession. Unexpectedly, burnout levels increased for those who participated in the coaching intervention, however qualitative comments in the questionnaires contradicted these results, providing only positive comments regarding the coaching intervention. The qualitative phase of the study examined this aspect further, asking participants about their perceptions of the coaching experience, particularly in relation to stress. Findings revealed that the participants found the experience provided a safe professional space, professional support, tailored professional development, and helped them to reflect on their practice. Some participants clearly stated the coaching was not stressful for them and one said it actually reduced her stress levels. For others, time pressures created stress. These existed in relation to being organised and completing their weekly action plan in preparation for their coaching session, in addition to their already full work schedules. Applying the changes discussed in coaching was stressful for one participant who found implementation of her action plan in practice was challenging.

7.1.2 Discussion of main findings. The purpose of this thesis was to answer the research questions set out in Chapter Two. An important aspect of mixed methods studies is the integration of the findings from each element of the study. In order to achieve this integration, answer the research questions, and demonstrate interplay between the various results, the findings from both phases of the study are discussed together in relation to the research questions.

The research questions that informed this study were:

1. To what extent does coaching have an effect on clinical nurse leaders' work engagement levels?
2. To what extent does coaching have an effect on clinical nurse leaders' burnout levels?

3. What is the effect of coaching on clinical nurse leaders' intentions to remain in their position or the profession?
4. To what extent does coaching assist clinical nurse leaders to attain their professional development goals?
5. What are clinical nurse leaders' perceptions of coaching?
6. To what extent does the qualitative phase of the study explain or enhance the interpretation of results from the quantitative phase of the study?
7. What do the quantitative and qualitative data together reveal about coaching as an approach for developing and supporting clinical nurse leaders?

7.1.3 Coaching and clinical nurse leader work engagement levels.

Results from the quantitative study found that coaching had a significantly positive effect on all aspects of clinical nurse leaders' work engagement levels. The clinical nurse leaders scored highly on all aspects of work engagement (vigour, dedication and absorption) and the qualitative findings report them feeling motivated. These results are in accord with the research on the Job Demands-Resources model (Bakker & Demerouti, 2007; Schaufeli & Bakker, 2004), which posits that the provision of job resources starts a motivational process, which then leads to work engagement. Managerial coaching is identified as one of the job resources within the JD-R model (Bakker & Demerouti, 2007; Schaufeli & Bakker, 2004; Schaufeli & Salanova, 2007). Although previous studies on work engagement identify coaching as a job resource, they utilise managerial coaching (where managers use a coaching style in their leadership approach). What is different about this present study is that a coach who was external to the organisation was used, rather than using the participants' own manager for the coaching. Results from this study therefore build on the previous work engagement studies (Bakker & Demerouti, 2007; Schaufeli & Bakker, 2004; Schaufeli & Salanova, 2007) and provide new knowledge in

relation to the positive effects of using an external coach. It appears that coaching continues to act as a job resource for clinical nurse leaders when utilising a coach who is external to the organisation. No previous research was found in the literature on interventions that promote work engagement in clinical nurse leaders, despite work engagement being a topic of discussion in the nursing literature (Bargagliotti, 2012; Keyko, 2014; Van Bogaert, Wouters, Willems, Mondelaers, & Clarke, 2013; Wang & Liu, 2015). The quantitative results on work engagement provide new knowledge with regards to using coaching as an intervention for potentially increasing work engagement levels in clinical nurse leaders.

The qualitative findings expand on the work engagement findings giving rise to the main theme, The Ripple Effect, which illustrates the presence of work engagement in the clinical nurse leaders. Highly engaged staff have the capacity to engage and positively influence others, taking them along on their journey to attain their vision (Bakker & Schaufeli, 2008; Bakker et al., 2008; Bakker et al., 2006; Engelbrecht, 2006). The Ripple Effect theme describes the impact the coaching had beyond the individual goals of the coaching. The majority of participants described coaching having a wider impact than just on themselves. They spoke of "spin offs" from coaching and gave examples of a flow on effect to their peers or teams, as a result of them applying their new skills, practices or attitudes in practice. They gave examples of how their teams now worked differently and spoke of sharing their coaching experiences, along with the tools, strategies and resources gained from coaching. The qualitative theme, a Ripple Effect, is consistent with other research, which shows that nurse leaders who have a positive attitude can have a positive impact on their staff (Brunetto et al., 2012; C.-H. V. Chen, Wang, Chang, & Hu, 2008a, 2008b; Davies, Wong, & Laschinger, 2011). What is new in relation to these findings is that using coaching to professionally develop clinical nurse

leaders can potentially have a wider impact, than just the person receiving coaching. Investing in coaching for clinical nurse leaders could provide wider benefits for organisations than just the attainment of the stated goals of coaching.

7.1.4 Coaching and burnout levels in clinical nurse leaders. One unanticipated finding from the quantitative phase of this enquiry was that burnout levels increased significantly for those clinical nurse leaders in the intervention group. The increased burnout levels alongside the increased work engagement levels was unexpected, however these findings are consistent with findings from Chambel and Peiró (2011), who found that patterns of high or medium levels of burnout could be displayed simultaneously with high or medium levels of work engagement in nurses.

The high levels of burnout were somewhat surprising and contradicted by the multiple positive comments in the open questions of the questionnaire. This unexpected finding from phase one was examined further in phase two of the study. Interviews with the participants explored their perceptions of the coaching they had received, and in particular tried to elicit their views regarding the presence of stress within the context of workplace coaching. In the qualitative interviews, participants spoke of being under stress in their current work circumstances, they lacked support and used words such as overwhelmed, drowning and stressful to describe their work situations. The clinical nurse leaders were carrying heavy workloads and appeared to have little support from their supervisors, particularly those who were new clinical nurse leaders transitioning into their roles. Although the participants who did not take part in the qualitative interviews may have provided a different picture, previous research studies in nursing confirm the heavy workloads experienced by many clinical nurse leaders (Lowe et al., 2013; Shirey et al., 2008; Suby, 2010; Udod & Care, 2013), feelings of being overwhelmed (Paliadelis, 2008)

and stress (Kath et al., 2012; Shirey et al., 2008; Shirey et al., 2010). Studies also confirm there an association between role overload and stress (Kath et al., 2012), and an association between lack of support and burnout for those in nurse leadership positions (Lang et al., 2012; Suzuki et al., 2009). When participants spoke of their coaching, only one made a comment about feeling stressed when starting to implement her action plan. Three participants spoke of tension relating to time pressures and being prepared for their session with the coach in addition to their heavy workloads, with one person saying she felt stressed because she had left her agreed action plan to the last minute, prior to her sessions with the coach. Two others differentiated between time pressure, stress and creative tension, saying they experienced "no stress" during coaching and one saying she felt that the coaching had "... reduced my [her] stress levels".

These qualitative findings provide a possible explanation for the increased level of burnout within the coaching group. Although participants enjoyed the coaching and felt motivated, the competing priorities of their existing heavy workloads and the additional increased work from coaching, could have increased their feelings of stress and their subsequent scores on the MBI-HSS. The six areas of worklife model (Leiter & Maslach, 2004, 2011) identifies workload as one of the areas that is predictive of burnout. It is possible the time frame of weekly coaching sessions may have been too short given the exiting heavy workloads that nurse leaders carry in health. Additionally, it is unclear how many participants used their professional development time to complete the weekly action plan. Although goals were refined and action plans continually adjusted according to the individual's workload each week, some participants appeared to have experienced completing the action plan as an added burden on top of their already busy schedules. There may have been different results if the participants had set regular time aside each

week to complete the work from coaching or if the coaching had been spaced out to every two weeks, or even monthly.

A second explanation regarding the increased burnout scores is that there remains no consistent definition of burnout in the literature and there is no standardised valid measure for a diagnosis of burnout (Korczak, Huber, & Kister, 2010). The term burnout is used in general parlance and perceptions of burnout are personalised, therefore reports of burnout are likely to vary among participants. It is possible that with no clear consistent understanding of what constitutes burnout, participants would vary in their responses regarding what they experienced during coaching. It is possible that the subjective nature of stress, the self-report nature of the MBI-HSS and the instrument itself may not have been sufficiently sensitive to capture the subtle outcomes of coaching or to clarify the relationship between coaching and stress.

A third potential explanation for the increased burnout results relates to circumstances external to the study over which the researcher had no control, which may have been a confounding factor, skewing the results. According to Passmore and Anagnos (2009), it may not be possible to remove all confounding variables when conducting research in the workplace. At the time of the study, the public health system in Queensland, was introducing a new payroll system, which failed when the system "went live". This resulted in many nurses not being paid their correct salary, with staff either not being paid at all, or being under paid or overpaid, for some months (Chesterman, 2013). A government report into the failure, recognised the stress that this placed on staff, particularly those who had not been paid (Chesterman, 2013). The inquiry described it as spectacularly unsuccessful and commented that it "… *must take place in the front rank of failures in public administration in this country. It may be the worst*" (p. 12) noting that

not only were there enormous financial costs for this failure, but that "*the human cost of implementation was also high*" (Chesterman, 2013, p. 12). The report provided some insight into that "human cost" and the impact the system failure had on staff:

> The system ignored many employees who went unpaid or underpaid. A number were made temporarily destitute, unable to afford the basic necessities of life. Some who were overpaid were falsely accused of fraud. It was, for all affected, a time of great anxiety and hardship. (Chesterman, 2013, p. 323)

As a result of this system failure, nursing leaders' workloads were also increased, as a consequence of the "no roster no pay rule" (Chesterman, 2013, p. 160) where additional time was spent on checking and providing information, to ensure payroll had accurate details of the hours all staff had worked each week. In the words of Commissioner Chesterman "The process was a fraught one" (Chesterman, 2013, p. 160). The payroll system failure lasted for several months and one year later there were still staff who had not had their historical underpayments rectified (Queensland Nursing Union [QNU], 2013). It is unclear how many clinical nurse leaders in the study were directly or indirectly affected by the payroll system failure, however there was potential for this incident to increase not only workloads but also stress levels and therefore alter how participants responded in the MBI-HSS responses.

The qualitative phase of the study provided greater insight into the participants' experiences in relation to coaching, particularly with regards to stress, and assisted in partially explaining the unexpected findings. The qualitative findings provided insight into differences in how some clinical nurse leaders experienced coaching. Some experienced "no stress" or felt it "...reduced ... stress levels" while others felt a creative tension, or time pressures in being prepared for their session with the coach in addition to

their heavy workloads. Only one participant made a comment about feeling stressed when starting to implement her action plan in clinical practice. These differences in relation to stress and coaching are reflected in the inconsistent results found in coaching studies on stress, with some studies showing that coaching reduced stress (Grant et al., 2009; Grant, Green et al., 2010) whereas others have found no relationship between coaching and stress (Bowles & Picano, 2006; Gyllensten & Palmer, 2005b). Interestingly, in a similar vein to this research, Gyllensten and Palmer in their studies on coaching and stress, found the qualitative and quantitative results provided contrasting findings. In their quasi experimental study (Gyllensten & Palmer, 2005a) and their correlational study (Gyllensten & Palmer, 2005b), results showed no significant difference in stress levels following coaching, whereas in the qualitative study (Gyllensten & Palmer, 2006), participants indicated they felt coaching had been beneficial, helped them cope better and reduced their stress levels.

The qualitative phase of this mixed methods study also identified the individualised nature of coaching and therefore the individualised nature of learning that can be obtained from coaching. Some participants managed to attend to their coaching action plans without feeling stressed at all, while others felt the time pressure of accommodating the work from their coaching, on top of their already busy workloads. There may be unknown factors at play within the coaching experience that act as stressors for coachees, however what can be noted with these results is that a full clear picture of the full coaching experience and its relation to stress was not captured in either element of the study and requires further investigation in future research.

7.1.5 Coaching and Intention to leave in clinical nurse leaders. Results from the quantitative phase of the study show that there were no significant differences

between the coaching group and the control group with regards to intentions to leave. This is unsurprising as the coaching literature is inconsistent in this regard (Dagley, 2006; Simpson, 2010). The findings from the qualitative interviews supported and extended the quantitative results. Findings revealed that coaching was enthusiastically received by the participants, and the majority commented on a personal vision for themselves as professionals. Some participants were enthused about the next step in their career, and engaging with new organisations, in new roles or in further study. For others, that personal vision meant being fully engaged in their role and seeking further challenges within their existing work circumstances. There was recognition that coaching had assisted them in developing transferrable skills, which could be utilised in future roles and in their personal life.

7.1.6 Coaching and goal attainment in clinical nurse leaders. All of the participants in the study attained their professional development goals. In the quantitative phase of the study, the extent to which participants felt they had attained their goals was identified using a goal attainment scale. Results found that 97% of the participants felt they had achieved their best possible outcome or a better than expected outcome regarding the attainment of their goals, with 56% attaining their best possible outcome and 41% attaining a better than expected outcome. Findings from the qualitative phase of the study also support these results as all participants spoke about attaining their goals in the interviews. These results are consistent with the majority of coaching studies indicating that coaching is associated with coachee success in setting (Moen & Federici, 2012) and attaining their goals (Grant, 2014b; Grant et al., 2009; Grant, Green, et al., 2010; Green et al., 2006; Spence & Grant, 2007). Previous studies have reported on coaching as a way for executives or other leaders to attain their professional development

goals. None of these studies however have examined clinical nurse leaders as a group, and so the results from this study provide new knowledge in this area.

All participants referred to the process of setting goals while being coached. This was a sub theme from Professional Enrichment, as the coaching provided them with an enriched professional space where they could focus on and prioritise their own professional development goals. Some participants commented that working with a coach clarified the goal setting process for them, while others enjoyed the process of setting realistic goals and action plans with the coach. Regular contact with the coach encouraged momentum and kept them on track with their goals. This is consistent with coaching studies, which confirm the importance of a goal- focused approach in coaching, as a significantly powerful predictor of coaching success (Grant, 2014a). What is new with this study is the use of coaching to assist clinical nurse leaders attain their professional development and work related goals.

7.1.7 Clinical nurse leaders' perceptions of coaching. Results from the questionnaire indicated that the majority of clinical nurse leaders were highly satisfied with the coaching experience with 94% rating it as good or excellent. Thirty one out of the thirty two clinical nurse leaders who were coached said they would engage in professional coaching again if available in the future. Findings from the qualitative phase of the study support these results, with all participants reporting in the interviews that coaching was a positive experience for them. The results from this study are consistent with previous coaching studies, which have reported individuals being highly satisfied with the experience of engaging in work related coaching (Grant, 2014a; Jowett, Kanakoglou, & Passmore, 2012; Timson, 2015). What is new in relation to this study is

the knowledge that coaching is a satisfying way for clinical nurse leaders to experience their professional development.

The qualitative phase of the study also revealed that participants strongly preferred having a coach who was external to the organisation. In the interviews, participants revealed that for them, the coaching provided a safe space, one of the sub-themes in the main theme of Professional Enrichment. One aspect of providing this safe space for them was that the coach was from outside the organisation. Several participants emphasised strongly that they would not have shared as much with the coach, nor gained as much from the coaching, if the coach had been their manager or from within their organisation. A large aspect of this safe space was related to the assured confidentiality within the coaching sessions. The clinical nurse leaders reported that when dealing with their managers, confidentiality, which they highly valued, was not always assured. These findings are consistent with the coaching literature, which identifies confidentiality as a key aspect in successful coaching (Budhoo & Spurgeon, 2012; Cox, 2012; Ladyshewsky, 2006; Passmore, 2010). Questions regarding which type of coach is more effective for organisations remain unanswered in the coaching literature, as there has been little research conducted on the effectiveness of internal compared with external coaches.

One of the major themes from the qualitative phase of the study was Personal and Professional Growth. Participants felt that not only was it a satisfying experience, but that coaching enhanced their professional growth as leaders. This was demonstrated by all of them attaining their professional development goals and also by the changes they made in their practice during or following the coaching. Results pertaining to professional growth are consistent with the coaching literature which reports on the achievement of professional development in various areas for business coachees

following coaching (Coates, 2013; Goebel, 2014; Ladegard & Gjerde, 2014; MacKie, 2014). This study extends existing coaching knowledge by confirming that coaching can enhance professional growth in clinical nurse leaders.

Participants also perceived there had been some personal growth for them following the coaching. Perceptions of increased self-awareness, self-efficacy and increased confidence were expressed by the participants in both the interviews and the open comments in the questionnaires. These findings are consistent with the literature on coaching, which confirms reports of increased confidence (Cortvriend et al., 2008; Grant et al., 2009), self-awareness (Wales, 2003) and self-efficacy (Franklin & Doran, 2009; Grant, 2014b; Ladegard & Gjerde, 2014; Moen & Federici, 2012) following coaching. The findings from this study extend this knowledge by confirming that coaching enhances personal growth in clinical nurse leaders. In relation to the main theme of Personal and Professional Growth, the findings from the study establish coaching as a professional development option that can promote both personal and professional growth in clinical nurse leaders.

A second sub-theme from the main theme of Professional Enrichment was Tailored Professional Development. Participants enjoyed the individualised nature of coaching and the unique tailored approach to professional development that it provided. The clinical leaders valued the time with the coach just focussing on their own professional development and working towards goals that were personally meaningful to them. They felt that coaching was a useful way to approach professional development, as it built on their existing skills, unlike attending a course with a set curriculum. They compared coaching favourably with their current professional development activities, viewing non-coaching activities as ad hoc and not meeting their needs. They also liked that coaching

was an approach that was flexible enough to take account of the individual's current workplace context and the unique demands on them. They particularly saw value in having coaching for those transitioning into new roles, for succession planning into leadership roles and as an approach for developing experienced leaders. Participants felt that coaching should be used more widely within the profession and allocated professional development points. These findings are consistent with the coaching literature which confirms coaching being used in the business sector for those transitioning into new roles (DiVittis, 2011; Reynolds, 2011) and for developing those already in leadership roles (O'Neil, Hopkins, & Bilimoria, 2015; Wasylyshyn, Shorey, & Chaffin, 2012). What is new knowledge from this study is that coaching can be used as professional development and can be tailored to meet the individual clinical nurse leader's needs, whether they be a novice or an experienced leader. What is also new knowledge is that clinical nurse leaders place value on such a tailored approach to their professional development.

Another aspect of Professional Enrichment was that coaching provided a safe space for clinical nurse leaders to learn and grow as leaders. They felt that coaching provided them with the space to learn and rehearse their roles in safety. Participants also felt they had the time to reflect on their practice and a safe space to be authentic. They could reveal how they truly felt about the issues and challenges confronting them in practice and honestly share their reflections regarding their own professional performance issues. The creation of a safe space within coaching is articulated in the coaching literature (Woodhead, 2011) as is the notion of being authentic or honest (Stone, 2013; Susing, Green, & Grant, 2011), and learning as an aspect of coaching (Smith, 2015; Wallis, 2010). What is new in relation to these findings is that providing a safe space for clinical nurse

leaders contributes towards a sense of professional enrichment and subsequent professional development.

Several aspects from the qualitative phase of the study provided some further evidence relating to the coaching experience for clinical nurse leaders. The first main theme was Professional Enrichment. Several aspects of the coaching contributed towards this theme. The first element was a Safe Space as discussed previously on pages eight and nine. Another element which contributed towards the theme of Professional Enrichment was that coaching provided a supportive relationship for the clinical nurse leaders. All participants mentioned the positive relationship with the coach. Most spoke of the trust inherent in that relationship. Trust plays a key role in the coaching relationship and a number of authors have identified it as one of the key components in the success of coaching relationships (Gregory & Levy, 2011; Gyllensten & Palmer, 2007; Jowett et al., 2012; Machin, 2010). The concept of support was referred to by all of the participants, as it was a key positive factor for them during the coaching. This was in contradistinction to how they viewed their roles, which they saw as very stressful and lacking in support, particularly for novices just moving into leadership positions. These findings are consistent with the nursing literature, which confirms that clinical nurse leaders are experiencing a great deal of stress, feeling overwhelmed and lacking support in their roles (Paliadelis, 2008; Paliadelis et al., 2007; Shirey et al., 2010). Having a supportive professional relationship was a positive factor leading to professional enrichment for the participants. It also provided them with the opportunity to reflect on their practice within a safe space. Support is one of the key factors in a coaching relationship (Godfrey et al., 2014) along with trust, confidentiality, empathy (Rekalde, Landeta, & Albizu, 2015) and rapport (Gan & Chong, 2015) all of which are elements of the coaching experience which can influence overall coaching effectiveness.

7.1.8 Synthesis of what is known and what is new knowledge

What is Known	What is New Knowledge
• Job resources such as supervisor coaching has been shown to increase employee engagement levels (Schaufeli, Bakker & Van Rhenen, 2009). • Workplace coaching has been shown to increase work engagement levels in senior managers within the banking industry (Grant & Hartley, 2014).	• An eight week professional development coaching program can significantly increase work engagement levels in clinical nurse leaders.
• The creation of a safe space for coachees is a concept that is articulated in the coaching literature (Britten, 2015.; Geber, 2010.; Hanssmann, 2014). • Coaching has been shown to create time and space for thinking and reflection (Cortrivend, Harris & Alexander, 2008; Gyllensten & Palmer, 2005a; Timson, 2015).	• Results from this study showed that coaching can create a safe space for clinical nurse leaders to: • Explore professional practice issues in confidence. • Learn and rehearse aspects of their role in private. • Openly discuss challenges and reveal their true attitudes and feelings about the issues facing them in practice. • Share their true feelings and thoughts about their own professional performance.
• Professional development activities for clinical nurse leaders are often classroom based for multiple leaders at a time (anecdotal evidence). • In classroom based professional development, the learning objectives are pre- set for the group instruction (anecdotal evidence). • Barriers to professional development can exist for nurse leaders (Fealy et al., 2011). • Some nurse leaders have reported receiving little formal management training, feel unprepared, learning their roles through reading books, asking colleagues or through trial and error (Paliadelis, 2005). • Coaching can be used as a leadership development tool (Ladegard & Gjerde, 2014).	• This study has shown that clinical nurse leaders enjoy the individualised nature of coaching. • Clinical nurse leaders also like the personalised, tailored approach to professional development provided by coaching, where they can selectively choose their own learning goals. • Clinical nurse leaders like that coaching builds on their existing skills and takes into account their existing work context. • Results from this study show that clinical nurse leaders are satisfied with coaching as an approach for professional development. Some also feel that existing professional development activities are not meeting their particular learning and development needs.

What is Known	What is New Knowledge
• Professional development for clinical nurse leaders is not commonly delivered using the telephone (anecdotal evidence). • Telephone coaching has been used successfully in health, to coach patients reach their health goals. Coaching has been done for patients with cardiac problems (Jelinek, Santamaria, Thompson, & Vale, 2012), asthma (Garbutt, Yan, Highstein, & Strunk, 2015), diabetes (González-Guajardo, Salinas-Martínez, Botello-García, & Mathiew-Quiros, 2015) and stroke (Spassova, Vittore, Droste, & Rösch, 2016). • Telephone coaching has been used successfully as an intervention in executive development (McLaughlin, 2013; Geissler, Hassenbein, Kanatouti and Wegener, 2014).	• The results from this study show that professional development for clinical nurse leaders can be delivered successfully using the telephone. • Telephone coaching can be used successfully with clinical nurse leaders.
• There is a lack of professional support for clinical nurse leaders in their roles (Bloomer & Cross, 2011; Chan, Tam, Lung, Wong & Chau, 2013; Lowe, Plummer & Boyd, 2013; Paliadelis, Cruickshank & Sheridan, 2007; Sayers, DiGiacomo & Davidson, 2011; Suzuki et al., 2009). • There is often a lack of succession planning or support for those transitioning into clinical leadership roles (Fealy et al, 2011; Kitson et al., 2011; Paliadelis, 2005,2008.)	• Participants experienced a lack of support for them in their roles. • Results from this study found that coaching created an enriched professional context for clinical nurse leaders. • Clinical nurse leaders felt coaching provided professional support for them in their everyday roles. • Clinical nurse leaders felt that coaching was a credible way to support existing leaders, for succession planning and for supporting those transitioning into new roles.
• Trust is acknowledged as an important factor in the coaching relationship (Ladyshewsky, 2010; Machin, 2010; Rock & Donde, 2008; Wotruba, 2016).	• Clinical nurse leaders liked the trusting relationship in coaching.
• Studies on coaching in the workplace report workplace wellbeing, increased ability to deal with change, enhanced solution focussed thinking and leader role efficacy (Grant et al., 2009; Grant, 2014b; Ladegarde & Gjerde 2014).	• Results from this study show that clinical nurse leaders found coaching a satisfying, positive professional experience which they would repeat it if provided with the opportunity.
• There is evidence on the positive benefits of both internal (McKee, Tilin & Mason, 2009; Rock & Donde, 2008) and external coaches (Grant, Curtayne & Burton, 2009; Wales 2003) with no conclusive evidence on which approach is the more effective for	• Results from this study show that utilising a coach who is external to the organisation, but with health industry knowledge and experience, can be effective for professionally developing

What is Known	What is New Knowledge
organisations. • Confidentiality is a key aspect in successful coaching (Budhoo & Spurgeon, 2012; Cox, 2012; Ladyshewsky, 2006; Passmore, 2010).	clinical nurse leaders. • Participants expressed preferences for a coach who was external to the organisation for reasons of confidentiality.
• Reflection is a necessary component of contemporary nursing practice (Nursing & Midwifery Board of Australia, 2016).	• Participants were challenged to find time for reflection in their busy roles. • Coaching provided the opportunity for clinical nurse leaders to reflect regularly on their practice and the professional issues they faced.
• Setting goals is a necessary skill for clinical nurse leaders. Goal setting is taught in many leadership education courses (anecdotal evidence). • Coaching is an activity which is associated with increased goal attainment (Moen & Federici, 2012; Grant, 2014b, Grant, Green & Rynsaardt, 2010).	• Results from this study show that coaching is a successful way for clinical nurse leaders to learn about and engage in goal setting. • Coaching can assist clinical nurse leaders to attain their professional development goals.
• Previous studies confirm that coaching can promote both personal growth of coachees (Green, Grant and Rynsaardt, 2007; Grant 2003) and professional growth in business leaders in relation to problem solving (Grant & Hartley, 2014), leader role efficacy (Ladegarde & Gjerde, 2014), build management skills and deal with organisational change (Grant, Curtayne & Burton, 2009).	• Coaching can promote clinical nurse leaders perceptions of personal growth (self-efficacy, self-awareness) and professional growth (practice change, personal vision and attainment of goals).
• Previous studies show that leaders can have a powerful effect on their teams, either positively or negatively (Chang, Teng, Chu, Chang & Hsu, 2012; Eberly & Fong, 2013; Gooty, Connelly, Griffith & Gupta, 2010). • The contagion effect (either positive or negative) can spread throughout a team or workplace (Bakker, Demerouti & Schaufeli, 2005; Bakker, Van Emmerik & Euwema, 2006; Sy, Côté, & Saavedra, 2005).	• The results from this study show that coaching clinical nurse leaders can potentially create a ripple effect. Others who work closely with the leader, such as their team or peers, have the potential to be influenced by the leader's change in practice or approach to their role.

What is Known	What is New Knowledge
• GAS has not been used before to measure progress in professional development for clinical nurse leaders (anecdotal evidence). • GAS has been used successfully in health to measure patients' progress towards their goals (Bravo, Dubois & Roy, 2005; Ertzgaard, Ward, Wissel & Borg, 2011; Klosec, 2007). • GAS is a valuable outcome measure in coaching for measuring goal attainment in coaches (Grant, Passmore, Cavanagh & Parker, 2010; Greif, 2007; Sepnce, 2007).	• Results from this study show that GAS is a useful way to measure progress in professional development for clinical nurse leaders. • GAS is a useful way to demonstrate clinical nurse leaders' progress towards and attainment of their professional goals.
• NMBA (2016) recommend that nurses complete a range of professional development activities, which may include both formal and informal activities as there is currently no established guidelines for point allocation when engaging in professional coaching within nursing. • NMBA (2016) recommend that CPD activities be relevant to the nurse's area of professional practice and have clear aims and objectives that meet their self-assessed requirements.	• Results from this study have shown that clinical nurse leaders' value coaching as a professional development activity. They thought that time spend participating in professional coaching should be allocated professional development points. • This study has shown that coaching can be a professional development activity for clinical nurse leaders, which has clear aims and objectives with coachees setting the agenda for their learning.
• There is no evidence relating to coaching and employee retention.	• Coaching has no effect on clinical nurse leaders' intention to remain in their role or the profession.
• Some studies have indicated that coaching can reduce stress for coachees (Grant et al., 2009; Grant get al., 2010; Gyllensten & Palmer, 2005a) • There is evidence on the positive benefits of both internal (McKee, Tilin & Mason, 2009; Rock & Donde, 2008) and external coaches (Grant, Curtayne & Burton, 2009; Wales 2003) with no conclusive evidence on which approach is the more effective for organisations.	• Results from this study show that coaching can provide an enriched professional context, where clinical nurse leaders experience professional support and a safe environment. • Experiences of coaching are individual. Some experience coaching as motivating, stimulating and not stressful at all. However, if coaching is viewed as an added activity on top of an already busy workload, then there is the potential for coachees to experience time pressures, stress and possibly burnout in relation to the work of coaching. • Coaching is a viable professional development option and therefore professional development time can be used for the activities associated with coaching. Engaging in coaching when there is no time capacity to accommodate the additional work

What is Known	What is New Knowledge
	associated with coaching, can potentially lead to increased levels of burnout, stress and time pressures.

7.2 Implications and Recommendations for Education, Practice and Research

7.2.1 Implications for education. The issues facing clinical nurse leaders are complex and unlikely to be remedied with one solution. However, results from this study infer that contemporary approaches to supporting and developing clinical nurse leaders should include coaching as an option. Positioning coaching as a viable professional development activity for clinical nurse leaders, does not negate the need for traditional curriculum based leadership courses. In fact, the two complement each other well, meeting different professional needs and providing a greater variety of professional development options and an increased choice for leaders. In essence, professional development arrangements for leaders need to contain a wider variety of options from which they can choose. Findings from this research show that coaching is a viable option for professionally developing and supporting clinical nurse leaders, and given that all of those coached said they would participate in coaching again, it seems reasonable to assume that other clinical nurse leaders would engage with coaching for their professional development.

7.2.1.1 Coaching as tailored professional development. Calls for leadership development have resulted in increased reports of education aimed at nurse leaders (Large, MacLeod, Cunningham, & Kitson, 2005; Martin, McCormack, Fitzsimons, & Spirig, 2012). Traditionally, leadership education is classroom based and focussed on teaching leadership concepts and the technical requirements of the role, such as managing budgets,

managing staff, and meeting other organisational goals. In addition, courses on leadership development are often aimed at novice leaders and focus on meeting organisational expectations of the role rather than the individual's learning needs. Few professional development activities in nursing focus on tailoring the professional development to meet the leader's individual learning needs, their unique strengths and talents, or helping them attain their individual professional goals. Understandably, few courses can allocate the time or resources to explore the individual leaders' background experiences, values, priorities and particular strengths and areas for development. Coaching has the potential to address these deficiencies.

7.2.1.2 Developing experienced nurse leaders. Highly experienced clinical leaders often know the mechanics of their roles very well, however, what is frequently missing for leaders at this level is individual feedback on their performance, and professional development activities that are tailored to individually challenge or stretch them personally and professionally. Results from this study showed that clinical nurse leaders valued professional development that was tailored to meet their unique learning needs and built on their existing skills. This was an important finding and the implications of this are wider than individuals, and relate to how professional development is offered within the profession.

7.2.1.3 Developing future generations of leaders. Research on generation X and Y reveals that younger employees in the workforce value coaching, and will move employers readily to obtain work circumstances that meet their needs (Hutchinson, Brown, & Longworth, 2012; McCrindle, 2006). If professional development is to meet leaders' needs now and in the future, then it must provide more than just the content knowledge related to the leadership roles. Supporting clinical nurse leaders as they face

the challenges inherent in the execution of their complex roles is essential, particularly for novices.

7.2.2 Recommendation 1. Results from this study show that coaching is one way to facilitate personal and professional growth in both novice and experienced clinical nurse leaders. In order to ensure there are professional development activities that can meet the needs of clinical nurse leaders at both ends of the spectrum, coaching should be available as a viable option for professional development.

7.2.3 Recommendation 2. Results from this study reveal that reflection on practice and personal and professional growth are all aspects of the coaching experience. Additionally, participants felt the professional development work associated with engaging in coaching should be recognised and rewarded. In order to recognise the professional development activities involved in coaching, time spent in professional development coaching should be allocated professional development points.

7.2.3.1 Delivering coaching for clinical nurse leaders. This study has revealed that there can be implications for the way that coaching as a professional development option is organised for clinical nurse leaders. Results from the study showed that clinical nurse leaders liked the regular contact with the coach and that it "kept them on track" with attaining their goals. However, the clinical work environment is complex in nature, with clinical nurse leaders' daily dealing with multiple unanticipated, unplanned events that require their urgent attention. In this context, agreed weekly action plans can take a lower priority against urgent clinical needs. This was demonstrated in the qualitative phase of the study where participants reported pressures in getting organised for the weekly coaching sessions and attending to their agreed action plans at the last possible moment prior to their weekly coaching session. The quantitative results showed that in

this context there is the potential for increased levels of burnout. It is possible that fortnightly or monthly appointments rather than weekly would have been more beneficial for the leaders, given their heavy workloads. It is possible that the use of allocated professional development time to complete the coaching related work could also have relieved the time pressures and possibly the stress or burnout issues.

7.2.4 Recommendation 3. To ensure coaching is not viewed as an added burden on top of an already heavy workload, and that the associated work involved in coaching is recognised as a professional development activity, coaching sessions and time to complete the agreed activities, should be organised within professional development time, at longer than weekly time intervals.

7.2.5 Recommendation 4. In order to ensure that coaching is a professional development option for future generations of nurse leaders, there requires to be an adequate supply of suitably qualified coaches. To ensure good quality preparation of coaches, coaching courses should be evidence based and accredited by the International Coach Federation (ICF). Individuals who wish to coach nursing leaders should hold an ICF credential and also be a member of the ICF. This means their practice is guided by the Code of Ethics, the Professional Standards and Core Competencies set out by the ICF.

7.3 Implications for Practice

Findings from this study have shown that coaching is an activity that can positively affect the work engagement levels of clinical nurse leaders. The leadership development and support issues discussed in Chapters Two revealed there is an urgent need for strategies that will provide support and development for clinical nurse leaders. Taken together, the quantitative and qualitative findings suggest a role for coaching in the professional development for clinical nurse leaders. Findings indicating personal and professional

growth for leaders, along with a ripple effect to other staff working closely with the leader, suggest that organisations should consider the positive opportunities offered by coaching for investing in their clinical staff.

7.3.1 Supporting leaders in practice. Previous research indicates a lack support for clinical nurse leaders in their role (Suzuki et al., 2009) and the research indicating that some employees lack trust in their relationship with their supervisors (Rudolfsson & Flensner, 2012), it is suggested that some clinical nurse leaders would be unlikely to approach their superiors for support, particularly in relation to articulating their decisions or issues they are facing, revealing gaps in their knowledge, or generally reflecting on their practice. Facilitating the time and space for reflection on practice is an important element of providing support for clinical nurse leaders in their roles. Reflection on practice is a necessity, given the complexity of their practice, the decisions they require to make and the issues they face in their roles. The findings from this study revealed the coaching relationship provided a safe space for leaders to reflect and learn in relation to their role. The findings indicate that this is a potential role that a coach could perform given their impartial stance regarding organisational politics, their lack of authority over the employee, and their non-judgemental supportive role as coach.

7.3.2 Promoting goal setting and goal attainment. It is important that nurse leaders are provided with the skills in goal setting, as the process of setting goals and making plans to attain them, are core components of a leader's role and are necessary if they are to create their vision and attain their personal and organisational goals. Ultimately effective goal setting contributes to the overall success of the organisation. Coaching is clearly an activity which can assist many leaders in goal setting, as a tool for clarifying direction and measuring progress towards their goals or their management

outcomes. This research indicates that nurse leaders can benefit from a coach's assistance in setting realistic self-concordant goals that motivated them.

However, attaining challenging goals is not easy. It requires support, focus, and maintenance of that goal, including refining what has and has not worked. In other words goal attainment requires constant vigilance. Having the intention to complete a goal is insufficient on its own to ensure the attainment of the goal (Sheeran and Webb, 2011; Gollwitzer & Sheeran, 2006; Webb, 2006). Prochaska's Transtheoretical Theory of Change (1992, 1995) and research on New Year resolutions (Norcross, 2002) are a testament to that. This research has shown that working in partnership with a coach in a supportive environment, can assist clinical nurse leaders attain their professional goals.

7.3.3 Recommendation 5. Coaches who are external to the organisation should be used as a way to provide a confidential safe space for clinical nurse leaders to learn and develop in their roles.

7.3.4 Recommendation 6. Coaching can be used as a way for clinical nurse leaders to attain their professional goals.

7.4 Implications for Research

Coaching is not a panacea for every nurse leader and assessment instruments that could enable selection of those clinical nurse leaders who would potentially benefit the most from coaching are not yet available. Results from this study indicate that there is the need for instruments that can sensitively measure the outcomes from coaching within a nursing context.

7.4.1 Recommendation 7. There is a need for more research that focuses on further examining the relationship between coaching within the clinical nursing context

and stress or burnout. Future research efforts should also focus on developing assessment instruments that can sensitively measure the outcomes from coaching, particularly within a clinical nursing context.

7.4.2 Recommendation 8. The exact nature of the relationship between burnout and coaching still requires further examination and testing. Until then, if clinical nurse leaders engage in coaching, and report that this is increasing their stress, coaches and coachees might need to revaluate the benefit of coaching for that individual at that particular time.

7.5 Limitations of the Study

This study has produced several valuable insights regarding the use of coaching as a professional development activity for clinical nurse leaders. However, there are some aspects that limit the generalisability of the findings from the study. The first is that despite considerable efforts to gain the maximum sample size, sampling only yielded sixty participants.

A second limitation is related to this aspect. In randomized controlled trials, double blinding is optimal. This was not possible since the researcher was the individual who collected data and provided the coaching. Potential bias was limited by requiring participants to anonymously complete the questionnaire online. Quantitative data analysis was fully completed prior to the qualitative phase, so that results in the follow up qualitative study did not influence interpretation of the quantitative study, ensuring that the statistical analysis was objective. However, the confluence of this study and the nursing pay issues probably played a role in the burnout of participants. Although this could not have been foreseen, it does highlight how unforeseen socio-political events can have a potentially significant impact on social research, such as this study.

As with most qualitative studies, the purposive data collection limits the generalisability to the greater population of nurse leaders, but it has identified that for these participants, the benefits of coaching are that they all attained their professional development goals within the eight weeks of the coaching program. In addition to this, there was a degree of personal growth, with increases in self-awareness and self-efficacy related to various aspects of their role. Whether these accomplishments could have been achieved in a shorter time frame (for instance during a four week coaching program) is unknown.

Finally, the coaching intervention itself was developed by an Australian nurse for Australian nurse leaders. As such, there is no way of knowing if this type of coaching can be directly adopted by clinical nurse leaders in other countries and cultures. It is expected that modifications appropriate to different social contexts and clinical settings may be required when using coaching with clinical nurse leaders outside Australia.

7.6 Summary and Conclusions

This research contributes to the body of knowledge on clinical leadership development and coaching. There have been calls for the need to provide support and further development for clinical nurse leaders. This research provides a creative answer to these calls, using a novel approach, coaching, to support and develop clinical nurse leaders.

The findings from this study indicate that coaching is a viable option for providing support and professionally developing clinical nurse leaders in their roles. Specifically, the findings show that coaching significantly increases clinical nurse leaders' work engagement levels. It also assists them in attaining their specific professional development goals. It provides an enriched professional context for them to grow and it facilitates both personal and professional growth. Coaching also has the potential of providing benefits beyond those who receive the coaching. The relationship between

coaching and the retention of clinical nurse leaders or their levels of burnout remains unclear and requires further investigation.

There is a need for more focus on supporting and developing those in clinical leadership roles and in particular for those newly transitioning into leadership roles, if leaders are to flourish. Organisations benefit on many levels when their leaders are engaged, including retaining existing staff and attracting new employees. The results from this study provides evidence that coaching for clinical nurse leaders can be a practical and effective approach for promoting work engagement and facilitating personal and professional growth.

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Appendix A—Participant Information Sheet

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

The Effectiveness of Workplace Coaching in Nursing

Principal Researcher: Loraine Thompson

Aim

The purpose of this study is to explore the outcomes of work related coaching in Clinical Nurse Leaders within Queensland.

Procedures

If you agree to participate, the following activities will occur:

1. You should sign the consent form and return it in the post reply envelope provided.
2. You will be asked to complete an online questionnaire at the beginning of the study (approx 10 minutes to complete).
3. Depending on which group you have been allocated to, the coach will contact you by telephone, each week for a period of up to eight weeks. The control group will not have weekly contact.
4. The coaching will be conducted via telephone for a period of approx 30 – 45 mins.
5. You will be requested to complete the online post-test questionnaires. (approx 10 minutes)
6. If you are in the control group, once we reveive your post-test questionnnaire (eight weeks after enrollment in the study) you will be offered a single complimentary coaching session. This means that participants in the control groups will receive one free coaching session.

Benefits

This research will give you the opportunity to work, one on one with a qualified coach, who will provide a supportive environment and guide you through a structured process of working towards your professional goals. Your coach is a Certified Master Coach from the Behavioural Coaching Institute and has many years' experience in Nursing and also in Education, supporting and guiding nurses towards their goals. You should also be aware that if you do choose to participate in this study, there may be no direct benefits to you. There is no reimbursement for participation in this study.

Risks

There are minimal risks in this study. Although unlikely, if you feel distressed and wish to speak with someone regarding this, I have included the number of Lifeline Community Care (3250 1900) where you can speak with someone in confidence, 24 hours a day, regarding your feelings. I have also included details of the UQ counselling service (07) 3365 1704 or a number at Ramsay Health (07) 3394 7624. You may also prefer to access the Employee Assistance Program for your hospital/institution who will provide you with guidance on accessing a counsellor.

Confidentiality

All information obtained in this study is confidential and used only for research purposes. Participant data will be identified only by a code name.

Right to refuse to participate or withdraw

Your participation in the study is entirely voluntary, and you are free to withdraw at any time without penalty. If you choose to withdraw from the study, information obtained will be destroyed.

Results

There will be a tick box on the questionnaire for participants to indicate that they wish to be notified when the summary report is complete. A summary of the study results will be sent upon request.

Questions

If you have any questions about the research, please do not hesitate to contact Lorraine Thompson, PhD candidate, School of Education, University of Queensland on [redacted] ([redacted]) or Dr Kathy Ahern, Senior Lecturer, School of Nursing and Midwifery at (07) 3381 1502 (k.ahern@uq.edu.au).

This study has been cleared by one of the human ethics committees of the University of Queensland in accordance with the National Health and Medical Research Council's guidelines. Approval number 2008000838. You are of course, free to discuss your participation in this study with project staff (contactable on [redacted]). If you would like to speak to an officer of the University not involved in the study, you may contact the Ethics Officer on (07) 3365 3924.

Appendix B—Consent Form

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

The Effectiveness of Workplace Coaching in Nursing

Lorraine Thompson

Email: [redacted]

My participation in this research is voluntary and I understand that I am free to withdraw from the study at any stage, without any penalty. If I withdraw from this study, I understand that any data I provide will be destroyed and not used in the research analysis.

I have read and understood the participant information sheet. I am clear regarding the purposes of this research. I have been given the contact details of the researcher and the opportunity to clarify or ask further questions regarding participation in this study. I also have been given the details of others to contact if I wish to discuss the research with someone other than the researcher.

The risks, potential benefits and implications of being involved in this research have been explained. I understand I will not be paid to participate. I have been given a number to contact if I feel distressed at any time during the research.

Although I understand that the purpose of this research project is to coach nurses on issues relating to professional practice, it has also been explained that my involvement may not be of any benefit to me. I understand that the researcher will keep my results confidential and no published study will identify me in any way.

***

Please print your full name below

Name: ……

I hereby consent to my involvement in the above study.

Signed ……..

Date ……

Appendix C—Coaching Protocol

Coaching Protocol

The GROW Model

Goal	What do you want to get out of the coaching session? Which area would you like to focus on? What goal do you want to achieve? What would you like to happen with_____? What result are you trying to achieve? What outcome would be ideal? What do you want to change?
Reality	Tell me what's happening for you right now Have you taken any steps towards your goal? On a scale of 1-10 where are you right now? Where are you in relation to your goal? What have you already tried?
Options	What are your options? What do you need to do next? What else could you do? What is the best / worst thing about that?
Will or Way forward	How are you going to do that? What resources can help you? Is there anything missing? On scale of 1-10 how committed are you to doing this? How will you feel when you have done that?

Appendix D—Ethics Approvals

THE UNIVERSITY OF QUEENSLAND

Institutional Approval Form For Experiments On Humans Including Behavioural Research

Chief Investigator:	Ms Lorraine Thompson
Project Title:	The Effectiveness of Coaching in Burnout and Engagement in Nurses
Supervisor:	Dr Kathy Ahern, Dr Stephanie Fox-Young
Co-Investigator(s)	None
Department(s):	School of Nursing and Midwifery
Project Number:	2008000838
Granting Agency/Degree:	PhD
Duration:	30th November 2009

Comments:

Name of responsible Committee:-
Behavioural & Social Sciences Ethical Review Committee
This project complies with the provisions contained in the *National Statement on Ethical Conduct in Human Research* and complies with the regulations governing experimentation on humans.

Name of Ethics Committee representative:-
Dr Jack Broerse
Chairperson
Behavioural & Social Sciences Ethical Review Committee

Date 27/05/08 Signature [redacted]

Appendix E—Ethics Amendment

THE UNIVERSITY OF QUEENSLAND

Institutional Approval Form For Experiments On Humans Including Behavioural Research

Chief Investigator:	Ms Lorraine Thompson
Project Title:	The Effectiveness Of Workplace Coaching In Nursing - 22/07/2010 - AMENDMENT
Supervisor:	Dr Kathy Ahern, Dr Mary McMahon
Co-Investigator(s)	None
Department(s):	School of Education
Project Number:	2008000838
Granting Agency/Degree:	PhD
Duration:	31st December 2010

Comments:

Name of responsible Committee:-
Behavioural & Social Sciences Ethical Review Committee
This project complies with the provisions contained in the *National Statement on Ethical Conduct in Human Research* and complies with the regulations governing experimentation on humans.

Name of Ethics Committee representative:-
Dr Jack Broerse
Chairperson
Behavioural & Social Sciences Ethical Review Committee

Date 27/07/10 Signature [redacted]

Appendix F—Online Pre-test and Post-test Questionnaire

Coaching Research Survey Pre test and Post test

1. Coaching Research Survey

Welcome to the online pre test, post test questionnaire for the Coaching Research Study. The following questions should only take 5-10 minutes to complete. Once you have completed and submitted the survey, you will receive an email from Lorraine with further details on how to proceed.
To protect your privacy, real names are not used in this online survey. Please choose a code name that you can easily remember (such as your pet's name). You must use this same codename when completing the questionnaires at the beginning (pre test) and at the completion of the study (post test) in approximately eight weeks time. The code name is used to protect your identity and is only used to match responses during data analysis and to send email reminders to those who have not yet responded.

Please insert your chosen code name and email address below.

Code Name: [ ]

Email Address: [ ]

How long is it since you qualified as a registered nurse?

☐ New graduate ☐ 2 - 3 years ☐ 4 - 5 years ☐ 6 - 7 years ☐ 8 years or more

Do you work full time or part time?

☐ Full time ☐ Part time

Do you work in a rural or urban setting?

☐ Rural ☐ Urban

Do you work in the private or public sector?

☐ Private ☐ Public

Do you work mainly in a hospital, community or other type of setting?

☐ Hospital ☐ Community

Other (please specify)

[ ]

2. MBI-HS

The purpose of this survey is to discover how various persons in the human services or helping professions view their jobs and the people with whom they work closely. Because persons in a wide variety of occupations will answer this survey, it uses the term recipients to refer to the people for whom you provide your service, care, treatment or instruction. When answering this survey, please think of these people as recipients of the service you provide, even though you may use another term in your work.
Below are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling tick the "0" (zero) after the statement. If you have had this feeling, indicate how often you feel it by ticking the descriptor (from 1-6) that best describes how frequently you feel that way.

MBI Question 1

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel emotionally drained from my work 0	○	○	○	○	○	○	○

Coaching Research Survey Pre test and Post test

MBI Question 2

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel used up at the end of the workday	○	○	○	○	○	○	○

MBI Question 3

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel fatigued when I get up in the morning and have to face another day on the job	○	○	○	○	○	○	○

MBI Question 4

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I can easily understand how my recipients feel about things	○	○	○	○	○	○	○

MBI Question 5

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel I treat some recipients as if they were impersonal objects	○	○	○	○	○	○	○

MBI Question 6

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
Working with people all day is really a strain for me	○	○	○	○	○	○	○

MBI Question 7

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I deal very effectively with the problems of my recipients	○	○	○	○	○	○	○

MBI Question 8

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel burned out from my work	○	○	○	○	○	○	○

MBI Question 9

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel I'm positively influencing other peoples' lives through my work	○	○	○	○	○	○	○

MBI Question 10

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I've become more callus toward people since I took this job	○	○	○	○	○	○	○

Coaching Research Survey Pre test and Post test

MBI Question 11

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I worry that this job is hardening me emotionally	○	○	○	○	○	○	○

MBI Question 12

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel very energetic	○	○	○	○	○	○	○

MBI Question 13

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel frustrated by my job	○	○	○	○	○	○	○

MBI Question 14

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel I'm working too hard on my job	○	○	○	○	○	○	○

MBI Question 15

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I don't really care about what happens to some recipients	○	○	○	○	○	○	○

MBI Question 16

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
Working with people directly puts me too much stress on me	○	○	○	○	○	○	○

MBI Question 17

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I can easily create a relaxed atmosphere with my recipients	○	○	○	○	○	○	○

MBI Question 18

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel exhilarated after working closely with my recipients	○	○	○	○	○	○	○

MBI Question 19

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I have accomplished many worthwhile things in this job	○	○	○	○	○	○	○

Coaching Research Survey Pre test and Post test

MBI Question 20

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel like I'm at the end of my rope							

MBI Question 21

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every bday
In my work, I deal with emotional problems very calmly							

MBI Question 22

	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day
I feel recipients blame me for some of their problems							

3. UWES

The following 17 statements are about how you feel at work. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, choose the "Never" option after the statement. If you have had this feeling, indicate how often you feel it by choosing the option that best describes how frequently you feel that way.

UWES Q1

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
At my work, I feel bursting with energy							

UWES Q2

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
I find the work that I do full of meaning and purpose							

UWES Q3

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
Time flies when I'm working							

UWES Q4

	never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
At my job, I feel strong and vigorous							

UWES Q5

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
I am enthusiastic about my job							

Coaching Research Survey Pre test and Post test

UWES Q6

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
When I am working, I forget everything else around me	○	○	○	○	○	○	○

UWES Q7

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
My job inspires me	○	○	○	○	○	○	○

UWES Q8

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
When I get up in the morning, I feel like going to work	○	○	○	○	○	○	○

UWES Q9

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
I feel happy when I am working intensely	○	○	○	○	○	○	○

UWES Q10

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
I am proud of the work that I do	○	○	○	○	○	○	○

UWES Q11

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
I am immersed in my work	○	○	○	○	○	○	○

UWES Q12

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
I can continue working for very long periods at a time	○	○	○	○	○	○	○

UWES Q13

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
To me, my job is challenging	○	○	○	○	○	○	○

Coaching Research Survey Pre test and Post test

UWES Q14

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
I get carried away when I'm working	○	○	○	○	○	○	○

UWES Q15

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
At my job, I am very resilient, mentally	○	○	○	○	○	○	○

UWES Q16

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
It is difficult to detach myself from my job	○	○	○	○	○	○	○

UWES Q17

	Never	Almost Never (a few times a year or less)	Rarely (once a month or less)	Sometimes (a few times a month)	Often (once a week)	Very often (a few times a week)	Always (every day)
At my work I always persevere, even when things do not go well	○	○	○	○	○	○	○

4. Nurse Retention Index

This section is about your intention to remain or leave the nursing profession

NRI Q1

	Definitely false(1)	False(2)	Mostly false (3)	More false than true (4)	More true than false (5)	Mostly true (6)	True(7)	Definitely true(8)
It is my intention to continue with my nursing career in the foreseeable future	○	○	○	○	○	○	○	○

NRI Q2

	Definitely false(1)	False(2)	Mostly false (3)	More false than true (4)	More true than false (5)	Mostly true (6)	True(7)	Definitely true(8)
I would like to stay in nursing as long as possible	○	○	○	○	○	○	○	○

NRI Q3

	Definitely false(1)	False(2)	Mostly false (3)	More false than true (4)	More true than false (5)	Mostly true (6)	True(7)	Definitely true(8)
As soon as it is convenient for me I plan to leave the nursing profession	○	○	○	○	○	○	○	○

Coaching Research Survey Pre test and Post test

NRI Q4

	Definitely false(1)	False(2)	Mostly false (3)	More false than true (4)	than false (5)	Mostly true (6)	More true True(7)	Definitely true(8)
I expect I will keep working as a nurse	○	○	○	○	○	○	○	○

NRI Q5

	Definitely false(1)	False(2)	Mostly false (3)	More false than true (4)	More true than false (5)	Mostly true (6)	True(7)	Definitely true(8)
My plan is to remain with my nursing career as long as I am able	○	○	○	○	○	○	○	○

NRI Q6

	Definitely false(1)	False(2)	Mostly false (3)	More false than true (4)	More true than false (5)	Mostly true (6)	True(7)	Definitely true(8)
I would like to find other employment by leaving nursing	○	○	○	○	○	○	○	○

I intend to leave this employer in the next six months

○ Yes ○ No

My reasons for leaving (employer / profession whichever applies to you) are:

- ☐ Stress
- ☐ Pregnancy
- ☐ Family commitments
- ☐ Relationship conflict
- ☐ Management Issues
- ☐ Bullying
- ☐ Staffing shortages
- ☐ Heavy workloads Better
- ☐ Job offer
- ☐ Another profession
- ☐ Promotion
- ☐ Illness
- ☐ Lack of support
- ☐ Lack of recognition for my efforts
- ☐ Lack of professional development opportunities

I would like to be notified when the summary report has been completed.

○ Yes ○ No

Appendix G—Online Coaching Evaluation

1. Coaching Evaluation

Welcome to the evaluation of your coaching with Lorraine. The following questions should only take 5-10 minutes to complete. To protect your privacy, real names are not used in this online survey. Please use the same code name that you used when completing the questionnaire at the beginning (pre test) and at the completion of the study (post test). The code name is used to protect your identity and is only used to match responses during data analysis and to send email reminders to those who have not yet responded.

1. Please insert your chosen code name and email address below.

Code Name:

Email Address:

2. Please provide an overall satisfaction rating for the coaching you received.

- ○ Poor
- ○ Fair
- ○ Good
- ○ Very good
- ○ Excellent

3. Please identify the areas where you feel coaching has facilitated your professional growth and development.

- ☐ Change management
- ☐ Leadership
- ☐ Career planning
- ☐ Strategic planning
- ☐ Decision making skills
- ☐ Delegation skills
- ☐ Conflict management
- ☐ Performance management
- ☐ Team work
- ☐ Motivating others
- ☐ Motivating self
- ☐ Achievement of goals

4. Please identify the areas where you feel the coaching has facilitated your personal growth and development.

- ☐ Increased self-confidence
- ☐ Increased self-awareness
- ☐ I feel empowered to act
- ☐ Clarified my career direction
- ☐ Increased enthusiasm
- ☐ Increased motivation
- ☐ Increased focus
- ☐ Increased accountability to complete my action plan

5. Please comment on what you learned during the coaching.

6. Please comment on how you have applied in practice, what you learned in coaching.

7. Please relate any quantifiable outcomes that have resulted from the coaching e.g. number of staff retained, satisfaction levels increased, number of people who now have "buy in' to a process, number of competencies achieved etc

8. Would you work with a coach again?

☐ Yes

☐ No

Please comment

9. During coaching, you worked with Lorraine to construct specific statements that would assist in measuring the attainment of your goal. Now that coaching has been completed, please select the option that best describes your final goal attainment.

	Much less than Expected Outcome -2	Less than Expected outcome -1	Expected Outcome 0	Better than expected +1	Much better than expected outcome +2
I feel my goal attainment scale rating is:	○	○	○	○	○

Appendix H—Telephone Interview Schedule

Good morning.

I know we discussed your consent to this interview prior to today and you have signed a consent form, but I just need to check for the recording—are you still willing to participate in this interview?

Questions

It's been at least six months since we last spoke, so to begin with I'd like to just quickly revisit your goal and your achievements at the end of the coaching.

1. Can you tell me about your goal and what you had achieved by the end of the coaching?
2. Do you think there were any advantages or gains for you as a result of participating in the coaching?
3. Do you think there were any disadvantages or stresses as a result of participating in the coaching?
4. Are there any aspects of what we addressed in the coaching that are still ongoing?
5. I'm interested to know if you have been able to apply what you learned in coaching to other situations or contexts. Can you comment on that?
6. I'm interested to know if you feel there were any long-term benefits or disadvantages from participating in the coaching?
7. Could you comment on coaching being used for professional development, particularly for those in clinical nurse leader positions like yourself?
8. Have you got anything to add about your experience of being coached?

Prompts

- Can you tell me more about that?
- Can you expand on that?
- Can you give me an example?
- Anything else?
- Tell me more