First-line Nurse Managers' Preconditions for Practise

The Important Interplay between Person and Organization

BERNICE SKYTT
Dissertation presented at Uppsala University to be publicly examined in Auditorium Minus, Museum Gustavianum, Akademigatan 3, 753 10 Uppsala, Monday, December 10, 2007 at 13:15 for the degree of Doctor of Philosophy. The examination will be conducted in Swedish.

Abstract

The aim was to study personal and organizational conditions for first-line nurse managers and to identify and assess the skills and abilities important for leadership and management. Interviews were conducted with 5 first-line nurse managers, 5 registered nurses, 5 assistant nurses and one head of department delineating their perceptions of current and ideal roles of first-line nurse managers. Factor analysis was conducted to estimate validity and reliability of the Leadership and Management Inventory, developed in the context of this thesis, in one sample of 149 registered nurses and one sample of 197 health care personnel. Interviews and questionnaires to study expectations, experiences and outcomes of two different development programmes for 13 first-line nurse managers in a Training Programme, 14 in a Leadership Development Programme and 14 in a Comparison group were conducted. Letters and questionnaires from 32 former first-line nurse managers were analysed to describe their reasons for leaving their posts. First-line nurse managers, registered nurses and assistant nurses’ descriptions of the first-line nurse manager’s role were corresponding; the main focus was on service on the ward. The head of department described the first-line nurse manager’s responsibility towards the staff with focus on development and co-operation. Analysis of the Leadership and Management Inventory resulted in three factors: “interpersonal skills and group management”, “achievement orientation” and “overall organizational view and political savvy”. Validity and reliability were considered acceptable. Expectations concerning the development programmes were generally met; improvements corresponding to the content of the programmes were reported. Reasons to leave were personal, organizational and linked to the relationship with the head of department. Conclusion: The first-line nurse managers’ individual experiences, skills, abilities and ambitions are important, but so are the conditions in which she/he practices her/his leadership and management. It is important that the interplay between person and organization functions well.

Keywords: first-line nurse manager, managerial role, instrument development, leadership development, support, turnover

Bernice Skytt, Department of Public Health and Caring Sciences, Uppsala Science Park, Uppsala University, SE-75183 Uppsala, Sweden

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List of original papers

This thesis is based on the following papers, which are referred to in the text by their Roman numerals:


II Skytt, B., Ljunggren, B., Carlsson, M., & Engström, M. Psychometric testing of the Leadership and Management Inventory: a tool to measure the skills and abilities of first-line nurse managers. (Submitted).

III Skytt, B., Ljunggren, B., Engström, M., & Carlsson, M. Expectations, experiences and outcomes of two development programmes for first-line nurse managers: one focused on organizational knowledge the other on personal growth. (Submitted).


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Abbreviations

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<td>Assistant nurse</td>
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<td>CCG</td>
<td>County Council of Gävleborg</td>
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<td>CG</td>
<td>Comparison group</td>
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<td>TP</td>
<td>Training Program</td>
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<td>FLNM</td>
<td>First-line nurse manager</td>
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<td>HCP</td>
<td>Health care personnel</td>
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<td>Head of department</td>
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<td>LaMI</td>
<td>Leadership and Management Inventory</td>
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<td>LDP</td>
<td>Leadership Development Program</td>
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<td>PCA</td>
<td>Principal component analysis</td>
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<td>RN</td>
<td>Registered nurse</td>
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Introduction

My interest in the roles and work situation of first-line nurse managers (FLNM) began in the mid-1990s when I worked as a nurse manager at the hospital level. I experienced that the roles had changed from when I worked as an FLNM some years earlier. Their scope of responsibility was wider, and as part of their day-to-day work, FLNMs were occupied with tasks that were unfamiliar to me. Although this role change had been planned, the FLNMs’ responsibilities seemed to be too extensive. The changed roles, including for example more managerial duties, called for related skills and entailed a need for training and support. In addition, for some of the FLNMs, preconditions for work were linked to factors established by the organization. All of this piqued my curiosity about these role changes and about how FLNMs could be supported.

During the 1980s, health care organizations underwent a process of decentralization, a change observed in other areas of the public as well as private sector (Nicklin, 1995). Decentralization of services has also been implemented in Swedish health care. When evaluating the FLNMs’ role, Petersson (1993) found that it had changed its focus, from patients to administration and economy. In a review covering the 1970s and 1980s, Duffield (1991) described similar changes in other countries. The FLNMs’ work activities are diversified, but the focus seems to be on service on the ward and making it run smoothly (Nilsson, 2003). Furthermore, in another Swedish study, first-line managers described perceiving themselves as not being part of the management system (Richard, 1997). FLNMs require clearly delineated duties, feedback, participation and empowerment as well as sufficient resources. These are areas of support that recur in literature, and areas in which the FLNM’s immediate superior and the organization’s leadership play a crucial role.

The overall aim of the present thesis was to study and describe organizational conditions for first-line nurse managers and to identify and assess the skills and abilities important to their leadership and management practice.
Outline of the thesis
In the following, the theoretical framework that has been used will be described in the first section. In the second section, FLNMs are defined and the scope of their role described. In the third section, the context in which the FLNMs work is described from a number of perspectives: changes toward a decentralized structure and some aspects of FLNMs’ work situation. FLNMs’ skills and abilities are described in the fourth section. In the fifth section, supportive structures or conditions are described. In section six, the focus is on formal requirements of FLNMs’ education together with examples and experiences from development activities for FLNMs. And in the seventh section, reasons for resignation from the managerial post are described. Although my ambition has been to describe the different topics separately, the descriptions do overlap. This could perhaps be understood as a consequence of the close relationship between the topics.

The introduction is followed by three sections: a description of the methodology for each of the four studies; a summary of findings; and lastly a discussion divided into subheadings that can be recognized from the background: the FLNM’s role (Study I, IV); skills and abilities (Study I, II, III, IV), development programmes (Study II, III, IV); organizational conditions (Study III, IV); supportive structures (Study IV); and resignation (Study III, IV), and finally a section in which the results are discussed in relation to the theoretical framework that have been referred to in the introduction. The last sections in the discussion contain methodological considerations and concluding remarks.

Theoretical framework
The focus of the present thesis is on the interplay between the manager and the organization. The organization gives the manager preconditions in the form of assignments and mandates as well as opportunities for development. Three theories or frameworks will be referred to that have been used to give structure to as well as to understand earlier research presented in the introduction. The theories and framework have further been used to understand and analyse the present findings.

The manager’s assignment includes roles to perform and skills that are of use when performing these roles. In the following, Mintzberg’s theory of the manager’s working roles (Mintzberg, 1973), Katz’s framework of managerial skills (Katz, 1955, 1974), and finally Kanter’s structural theory of power in organizations (Kanter, 1993) will be presented.
Mintzberg’s theory of the manager’s working roles

Mintzberg (1973) found that managerial work is similar across organizations and that, in his theory of managers’ working roles, the roles are carried out by a wide range of managers. The theory is based on ten roles common to managers. The roles are categorized into three major roles: 1) interpersonal, derived from the manager’s authority and status, including the role’s figurehead, leader, liaison; 2) informational, derived from interpersonal roles and the access they provide to information, including the role’s monitor, disseminator and spokesman; and 3) decisional, derived from the manager’s authority and information including the roles of entrepreneur, disturbance handler, resource allocator and negotiator. The ten roles should be seen as an integrated whole. “In essence the manager is an input-output system in which authority and status give rise to interpersonal relationships that lead to inputs (information) and that in turn lead to outputs (information and decisions)” (Mintzberg, 1973:58). Mintzberg himself, however, developed the theory in a later work, as he saw the need for development from a “decomposed list” to “an interactive model” (Mintzberg, 1994:29).

Katz’s framework of managerial skills

In 1955, Katz (1955, 1974) presented managerial ability by identifying three skills that were observable: technical skills – understanding and mastering a specific activity; human skills – the leadership ability on one’s own unit, working as a member of a group and creating a functioning team in the sense of being good at communication, creating a good atmosphere and being sensitive to needs as well as talents in inter-group relationships and; conceptual skills – seeing the whole picture, how the different parts work together. The importance of the different skills was believed to vary between the levels of management. Technical skills were described as being of greatest importance in the first-line, followed by human skills, especially intra-group skills, while conceptual skills were regarded as less important at this level of management (Katz, 1955, 1974). Recall, however, that this research was done some decades ago, and the importance of different skills for different levels may have changed. In a retrospective commentary (Katz, 1974), Katz stated that he had re-valued some of his original standpoints regarding the three skills. The human skills that are divided into intra- and inter-group relationships have been described in Katz’s later work as essential to management at lower and middle levels (Katz, 1974).

Kanter’s structural theory of power in organizations

To help us understand the importance and positive effects of sufficient supportive structures, Rosabeth Kanter’s (1993) structural theory of power in
organizations will be described. She argues that the work environment has more impact on work attitudes and behaviour than does personal predisposition or socialization. In the theory, three organizational structures are described that influence work effectiveness: opportunity, power and proportions. According to Kanter, power is a person’s “ability to mobilize resources (human and material) to get things done” (Kanter, 1979:66). Opportunity is described as a person’s possibility for growth and for moving to other posts, for example clear career paths, possibilities to try and to take part in new assignments or tasks/projects, education and training. Having power is described as having access to resources, information and political support. One is likely to have access to these things in posts characterized by formal and informal power. Formal power increases if the activities a person performs are extraordinary (discretion in the job), visible and relevant when the organization is facing problems. Informal power is derived from relationships with persons both within and outside the organization. Persons in certain positions are powerless owing to the nature of their posts. But powerlessness can also occur when management limits opportunities for power. The third concept is proportions and refers to the composition of people in the organization. Being part of a small proportion is described as more difficult and entails problems rather than possibilities. It is more likely that managers who are empowered will empower their subordinates, in that way also achieving organizational goals (Kanter, 1993).

Laschinger and Shamian (1994) described the relationships in Kanter’s structural theory of power in organizations. See Figure 1. Formal and informal power influence/determine access to job-related empowerment structures. Furthermore, these empowerment structures have a positive impact on the employees regarding, for example, their self-efficacy, motivation and organizational commitment, which in turn results in work effectiveness (Laschinger & Havens, 1997; Laschinger & Shamian, 1994)
The first-line nurse manager

Definition of the FLNM

The unifying title first-line nurse manager is used in the present thesis. The focus is on managers on wards and at outpatient clinics who have 24-hour responsibility for patients, staff and resources. The term “first-line” has been chosen as it indicates that FLNMs supervise others who work directly with patient care. ‘First-line’ also differentiates them from other managers independent of how many managerial levels there are in the organizational structure. When referring to other studies, the title FLNM will be used if it is used in the study or if the nurse managers in question are described as working first-line. In other cases, the title used in the referenced study will be used.

The titles used when FLNMs are described or studied vary over time and between countries and organizations. In their review, Cameron-Buccheri and...
Ogier (1994) made an illustrative comparison between the use of titles in the US and the UK; some examples are head nurse, ward sister, nurse manager and ward manager. In a Swedish dissertation, Nilsson (2003) gave examples of different titles used and pointed out that changes in the title reflect changes in the nurse manager’s role, from having a patient-care focus to a focus on management of staff and finances as well as operations on the ward. The fact that different titles have been used for the same position or that the same title has been used on different organizational levels has been discussed or commented on in a number of studies (Acorn, Ratner, & Crawford, 1997; Firth, 2002; Fullerton, 1993; Pedersen, 1993; Sanders, Davidson, & Price, 1996; Wilhite, 1988). When use of titles differs between studies and when the organizational context is not particularly well described, it can be somewhat difficult to be certain that the FLNM is in focus and not nurse managers on other organizational levels.

FLNMs are described as having responsibility for personnel and the unit’s economy on a 24-hour basis (Cameron-Buccheri & Ogier, 1994; Everson-Bates, 1992) and for the efficient management of the unit (Fullerton, 1993). They are to ensure the provision (Hall & Donner, 1997) and quality of patient care (Everson-Bates & Fosbinder, 1994; Fullerton, 1993), quality of working life for personnel (Fullerton, 1993), and the working relationships with the unit’s support service (Everson-Bates, 1992). In terms of economics, they are also responsible for organizational effectiveness and efficiency (Nicklin, 1995). Other studies use definitions that are less precise regarding specific responsibilities, but define the setting as “the management of a unit(s) or area(s) within a health care organization” (Carroll & Adams, 1994; Manfredi, 1996:319). In other studies, the context is acute care facilities (Hess & Drew, 1990; Ringerman, 1990; Tumulty, 1992; Westmoreland, 1993). Everson-Bates (1992) also mentioned that FLNMs have line authority for staff, and that they report to the director of nursing. In some studies, it is stated explicitly that only registered nurses hold the posts that are included (Carroll & Adams, 1994; Hess & Drew, 1990; Manfredi, 1996). In a few studies, a definition of new and experienced managers is provided (Dunn & Schilder, 1993; Hess & Drew, 1990; Westmoreland, 1993). When FLNMs’ responsibilities are described in a Swedish context, the areas are identified as nursing, staffing, budgeting and organizational development, including assumed full executive status (Persson & Thylefors, 1999).

In many of the definitions and descriptions, it is stated explicitly that the FLNMs are nurses. The organization used as the empirical base for the present study has changed over time, and at present, professional groups other than registered nurses (RN) can hold managerial positions on wards and at outpatient clinics.
Allocation of time

Depending on their place in an organization, there are differences in managers’ orientation (Mintzberg, 1973). Those working at a “lower level” focus on the work flow in their organization, while top managers use their information for strategic considerations. In addition, Mintzberg (1973) described lower level management as more fragmented and as involving briefer efforts than management at higher levels and gave the example of chief executives spending an average of 22 minutes on each activity as compared to foremen who spend 48 seconds. The brevity of FLNMs work can be exemplified by results from a study by Dunn and Schilder (1993). Observations of FLNMs showed that half of their activities were initiated by the managers themselves. Ninety-seven percent of their activities were unscheduled, and the remaining three percent were scheduled 30 minutes in advance. FLNMs performed 143 activities a day; 138 were unscheduled and five scheduled. The average time per activity was 3 minutes. No differences in activities were found when experienced and inexperienced managers were compared (Dunn & Schilder, 1993). Further, Dunn and Schilder (1993) found that novice head nurses were more task orientated and rule dependent than their experienced colleagues, who were better at seeing the whole picture and had other preconditions for long-term planning. Manfredi (1996) discussed how FLNMs often found it difficult to work with long-term visions. In many respects, FLNMs are constrained by the organizational structure. If their vision is suited to the mission, goals and objectives of the organization, they may be able to encourage staff to work towards this vision. If their vision is inconsistent with that of the organization, nurse managers have little chance of achieving their goals. If the managers’ frame of reference for their jobs is vague, the different activities and issues they initiate may not lead to any long-standing results (Manfredi, 1996).

FLNMs described their job as stressful due to increased responsibility within the framework of their position, but this increased responsibility had also brought “freedom, authority, autonomy and respect” (Wong, 1998:347). Similar results were shown by Willmot (1998); although nurse managers were content with the changed role, they also experienced a great increase in work stress (Willmot, 1998).

First-line nurse managers’ roles

A number of studies with different aims, designs and data collection methods have been used in describing the work of FLNMs. These differences make it difficult to get an overview of the boundaries of their work. To give an overview of the results from these studies the results have been analysed and categorised according to Coulson and Cragg’s adaptation of Mintzberg’s theory (Coulson & Cragg, 1995) see Table 1. It is important
to emphasize that the overview in Table 1 should be interpreted with caution, as there may be nuances in the original material that are lost in the presentation of results and that, thereby, have been overlooked in the overview.

**Table 1** FLNMs’ roles or activities categorized according to Coulson and Cragg’s model (adapted from Mintzberg)

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<td>Standards maintainer</td>
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Mintzberg’s theory has been used in two studies (Baxter, 1993; Coulson & Cragg, 1995) to categorize FLNMs’ work. Coulson and Cragg (1995) found it difficult to classify all their data according to the roles in the theory. Another major role, “the Professional”, including practitioner, carer and standards maintainer, was therefore added. As it has been reported that, due to decentralization, FLNMs now have more managerial duties than clinical, it was judged as interesting to add the category “the Professional” to Mintzberg’s theory (see Table 1).
The overview shows that FLNMs describe a number of tasks as belonging to their framework of responsibility. Although there is variation across the studies, the FLNMs’ scope of responsibility seems to be broad, as many of the roles are described and there seem to be similarities over time. It is further interesting that the roles related to “the professional”, i.e. practitioner, carer and standards maintainer, have been described in the majority of studies. How frequently FLNMs were occupied with the different tasks varied, as did how they perceived the importance of these tasks. The FLNMs in both studies (Baxter, 1993; Coulson & Cragg, 1995) in which Mintzberg’s theory has been used were familiar with all reported roles in his theory, although there were some discrepancies. In the study by Baxter (1993), for example, the head nurses were most familiar with the roles of leader, liaison, monitor, disseminator, entrepreneur, disturbance handler and resource allocator.

Different ways to perform the role

Although it has been found that the managers performed the same roles, there were also differences (Coulson & Cragg, 1995). Examples of areas of difference are efforts to share information and ways to empower the staff group (Aroian et al., 1997; Coulson & Cragg, 1995). Some regarded themselves as clinical experts, while others deferred that responsibility to the staff (Coulson & Cragg, 1995). Studies have shown that nurse managers are important for nurse retention, both directly, through their attitudes towards and concerns for their staff, and indirectly, for example, through staffing and their way of involving nurses in the decision-making (Parsons & Stonestreet, 2004; Taunton, Boyle, Woods, Hansen, & Bott, 1997). The managers’ different preconditions, such as workload and autonomy, as well as differences in role definition and leadership style led to resentment, misunderstandings and lack of respect from other persons in the institution (Coulson & Cragg, 1995). Different delineation of the role by the individual manager has been described in other studies (Aroian et al., 1997; Sanders et al., 1996). It has been reported that FLNMs have their identity in the nursing profession. In one Swedish thesis, Richard (1997) described FLNMs as reluctant to take on their managerial role; they had a great deal of their identity in their nursing profession. Another Swedish study showed a similar result; one FLNM’s role identification was described, revealing that she had three goals within her profile. To her, the most important goal was being a nurse, an area in which she had both knowledge and control (Johansson, Pörn, Theorell, & Gustafsson, 2006). Various reasons for the differences have been suggested: the different situations at the ward (Baxter, 1993), personal or life experience (Aroian et al., 1997), different skills, competencies and management styles (Doherty, 2003) and also experience as an FLNM, for example the novice head nurse had more focus on her own
ward and the patients (Dunn & Schilder, 1993). In a study by Anthony et al. (2005), FLNMs with different educational backgrounds viewed the role of nurse manager differently: “Nurses with a master’s degree expressed a more global and balanced assessment of their roles…” (Anthony et al., 2005:153). Bondas (2006) described in the model “paths to leadership” four different paths towards leadership. The four different paths are named the path of ideals, the career path, the path of chance and the temporary path. As the names of the paths indicate, the reasons why nurses became managers vary and, thereby, their attitudes towards their role vary as well (Bondas, 2006).

The effect of role change on available time
Nicklin (1995) pointed out that there is a risk of increased workload when the transition from head nurse to FLNM is not planned and analysed beforehand. Her opinion is that although the workload does change, it should not increase (Nicklin, 1995). Studies have shown no difference regarding perceived job tension between veteran and new FLNMs (Hess & Drew, 1990). Both groups worked overtime, the experienced managers 10 hours a week, the novice head nurses twice as much (Dunn & Schilder, 1993). Time seems to be a scarce resource for FLNMs. Constricting rules, needless tasks and performing duties that were accepted by some and not by others are reported to create role conflict (Tumulty, 1992). When they had problems managing their duties while at work, some took work home (Westmoreland, 1993; Willmot, 1998) or adjusted their work so they were available to all shifts (Westmoreland, 1993).

In summary, the descriptions of the FLNMs’ responsibilities show similarities. With some exceptions, FLNMs seem to have 24-hour responsibility for personnel, economy and the services at the unit. In terms of the roles they have in the framework of their responsibility, there are also similarities (Table 1). But studies also show differences with regard to factors such as workload, staffing responsibilities as well as the FLNMs’ own leadership style. Their work is described as fragmented, and they shoulder a heavy workload characterized by lack of time, and as a consequence, overtime work.

Organizational conditions

Swedish Health Care
In Sweden, the majority of health care is financed, administrated and provided by county councils. The county councils are independent regional
political units. Laws and ordinances establish the guidelines and principles for health care, as do agreements with the Swedish Association of Local Authorities and Regions (Karlström, 2007; The Swedish Institute, 2007).

In Sweden there are 18 county councils, two regions and one municipality that have the responsibility for health care. The services consist of 1000 health care centres, 65 county or district hospitals and 8 regional hospitals. The county councils are free to organize their services to suit their specific needs and prerequisites. They must take into consideration, however, the statutes of the National Board of Health and Welfare that describe the responsibility at three organizational levels: that of the caregiver (the political level in the county councils), the head of department and the responsibilities of individual health care personnel, for example registered nurses and physicians (Falk & Nilsson, 1999; The Swedish Institute, 2007).

In the mid-1950s the matron’s role (matron is used here as a unifying term for the head nurse/nurse manager/nurse director at the hospital level) was under discussion; their workload was high and their sphere of responsibility wide (Rydholm, 1992). In 1963, a new model for leadership and management at the hospitals was proposed, and the proposals in the inquiry were reflected in the health care legislation from 1962 to 1964. The hospital director had the overall responsibility for operations, and a chief physician was appointed as advisor. The roles of the matron were refined and a new function as clinical advisor was established at the departmental level; all nursing staff were organized subordinate to the matron. A new change was due at the beginning of the 1970s, and in the revised health care legislation, neither the matron’s work nor day-to-day work with patients was mentioned. The hospital managers’, medical advisors’, and head of departments’ as well as senior physicians’ responsibilities, however, were described. The issue of the matron as having a staff or line position was in focus, and a change towards a staff function became more and more common. At the end of 1970s, further changes within the organization occurred, and the clinical advisor as well as the nursing staff came to belong to the department structure, with the head of department as manager (Rydholm, 1992).

The FLNM’s role in a decentralized structure

The process of decentralization that was implemented in health care organizations during the 1980s is described as a strategy to meet the demands of complex environments (Nicklin, 1995; Ringerman, 1990). In a study from the US, Ringerman (1990) summarized five factors that influence complexity in health care: technological and scientific development; competitive diversification among hospitals; an educated nursing group that strives to participate; public interest in health care modalities and; the needs of an aging population. Within Swedish health care, financial strain and
demands for efficient management are described as motives for the change (Persson & Thylefors, 1999; Rydholm, 1992) as well as criticism of an excessively bureaucratic organization that lacks a patient focus (Richard, 1997). Kihlgren, Johansson, Engström and Ekman (2000) discussed how the 1982 Swedish health care act also came to contribute to the changes, as it does not regulated in detail the management of health care. In the process of decentralization, the FLNM’s role has expanded in terms of scope and accountability (Kihlgren et al., 2000).

The changes seem to be similar across contexts and have been described by authors from the US (Everson-Bates, 1992; Krejci, 1999; Ringerman, 1990), Canada (Acorn & Crawford, 1996; Baxter, 1993; Fullerton, 1993; Nicklin, 1995), the UK (Bradshaw, 1995; Doherty, 2003; Kitching, 1993; Willmot, 1998), Australia (Duffield, 1989; Duffield et al., 2001), Asia (Wong, 1998) and Sweden (Nilsson, 2003; Persson & Thylefors, 1999; Petersson, 1993; Richard, 1997). The concept or term decentralization, due to its complexity, has been described as somewhat difficult to outline (Mintzberg, 1983; Södergren, 1992). Robbins (1983) maintained that, in decentralized organizations, decision-making is not concentrated to one point in the organization. In her thesis, Södergren (1992) investigated the decentralization process in Swedish companies and described how decentralization has been studied as a symbolic change from different perspectives, for example from top-down, organizational structure, and decision-making perspectives, or from the perspective of basic operations. Based on her empirical material, she presented three major components of decentralization processes: changes in structure, formal responsibilities and control systems; changes in working roles and competence profiles; and changes in organizational priorities and attitudes towards organizational efficiency. She described how the greatest changes in the companies seemed to be for local managers (some at first-line, but also among middle managers). As a consequence of decentralization, their range of tasks and responsibilities had became broader and they were also expected to adapt to another managerial role (Södergren, 1992).

Prior to decentralization, the role had focused on patient care. In a Swedish study by Kerstell and Gabrielsson (1976), the FLNM was described as the leading nurse at the unit/ward, and her main tasks included direct patient care, indirect patient care and unit/ward issues. The latter included methods, planning, equipment, staff development and education, administrative (staff) co-operation and representing the organization externally. The changed conditions have affected the FLNM’s work, transitioning it from a focus on patients to a focus on management (Kerstell & Gabrielsson, 1976). In order to perform a role that meets these new demands, changes are required to ensure quality of care and empowerment of staff (Flarey, 1991). In nursing organizations, decentralization has been shown to enable staff nurses to make decisions regarding nursing (Fullerton,
As a result of the decentralization process, nurses are more directly involved in decision-making, which among other things increases their job satisfaction (Acorn et al., 1997; Ringerman, 1990). Job satisfaction is considered to be a predictor of organizational commitment (Acorn et al., 1997). In a study by Tumulty (1992), out of the six tested components of job satisfaction, autonomy was reported to be the most important.

Furthermore, the shift towards decentralization has been described as an increase in accountability with regard to time, number of units or programmes and an increase in responsibility, including budgets and personnel (Hall & Donner, 1997). The benefits of the role change have been described as: more effective budget management; enhanced problem resolution; decreased staff turnover rate due to enhanced staff satisfaction; a strengthened and more collaborative work environment; and improved staffing/nursing expertise (Nicklin, 1995:108-109). When FLNMs described changes in their role over a period of 5-10 years, they identified the major changes as job enlargement, emphasis on efficiency and issues regarding human resources (Thorpe & Loo, 2003).

Another consequence of decentralization has been shifts in responsibilities in the organization. Head nurses and ward sisters have become ward managers and, as a consequence of the changed responsibility, FLNMs are more often managers than clinicians (Duffield, 1991). One example of a similar change from the US is described: After head nurses had participated in a development programme, their title was changed to nurse manager (Kalo & Jutte, 1996).

The changing conditions of health care have affected the role of FLNMs, and changes in and devolvement of the role have been described in a number of studies, though there is little consensus (Duffield & Franks, 2001). The fact that differences in descriptions make comparisons difficult was highlighted by Oroviogoicoechea (1996). Carroll and Adams (1994) explained the lack of consensus in terms of differences in the health care systems. Furthermore, results have shown that opinions vary from nurse to nurse (Corser, 1995), between different groups (nurse managers, politicians, physicians) (Lindholm, Uden, & Råstam, 1999) and between the same groups working at different hospitals (Sanders et al., 1996).

Decentralisation in the County Council of Gävleborg

As in other health care organizations in Sweden and internationally, a decentralization process was initiated in the county council of Gävleborg (CCG) in mid-1980s, the aim of which was to give managers at all organizational levels total responsibility for services, including budgeting, finances, and human resources (Landstinget Gävleborg, 1987b). The reason for these changes was to create the necessary conditions for cost effectiveness and increased creativity, motivation and commitment. For the FLNMs, this re-
sulted in increased responsibility and authority as well as a change in their title, corresponding to their new management status (from head nurse to first-line nurse manager). A leadership policy was formulated by the department for human resources at the county council and was ratified by the governing board (Landstinget Gävleborg, 1987a). The policy included the number of management levels, and roles, limitations on duration of management positions and leadership development. Five management roles were identified: coach, administrator, visionary, employer and communicator. Although the duration of the commission was limited to one to six years for all managers, this policy was combined with permanent employment related to the managers’ profession. Accordingly, FLNMs had the right to return to a post as registered nurse when they left their managerial post. The idea was to make it easier for both the employer and the employee to end management commissions, making the decision to leave voluntary or, when at the employer’s initiative, at least less dramatic. Different initiatives for management support, such as mentoring and development programmes, were implemented (Landstinget Gävleborg, 1987a).

Close in time to the decentralization process mentioned above, a number of reorganizations were implemented in the county council, all of which aimed at getting better control over the increasingly strained budget. In 1993, there was a change in health care financing, from grants to a provider-purchaser organization. Four purchaser boards replaced the five hospitals local boards with elected politicians (Landstinget Gävleborg, 1992). During the following period, from 1993 to 1998, a number of reorganizations in the health care organization were realized. Primary care and hospital care were separated, and two new primary care organizations were established. The hospital structure was changed by merging five hospitals located in five towns into two hospital organizations with services in the five towns (Landstinget Gävleborg, 1994). Changes were also made within the hospitals and primary care organizations and in their areas of responsibility. After this five-year period, the reorganizations have continued, and at the beginning of the year 2000, the county council again had three hospitals, although with newly defined commissions (Landstinget Gävleborg, 2002a, 2002b).

FLNMs’ role change – a risk for conflicts

The notion that the change from head nurse to FLNM brings with it conflicts has been described in a number of studies. The conflicts between the practice of the nursing profession and the managerial role have been described in international (Cooper, 2003; Coulson & Cragg, 1995; Duffield, 1991; Firth, 2002; Willmot, 1998) as well as Swedish studies (Persson & Thylefors, 1999; Petersson, 1993; Richard, 1997). Although content with their new role, 78% of the managers in one study felt that the new responsibilities took
them away from their patients (Willmot, 1998). Bunsey, DeFazio, Pierce and Jones (1991) reported that it is more likely that FLNMs will perceive lower job satisfaction if their supervisors and the physicians do not approve of their time allocation. Because FLNMs have to interpret between two paradigms, between that of patients and caring and the administrative and economic paradigm, they experience loneliness and isolation (Westmoreland, 1993). Head nurses reported higher levels of work satisfaction when they did not work as charge nurses. At the same time, the head nurses in another study were relatively satisfied with activities related to direct patient care and patient care management, activities that accounted for a large percentage of their time. They also expressed dissatisfaction with secretarial activities and activities related to the working environment and equipment, although little time was spent performing such tasks (Lufkin et al., 1992). In another study, quality of care, achieving goals, and relationships with patients and staff were factors perceived to affect satisfaction (Sanders et al., 1996). Filling in when staffing was short was an area of conflict (Sanders et al., 1996; Willmot, 1998). Wong (1998) concluded that nurse managers are moving away from direct patient care and described them as “mental workers” (Wong, 1998:349) who still cared for patients, but not in a physical sense, rather with mental labour. The FLNMs in Richard’s (1997) study expressed a concern about losing their professional knowledge, as they found it difficult to prioritize time for patients and care. Some managers expressed anger when reporting that their role has changed from being patient centred to mostly dealing with management (Firth, 2002). It is reported that nursing staff and physicians believe nurse managers should allocate more time to direct patient care (Bunsey et al., 1991).

Some studies have also illuminated other professionals’ perceptions of FLNMs’ roles. Corser (1995) asked staff nurses to rate their perception of preferred activities for FLNMs. Opinions varied from nurse to nurse. The unit type at which the nurses worked appeared to be of significance for their perception. A Swedish interview study showed that opinions about nurse management (not explicitly concerning first-line) were influenced by the needs and interests of the group the informants belonged to (nurse managers, chief physicians, hospital directors and politicians) and that the groups’ knowledge affected their acceptance of nurses as managers. For example, chief physicians regarded medical knowledge as necessary for management, while the nurse managers argued for the importance of nursing knowledge (Lindholm et al., 1999).

In summary, decentralization of services within health care can be observed across different countries and health care systems. The FLNMs’ work situation seems to be characterized by lack of time and conflicting demands, and their possibilities to influence their day-to-day work are limited. Decentralization as such enables differences in the demands, mandates and
constraints associated with the FLNMs’ role. The expectations of subordinates and other professionals may also affect the delineation of the role or FLNMs’ way of adjusting to the demands, thereby shaping their role.

Skills and abilities in leadership and management

The individual manager’s personal conditions, such as personality traits, experience, abilities, skills and education, are factors that influence his/her possibilities to meet the demands and expectations of this managerial position. Although personal conditions are complex, the focus here is limited to skills and abilities.

In a study by Duffield (1994), an expert panel sorted 156 identified skills for FLNMs into Katz’s classification of technical, human and conceptual skills (Duffield, 1994). Most of the skills were defined as technical (49%), followed by human (34%) and lastly conceptual (17%). This result is consistent with Katz’s belief that technical skills are of importance to first-line managers. It is also thought to be congruent with the findings of Guglielmino, who described the required skill mix for first-line managers as being 47% technical, 35% human and 18% conceptual (Duffield, 1994).

The interest in knowledge about the skills that are required is linked to the changed role of FLNMs and to the fact that skills and abilities can be supported. A number of studies have focused on trying to understand more about what is needed in the changed roles of FLNMs. Some studies have focused on the concept of competence, still others on skills or abilities. The design and data collection methods vary, as do the participants: they are sometimes the nurse managers themselves, their superior or members of the staff. To get an overview of results from earlier studies, the findings have been analysed and categorized according to Katz’s framework of managerial skills; this categorization has been discussed with a colleague; see Table 2.
Table 2 FLNMs’ skills, abilities and competence categorized according to Katz’s framework of managerial skills

<table>
<thead>
<tr>
<th>Classification of competences and skills</th>
<th>Technical skills</th>
<th>Human skills</th>
<th>Conceptual skills</th>
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There may be a risk in categorizing the descriptions of competences, skills and abilities as is done in Table 2, but it nonetheless provides an overview that constitutes a good starting point for comparing results from the different
studies. Dubnicki and Sloan (1991), for example, included the category self-confidence, which could be understood as a personal characteristic rather than a skill, ability or competence. Persson and Thylefors (1999) did likewise, and also presented one category called “other individual personal characteristics”. All studies describe human skills to a varying degree. All except one (McNeese-Smith, 1996) that have used the Leader Practices Inventory (LPI) (Posner & Kouzes, 1988) included technical skills.

Different opinions about necessary skills and abilities

A number of variables, including demographic ones, have an impact on the rating of different skills (Care & Udod, 2003; Chase, 1994; Mathena, 2002). Clinical knowledge has been pointed out as an important variable, but there is no agreement on the extent to which this is important. Having enough knowledge to uphold the standards of care and having an interest in taking responsibility were agreed on. Managers at ICUs (Intensive Care Units) expressed the need for a strong ego, and experienced managers expressed the need for political skills (Everson-Bates, 1992). In a Swedish study Sellgren, Ekvall and Tomson (2006) compared what subordinates perceived to be important and their opinions about their FLNMs’ leadership performance using a questionnaire based on the change, production, employee (CPE) model. The group of subordinates’ mean values regarding perceived leadership, on all three dimensions, were significantly lower than the preferred values. Further, managers’ and subordinates’ ideas about preferred leadership were compared, revealing that the subordinates’ mean values for all dimensions were significantly higher. The largest difference was reported for production orientation (Sellgren et al., 2006). Another area of differing opinions is political skills; here, experienced managers expressed a need for such skills (Dienemann & Shaffer, 1993; Everson-Bates, 1992), whereas, in a study by Mathena (2002), experienced managers did not perceive such skills to be as important as did newer managers. Another difference between the groups was that the new managers focused on communication skills, whereas experienced managers perceived a range of skills to be of importance. Nurse managers and nurse executives at community hospitals ranked human relations/communication skills highest, whereas the nurse executives at university hospitals ranked nursing knowledge/clinical skills and management/business skills higher than human skills (Dienemann & Shaffer, 1993).

The fact that professionals other than RNs can hold the FLNM position is a situation that has been discussed with concern (Duffield & Franks, 2001). Mark (1994) put forward nurse managers’ ability to integrate their knowledge and experience from nursing into effective and appropriate decision-making. In addition, others have underlined the importance of
nursing leadership being effective and strong if it is to survive (Kitching, 1993).

In summary, the role of FLNMs has changed over time, as have the skills and abilities required of them. Depending, for example, on earlier experience as manager or professional, individual FLNMs have also developed different skills and abilities and may need to develop others. If FLNMs are to fulfil their role expectations, one important means of support is to help them develop their skills and abilities by offering development programmes. Such programmes give FLNMs the opportunity to succeed in their role and give organizations the opportunity to meet their responsibilities.

Supportive structures

Cunningham and Kitson (2000) reported that first-line nurse managers often are inadequately supported and prepared for their role. The need for ongoing support has been stressed in Kerfoot’s (1988) claim that it takes nurse managers 2-5 years to become comfortable in a new managerial position and Baxter’s (1993) question of whether one can expect head nurses new to their position to function as well as those with experience.

Kanter’s theory (1993) has been used to describe structural factors of importance to nurses’ and nurse managers’ work. Results have shown that middle managers report higher levels of empowerment than do first-line managers (Goddard & Laschinger, 1997) and that the FLNMs report higher empowerment than do staff nurses (Laschinger & Shamian, 1994). Managers who are empowered also empower other persons in their work environment, and when staff nurses perceive their FLNMs as confident and as having influence in the organization, it is more likely that they themselves will feel empowered (Kanter, 1993; Laschinger & Shamian, 1994). Supportive or empowering structures are important in retaining FLNMs, but they also indirectly influence RNs’ job satisfaction and work effectiveness, and it is further put forward that this is likely to affect their ambitions or attitude towards applying for management positions (Laschinger, Almost, Purdy, & Kim, 2004). Empowering work environments are more likely to lower the frequency of burnout among nurse managers and that they also promote better physical and mental health (Laschinger et al., 2004). The nurse manager’s behaviour, in turn, influences the nursing staff, as empowering behaviour on the part of nurse managers affected subordinates’ perception of formal and informal power and access to empowering structures. A high perceived level of or access to empowerment structures predicted low levels of job tension and increased work effectiveness among subordinates (Laschinger, Wong, McMahon, & Kaufmann, 1999).
Studies have stressed that positive attitudes and outcomes seem to be found in some hospitals, but not in others (Tumulty, 1992). In the 1980s, when there was a severe shortage of nurses, US hospitals that were able to attract and retain nurses were identified and designated as ‘magnet hospitals’ (Buchan, 1999). These magnet hospitals have been of interest over the years, as research has shown that staff members’ job satisfaction is better than average at these hospitals (Buchan, 1999; V. V. Upenieks, 2003a) and that mortality also seem to be lower than at non magnet hospitals (Aiken, Smith, & Lake, 1994). The hospitals have been characterized as organizations that emphasize “professional autonomy, decentralized structures, participatory management and self governance” (V. V. Upenieks, 2003a:84). Nurse managers in magnet hospitals has been described as supportive, visible/accessible, honest, positive, collaborative, good listener/communicator and empowering (V.V. Upenieks, 2003b). Laschinger, Almost and Tuer-Hodes (2003) described Kanter’s work as a possible forerunner to the characteristics of magnet hospitals. In their research, they show that dimensions of empowerment, as they are described by Kanter, were significantly related to all characteristics of magnet hospitals (Laschinger et al., 2003).

The FLNM’s superiors

Feeling the support of one’s immediate supervisor is of great importance to FLNMs (Cameron-Buccheri & Ogier, 1994; Coulson & Cragg, 1995). Such support is at risk, however, when an FLNM’s leadership style and expectations differ from those of the superior (Coulson & Cragg, 1995). The structure of the manager’s work and unclear role expectations may be the problem, rather than the individual manager (Hayes & Dunn, 1989). Lack of clarity may lead to lack of understanding and, thereby, to an absence of acceptance and support from people in the environment (Nicklin, 1995). The need for clarification to enhance understanding from other staff groups has been reported (Firth, 2002). One way to clarify the role and to give FLNMs the opportunity to receive support from their superiors is for FLNMs to share with their superiors the responsibility for clarifying expectations, values and boundaries (Coulson & Cragg, 1995). That is also of importance in relation to staff members, as changes in one role may lead to changes in the roles of other staff groups (Duffield, Pelletier, & Donoghue, 1994; Nicklin, 1995; Willmot, 1998).

When reporting the preconditions that make their work difficult, FLNMs mentioned a dysfunctional central management team, lack of information, lack of clarity regarding decision-making, regularities and structure of meetings as well as locked positions among the staff group members (Petersson, 1993). Acquiring adequate resources from senior administrators has been described as important (Thorpe & Loo, 2003). Examples of such
resources are secretarial support (Dunn & Schilder, 1993; Everson-Bates, 1992), providing administrative time and relieving FLNMs of charge nurse responsibilities (Dunn & Schilder, 1993).

The FLNM’s superior as a bearer of values and goals
A high degree of consistency between nurse managers’ activities and the expectations of their superiors has been reported (Bunsey et al., 1991). As nurse managers’ job satisfaction has been reported to be lower if there is a discrepancy between their time allocation and the expectations of superiors and physicians, support from superiors is of importance (Bunsey et al., 1991). Insufficient support and feedback from senior administrators have been described (Tumulty, 1992), as has the need for feedback (Dunn & Schilder, 1993; Tumulty, 1992). Superiors expressing their opinion about what they feel should be given priority has been shown to be of importance to newer nurse managers, as they have difficulties themselves in establishing priorities among their tasks (Westmoreland, 1993). Similar findings have been described by Dunn and Schilder (1993). In their study, the novice head nurses expressed a greater need for feedback than did their experienced colleagues. They also needed help in difficult situations and found it difficult to handle unclear job expectations (Dunn & Schilder, 1993). Experienced head nurses required less feedback than their inexperienced colleagues, but regarded the feedback they receive from their superiors as crucial (Dunn & Schilder, 1993). Feedback alone has been shown to predict 40% of the variance in head nurses’ job satisfaction (Tumulty, 1992). Flarey (1991) argued that nurse executives should establish goals for the new role to help FLNMs perform their new tasks in the role (Flarey, 1991). Measurement of outcomes is also described as a needed tool to help FLNMs’ superiors analyse how changes and innovations are being managed. The perceptions of RNs, support staff, physicians and patients as well as productivity, quality and fiscal variables and their measurements are described as outcome measures (Urden, 1996).

FLNMs’ possibilities of involvement
Apart from clearly expressed expectations, delineated goals and feedback, it is important that FLNMs be involved in changes regarding their role. The fact that FLNMs are not involved in the changes in their roles has been described by Willmot (1998). Nurse managers were discontented with their lack of involvement in the process, and fifty percent felt that the changes had been imposed on them. At the same time, the nurse managers were of the opinion that the change was needed and should have been made. Of the nurses who were content with their new role, one-third were unclear about its scope and their new responsibilities (Willmot, 1998). The responsibility
for managing the ward’s budget caused great anxiety among the nurse managers, and they expressed a lack of involvement in the process of setting the budget. Furthermore, the nurse managers felt they did not have the information needed to perform their duties adequately (Willmot, 1998). In a study by Knox and Irving (1997), nurse managers ranked ten statements describing desirable behaviours for health executives during periods of change. The results showed that most important were frequent information about the plan and its progress, followed by visibility on the units during the change and a verbalized commitment to the importance of patient care quality (Knox & Irving, 1997).

Colleagues as role models, networkers and mentors

Willmot (1998) reported that the nurse managers’ colleagues are a group that is perceived to be of help. The transition from clinical nurse to the role as FLNM has been described as somewhat of a shock (Everson-Bates, 1992), as the role change demanded that they stand up for “new” values, represent the employer and often lose support from earlier allies at work. In such a situation, the nurse manager needs peers as role models with whom they can share their problems (Everson-Bates, 1992).

Regular opportunities to share experiences with colleagues are helpful to FLNMs, as they learn that others have the same problems. This also helps them understand that their problems are not unique or solely dependent on their own perceived shortcomings (Westmoreland, 1993). Both veteran and new managers share the experience of learning and developing by listening to other FLNMs (Everson-Bates, 1992). The peer group of managers, especially those in the same clinical division, are regarded as those who provide the greatest personal, emotional, political and practical support (Coulson & Cragg, 1995). Hyrkäs, Appelqvist-Schmidlechner, & Kivimäki (2005) reported that clinical supervision is described by the FLNMs themselves as having positive long-term effects on leadership, communication skills, desire for self-development and coping.

Mentoring is reported to be an effective way of developing nurse managers (Mathena, 2002; Sanders et al., 1996; Waters, Clarke, Ingall, & Dean-Jones, 2003). By using members of the peer group, mentoring could be formalized, which could lead to greater continuity and adaptation to the role as well as to overall satisfaction (Sanders et al, 1996). Positive experiences of mentors have been reported. Mentors are described as successfully expressing their belief and confidence in the novice, and they were also described as encouraging (Allen, 1998). Yet Cunningham and Kitson (2000) reported that ward sisters do not view their colleagues as supportive.
Staff group and physicians

Nurse managers have voiced a need to explain what they do when they are not at the ward. They feel they have an understanding of the staff nurses, but that the understanding is not mutual (Westmoreland, 1993). Taking an active part in direct patient care has been described as one way of gaining respect and getting support from the staff (Firth, 2002). In a study by Tumulty (1992), head nurses had a more positive attitude towards their interaction with nurses than with physicians. Nearly half of the group perceived a lack of understanding and appreciation from the physicians and wished physicians would show more respect for their skills and knowledge. Nilsson (2003) reported that feedback from staff members is the kind of feedback that is perceived as most important, although other groups such as superiors and colleagues also provide valuable feedback.

In summary, some of the conditions in the organizational framework that can be important to FLNMs have been described and the importance of these conditions has been highlighted. Yet while these groups or structures may be of importance, they may also be perceived as demanding and in the worse case as stressful and as entailing conflicting demands.

Development programmes as means to prepare and develop

Changes in health care, marked by decentralization of responsibility and restructuring of services, have increased demands on FLNMs’ knowledge and skills (Allen, 1998; Duffield, 1991, 2005; Menix, 2000; Porter-O’Grady, 2003). Studies have also indicated that nurse managers are not particularly well prepared for their managerial responsibilities (Duffield, 1991; Hall & Donner, 1997; Kleinman, 2003; McGibbon, 1997; Roemer, 1996; Willmot, 1998). The advantages of educational activities prior to taking the post and of having the opportunity to continually participate in lecturers and development programmes have been described in earlier studies (Gould, Kelly, Goldstone, & Maidwell, 2001; Parsons & Stonestreet, 2003).

In Swedish health care, there are no special requirements for holding an FLNM position. For many years, an implicit requirement has been that the FLNM should be an RN or Registered Midwife. For those two professions, the description of qualifications includes leadership in one of three described competence areas (Socialstyrelsen, 2005, 2006). Still, it is most often the case that RNs hold FLNMs posts, but there are exceptions, for example, other health care professionals such as psychologists and social workers. But even general managers with no health care experience have been reported to hold FLNM posts.
In 1917, the Swedish Society of Nursing offered the first programme for matrons. The outline of the programme changed over the years, and in 1958, the government took over responsibility for providing RNs with an administrative as well as pedagogic education. From 1975 onwards, administrative training was transferred to the universities. These programmes have changed in content over the years, and the applicants are no longer only RNs (Rydholm, 1992).

Participating in continuing education is regarded by FLNMs themselves as very important (Sanders et al., 1996), as it both maintains and develops their competencies (Chase, 1994). In one study, experienced managers reported that on-the-job training was insufficient (Anthony et al., 2005). Some examples of areas that have been described as being in demand or that should be offered in development programmes are: managing conflicts or disturbances and understanding unit budget management (Baxter, 1993; Persson & Thylefors, 1999), problem solving, team building, leadership (Coulson & Cragg, 1995; Persson & Thylefors, 1999), computer skills and staff development (Coulson & Cragg, 1995), personal growth (Persson & Thylefors, 1999), and organizational knowledge (Thorpe & Loo, 2003).

Everson-Bates and Fosbinder (1994) maintained that a master’s level degree should be recommended for nurse managers, as managers with this level of education reported that the degree gave them confidence in their role (Everson-Bates & Fosbinder, 1994). Fullerton (1993) found it difficult to support the opinion that the master’s level is necessary, as other types of training programmes have helped managers develop the necessary skills. Participants’ educational background has been shown to influence recommendations for education; their own type of education was the type that was recommended (Krejci, 1999).

Examples of development initiatives

Leadership development activities differ in character, from courses at the university level to education programmes sometimes focused on specific topics. When reviewing the literature, a number of studies were found that describe training/development programmes for nurse managers. In one Australian study, topics had been suggested by the nurse managers themselves (Duffield, 2005). In other studies, the course was put together in a collaborative effort between health care organizations and universities (Greenwood & Parsons, 2002b; Tourangeau, Lemonde, Luba, Dakers, & Alksnis, 2003).

The form of the interventions has varied from 2-day workshops (Krugman & Smith, 2003) to a programme that spanned over 24 months (Sullivan, Baumgardner, Henninger, & Jones, 1994). A number of the training programmes were combined with peer teams/support (Kalo & Jutte, 1996) and mentoring (Cooper, 2003; Henninger, Jones, Baumgardner, &
All the programmes covered leadership knowledge and some also included managerial perspectives, for example strategic planning and fiscal issues (Greenwood & Parsons, 2002a, 2002b; Henninger et al., 1994; Johnson & D'Argenio, 1991; Kalo & Jutte, 1996; Simpson et al., 2002; Sullivan et al., 1994; Tourangeau, 2003).

Overall, participants in development programmes were content with the intervention and their own accomplishments. However, disparate results from self-ratings after development programmes have been reported, both significant improvements (Cooper, 2003; Krejci & Malin, 1997) and non-significant improvements (Tourangeau et al., 2003). In the self-report, established leaders scored higher than did aspiring leaders (Tourangeau et al., 2003).

In summary, the outlines of the development programmes found in different studies vary from focusing on leadership alone to a combination of leadership and managerial skills. Moreover, in the studies, different ways of preparing the outline of the programme have been described. The results from self-assessments after participation were also different.

Resignation from managerial positions

Seventy to seventy-nine percent of the FLNMs in American and Australian studies (Johnstone, 2003; Parsons & Stonestreet, 2003; Stengrevics, Kirby, & Ollis, 1991) and 45% in a Swedish study planned or were happy to stay at their posts (Persson & Thylefors, 1999). When comparing the FLNM profiles from 1989 and 1999, Duffield et al. (2001) showed that, although the FLNMs had more working experience, a decrease was found in the number of years in the current position, which could indicate an increase in turnover (Duffield et al., 2001). In another Australian study, of those registered as nurse managers in 1990, 19% no longer had a nurse manager post ten years later (Johnstone, 2003).

A number of models have been developed to explain turnover, and they vary in complexity and the factors used. In a path analysis based on meta-analytic findings, Tett and Meyer (1993) showed that job satisfaction and organizational commitment each contributed independently to the prediction of turnover intention. They found in addition that turnover intention/cognitions is predicted more strongly by satisfaction than by organizational commitment and that turnover intentions are the strongest predictor of turnover (Tett & Meyer, 1993). In a study attempting to explain turnover among nurses, it was suggested that job satisfaction only has an indirect effect on the turnover intention; organizational commitment had the
most direct and strongest impact on leaving, and satisfaction with pay had both an direct and indirect effect on turnover intentions (Lum, Kervin, Clark, Reid, & Sirola, 1998).

In a study by Johnstone (2003), nurse managers were asked to select and rank among 14 factors what caused them to leave their job and to rate 10 statements dealing with their intention to stay. The results showed that 70% had left their jobs for “positive” reasons, i.e. personal or/and professional. The remaining 30% made their change because they found their situation dissatisfying, stressful and/or unbearable. It has also been suggested that insufficient preparation for the managerial role has an effect on rapid turnover (Duffield, 2005). Clearly expressed expectations and involvement in planning and decision-making are important factors for nurse managers’ retention (Parsons & Stonestreet, 2003). Duffield et al. (2001) pointed to high turnover among FLNMs as a problem, as turnover entails loss of leadership ability and talent.

Independent of the model used to explain an organization’s turnover, knowledge of organizational conditions or factors will enable planners and managers to minimize costs or loss of efficiency or perhaps to prevent someone from quitting (Morrell, Loan-Clark, & Wilkinson, 2004; Price, 2001).

In a Swedish study, ward managers were asked about their future professional plans (Persson & Thylefors, 1999). Fifteen of 33 FLNMs answered that they wished to continue in their role. Reported motives were that they were engaged and content in their role, they perceived themselves as being too old for new roles or for returning to nursing, or that they were new as managers and felt they could still accomplish things. In the same study, of the 17 FLNMs who intended to leave, only three had plans to return to nursing. The FLNMs in the study described management as a direction or a choice that could make it difficult to go back to nursing (Persson & Thylefors, 1999).

In summary, the reasons that FLNMs leave their post vary from discontent with their work situation to reasons of a positive character, both professional and personnel.
Problem statement

Although FLNMs’ role, skills and abilities, reasons for leaving management and contextual conditions, such as support and experience of development activities, have been studied earlier, little of this work has concerned the Swedish context. Results from previous studies correspond in many respects, in that health care decentralization has led to changes in the role of FLNMs. At the same time, personal conditions, such as skills and abilities, and managerial experience vary, as do organizational preconditions, such as mandates and supportive structures. Because conditions seem to vary and be interrelated, allowing scope for differences across different contexts, it would be interesting to study personal and organizational factors within the framework of one organization.

Aim

The overall aim of the present research project was to study and describe organizational conditions for first-line nurse managers and to identify and assess skills and abilities important to their leadership and management.

The specific aims were:

- To study first-line nurse managers’, registered nurses’ (RN), assistant nurses’ (AN) and head of departments’ (HD) perceptions of the first-line nurse manager’s current and desired roles.

- To estimate the validity and reliability of the Leadership and Management Inventory (LaMI), a tool designed to measure the skills and abilities of first-line nurse managers.

- To study the expectations related to and the experiences and outcomes (i.e., leadership and managerial skills and abilities) of two development programmes for first-line nurse managers that focused on organizational knowledge and personal growth, respectively, and to compare the outcomes with those of a comparison group.

- To investigate the reasons for first-line nurse managers to resign, their perceptions of difficult situations as a manager, and their experiences of support and satisfaction with work.
Method

Setting

The study took place in a Swedish county council, with hospitals and primary care organizations serving slightly more than 270,000 inhabitants.

The health services had three levels of management in their organizational structure: the hospital/primary care director, head of department/head of primary care centre and first-line manager. The hospital/primary care director’s group of staff included the positions of nursing director, finance director and human resources (HR) director. Within the hospitals and primary care organizations, there were also, depending on the organizational size, units or specialists in finance and human resources. The heads of department were most often physicians, although some departments, and not only nursing departments, had nurses as heads. Registered nurses most often held the posts as first-line nurse managers, but in psychiatric care, other professionals also held the managerial posts at first-line, for example psychologists, social workers and assistant nurses. At the laboratory service, those with special training in laboratory medicine held the posts. The dominant organizational structure at the departmental level has been departments for different medical disciplines encompassing outpatient clinics and one or more wards. At one time, there were nursing departments at two of the hospitals. At the nursing departments, the organization of beds did not follow different specialities, which resulted in a mixture of patients. At the same time, the outpatient clinics for the medical specialties in question have been separated and heads of department have been appointed for each.

Overview of study designs

In Table 3, an overview of the design in the different studies is presented together with descriptions of samples, year of data collection and the data collection methods used.
Table 3 Overview of study designs, sample, year of data collection and data collection methods

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Sample</th>
<th>Year</th>
<th>Method</th>
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<tbody>
<tr>
<td>Study I</td>
<td>Descriptive design</td>
<td>5 FLNMs, 5 RNs, 5 ANs, 1 HD</td>
<td>1997</td>
<td>Interviews</td>
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<td>Study II</td>
<td>Cross-sectional and psychometrically explorative design</td>
<td>149 RNs in sample I and 197 HCP in sample II</td>
<td>2001</td>
<td>Questionnaires</td>
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<tr>
<td>Study III</td>
<td>Descriptive, comparative and prospective design</td>
<td>42 FLNMs</td>
<td>2001 and 2002</td>
<td>Questionnaires (2 data collection points) Group interviews (4 data collection points)</td>
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<tr>
<td>Study IV</td>
<td>Descriptive and retrospective design</td>
<td>32 former FLNMs</td>
<td>2001</td>
<td>Questionnaires and letters</td>
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Study I - current and desired roles

Design
The design of the study was descriptive.

Subjects
The participants were 16 nurses from a newly formed nursing department with five wards. The head of department had 5 years’ experience as HD. The five FLNMs at the department were between 42 and 55 years of age and had from one to 18 years of managerial experience. The five RNs were from 38 to 52 years of age with 1 to 21 years experience as registered nurses, and the five ANs were 41 to 55 years of age with 5 to 30 years experience as assistant nurses. The RNs and ANs were randomly selected (by the drawing of lots). All except one of the 16 informants were women.

Data Collection
Semi-structured interviews were conducted to gather data about the present and desired roles of FLNMs, about important responsibilities for FLNMs and about the manager’s role in development of care. In addition, the FLNMs were asked to describe a working day in two ways: as it is in reality
at present and as it should be under ideal circumstances. Follow-up questions such as “Would you elaborate on that?” and “You said …, what do you mean by …?” were posed.

Procedure
Permission to perform the study was granted by the head of department. The HD and FLNMs were informed about the study’s aim and design. After the HD and all five FLNMs agreed to participate, the HD presented a list of all the staff. Staff from each of the five wards were identified as either assistant nurses or registered nurses. One RN and one AN were then randomly selected from each ward (by the drawing of lots). After being contacted by phone, informed about the study and told that participation was voluntary, all RNs and ANs agreed to participate. The interviews were performed in 1997 in a place near the respondents’ workplace at times suitable to the participants.

Data analysis
The interviews were analysed by manifest and latent qualitative content analysis (Sandelowski, 2000) using concepts and procedures described by Graneheim and Lundman (2004). In manifest content analysis, the written words are used as the basis for analysis. In the latent content analysis, the aim is to find underlying meanings in the text (Down-Wamboldt, 1992). The manifest analysis answers the question “what” and the latent analysis the question ”how” (Krippendorff, 1980).

The texts were read and re-read in order to facilitate understanding of and familiarity with the text. The meaning units, i.e., a word, a sentence or a paragraph were identified, condensed and given a code. The meaning units and the codes were constantly compared to establish congruence in the coding. The meaning units corresponded to the current and desired roles. The codes were sorted into the ten roles described in Mintzberg’s (1973) theory of managers’ working roles. The codes were grouped into categories that were continually compared during the process. The analysis continued in order to discover themes, that is, the latent content of the text.

Study II – psychometric properties of LaMI

The development of the first version of LaMI
Study II is based on interviews with 19 persons focusing on “the competent FLNM”. The purpose of developing the LaMI was to measure the skills and abilities of first-line nurse managers. (See Study II for a detailed
description). The interviews were transcribed verbatim and statements that described competent FLNMs were extracted from the texts and formed a pool of statements. Working on the basis of relevant literature, using an inductive approach and by rejecting items that addressed the same aspect, the statements were grouped into topics. The six topics were: organization and assignment; information and communication; social skills and interpersonal relations; development and support of subordinates; cooperation; and analysis and decisions, in all 56 items. An initial, tentative principal component analysis (PCA) was performed on data from a sample of RNs who had assessed the FLNM on their ward.

Unclear understanding, items without correlation with other items in the correlation matrix, items with high correlation with each other, and items with cross-loadings on two different factors in the rotated factor loading matrix were the criteria for rejection, in all 28 items were rejected. Figure 2 presents the items in the LaMI.
He/she

1. Knows about and understands how the hospital functions at the organizational level
2. Can describe and explain decisions made at the hospital or county council level
3. Can describe and explain the consequences of political decisions
4. Recognizes and makes connections between the goals of the ward/unit and those of the hospital
5. Contributes to the development of goals for the ward
6. Sees to it that the ward’s/unit’s goals are reached
7. Knows where in our organization he/she can get help with various questions
8. Knows how to make an impact and pursue questions at the clinic management and hospital level
9. Knows about the ward’s and the clinic’s financial conditions
10. Has knowledge about laws, agreements and guidelines affecting hospital personnel
11. Provides information in an intelligible manner
12. Listens to the opinions and viewpoints of personnel
13. Can easily make contact with other people
14. Makes assessments, positive and negative, in a constructive manner
15. Is tolerant of other people’s mistakes
16. Is consistent in what he/she says and does
17. Acknowledges and takes responsibility for his/her own mistakes
18. Is clear about requirements and expectations
19. Sees to it that what has been agreed upon gets done
20. Doesn’t discriminate – values the work efforts of all personnel
21. Is active in and supportive of personnel development
22. Takes the initiative in working towards improvements
23. Trusts in his/her co-workers and their competence
24. Inspires and motivates co-workers
25. Works consciously to improve the team spirit and atmosphere in the personnel group
26. Delegates tasks correctly
27. Takes the initiative in promoting co-operation and encourages co-operation between his/her own unit and other units
28. Deals with problems and conflicts in time

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<tr>
<th>Item</th>
<th>Not at all</th>
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<th>To some extent</th>
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<th>To a very large extent</th>
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**Figure 2** Items included in the questionnaire LaMI
Design
The design of the study was cross-sectional and psychometrically explorative.

Subjects
Two data collections with two different samples of participants were performed. In the first sample, 300 registered nurses (RN sample) were included, 149 of whom (50%) returned usable questionnaires. The RNs had worked with the FLNM they evaluated for an average of 42.4 months (SD 40.0). Length of acquaintance varied between 1 month and 20 years, 55% had known their manager over 2 years and 63% perceived that they knew their manager well or very well.

In the second sample, 225 health care personnel (HCP sample) were included and 197 persons (88%) answered the questionnaire. They had various professions: registered nurses, nurse assistants and other professions such as social workers, psychologists and medical secretaries. Four persons did not state their occupation. The HCP had worked with the FLNMs they evaluated for an average of 36.1 months (SD 34.5). The length of acquaintance varied from 1 month to over 20 years, 45% had known their manager over 2 years and 55% stated that they knew their manager well or very well.

Data Collection
The LaMI was devised based on interviews within the organization. In order to give the questionnaire structure, the items were sorted into six groups: 1) organization and assignment, 2) information and communication, 3) social skills and interpersonal relations, 4) development and support of subordinates, 5) cooperation, and 6) analysis and decision. The items were formulated as statements, e.g., “Trusts in his/her co-workers and their competence” and “Sees to it that the ward’s/unit’s goals are reached”. There were five response alternatives: 1) not at all, 2) to a small extent, 3) to some extent, 4) to a large extent, and 5) to a very large extent. High scores are more desirable. The respondents were also asked to state how long they have worked with the particular FLNM in her/his capacity as manager and to state “how well do you know each other” by choosing one of four alternatives: 1) almost not at all, 2) rather well, 3) well and 4) very well.

Procedure
In spring 2001, three hundred RNs were identified by selecting every fifth person from a list of all employed registered nurses at two hospitals. In a letter, the study was described and a self-addressed envelope was enclosed.
In autumn 2001, HCP whose FLNM participated in a study focusing on development programmes participated. The FLNMs handed out a letter with information, the questionnaire, and a self-addressed envelope to five subordinates. These five persons had been randomly selected from the group of staff in each manager’s unit.

Data analysis
A principal component analysis with varimax rotation was performed to reduce the items to a number of factors (Tabachnick & Fidell, 2001). Bartlett’s test of sphericity was used to assess the factorability of the correlation matrix. Bartlett’s test is recommended when there are fewer than five cases per variable (Tabachnick & Fidell, 2001). Kaiser-Meyer-Olkin’s (KMO) measure of sampling adequacy was also used to assess factorability. Results from the scree test, eigenvalues together with interpretability of the factors have been taken to account when determining the number of factors (Tabachnick & Fidell, 2001; Watson, 1998; Watson & Thompson, 2006). Internal consistency expressed as Cronbach’s alpha values was calculated for the factors and for the questionnaire to estimate reliability. To study the occurrence of bivariate correlations between the included items and factors, Pearson’s correlation coefficient, two-tailed test, was used. Missing values were replaced by the mean values. The total scores for the factors have been transformed to values between 20 – 100 by summarizing the scores of items in a factor, dividing them by the maximum score, and multiplying by 100.

A PCA of the 28 items in the LaMI was first performed using data from the RN sample. Moreover, in a second step, in order to test these results, data from the HCP sample were used to perform another PCA with varimax rotation.

Study III – expectations, experiences and outcomes of development programmes

Design
The design of the study was descriptive, comparative and prospective.

Subjects
A total of 42 FLNMs participated in the study, 13 in a “Training Programme”, 15 in a “Leadership Development Programme” and 14 in a Comparison group.
With few exceptions, participants in the three groups were registered nurses, although some were psychologists, social workers, assistant nurses or specialists in laboratory medicine. In all three groups, women were in the majority (77 - 86%) and most were born between 1951 and 1960. Most of the FLNMs had attended some kind of development programme for managers (79 - 92%). Their experience as managers varied between 4.5 (SD 4.0) and 7.9 (SD 8.8) years. They had worked in their current position between 2.8 (SD 2.5) and 5.2 (SD 5.6) years. There were no differences between the groups.

Development programmes
The need for development programmes for FLNMs had been identified by the county organization. In response to this need, training officers from the county council human resources (HR) unit conducted interviews with nursing directors, heads of department, first-line nurse managers and union representatives to learn more about these expressed needs. Based on the interviews, the training officers suggested that two programmes be initiated by the county council HR unit: one programme aimed at strengthening FLNMs in their role and the other at giving them information about the county council operations. The reason for organizing two programmes was based on the training officers’ experience of arranging development programmes aimed at strengthening FLNMs in their roles. Different structures, lecturers, and programme durations were needed to address the two areas of interest. Another factor supporting the suggestion to use two programmes was that some of the FLNMs had already participated in one of the suggested development programmes. The overall purpose of the development programmes was to strengthen the FLNMs in their role.

The aim of the Training Programme - TP was to make day-to-day work easier for the FLNMs by giving them information about the county council and the hospital or primary care organization in which they worked.

The aim of the Leadership Development Programme - LDP was to support and strengthen the FLNMs in their role and to give them opportunities to discuss, define and reflect on their role, themselves as leaders and their scope of action.

Data Collection
Group interviews
Data were collected at 4 occasions from participants in the TP and LDP: before the start of the development programmes, during the programmes, directly after and 4-5 months after the programmes. Group interviews took place in smaller groups with 2-5 persons at a time. The participants were informed about the study and had the opportunity to ask questions. Before
the start of the development programmes, the question posed to the groups was “What are your expectations regarding the forthcoming development programme?” At the interviews during and after the programme, the groups were asked “Can you please tell me about the development programme?” “Does it meet your expectations?”

The Comparison group - CG met in smaller groups for four interviews, two of which were coordinated with the distribution of questionnaires. No further contact was made with the CG participants and they were not offered educational interventions.

Questionnaire
The Leadership and Management Inventory - LaMI was designed to study different aspects of FLNMs’ skills and abilities (II); see page 40.

A study-specific questionnaire covering questions about age, sex, education, previous experience of management development, professional experience (years), management experience (years) and type of unit, access to mentor or network and group supervision. One question addressed their thoughts about leaving the managerial post during the period of the study. One reminder with questionnaires was sent at baseline and follow-up.

Procedures
When FLNMs working at wards and outpatient clinics in hospitals and primary care organizations at the county council were invited to participate in the two development programmes, in all about 110-120 persons, they were at the same time briefly informed about the intentions of the study and told that participation was voluntary. After receiving confirmation from the human resources unit about admission to the development programmes, the participants were informed by letter about the study, including information stating that participation was voluntary and that they had the right to discontinue at any phase of the study. The FLNMs not participating in the development programmes were invited to participate in a comparison group (46 persons). Two training officers at the county council’s human resource unit selected the participants in the two development groups. The purpose was to form two groups as similar as possible regarding length of experience as FLNMs, profession, earlier participation in any development programme for managers, sex and type of unit. See Figure 3 for inclusion and drop out.
Data analysis

Group interviews
Interviews were analysed utilising qualitative content analysis. As in Study I and IV, procedures and concepts suggested by Graneheim and Lundman (2004) were followed. The transcriptions were read and re-read, and “meaning units” concerning expectations and experiences of the development programmes were identified and coded. The meaning units and the codes were constantly compared to establish congruence in the coding. The codes were grouped into categories that were continually compared during the process.

Questionnaires
As the groups were small, non-parametric test have been used (Polit & Beck, 2004): Wilcoxon’s Signed Rank test to test within-group differences between baseline and follow-up, and the Kruskal-Wallis and Mann-Whitney U test for comparisons between the groups. Reliability (internal consistency) of the study instruments was expressed as Cronbach’s coefficient α; p-value < 0.05 was considered statistically significant.
Study IV- reasons to leave

Design
The design of the study was descriptive and retrospective.

Subjects
Of the 43 FLNMs who had left their managerial positions during 1999 and 2000, 37 responded to the invitation to participate. A lack of trust in management was the reason one person gave for not participating in the study. The 32 persons who both answered the questionnaire and wrote a letter were included in the study. The mean stay at the latest managerial post was 8.2 years (SD 6.3).

Data collection
Study specific questionnaire
The participants were asked to state whether the reorganization, other changes or other personal factors were the reasons to leave their post and to state their length of tenure in their most recent post. Further, they were asked to state how they perceived their work situation as an FLNM the past year and current year, and to describe their present work situation. For the last three questions, they had to choose between five alternatives, ranging from very good to very bad.

Letter
The participants were asked to write, in the form of a letter, about their main reasons for leaving the post as manager, difficult situations in the role as manager, support that was given to handle difficult situations, and support that would have been of help in the difficult situations. The letters were used as an alternative to interviews, as the subject was considered delicate.

Procedure
After the hospital directors had been informed about the intention of the study and had approved it, the human resources directors at the two hospitals were contacted. They provided lists of FLNMs at units providing care who had left their position during 1999 and 2000. In 2001, a letter describing the study, including information stating that participation was voluntary, was sent to these managers together with a questionnaire containing five questions and a request to write a letter addressed to the researcher BS. One reminder was sent together with a copy of the questionnaire.
Data analysis

Letters
The letters were analysed using manifest and latent qualitative content analysis (Sandelowski, 2000), and the concepts and procedures described by Graneheim and Lundman (2004) were used.

The texts were read and re-read in order to facilitate understanding of and familiarity with the text. Three content areas representing the aims of the study were identified along with meaning units corresponding to them. The meaning units were identified, i.e., a word, a sentence or a paragraph was condensed and given a code. The meaning units and the codes were constantly compared to establish congruence in the coding. The codes were grouped into categories that were continually compared during the process. Thereafter, the analysis continued until themes, revealing the latent content of the text, emerged.

Study-specific questionnaire
Descriptive statistics were used to describe reasons for leaving, number of years at the latest managerial post, present situation and satisfaction with work years at the latest managerial post. Wilcoxon’s signed rank test was used for comparison of work situation at present and when working as an FLNM.

Ethical Considerations concerning Study I-IV
At the time when the present studies were conducted, ethical approval was not necessary for research addressing staff. The following considerations have been made to assure the rights of the participants. For Study I, the head of department gave permission to perform the study. Regarding Study II, III and IV, the county council Chief Executive was informed about the intentions, after which he gave his approval to carry out the studies. The presumptive participants in all four studies were informed about the intentions of the research, that their participation was strictly voluntary, and that they were free to withdraw at any point in the data collection. Regarding the interviews, the participants were given a guarantee that their answers would be kept confidential. The questionnaire was answered anonymously. A limited number of demographic questions were posed to the participants, and they were given the option to refrain from answering if they felt uneasy about it. A procedure with a personal code selected by respondents to the questionnaire used in Study III was implemented in order to safeguard respondents’ anonymity.
Summary of findings

Study I – current and desired roles

Study I was conducted to describe first-line nurse managers’ (FLNMs), registered nurses’ (RNs), assistant nurses’ (ANs) and head of departments’ (HDs) perceptions of the first-line nurse manager’s current and desired roles. When describing the current roles of the FLNM, the number of roles that each group mentioned varied across the four groups; see Table 4. The FLNMs themselves described all ten roles in Mintzberg’s theory (1973) and the RNs and ANs described several roles, whereas the HD focused on some of the roles. Four themes, one for each group, were identified and are presented in Table 4.

Table 4 Themes describing the current roles of FLNMs and categorization of roles according to Mintzberg’s theory of manager’s working roles as described by FLNMs, RNs, ANs and HD

<table>
<thead>
<tr>
<th>Informants and themes</th>
<th>Roles</th>
<th>Figurehead</th>
<th>Leader</th>
<th>Liaison</th>
<th>Monitor</th>
<th>Disseminator</th>
<th>Spokesman</th>
<th>Entrepreneur</th>
<th>Disturbance Handler</th>
<th>Resource Allocator</th>
<th>Negotiator</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLNMs – Smooth functioning of day-to-day work and well-cared-for personnel</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>RNs – Empowerment of and supporting the staff for the best of the ward</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ANs – Daily management with focus on patients and personnel</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HD – Care and empowerment of personnel leading to good patient care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

X - indicates that the role was described

When describing the current role, the FLNMs, RNs and ANs focused on the coordination of day-to-day activities contributing to a well-functioning service and care of patients. They also described the FLNMs’ work with recruitment, support, and development of the personnel when describing the
current role. The RNs, ANs and HD described how the FLNMs ensured that
the staff group was well informed. The RNs and HD described how the
FLNMs ensured participation in decision-making. In the interview, the HDs
focused on the FLNMs responsibilities for personnel, especially regarding
empowerment and staff well-being. A concordance in the descriptions is to
be found regarding the FLNMs’ current responsibilities towards the
personnel (Table 4).

When describing the ideal role, the number of roles varied across the four
groups; see Table 5. The FLNMs themselves and the ANs focused on six
roles and the RNs on seven. The HD focused on three roles. Four themes
describing the ideal roles of the FLNMs are presented in Table 5.

**Table 5** Themes describing the desired roles of FLNMs and categorization
of roles according to Mintzberg’s theory of manager’s working roles as
described by FLNMs, RNs, ANs and HD

<table>
<thead>
<tr>
<th>Informants and themes</th>
<th>Roles</th>
</tr>
</thead>
</table>

X - indicates that the role was described

Describing the desired/ideal roles, the FLNMs, RNs and ANs emphasized
service on the ward, the day-to-day work – the care of the patients – as being
the top priority (Table 5). The FLNMs expressed a wish to be able to work
with long-time planning and development of services. The RNs emphasized
coop-eration among the group of FLNMs. Another issue was for the FLNMs
to be updated on news and have knowledge about operations at the ward,
aspects of importance in developing day-to-day work. The ANs wished that
the FLNMs could prioritize spending time at the ward instead of attending
meetings within the hospital. The ANs further felt it would be ideal if
FLNMs facilitated participation in ward matters and opportunities to
influence decision-making at the ward. The HDs underlined the development
of services and co-operation with other nurse managers and expressed the importance of enabling staff to participate and contribute.

Study II – psychometric testing of LaMI

Study II was conducted to estimate the validity and reliability of the Leadership and Management Inventory (LaMI), a tool that has been developed to measure the skills and abilities of first-line nurse managers. Of the principal component analyses (PCA) of the RN sample, the solution with three factors was interpreted as meaningful and explained 65.8% of the variance; see Table 6.

Table 6 Rotated component matrix, eigenvalues, percentages of variance for the sample of Registered Nurses

<table>
<thead>
<tr>
<th>Factor name and items</th>
<th>Rotated solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal skills and group management</td>
<td></td>
</tr>
<tr>
<td>Presents understandable information</td>
<td>0.566</td>
</tr>
<tr>
<td>Listens</td>
<td>0.711</td>
</tr>
<tr>
<td>Interacts easily</td>
<td>0.547</td>
</tr>
<tr>
<td>Gives constructive criticism</td>
<td>0.630</td>
</tr>
<tr>
<td>Is tolerant of people’s mistakes</td>
<td>0.746</td>
</tr>
<tr>
<td>Consistent – what is said is done</td>
<td>0.707</td>
</tr>
<tr>
<td>Responsible for own mistakes</td>
<td>0.772</td>
</tr>
<tr>
<td>Values efforts of all personnel</td>
<td>0.742</td>
</tr>
<tr>
<td>Trusts co-worker’s competence</td>
<td>0.608</td>
</tr>
<tr>
<td>Achievement orientation</td>
<td></td>
</tr>
<tr>
<td>Contributes to goal formulations</td>
<td>0.743</td>
</tr>
<tr>
<td>Focuses on goal achievements</td>
<td>0.774</td>
</tr>
<tr>
<td>Clear about requirements and expectations</td>
<td>0.517</td>
</tr>
<tr>
<td>Sees to it that things get done</td>
<td>0.641</td>
</tr>
<tr>
<td>Active in personnel development</td>
<td>0.691</td>
</tr>
<tr>
<td>Initiates improvements</td>
<td>0.748</td>
</tr>
<tr>
<td>Inspires co-workers</td>
<td>0.609</td>
</tr>
<tr>
<td>Improves team spirit</td>
<td>0.638</td>
</tr>
<tr>
<td>Delegates correctly</td>
<td>0.617</td>
</tr>
<tr>
<td>Encourages cooperation</td>
<td>0.596</td>
</tr>
<tr>
<td>Deals with problems and conflicts</td>
<td>0.571</td>
</tr>
<tr>
<td>Overall organizational view and political savvy</td>
<td></td>
</tr>
<tr>
<td>Knows about hospital functions</td>
<td>0.754</td>
</tr>
<tr>
<td>Describes and explains decisions</td>
<td>0.753</td>
</tr>
<tr>
<td>Describes and explains consequences</td>
<td>0.782</td>
</tr>
<tr>
<td>Sees the whole picture</td>
<td>0.596</td>
</tr>
<tr>
<td>Knows where to find help</td>
<td>0.590</td>
</tr>
<tr>
<td>Knows how to make an impact</td>
<td>0.621</td>
</tr>
<tr>
<td>Knows about financial conditions</td>
<td>0.508</td>
</tr>
<tr>
<td>Knows about laws, agreements and guidelines</td>
<td>0.627</td>
</tr>
</tbody>
</table>

Initial eigenvalues 15.37 1.70 1.35
Initial percentage of variance 54.89 6.07 4.82
Percentage of variance after rotation 23.24 24.30 18.24
k: 28 9 11 8
The factors were labelled “interpersonal skills and group management”, “achievement orientation” and “overall organizational view and political savvy”. One item was assigned to a factor based on interpretation, although given a lower loading on the factor. Internal consistency measured as Cronbach’s-α varied between α= 0.90 - 0.95; see Table 7. Due to strong intercorrelation between the three factors (r = 0.73 - 0.83), a second order factor analysis was performed. Although the un-rotated analysis indicated a one-factor solution, a PCA forcing two factors and resulting in the higher-order factors “leadership and management factor” and the “organizational knowledge factor” was performed.

In the HCP sample, the PCA resulting in three factors was regarded as both interpretable and meaningful, and it explained 64.2% of the variance. As in the RN sample, the factors were labelled “interpersonal skills and group management”, “achievement orientation” and “overall organizational view and political savvy”. Cronbach’s-α for the factors varied between α= 0.88 and 0.96; see Table 7. Inter-correlations between the factors indicated the existence of second-order factors (r = 0.54 - 0.79). This second-order factor analysis was also forced for two factors and they were labelled, as in the RN sample, “leadership and management factor” and the “organizational knowledge factor”.

<table>
<thead>
<tr>
<th></th>
<th>Registered Nurses (II)</th>
<th>Health care Personnel (II)</th>
<th>First-line nurse managers (III), 3 groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal skills and group management</td>
<td>0.93</td>
<td>0.88</td>
<td>0.73 - 0.89</td>
</tr>
<tr>
<td>Achievement orientation</td>
<td>0.95</td>
<td>0.96</td>
<td>0.85 - 0.89</td>
</tr>
<tr>
<td>Overall organizational view and political savvy</td>
<td>0.90</td>
<td>0.90</td>
<td>0.83 - 0.85</td>
</tr>
<tr>
<td>Total scale</td>
<td>0.97</td>
<td>0.96</td>
<td>0.90 - 0.92</td>
</tr>
</tbody>
</table>

Study III – expectations, experiences and outcomes of development programmes

Study III was conducted to examine the expectations related to and the experiences and outcomes (i.e., leadership and managerial skills and abilities) of two development programmes for first-line nurse managers that
focused on organizational knowledge and personal growth, respectively, and to compare the outcomes with those of a comparison group.

The content analysis of the FLNMs’ expectations and experiences in both groups resulted in four categories: “Content and outline of the programme”, referring to statements regarding the topics, outline and comprehensiveness of the programme as well as the quality of the lecturers and the pedagogical approach; “The participants”, describing statements about the participants as the group they formed in the framework of the programme, the contacts they generated and their significance as a resource in the programme; “The overall value”, referring to statements regarding judgements about the value of the programme and descriptions implying that the knowledge has been reflected upon, used in day-to-day work as well as the knowledge’s consistency with the perceived “reality”; and “Organizational aspects”, referring to statements regarding the organization’s investments in the development programmes and management’s attitudes see Table 8.

**Table 8 FLNMs’ expectations and experience regarding the Training programme and Leadership Development Programme**

<table>
<thead>
<tr>
<th></th>
<th>TP</th>
<th>LDP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The content and outline of the programme</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>topics</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>outline</td>
<td>–/+</td>
<td>–/+</td>
</tr>
<tr>
<td>comprehensiveness</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>the pedagogical approach</td>
<td>x</td>
<td>–/+</td>
</tr>
<tr>
<td>quality of the lecturers</td>
<td>x</td>
<td>–/+</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The participants</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>as a group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>contacts they generated</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>significance as a resource</td>
<td>x</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The overall value</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>value</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>knowledge reflected upon</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>day-to-day use</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>consistency with reality</td>
<td>x</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Organizational aspects</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the investment</td>
<td>–/+</td>
<td>–</td>
</tr>
<tr>
<td>management’s attitudes</td>
<td></td>
<td>+</td>
</tr>
</tbody>
</table>

X expressed expectation, + expressed positive opinions, – expressed negative opinions

The participants in the Training Programme (TP) expected to gain knowledge about the operation of the organization, establish networks and share ideas with other participants. The participants in the Leadership Development Programme (LDP) expected to become more secure in their role, to
become a better manager and to get to know the other participants in the group.

The participants in the TP had gained an understanding of the organization’s operations and shortcomings; the meetings and dialogue with the other participants were appreciated and became a source for learning. They expressed dissatisfaction with some parts of the programme and with some lecturers. The participants in the LDP had gained an understanding of themselves, but also of how to use different methods and tools. They were not fully aware of the outline of the programme, which was described as demanding. Their experiences of the lecturer were both positive and negative. Testing, discussing and reflecting on ideas as a group was appreciated, and the contacts with other participants were described as enriching. They expressed a disappointment that the HDs had chosen a meeting at the hospital instead of attending a part of the programme.

Regarding the results from the participants’ self-assessment on the LaMI, the results at baseline and follow-up showed no differences between the groups. The changed scores in “overall organizational view and political savvy” showed a statistically significant difference ($\chi^2 = 8.10; p = 0.017$) between groups, TP and LDP ($Z = -2.68; p = 0.007$) see Table 9.

<table>
<thead>
<tr>
<th>Table 9 Differences between and within development and comparison groups at baseline and follow-up and change scores regarding LaMI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interpersonal skills and group management</strong></td>
</tr>
<tr>
<td><strong>Baseline</strong></td>
</tr>
<tr>
<td>Interpersonal skills and group management</td>
</tr>
<tr>
<td>Interpersonal skills and group management</td>
</tr>
<tr>
<td>p-value</td>
</tr>
<tr>
<td><strong>Achievement orientation</strong></td>
</tr>
<tr>
<td><strong>Baseline</strong></td>
</tr>
<tr>
<td>Achievement orientation</td>
</tr>
<tr>
<td>Achievement orientation</td>
</tr>
<tr>
<td>p-value</td>
</tr>
<tr>
<td><strong>Overall organizational view and political savvy</strong></td>
</tr>
<tr>
<td><strong>Baseline</strong></td>
</tr>
<tr>
<td>Overall organizational view and political savvy</td>
</tr>
<tr>
<td>Overall organizational view and political savvy</td>
</tr>
<tr>
<td>p-value</td>
</tr>
</tbody>
</table>

53
However, the two development programmes seem to have influenced FLNMs’ perception of their leadership and management skills and abilities. Participants in the Training Programme (TP) showed improvement regarding “Overall organizational view and political savvy” \((Z = -2.524; \ p = 0.012)\). Moreover, those that had attended the Leadership Development Programme improved regarding “Achievement orientation” \((Z = -2.120; \ p = 0.034)\). Internal consistency measured as Cronbach’s-\(\alpha\) is presented in Table 7.

### Study IV – reasons to leave

Study IV was conducted to investigate the reasons for first-line nurse managers to resign, their perceptions of difficult situations as a manager, and their experiences of support and satisfaction with work. When choosing between two alternative answers, eleven of the former FLNMs stated that they decided to leave due to reorganization or other changes, nineteen due to other personal factors and two indicated both alternatives see Table 10.

<table>
<thead>
<tr>
<th>Reason to resign</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reorganization or other change</td>
<td>11</td>
</tr>
<tr>
<td>Own accord</td>
<td>19</td>
</tr>
<tr>
<td>Reorganization or change and own accord</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Present situation</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not working</td>
<td>1</td>
</tr>
<tr>
<td>Retired</td>
<td>2</td>
</tr>
<tr>
<td>Not working in public sector</td>
<td>4</td>
</tr>
<tr>
<td>Teach at nurse college</td>
<td>1</td>
</tr>
<tr>
<td>Employed by the county council ((n=24))</td>
<td></td>
</tr>
<tr>
<td>First-line nurse manager</td>
<td>2</td>
</tr>
<tr>
<td>Registered nurse</td>
<td>15</td>
</tr>
<tr>
<td>Administrator and Registered nurse</td>
<td>4</td>
</tr>
<tr>
<td>Head of department</td>
<td>3</td>
</tr>
</tbody>
</table>

When comparing the participants’ perception of work satisfaction during their time as an FLNM with their current work, satisfaction was higher at present. At the time the study was completed, four of the participants worked outside the public sector, three did not work (two of them were retired) and one worked as a teacher at a nursing college. The majority, 24 of the participants, still worked within a county council, 2 as FLNMs, 3 as HDs, 15 as RNs and 4 as both RNs and administrators (Table 10). The participants
satisfaction with work had increased compared to when they worked as FLNMs (p < 0.001).

The letters further revealed their reasons for leaving the post see Table 11. Personal reasons mentioned were other employment, a feeling of being insufficient in the role, personal development or a need to wind down, and that they were through with being a manager. Other reasons concerned organizational factors, examples of which were early retirement, what came with this intermediate position, in between superiors and staff, as well as the unclear framework of the job and lack of authority. Lack of support from the HD and their relationship to the HD were other reasons to leave.

Table 11 Themes and categories describing reasons to leave, difficult situations and support of importance as described by former FLNMs

<table>
<thead>
<tr>
<th>Have to leave or have something to go to</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason to leave</td>
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In the letters, participants further described how they found it difficult to combine the expectations of the role with the current working conditions. The unclear work conditions and lack of interest and support from superiors and unclear authority and mandates together with different tasks such as implementing changes, staff matters of different kinds and finances were described as making their work situation difficult. The role had changed over time, with larger staff groups, increased responsibilities, more meetings and new tasks, which were perceived as difficult because they were not accompanied by new mandates. Implementing change was perceived as difficult, and not being part of the decision-making process made it difficult to feel confident about the change and to carry out practical tasks that followed the decisions about changes.

Although the support that the former FLNMs found important was available within the county council organization, they felt it could be difficult to benefit from it. Support from the staff, colleagues and from the
HD was important. It was also considered important that the county council follow a distinct course. Further an opportunity to participate in decision-making was essential. Fewer meetings outside the ward and help with practical tasks, such as staffing, were central, as were education and development.
Discussion

The overall aim of the present thesis was to study and describe organizational conditions for first-line nurse managers and to identify and assess the skills and abilities important to their leadership and management. The results showed that FLNMs, RNs, ANs focused on activities related to the service at the unit when describing the FLNMs’ present role, whereas the HDs focused on responsibility for the group of staff. When describing the desired/ideal role for FLNMs, the FLNMs themselves, the RNs and ANs further emphasized the service and the patients, whereas the HDs wanted the focus to be on development of services and cooperation. The skills and abilities that are important to FLNMs’ leadership and management, as they have been expressed in the Leadership and Management Inventory, are “interpersonal skills and group management”, “achievement orientation”, and “overall organizational view and political savvy”. Prior to their participation in two different development programmes, the participants expected to gain knowledge, establish networks, and understand the organization’s operation and to become secure in their managerial role. The expectations were generally met, although some negative experiences were reported related to the outline of the programmes and the attitude of some of the lecturers. When evaluating the outcome of the programmes using the LaMI, results showed that the participants perceived significant improvements, in the Training Programme regarding organizational knowledge and in the Leadership Development Programme regarding achievement orientation – a result that corresponds with the content of the programmes. The difficult situations the former FLNMs described during their managerial time were: unclear conditions; lack of interest and engagement from superiors; implementation of changes and reorganization of staffing and economy; and difficult staff matters. Aspects of support that were described as important were: personal, emotional and strategic support from the leadership, colleagues, and personnel; a distinct organizational course; practical conditions and support from specialists; and possibilities to participate in development activities and education. The reasons the former FLNMs stated for leaving their posts were personal, organizational and related to lack of support from and relationships to the HD.
Perception and practice of the FLNM’s role

In Study I, the first-line nurse managers, registered nurses and assistant nurses gave concordant descriptions of the FLNMs’ roles. They described a number of roles in the framework of the FLNMs’ work, focusing on daily management on the ward and well-cared-for patients and personnel. Regarding care for patients, these three groups seemed to have a similar understanding of what the FLNM’s role in caring for patients should be (I). This is interesting, as working with patients as a practitioner, a carer, or as a standards maintainer has been reported in a number of studies describing the roles and activities of FLNMs (see Table 1). Drach-Zahavy and Dagan’s (2002) study, in which time spent with different tasks was registered, showed that the head nurses spent as much as 41% of their time in clinical care.

The results of Study I further showed that when the FLNMs, RNs and ANs described the desired/ideal role for FLNMs, they further emphasized the day-to-day work at the ward, which comprised personnel and patients (I). That FLNMs have an important task in “organizing the day” at the ward, and “to care for the caregivers” was also described by Nilsson (2003:163). The RNs in Study I confirmed the FLNMs’ experience of not having sufficient mandates for their role and argued that FLNMs should have wider mandates (I) findings that are supported in other studies (Tumulty, 1992). The ANs in the same study voiced the need for FLNMs to be more present at the ward, and in this way also related their feeling that FLNMs have a great number of engagements outside the unit (I). The concern about FLNMs’ absence from the ward was expressed by nurse managers in a study by Firth (2002) and also implicitly described by the FLNMs themselves (I). An Israeli observational study presented different results, showing that the head nurses spent 73% of their time at the unit and 18% in their office (Drach-Zahavy & Dagan, 2002). The FLNMs in Study I expressed a wish to work with long-term issues and development of services. These ambitions are congruent with their superiors’ perception of what the role of FLNMs should comprise (I). That nurse managers seem to operate from a framework of short-term goals rather than long-term vision has be reported earlier (Manfredi, 1996). This could be explained by the character of the FLNMs work (Baxter, 1993; Nilsson, 2003).

In Study I, the head of department did not primarily describe FLNMs as having a role in care for patients, instead the focus was on caring for personnel as a way of achieving high-quality patient care (I). That opinion did not seem to create a conflict situation for the FLNMs, despite the fact that they themselves and the RNs and ANs emphasized care of patients and the day-to-day work on the ward (I). Superiors’ opinions about FLNMs’ time allocation have been claimed to be important to FLNMs (Bunsey et al., 1991; Coulson & Cragg, 1995). It may be that the FLNMs in Study I had
learned to handle the conflicting opinions about what to prioritize or that the support they perceived from their staff together with their own opinion, or perhaps conviction, was support enough. Another explanation could be that the HD provided sufficient feedback.

In Study IV, former FLNMs described challenging demands. For example, they have to allocate a great deal of time to meetings outside their unit, the personnel group is large, and the recruitment of staff takes a considerable amount of time (IV). Although the FLNMs have the same position, a number of factors are described that influence how they individually perform their role. Some factors are their own experience as an FLNM, their education, the workload at their unit, their leadership style, number of subordinates and the expectations placed on the FLNM. The fact that expectations placed on FLNMs can vary within the group of subordinates and between subordinates and superiors puts FLNMs in a vulnerable situation (Bunsey et al., 1991). Depending on their experience and skills, the FLNMs’ individual potential to handle that situation varies. As bearers of the organization’s expectations of the FLNM, the importance of their superiors’ support is indisputable.

Skills and abilities in leadership and management

The role as FLNM requires skills and abilities in both leadership and management. In management, one must be able to fulfil the duties encompassed by the formal post as manager. Regarding their formal role, FLNMs have faced changes over the years.

In Study II, testing the LaMI was in focus. One could describe the LaMI as a list of skills and abilities that have been regarded as useful for FLNMs. As a result of principal component analysis, the first version of the LaMI instrument, which is illustrated on page 40, encompasses three factors that are discussed separately in the following section.

The items that form the factor “interpersonal skills and group management” focus on personal skills, for example interaction with others as well as communication skills and attitudes towards members of the staff group (II). These identified skills correspond with staff experience of and expectations about receiving information and being involved in decision-making on the ward (I). In the factor “achievement orientation”, the items focused on getting the day-to-day work done. The items reflected skills such as goal formulation and goal achievement, improvement of services and cooperation, and the skills to inspire, motivate, delegate and support development activities for the staff group, as well as to handle conflicts (II). These skills seem to be of value in meeting the expectations of RNs and ANs when they emphasized the development of day-to-day work and the importance of co-operating with other FLNMs, supporting individual staff
members, fostering well-functioning teams and resolving conflicts (I). The factor “overall organizational view and political savvy” focuses on skills such as knowledge about directives, regulations, operations in the organization, the ability to describe decisions and consequences, seeing the whole picture, and knowing how to influence and find help (II). The FLNMs themselves and the RNs felt it was desirable for FLNMs to have knowledge about overall operations, as they saw this as a prerequisite for adequate decision-making (I).

In the CCG, persons who are not RNs can hold FLNM positions (III, IV), and in these cases they most often have other health care professions, but there are exceptions. That is due to the mix of skills the employer seeks, skills that are implicitly related to the responsibilities of the FLNM. The LaMI (II) does not encompass skills related to nursing or patient care. In Study I, on the other hand, the FLNM’s role in patient care has been described by the FLNMs, RNs and ANs, both with regard to perceptions of the role at present and the role in its ideal state. If the role includes responsibilities that focus only on economic and staff issues, a general manager without nursing experience could be appointed.

As the role of the FLNM expands and the complexity of the role grows, it will be challenging to find qualified persons for the positions (Allen, 1998). Although it may be difficult to find both experienced and skilled persons, one could argue that it is important not to refrain from high ambitions, as well-functioning FLNMs are essential to both patients and staff. That the nurse manager has to take into account the fact that different groups have different perceptions about the role (Coulson & Cragg, 1995) further underlines the importance of sharing understandings about the FLNM’s role. The issue as such ought to be of great importance to the organization’s management and not left to individual managers’ skills in describing and adjusting to the new role.

Because health care organizations are free to employ persons with or without professions related to healthcare, one consequence of focusing on ward or unit outcomes may be that management will thoroughly analyse what competences FLNMs should have. Such a decision might also be influenced by, for example, the competences and experience of the staff group and goal attainment at the unit. The person who is appointed to the position, independent of his/her profession, would probably benefit from development activities of one sort or another, for personal growth or to gain knowledge about the specific operations of the organization. In the following section, the results from Study III, which focuses on development activities for FLNMs, will be discussed.
Expectation, experiences and outcomes of development programmes

The FLNMs expressed a need to have the opportunity to participate in development programmes and seminars arranged by the county council (IV). One indication of the importance of meeting such needs is that nurse managers who perceive themselves as well prepared for their assignment report a higher level of job satisfaction than do other nurse managers (Gould et al., 2001). As a response to an articulated need for a development programme for FLNMs, the HR unit at the county council interviewed a number of people, among them FLNMs, about the required content of the programmes (III). This procedure is in line with some of the recommendations expressed by Thorpe and Loo (2003), in that it linked the planned training to needs expressed in the organization; the nurse managers were, at least to some extent, involved in the planning, and the programme was tailored to the FLNMs. The planning resulted in two programmes: the “Training Programme” (TP), focusing on the organization’s structure, content that has been advocated in the present thesis (II) and in other studies (Thorpe & Loo, 2003), and the “Leadership Development Programme” (LDP), focused on the leader’s personal growth. In a Swedish study (Persson & Thylefors, 1999), personal growth was the content area that the majority felt should be included in a development programme. In the following two sections, the expectations, experiences and outcomes of the two development programmes will be discussed.

Results from Study III showed that participants in the “Training Programme” had acquired knowledge about different topics, established relationships with other participants and described that most of the sessions had been of value. They expressed that they gained insights into operations within the county council and into the lack of cooperation between different parts of the organization (III). A study by Cunningham and Kitson (2000) showed that political awareness has been a positive outcome of development programmes. In the present study, the FLNMs expressed dissatisfaction with the outline of parts of the programme (III), which further stresses the importance of their involvement in the planning of the programme. The FLNMs had both positive and negative experiences from their contact with the lecturers. On the negative side was a lack of communication, and this was perceived by the FLNMs as no or little interest in FLNMs’ opinions and experiences (III). The participants in the TP scored on their self-ratings significantly higher at follow-up for the factor “overall organizational view and political savvy” (III).

Results from Study III showed that the participants in the “Leadership Development Programme” felt the programme had led to increased knowledge about themselves, better self-esteem and a feeling of strength (III). Increased self-awareness after development programmes has earlier been
The results from Study III showed a tendency towards significant improvement for the comparison group regarding the factor “overall organizational view and political savvy”. It may be that the group interviews addressing questions about day-to-day work and the handling of difficult situations had served as an opportunity for learning.

Between-group differences in change scores were found between the TP and LDP groups regarding “overall organizational view and political savvy”. This could be explained by the large positive change in the TP group, which corresponds to the aim of that programme. The negative result in the LDP group is more difficult to explain. One could perhaps speculate that the content of that programme, for example defining and reflecting on the role as FLNM, themselves as leaders, their scope of action, has influence their perception of their own knowledge.

The results from Study III indicate that development programmes seem to be beneficial for FLNMs’ skills and abilities. Thus, one could argue that development programmes should be mandatory. On the other hand, forcing FLNMs to participate could negatively influence their attitude towards the programmes and thereby their experiences and the outcome. As participants in the CG scored high at follow-up regarding “overall organizational view and political savvy”, one could question whether, for example, supervisory groups (in which the same persons have a structural contact with a professional leader) would be an alternative to development programmes such as the TP.

It is important that FLNMs’ superiors, in the context of performance evaluations, discuss and suggest appropriate development activities suited to the individual FLNM’s needs. Data on the participants in Study III showed that the majority had attended at least one previous management development programme. This is an indication of the county council’s ambitions to offer managers and potential managers development programmes of different kinds. Although results from the two development programmes showed improvements in corresponding factors in the LaMI (II) and the interviews were generally positive (III), it is important to stress that not only the individual manager’s skills and abilities regarding leadership and management should be in focus, but also the organizational conditions at his/her workplace (Hewison & Griffiths, 2004). Difficulties within the organization, such as unclear delineation of responsibilities (IV), lack of support from the superior (IV), insufficient cooperation between
organizational levels and units (III) and an experience of being of marginal value as a group (III, IV), have been reported. If we are to provide FLNMs with favourable conditions for their assignment and reinforce the value of development programmes, it would seem we must also assess the organizational conditions in which they work.

Organizational conditions

The CCG, just as many other health care providers, has decentralized its services owing to external demands (Landstinget Gävleborg, 1987b) such as research and development, competition, expectations from professionals, public interests and needs (Ringerman, 1990).

The FLNMs described difficulties in their work, as they perceived their conditions to be unclear – unclear in that they lacked the formal mandates to carry out tasks within their framework of responsibility. That their role was undergoing a process of change made it difficult for them. Changes not only in FLNMs’ work and role, but also in the organization’s assignments and structure seem to be a factor requiring special attention. External demands such as budget cuts place continuously new demands for change on the organization and its managers. The FLNMs in Study IV, those who had left their managerial posts, found it difficult to implement changes/reorganizations. They described finding the reorganizations difficult to justify, trust and believe in and that it was difficult to implement changes that they had not been involved in (IV).

It is notable that the FLNMs were not involved in decisions regarding changes and reorganizations (IV). In line with the decentralization of the organization, they are responsible for the operations, budget, and personnel at their unit (Landstinget Gävleborg, 1987b). Possible explanations could be that, in reality, FLNMs do not have full responsibility for operations at their unit, and their lack of mandates would seem to indicate this. Alternatively, the organization management has misjudged the importance of FLNMs for patient and personnel. On the other hand, it may be that the focus of organizational achievements has been more on budgetary goals than on patients and staff. Leaving this managerial group outside decision-making could also be related to organizational culture or values.

The FLNMs have raised the issue of their own marginal importance (III). Because health-care providers are subject to demands for adjustments and changes due to budgetary constraints, concerns about quality of care, patients’ assess to care and the well-being of well-educated personnel (who are a scarce resource), the conditions for FLNMs need to be appraised to fully make use of their potential.

If we return to decentralization and the work of Södergren (1992), she described the components of the decentralization process as changes in
structures, competence patterns and organizational attitudes. Further, she maintained that change in these three components leads to an orientation towards operations at the very local level of the organization. The lack of focus on the operation, more precisely on the care of patients at the ward/unit level, is perhaps an indication of a need to further emphasize the process of decentralization.

Supportive structures

In Study IV, the former FLNMs described the importance of the personal, emotional and strategic support they received from ward staff, colleagues and the head of department. The importance of response from the staff group have also been described by Nilsson (2003). The support, appreciation and approval of the head of the department were also described as essential (IV). Conflicts may arise when managers have to choose between their own and others’ perceptions of the content of their role or when they experience dissatisfaction or lack of support from staff or superiors (Bunsey et al., 1991). Coulson and Cragg (1995) maintained that conflicts arose when nurse managers did not receive the support they expected from staff, superiors and others. The FLNMs found it difficult to have a superior who did not give support. Moreover, no clear delineation regarding FLNMs’ responsibilities, mandates and authority was described as a reason for leaving the post (IV).

A distinct organizational course has been described as essential to practicing this role and constitutes, therefore, a most important form of support. Openness on the part of management paired with the possibility for FLNMs to participate in decision-making is described as central (IV). If needs for a distinct course cannot be fulfilled, this may become a factor of importance. In different contexts (III, IV), the FLNMs portrayed their understanding of their status in the organization as low, and described that it would be of significance if their role were upgraded. It is interesting to note that Hall and Donner (1997), in their literature review, identified the need for reorganization in a number of areas, some of which can be recognized here, i.e. clear delineation of expectations, feedback and reinforcement. They further emphasized the potential of using colleagues as a supportive resource (Hall & Donner, 1997).

The role of FLNMs has been expanding due to decentralization, and the FLNMs (IV) reported needing help with practical issues and support from specialists. To save time for other duties, they described wanting, for example, administrative assistance, help with short-term staffing and fewer meetings. Their staff (I) also expressed a desire for fewer meetings. Given that FLNMs’ responsibilities have become broader and now encompass staff, budgeting as well as the operation of the unit, their expressed need for support from different kinds of specialists seems logical. As regards support,
the forth category of importance was development and education. They described the advantages of educational activities prior to taking the post and of having the opportunity to continually participate in lecturers and development programmes (IV). Education and development seem to be well provided by the employer, as many of the FLNM in Study III had participated in previous development activities.

From an organizational perspective, the supportive structures the FLNMs described as important (IV) can be regarded as a hint and, as such, a guide to possible supportive structures for managers as a group. With that as a standpoint, a support structure including different orientations from which individual FLNMs and their superiors can choose would probably be of value. An individual manager’s needs depend on a number of factors, such as experience, skills, workload and operations at the unit, his/her group of subordinates and superior. She/he can influence the FLNM’s working conditions by addressing them in the management team at the hospital. However, more directly, she/he controls the FLNM’s conditions by giving or withholding authority, mandates and feedback. That the relationship between FLNMs and their superiors can be insufficient is described in Study IV and other studies (Nilsson, 2003; Tumulty, 1992). The possibilities of a supportive organizational climate for nursing leadership were described by V. Upenieks (2003). As there seems to be benefits to gain here, this issue needs to be further addressed by management.

Resignation

The results from Study IV showed that FLNMs have left their posts due to personal factors, organizational reasons and unsatisfactory relationship with and insufficient respect from the head of department (IV). Among the personal factors both those that can be described as positive and those that can be described as negative were presented. These results, showing that leaving a post can be precipitated by positive as well as negative events, have been supported in other studies (Lee, Mitchell, Holtom, McDaniel, & Hill, 1999; Morrell, 2005).

In the category unsatisfactory relationship with and insufficient respect from the head of department, the FLNMs described insufficient respect and appreciation from their superior, examples being dissatisfaction with salary and feedback and lack of relational and managerial trust (IV). Organizational reasons were described to be consequences of structural changes in the organization, unclear task conditions and early retirement (IV). The FLNMs did not regard offers of early retirement as positive. From the perspective of retaining competent or well-functioning FLNMs, it would be interesting to know whether the individual’s performance and/or value for operations and their staff group had been assessed or whether age has been used as the
reason for early retirement. At least eleven of the 43 FLNMs left their post due to organizational change (IV). One could argue that managers who cannot advocate decisions that affect them, their staff or their service do right by deciding to leave, as the loyalty of managers is of importance. On the other hand, it is unclear whether a culture of involvement in decision-making and sufficient information would have affected the managers’ decisions. During the time of the development programmes, participants in all three groups had considered leaving their posts (III). In the LDP group, the number was 11 of 14. The outline of that programme gave participants many opportunities to talk and reflect about themselves and their work situation. The FLNMs themselves raised the question of whether management had intended for them to leave their posts (III).

The present results (IV) showed that both positive and negative factors could explain the reason FLNMs left their posts. We may assume that the positive reasons for leaving could be difficult for the organization to deal with. It would be interesting to know whether the organization or the FLNMs’ superiors could have affected the factors perceived as negative by the FLNMs, thus causing the FLNMs to stay. One first step in a strategy for retaining well-performing managers could be to learn more about the individual manager’s preferences and attitudes. Using performance evaluations may be one opportunity for the HDs to engage in a dialogue with their FLNM. Such a dialogue could serve as a source of support, but also promote an understanding of what FLNMs feel is important in their work situation. The use of performance evaluations has been suggested as one activity for superiors, such as head nurses, to use to help nurses reconcile their thoughts about leaving their posts (Gardulf, Söderström, Orton, Eriksson, Arnetz, & Nordtröm, 2005).

Findings in relation to the theoretical framework

In the following section, results from the current studies will be discussed in relation to the models and theories presented in the introduction.

Mintzberg’s theory of manager’s working roles

Mintzberg’s theory of manager’s working roles was used in the analysis of the interviews in Study I and was found to give a useful structure of that material (Mintzberg, 1973). The FLNMs themselves have described all roles in the theory and the RNs and ANs have described 9 and 8 roles respectively that agree with Mintzberg’s descriptions about managerial roles as similar across organizations.

Further, there are connections between the roles in the theory and the items in the LaMI (II), e.g., between the leader role and items on, for
example, listening, inspiring co-workers, improving team spirit and focusing on goal achievement. Another example is the roles as a monitor and disseminator, which have many connections to the factor “overall organizational view and political savvy” and “interpersonal skills and group management”.

The development programmes in Study III could be described as improving FLNMs’ possibilities to master the roles in Mintzberg’s theory, the LDP programme focusing on two of the major roles – interpersonal and decisional – and the TP focusing on informational roles. With this outlook, the two programmes are not to be chosen between, but they are instead complementary.

The former FLNMs in Study IV described how they felt it was difficult to carry out the reorganizations and other changes previously decided upon. Other difficult aspects were staffing of the unit and some staff issues, such as conflicts and alcohol abuse. These descriptions can be recognised as concerning decisional roles, and such roles seem to be what the FLNMs are occupied with when trying to get the day-to-day work to function.

Katz’s framework of managerial skills

There are similarities between the three factors in the LaMI (II) and Katz’s (1955; , 1974) framework encompassing technical, human and conceptual skills. Human skills are divided into intra- and inter-group relationships and resemble the factor in the present study (II) regarding “interpersonal skills and group management”, which Katz believed to be essential to management at lower and middle levels. The content of the factor “achievement orientation” could be interpreted as that of technical skills, described in Katz’s framework (1955; , 1974) as understanding and ability regarding methods, processes or procedures. And finally conceptual skills, as they are described by Katz (Katz, 1974), show similarities to the factor “overall organizational view and political savvy”. These similarities could be an indication that skills and abilities in leadership and management are rather fundamental and do not varying over time. In this respect, one could perhaps argue that, according to Katz’s framework, adequate skills have been identified as important. This simplified comparison does not say anything about the importance of the different factors (II) and the skills and abilities in relation to one another.

As there are similarities between the LaMI and Katz’s framework, the development programmes in Study III have increased skills and abilities that can be recognized from the description of technical and conceptual skills.
Kanter’s structural theory of power in organizations

The results from Study II and III will be discussed in relation to the three concepts of opportunity, power and proportions as they are described by Kanter (1993). The work of Kanter (1993), which describes empowering structures, has been used to give an understanding of the interaction between the FLNMs and the structure of the CCG.

Opportunities in the meaning of possibilities for knowledge and skills are described in Study IV, where learning and developing are described as important. It seems like the FLNMs in CCG have had good opportunities to enhance their skills; of the FLNMs in Study III, as many as 34 had previously participated in development activities for managers (III).

However, they did perceive restricted formal responsibility and were therefore insecure about the reasons why they were given the opportunity to attend. Opportunities in the understanding of possibilities to move to other posts are described in Study IV. Among the FLNMs who had left their positions (Study IV), 24 of 32 still worked within the organization. Two had gone to other posts as FLNMs, three to posts as head of department and 19 worked as RNs, four of them with additional administrative duties.

It is difficult to describe the results in relation to the concept of formal power, as the focus of the studies has not been explicitly on discretion, visibility and relevance. Regarding discretion, the former FLNMs in Study IV described having restricted mandates both as a reason to leave and as a difficulty, something that was also described by RNs and ANs in Study I and by the FLNMs in Study III. In Study IV, the former FLNMs reported that they had not participated in the decisions they had to implement. Regarding visibility, the FLNMs in Study III told how some of the lecturers had not invited them to participate in a dialogue, and in the LDP group, the HDs had chosen a meeting within the hospital instead of a planned activity in the framework of the programme. These examples indicate that the FLNMs are not a visible group. Regarding relevance, the participants in Study I described a number of FLNM roles that at least could be described as important for the organization, as they concerning having the responsibility for patients and staff. In Study IV, the issue of problematic situations is more pronounced, as the former FLNMs described difficulties they had faced in the reorganization of services. In this regard, the work of the FLNMs seems to be of importance. As an illustration of informal power, the results from Study III and IV indicate that the FLNMs have many connections within the organization. Examples of this are the former FLNMs in Study IV who described having had contacts with other FLNMs at the department, but also within the hospital (Study IV). Of the 42 FLNMs in Study III, 21 reported that they belonged to networks, 10 had contacts with mentors and 20 participated in supervisory groups (Study III).
The concept of proportion is not addressed in the studies, but the FLNMs as a group are not a minority as such when compared to other managerial groups in a county council.

The former FLNMs described a number of issues of importance to support (Study IV) that can be recognized in Kanter’s structural theory of power in organizations. It seems as if the FLNM position gives them opportunities and informal power. Still, describing this in Kanter’s terms, the FLNMs’ formal power could be increased.

When reflecting over the theory in relation to the results of Study II, one should shift the perspective from the FLNMs to their subordinates. Among the items in the LaMI, one can find those who empower the staff. Examples of this are – being active in personnel development, inspiring co-workers, delegating correctly and encouraging cooperation.

Methodological considerations

Design and research perspectives

The strength of the present thesis was the use of different designs and perspectives to describe the working conditions for FLNMs. The research questions have guided the choice of research approach in the individual studies. Thus, both qualitative and quantitative research approaches have been used. In two of the studies (I, II), a qualitative or quantitative approach has been used, but in Study III and IV, the two approaches have been used to complement one another. Using both approaches allowed more comprehensive descriptions of the conditions of the FLNMs.

The present results comprise reports from the FLNMs themselves, both former FLNMs and those who are still active, their superiors, subordinates and other persons. For example, the FLNMs, their superiors and subordinates (I) described their understandings of the same topic/issue/question, thus increasing the possibility of describing the issue in a comprehensive manner.

One weakness is that the participating FLNMs vary across the studies. It is only in Study III that all FLNMs had an opportunity to participate by attending one of the development programmes or being in the comparison group. In Study I, the research approach was qualitative and the number of participants was adequate. The sizes of the two samples in Study II were small, 149 and 197 respectively, but within the required range for factor analysis, 1:5-1:10, according to Kline (1994). The number of items in the LaMI is 28. The similarities between the results of the two samples indicate acceptable validity (II). The groups in Study III were also small. The reason for this was that the numbers of participants were set to suit the
education/development situation. There is also the question of selection bias, as the participants were included in the two groups based on their interest in the programmes. For this reason, the design was not randomized. Small groups do lead to the risk of committing a Type II error regarding the between-group differences (III). In Study IV, the number of participants as such was small, but all FLNMs that had left their managerial post during the two-year period were invited to participate.

Cross-sectional, prospective and retrospective designs have been used. The retrospective design in Study IV could have affected the respondents’ recollection, leading to uncertainties regarding the results. In Study III, data were collected before and after participation in the development programmes, and interviews were held at four occasions.

**Trustworthiness**

In qualitative and quantitative research approaches, different concepts are used for describing trustworthiness. In describing the trustworthiness of the results from the qualitative studies, the concepts of credibility, dependability and transferability will be used, and regarding the results from the quantitative studies, the concepts are internal and external validity (Graneheim & Lundman, 2004; Kazdin, 1998; Long & Johnson, 2000; Polit & Beck, 2004).

**Data from qualitative studies**

Credibility The designs of the present studies have been thoroughly discussed in the research group. In Study IV, all FLNMs who had left their post during the two-year period were addressed. It is important to remember that this may influence the participants’ opinions about difficult situations as well as their perceptions of support. In Study III, data were collected at four occasions. The fact that the researcher BS worked within the organization could have affected the informants’ sincerity in describing their opinions, expectations and experiences. On the other hand, the researcher’s knowledge of the organization could be of value for credibility (Lincoln & Guba, 1985). The obtained data from all of the present qualitative studies have been rich, however, and the informants have stressed opinions of both a positive and a negative character. The selection of meaning units, coding, categorization and the setting of themes have been discussed with supervisors and fellow researchers, as has the selection of citations.

Dependability To strengthen the dependability of the analysed data, an open dialogue has been pursued with supervisors and fellow researchers over time to discuss the content or meanings of the categories and themes as well as the agreement in coding, categorization and theme setting. The results did reveal, however, what the participants recalled of their time as FLNMs and their reason for leaving. For some the recollection was only positive, for others negative (IV).
**Transferability** The perceptions, experiences and opinions of informants in the present studies are similar to those observed in other studies, both from Sweden and from other countries. It would seem that the working conditions of the FLNMs in the present study can be transferred to other contexts, at least in certain respects. However, it is important to underline that the organizational structure in Study I is not common in Swedish hospitals, i.e. a nursing unit, and HDs are most often physicians, though not in nursing units.

**Data from quantitative studies**

*Internal validity* During the time for Study III, changes were occurring within the organization and the researcher BS had close contacts with members of the directors’ staff group to obtain information about events within the organization that could affect the results. To address these threats to internal validity a comparison group was used. As group assignment was not randomized, there is a risk of selection bias. The participants’ characteristics at baseline, however, did not show any differences. The participants in the study (III) were well aware of their participation, which may have affected their sensitivity to the questions posed. The timing of the measurement is another factor that is important to address.

*External validity* The fact that the samples (II, III) are from one county council is a limitation, as organizational structure and culture are aspects that should be taken into consideration.

The generality of the results in Study II are limited due to the small samples and the inclusion criteria. One could argue that the selection of participants in Study III constitutes a weakness, as participation in the two development groups was based on interest. Interest in or motivation for development programmes, however, has been judged as a basic prerequisite for participation. An ideal situation would have been to have enough interested FLNMs to be able to randomly assign participants to a TP group and a comparison group, and likewise to an LDP group and a comparison group.

The fact that the participants were aware they were participating in a study is also a threat to external validity. In Study III, a follow-up assessment was performed 4-5 months after the end of the programmes. It was in the interest of the researchers to perform yet another assessment after the development programmes. The reason for not doing so was that some of the participants in the comparison group had applied to programmes that started after the summer, another reason was that a number of FLNMs announced that they would be leaving their posts. These things together increased the attrition to a level that was judged to be too high.
Data collection methods

Interviews
Interviews were carried out in two of the studies (I, III). Question areas and probing questions have been prepared and discussed among the authors. The interviews were conducted at times and places chosen by participants. The interviews were tape-recorded to secure data collection, and prior to taping, the interviewer ascertained that participants felt comfortable with the tape recorder. Participants were given the opportunity to read through the transcribed material for correction of any errors and to provide clarifications or deeper descriptions if they found this necessary.

In Study III, the interviews were held in groups. There were two reasons for this: 1) the idea that the group activity could help participants remember and associate, thus providing rich material (Morrison-Beedy, Côté-Arsenault, & Feinstein, 2001), and 2) for practical reasons, it was difficult to conduct interviews with all participants at 4 occasions. The group interviews could be considered as a limitation, as they might restrain some participants (Polit & Beck, 2004). However, although participants expressed themselves to different degrees, all of them contributed. The material is rich, and the participants have expressed both positive and negative opinions (III).

Questionnaires
The instruments used in the present thesis were developed for the specific studies (II, III, IV).

The Leadership and Management Inventory was developed to give us a measure that comprises managerial as well as leadership skills and that focuses on FLNMs. The fact that the participants in the two samples (II) were RNs and HCPs, respectively, and not FLNMs is a weakness in Study III. Another weakness is that the instrument has not been used in other studies. Psychometric properties of the LaMI have been established. To address the issue of validity, the items in the LaMI originate from interviews with persons from the health care context who have relationships to FLNMs. The initial six topics that gave structure to the first set of items have similarities to the three factors that gave structure to the LaMI (II). Further, other researchers have found the items and the factors to be relevant.

The Cronbach’s alpha coefficient for the LaMI have been measured for the samples in Study II and III, see Table 7. The estimated values in the studies (II, III) indicate that the consistency of the instruments and its factors are high, and high levels are an indication that still other items in the instrument could be excluded. Although the use of the instrument should be the guiding factor when judging the Cronbach’s alpha level, 0.70 is described as an acceptable level (Polit & Beck, 2004; Streiner, 2003a, 2003b). The mean values (II), which varied from very low to the highest possible, could be an indication of the instrument’s sensitivity.
The questionnaire in Study IV addresses the issue of FLNMs leaving their posts. The instrument could be considered short, as it consists of five items, which was our intention, as we hoped that the limited number of questions would motivate the informants to complete the questionnaire.

**Letters**
Using letters to collect data was intended to assure informants’ anonymity, as the issues in question could be perceived as delicate. The letters did not give the opportunity to ask for clarifications, but it did give informants time to think through the question and carefully formulate their answers. The letters were informative and provided rich material for analysis (IV).
Concluding remarks

In the present thesis, the ambition has been to describe both personal skills and abilities and some organizational conditions that are important to FLNMs’ leadership and management.

- The FLNMs’ role has changed due to decentralization, a change that has brought with it new tasks, a wider scope of responsibilities and unclear mandates.
- The FLNMs, RNs and ANs have a corresponding view of the FLNM’s role. The three groups describe the manifoldness of the FLNM role and its focus on day-to-day activities on the ward. The HD describes the FLNMs’ care for the staff, leading to good patient care (I).
- Results from PCA of the LaMI gave three factors “interpersonal skills and group management”, “achievement orientation” and “overall organizational view and political savvy” (II).
- Results indicate that the estimated validity and reliability of The Leadership and Management Inventory – LaMI is acceptable (II).
- Results from the self-assessment showed improvement after participation in the development programmes, improvements corresponding to the content of the programmes. The expectations the FLNMs expressed concerning the development programmes were generally met, although some negative experiences were reported (III).
- The support FLNMs describe as important is linked to the working conditions in their practice. Supportive structures are important. That is, it is essential that FLNMs have access to, for example, education, mentors and networks (IV).
- The results show that FLNMs’ commission needs to be clearer and that their mandates should correspond with their commission (IV).
- The difficulties the FLNMs perceive are linked to their reasons for leaving their managerial posts (IV).
- The FLNM’s immediate superior plays a pivotal role, as she/he has influence over authority, mandates and provides feedback (IV).
- Taken together, the FLNM’s individual experience, skills, abilities and ambitions are important, but so are the conditions in which she/he practices her/his leadership and management. It is important that the interplay between person and organization functions well.
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Sammanfattning (Summary in Swedish)

Det övergripande syftet med studierna i avhandlingen var att beskriva personliga och organisatoriska förutsättningar för avdelningschefer samt att identifiera och mäta färdigheter och förmågor som är viktiga för deras chefs- och ledarskap.

För att studera uppfattningar om avdelningschefens roll, som den är i nuläget respektive önskas vara, genomfördes intervjuer med fem avdelningschefer, fem sjuksköterskor, fem undersköterskor och en verksamhetschef. Intervjuerna bearbetades med hjälp av kvalitativ innehållsanalys. Faktoranalys har utförts för att värdera validitet och reliabilitet i ”The Leadership and Management Inventory”, ett instrument som tagits fram inom ramen för avhandlingen. Två undersökningsgrupper har ingått i studien, en grupp med 149 sjuksköterskor och en grupp med vårdpersonal, 197 personer. För att undersöka förväntningar, erfarenheter och resultat från två olika utvecklingsprogram för avdelningschefer har gruppintervjuer och självskattningar genomförts. Tretton avdelningschefer i ett utbildningsprogram, 14 i ett ledarskapsutvecklingsprogram och 14 i en kontrollgrupp har ingått i undersökningen. För att beskriva varför avdelningschefer slutar, vad de uppfattar som svåra situationer i sitt uppdrag och vilket stöd som är av betydelse för dem har frågeformulär och brev från 32 personer som tidigare arbetat som avdelningschefer analyserats.

Resultaten visade att avdelningschefernas, sjuksköterskornas och undersköterskornas beskrivningar av avdelningschefens roll är likartade, då de fokuserade verksamheten på avdelningen. Verksamhetschefen däremot beskrev främst avdelningschefens ansvar för personal, utveckling och samarbete. Analysen av ”The Leadership and Management Inventory” resulterade i tre faktorer ”interpersonal skills and group management” (mellanmänsklig färdighet och ledning av arbetsgruppen), ”achievement orientation” (resultatinriktning) samt ”overall organizational view and political savvy” (organisationsskulskap, överblick och kännedom om beslutsvägar). Instrumentets validitet och reliabilitet bedömdes vara godtagbar. De förväntningar som avdelningscheferna hade på utvecklingsprogrammen infriades i stort men en del brister och negativa erfarenheter framfördes också. Resultat av självskattningen (The Leadership and Management Inventory) visade förbättringar som överensstämmer med innehållet i respektive utvecklingsprogram. Orsaker till att sluta som avdelningschef beskrevs vara personliga, organisatoriska samt ha att göra med relationen till verksamhetschefen. Svåra situationer beskrevs vara oklarheter i själva uppdraget, brister i ledningen eller relaterade till en del arbetsuppgifter. Att få personligt, känslomässigt och strategiskt stöd, att tydliga mål för organisationen finns uttalade, att goda prak-
tiska förutsättningar finns samt att ha möjlighet till utbildning och utveckling beskrevs vara viktigt stöd i uppdraget. Slutsatsen blev att avdelningschefens erfarenheter, färdigheter, förmågor och ambitioner är viktiga men det är också de förutsättningar som hon/han har för att utöva sitt chefs- och ledarskap. Ett välfungerande samspel mellan individen och organisationen är därför av betydelse.
References


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