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New Graduate Nurses' Experiences of Engaging in a Leadership Role in Hospital Settings During the COVID-19 Pandemic

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ABSTRACT

New graduate registered nurses are often expected to assume leadership roles and responsibilities quickly upon entering practice. Since the emergence of the COVID-19 pandemic, new nurses may find their leadership capabilities tested even further as the demands of leadership have been made increasingly complex in the context of an infectious disease outbreak. The purpose of this interpretive descriptive study was to explore new graduate registered nurses' experiences of engaging in frontline leadership roles in hospital settings during the COVID-19 pandemic. In-depth interviews were conducted with 14 participants across Ontario. Content analysis revealed four main themes: *nominated and necessitated into leadership*, *managing diverse and demanding responsibilities, a spectrum of factors that help or hinder*, and *reflecting on leadership as an impactful experience*. Study findings provide insights into potential educational and organizational strategies to support new nurses in roles of frontline leadership, particularly during periods of crisis.

Keywords: new graduate nurse, leadership, charge nurse, COVID-19

SUMMARY FOR LAY AUDIENCE

Leadership is an expectation of nurses across all practice settings, including those who are newly graduated. However, new graduates often feel unprepared to take on leadership roles. As frontline nursing leadership roles (frequently called "charge nurse" or "team leader") are often rotated through staff registered nurses on a shift-by-shift basis in Ontario hospitals, new graduates can be appointed into a position of nursing leadership very quickly upon starting their nursing career. Since the emergence of the COVID-19 pandemic in March 2020, new nurses may find their leadership capabilities tested even further in the context of an evolving infectious disease outbreak. The purpose of this qualitative study was to explore new graduate registered nurses' experiences of engaging in frontline leadership roles in hospital settings during the COVID-19 pandemic. Individual interviews were conducted with a sample of 14 registered nurses who had up to three years of experience and who had taken on a frontline leadership role in a hospital during the COVID-19 pandemic. From these interviews, four main themes were identified. The first theme, *nominated and necessitated into leadership*, described various circumstances that prompted new graduates to take on roles of frontline leadership. The second theme, *managing diverse and demanding responsibilities,* highlighted the multiple responsibilities juggled by new graduate nurses in frontline leadership roles. The third theme, *a spectrum of factors that help or hinder*, outlined a range of factors that influenced new graduates' experiences as they took on a frontline leadership role. Lastly, the fourth theme*, reflecting on leadership as an impactful experience*, described the professional and personal impacts stemming from participants' frontline leadership experiences. Insights gained from this study shed light on the experiences of new graduate nurses in roles of hospital-based frontline leadership, factors they find helpful and

unhelpful, and ways in which practice settings and nursing education programs can support

them, particularly during times of increased practice setting pressures and uncertainties.

CO-AUTHORSHIP STATEMENT

Justine Ting completed this master's thesis under the supervision of Dr. Yolanda Babenko-Mould and the advisement of Dr. Anna Garnett, who will be co-authors on all manuscripts and presentations stemming from this work.

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF APPENDICES

CHAPTER ONE

INTRODUCTION

The Coronavirus Disease of 2019 (COVID-19) pandemic has presented an unprecedented challenge for nurse leaders who oversee and manage the health and safety of patients, families, and healthcare staff (Aquilia et al., 2020; Rosser et al., 2020). Nurses at all levels, including new graduate registered nurses (NGNs), are called upon to contribute to patient safety and quality of care by demonstrating strong leadership skills and by assuming leadership roles (Institute of Medicine, 2011). The nursing profession has advocated for the need for visible nursing leadership during COVID-19 to ensure that both nurses' wellbeing and the principles of patient-centered care remain in central focus during crisis situations (Rosser et al., 2020). Leadership is integrated into the entry-to-practice competencies outlined by the College of Nurses of Ontario (CNO) (2014), and as such, NGNs are ostensibly prepared during their undergraduate education to competently enact professional leadership roles and responsibilities upon licensure (Gore et al., 2015; Strickland & Welch, 2019). Accordingly, upon graduation, NGNs have faced significant expectations from employers and practice settings to meet the demand for nursing leadership at all levels of the healthcare system (Gore et al., 2015; Tingvoll et al., 2018).

Despite few new graduates transitioning into practice with explicit leadership aspirations (Scott & Miles, 2013; Topola & Miller, 2021), leadership competencies are nevertheless required to autonomously manage and prioritize care; to effectively and ethically delegate and allocate resources; to advocate for patients and healthcare reform; and to act as full partners within an interdisciplinary team (Institute of Medicine, 2011; Sharpnack et al., 2013; Welch et al., 2019). NGNs are also considered to be leaders within the healthcare team by virtue of their professional scope of practice as registered nurses

(RNs) (Ekström & Idvall, 2015), and are not exempt from being appointed into frontline clinical leadership roles such as charge nurse or team leader (Dyess & Sherman, 2010; Gore et al., 2015; Laut et al., 2018; Rush et al., 2014). Frontline clinical leadership competencies present a significant challenge for NGNs, even under typical healthcare conditions (Ekström & Idvall, 2015). During the COVID-19 pandemic, the challenges facing frontline nurse leaders have been compounded by the need to adapt to changing policies, to advocate for critical frontline needs, and to optimize the allocation of staff and resources to meet the increased demand for intensive and acute care services (Aquilia et al., 2020; Juan et al., 2021; Prestia, 2020). Thus, supporting NGNs' leadership competencies at undergraduate and post-graduate stages is integral to facilitating their successful transition into practice, and necessary to ensure they are prepared to meet the considerable demands of frontline clinical leadership roles, particularly in the challenging context of the COVID-19 pandemic.

Background

Frontline Nursing Leadership Roles

Nurses engaged in frontline leadership roles (e.g., charge nurse) are responsible for the operation of a patient care area over a designated time period (often over one shift) and provide critical leadership and support for clinical decision-making at the unit-level (Eggenberger, 2012; Ohio Nurses Association, 2016). As such, frontline leadership roles demand both a robust foundation of clinical knowledge and skills, in addition to strong leadership competencies (Ohio Nurses Association, 2016). These competencies include navigating and directing the operation of a complex clinical environment, strategically and compassionately managing human resources, and demonstrating strong diplomacy and teamwork skills within an interprofessional team (Normand et al., 2014; Sherman et al., 2011). A review of the literature on the development of unit-based frontline leaders by

Delamater and Hall (2018) further identified key leadership traits, including strong communication skills and the ability to manage healthcare teams, resolve conflict, delegate tasks, and support healthy work environments. Frontline leaders are also relied upon to assume responsibility for quality outcomes and to influence positive change to help meet organizational performance measures (Sherman et al., 2011). With such a diverse set of competencies and responsibilities, it is unsurprising that nurses in frontline leadership roles have been identified as instrumental to the effective delivery of care at the unit level with regards to safety, timeliness, efficiency, effectiveness, equity, and patient-centeredness (Agnew & Flin, 2014; Eggenberger, 2012).

The dynamic roles and responsibilities of frontline nurse leaders reinforce the importance of creating and supporting opportunities to develop leadership capacity in frontline nurses (Patrician et al., 2012; Registered Nurses' Association of Ontario [RNAO], 2013). Accordingly, the RNAO (2013) recommends that organizations facilitate the rotation of frontline leadership roles throughout their registered nursing staff. However, the literature indicates that nurses are often thrust into this multidimensional role with little training or organizational support (Delamater & Hall, 2018; Sherman et al., 2011; Thomas, 2012; Wojciechowski et al., 2011).

NGNs as Frontline Leaders

Considering the significant influence of nursing leadership on patient, staff, and organizational outcomes, the question of whether NGNs are prepared to meet the demand for nursing leadership upon entry to practice remains a topic of debate (Mbewe & Jones, 2015). This issue is of heightened importance in hospitals that operate under a rotating charge nurse model, in which the role of frontline nursing leadership is appointed on a rotating basis per unit and shift; this model of leadership is prevalent in the province of Ontario (Bard, 2018).

NGNs are experiencing increasingly rapid placement into frontline leadership roles (Dyess & Sherman, 2010; Gore et al., 2015; Laut et al., 2018; Rush et al., 2014). The high leadership expectations placed upon NGNs on entering practice may be attributed to expectations that undergraduate education has adequately prepared them to immediately assume leadership responsibilities (Gore et al., 2015). Work redesigns and alterations in skill mix, such as reductions in the number of RNs to registered practical nurses (RPNs) and nonregistered staff, may also contribute to increased supervisory responsibilities for new RNs (Hood, 2013). As well, staffing shortages, intensified by the COVID-19 pandemic, can contribute to a lack of senior nurses who might otherwise typically be selected for rotating leadership roles (Sherman & Eggenberger, 2009; Rush et al., 2014). However, there is a dearth of research exploring NGNs' experiences in roles of leadership, including charge nurse roles or similar positions of frontline leadership in hospital settings. There is also no known research about NGNs' engagement in leadership roles in the context of the COVID-19 pandemic.

The Impact of COVID-19 on Nursing Leadership

A systematic review of nurses' experiences working in hospital settings during a respiratory pandemic highlighted the negative impact of virus outbreaks on the mental and physical health of the nursing workforce, although some perceived the experience as an opportunity for professional growth (Fernandez et al., 2020). Nurses have also reported concerns regarding patient care and increased pressure and stress in the workplace during the COVID-19 pandemic (Cai et al., 2020; Dong et al., 2020; Sun et al., 2020). Amidst these impacts on frontline nursing, nurse leaders have needed to grapple with rapid yet often uncertain decision-making; to support and engage staff and patients amidst ever-changing operational policies; and to ensure the reliable delivery of high-quality care during an

unprecedented crisis (Aquilia et al., 2020). Nurse leaders may experience additional moral

conflict as the balance between the care of staff and the care of patients becomes increasingly

complex in the context of an evolving infectious disease outbreak (Prestia, 2020).

Considering the significant impact of the COVID-19 pandemic on nurses' work

environments as well as their physical and emotional wellbeing (Fernandez et al., 2020),

NGNs' experiences of frontline leadership roles within the past year have undoubtedly been

influenced by the context of the global pandemic.

Significance

Presently, the experiences and perspectives of NGNs engaged in frontline leadership

roles are not well defined. With NGNs being called upon to fulfill frontline clinical

leadership roles in hospital settings (Dyess & Sherman, 2010; Gore et al., 2015; Laut et al.,

2018; Rush et al., 2014), there is an urgent need to develop an understanding of the factors

which NGNs perceive as helpful or detrimental to their leadership experiences. The

challenges of COVID-19 have also highlighted the need to educate and support the next

generation of nurse leaders who are equipped with the resilience and collaborative decision-

making skills needed in times of crisis (Rosser et al., 2020). Elucidating NGNs' experiences

in frontline leadership roles will contribute to a stronger understanding of how to help new

nurses survive and thrive in positions of clinical leadership, both during and beyond the

COVID-19 pandemic. Fostering effective early-career leadership can help mitigate the

ongoing shortage of nurse leaders, as success in frontline leadership roles can improve job

satisfaction and motivate nurses towards more advanced positions of leadership (Patrician et

al., 2012; Sherman et al., 2011). Conversely, failing to provide NGNs with adequate attention

and support in frontline leadership roles can result in excessive stress, errors leading to a

breakdown in care by the clinical team, and the potential attrition of promising nursing leadership talent (Cowin & Hengstberger-Sims, 2006).

Statement of Study Purpose

The purpose of this study was to explore NGNs' experiences of engaging in frontline leadership roles in hospital settings during the COVID-19 pandemic. For this study, frontline leadership roles encompass any role representing clinical nursing leadership in one or more patient care areas, including role titles such as charge nurse, team leader, lead nurse, resource nurse, most responsible nurse, in-charge person, or unit leader. This research aims to develop knowledge that may help inform educational and organizational strategies to support NGNs who engage in frontline hospital leadership roles, particularly during periods of crisis such as infectious disease outbreaks.

Research Question

The overarching research question for this study was: How do NGNs experience frontline leadership roles in hospital settings during the COVID-19 pandemic? The sub-questions were: a) What facilitated or challenged NGNs' engagement in a frontline leadership role?, and b) What changes in nursing education or practice do NGNs propose would have helped them to be more successful as leaders in their workplace during the COVID-19 pandemic and/or during future crisis situations?

Declaration of Self

I have worked as an RN for six years in an acute care hospital and have experience with rotating into a frontline leadership role as a new graduate; although, I have not experienced enacting this role as a new graduate during a global pandemic or a crisis of comparable magnitude. As I have continued to encounter NGNs who find themselves in roles of frontline leadership, I have empathized with their efforts to develop their leadership

potential and to reconcile the responsibilities of a leadership role with their nascent nursing identity—particularly in the context of the added complexities presented by COVID-19. These experiences from my practice spurred my interest in pursuing this area of study.

The purpose of describing these experiences is in keeping with Thorne's (2016) recommendation to define the researcher's positioning insofar as to be transparent regarding motivations and personal experiences that may influence the angle to which the study is approached. I acknowledge that my experience with the phenomenon of interest informs my inquiry and spurs my desire to explore the opportunities and challenges that NGNs encounter as they engage in roles of frontline leadership during the COVID-19 pandemic. As my motivations are practice-driven, I acknowledge that I intend for the study's findings to help contribute to supportive conditions for NGNs in leadership roles. This impetus will inevitably influence the direction of my inquiry. However, through transparency in my motivations and experiences, I intend to provide the "fixed point" from which I and the reader can determine how the study may be influenced by my early conceptions (Thorne, 2016, p. 76).

Overview of the Thesis

This thesis consists of three chapters and is presented in integrated article format. Chapter One provides an overview of nursing leadership during COVID-19 and leadership by NGNs. The significance of the study, study purpose, and research questions are also stated. Chapter Two comprises the thesis manuscript and presents the main components of this thesis, including the literature review, methodology, methods, findings, and discussion. Chapter Three contains the study implications and recommendations for nursing practice, education, research, and policy. This chapter also presents the summary conclusions of the thesis.

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CHAPTER TWO

MANUSCRIPT

Background and Significance

Leadership is often a daunting prospect for newly qualified registered nurses (RNs), and yet many new graduates are expected to assume team leadership roles and responsibilities early in their careers (Källestedt et al., 2020; Lea & Cruickshank, 2015). As frontline nursing leadership roles (e.g., charge nurse) are often rotated through staff RNs on a shift-by-shift basis in Ontario hospitals, new graduate registered nurses (NGNs) can be appointed into a position of nursing leadership very quickly upon entering practice (Bard, 2018). Since the emergence of the COVID-19 pandemic in March 2020, NGNs may find their leadership capabilities tested even further as the demands of leadership are made increasingly complex in the context of an evolving infectious disease outbreak (Aquilia et al., 2020; Prestia, 2020).

Frontline nurse leaders play a critical role in unit functioning, patient care delivery, and human resource management (Agnew & Flin, 2014; Eggenberger, 2012). Previous research has demonstrated the positive impact of strong nursing leadership on patient and organizational outcomes, including fewer patient safety incidents and improved patient/family experiences (Agnew & Flin, 2014; Boamah, 2018). The role of charge nurse and other similar roles of frontline nursing leadership demand clinical, managerial, and leadership expertise (Delamater & Hall, 2018; Sherman et al., 2011). Such roles have become increasingly complex as the boundaries between nursing leadership and nursing management competencies have narrowed, and as nurse managers increasingly depend on frontline leaders to assume responsibility for quality outcomes (Jennings et al., 2007; Sherman et al., 2011). As such, roles of frontline leadership in nursing are often thought to be

held by experienced and senior nurses (Delamater & Hall, 2018; Eggenberger, 2012; Spiva et al., 2020). However, NGNs are experiencing increasingly rapid placement into frontline leadership roles (Adamack & Rush, 2014; Dyess & Sherman, 2010; Gore et al., 2015; Laut et al., 2018). The significant leadership demands that NGNs contend with upon entering practice may be attributed in part to low ratios of RNs to registered practical nurses (RPNs) or nonregistered staff within a clinical area, ultimately resulting in increased supervisory responsibilities for RNs (Hood, 2013; Jacob et al., 2015). As well, the intersection of a pre-existing nursing shortage with the toll of COVID-19 on the healthcare workforce (Drennan & Ross, 2019; Mehta et al., 2021) may contribute to a lack of senior nurses who might otherwise be appointed into charge nurse roles or other positions of frontline leadership.

Previous research indicates that NGNs are challenged to meet employer expectations regarding their leadership development and competencies (Källestedt et al., 2020; Theisen & Sandau, 2013). However, expectations for new nurse leadership have not been well explored (Miehl, 2018), and there is a dearth of research that acknowledges NGNs who engage in frontline leadership roles, particularly in Canadian clinical contexts and during periods of crisis. This study seeks to address these gaps by exploring the experiences of NGNs as they enact hospital leadership roles during the COVID-19 pandemic. Knowledge gained from this study may shed light on opportunities and challenges new graduates encounter in roles of frontline leadership in hospital settings, factors they find helpful and unhelpful, and ways in which practice settings and education programs can support them, particularly during times of increased practice setting pressures and uncertainties.

As little research has been conducted about NGNs engaging in leadership roles, the findings of this study may also contribute to greater recognition of NGNs as leaders during COVID-19 in their practice areas. Greater awareness of NGNs' leadership experiences

during this challenging time may stimulate further interest and investment by senior leadership, nurse educators, and healthcare organizations, to collaboratively work towards educational and organizational strategies that can help NGNs survive and thrive in roles of frontline leadership.

Literature Review

A literature review was conducted to summarize research exploring current understandings and issues surrounding leadership by NGNs. A systematic search was conducted in four online databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), PubMed, Scopus, and ProQuest Nursing and Allied Health Database. Keywords used to guide the search included a combination of terms relating to "new graduate nurses" (*new graduate nurse* OR *new graduate registered nurse* OR *newly graduated nurse* OR *newly graduated registered nurse* OR *newly qualified nurse* OR *newly qualified registered nurse* OR *new nurse* OR *new registered nurse* OR *junior nurse* OR *junior registered nurse* OR *novice nurse* OR *novice registered nurse*) and "leadership" (*leadership* OR *leader* OR *leading* OR *lead* OR *supervis** OR *charge nurse* OR *in charge* OR *lead nurse* OR *head nurse* OR *team lead** OR *resource nurse* OR *coordinat**). Manual searches of related articles in key journals, as well as ancestry searches of included and related articles, were also conducted.

Criteria for inclusion were as follows: (1) peer-reviewed articles, (2) published between January 2010 and May 2021, (3) available in the English language, and (4) addressing leadership as enacted by NGNs or novice nurses. Results were limited from 2010 onwards to capture the current state of available evidence regarding NGN leadership. Duplicates from combined searches were removed and remaining articles were screened by title and abstract. This was followed by a review of the full text to assess for eligibility

criteria. Sources were excluded if they were reviews, conference proceedings, dissertations, or commentaries. Articles that exclusively concerned nursing students were also excluded. Figure 1 depicts the literature search and study selection process.

Twenty-two studies met the eligibility criteria and were included for review. The findings of this review have been organized into three subheadings: (1) NGNs' preparedness for leadership, (2) Programs supporting NGNs' clinical leadership skills, and (3) NGNs' experiences of leading.

Figure 1

Literature Search and Study Selection Process

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┌─────────────────────────────────┐
│ Records identified through       │
│ database searching (n = 1776)    │
│                                  │
│       Scopus (487)               │
│       CINAHL (492)               │
│       PubMed (519)               │
│ ProQuest Nursing and Allied      │
│      Health Database (278)       │
└─────────────────────────────────┘

                    ┌──────────────────────────┐
                    │ Records identified from   │
                    │ other strategies (n = 7)  │
                    └──────────────────────────┘

        ┌──────────────────────────┐
        │ Records after duplicates  │
        │ removed                   │
        │ (n = 1237)                │
        └──────────────────────────┘

        ┌──────────────────────────┐      ┌──────────────────────────────┐
        │ Title and abstract        │─────▶│ Articles excluded per         │
        │ screened                  │      │ inclusion/exclusion criteria  │
        │ (n = 1237)                │      │ (n = 1182)                    │
        └──────────────────────────┘      └──────────────────────────────┘

        ┌──────────────────────────┐      ┌──────────────────────────────┐
        │ Full-text articles        │─────▶│ Articles excluded after full  │
        │ assessed for              │      │ text review, with reason      │
        │ eligibility               │      │ (n = 33)                      │
        │ (n = 55)                  │      │                               │
        └──────────────────────────┘      │ Not specific to new           │
                                          │ graduates (18)                │
        ┌──────────────────────────┐      │ Commentary (9)                │
        │ Articles included in      │      │ Review (3)                    │
        │ review                    │      │ Dissertation (1)              │
        │ (n = 22)                  │      │ Book (1)                      │
        └──────────────────────────┘      │ Full-text not available in    │
                                          │ English (1)                   │
                                          └──────────────────────────────┘
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NGNs' Preparedness for Leadership

Nurse educators continue to explore innovative means to effectively teach leadership competencies during undergraduate education, trialing strategies such as simulation to boost students' leadership capacity and confidence (Frampton et al., 2017; Gore et al., 2015; Novotny et al., 2021; Sharpnack et al., 2013; Strickland & Welch, 2019; Welch et al., 2019). Despite these efforts, little research has been done to investigate NGNs' readiness to assume leadership roles and responsibilities once they have entered practice. Two studies identified in this review explored NGNs' preparedness and confidence to practice leadership skills in the complex realities of the clinical practice environment.

Mbewe and Jones (2015) explored NGNs' comfort with leadership skills and perceptions of how their nursing education prepared them for leadership in practice. From their survey of 50 American RN graduates, most respondents (84%) reported that they did not feel comfortable with their leadership skills. In rating the degree to which they perceived their education had prepared them for specific leadership skills, the average responses were highest for working and collaborating in a team (56%), followed by managing and directing nursing care (32%). NGNs conferred the lowest score on their educational preparation for working in a nursing leadership role (28%). In the qualitative response section of their survey, Mbewe and Jones (2015) also identified a lack of educational preparation for nursing leadership roles as a dominant theme. When prompted for suggestions to improve nursing curricula, participants proposed, "The charge nurse role should be implemented early on in our nursing education," and "After fundamentals, students should be given assignments where they have to act like leaders, so we can build our confidence" (Mbewe & Jones, 2015, p. 10).

Similarly, Bayliss-Pratt et al. (2013) surveyed newly qualified health professionals working in the UK to assess their confidence in detailed leadership competencies, as outlined by the National Health Service (NHS) Clinical Leadership Competency Framework (2013). From 59 respondents (69% nursing and 31% allied health), most felt assured in their personal leadership qualities and in their ability to work well with others. However, respondents were less assured of their ability to manage services or improve care. A lower degree of confidence was also reported in contributing to decisions about future organizational direction. Bayliss-Pratt et al. (2013) speculated that these results may be attributed to the relatively greater emphasis on personal qualities and teamwork in new staff's training, compared to managing or improving services or contributing to organizational decisions.

Both studies by Mbewe and Jones (2015) and Bayliss-Pratt et al. (2013) identified NGNs' confidence in their teamwork and collaboration skills, while highlighting a need for greater preparedness for nursing leadership roles and responsibilities. Though limited by small sample sizes drawn from geographically localized regions, these results suggest that there remains room for improvement in the leadership components of prelicensure RN curricula, and that NGNs require greater undergraduate or early-career support to confidently enact leadership role competencies.

Programs Supporting NGNs' Clinical Leadership Skills

Acknowledgement of the need for greater support for NGNs' leadership skills is reflected in continuing interest in residency/transition programs, mentorship programs, and continuing education interventions targeting novice nurses' leadership development. Much of the research conducted about NGN leadership in the last decade explores the impact of such programs on new graduates' clinical leadership behaviours and skills, with 11 studies on this topic retrieved for review. Most studies were conducted in the United States (8 studies),

while the remainder originated from Saudi Arabia (1 study), Canada (1 study), and Turkey (1 study). Notably, most of the studies exploring the impacts of programs aimed to support NGNs' leadership development refer to informal leadership skills and behaviours demonstrated in everyday clinical practice, without explicit connection to a formal leadership role. Patrick et al. (2011) differentiate the concept of clinical leadership as distinct from formal role-related leadership, describing it as being "demonstrated in the leader behaviours of staff nurses providing direct patient care" (Patrick et al., 2011, p. 450). To measure NGNs' clinical leadership competencies, included studies most commonly utilized the Leadership Practices Inventory (Kouzes & Posner, 2003) and the Student Leadership Practices Inventory-Self (Kouzes & Posner, 2008). These surveys consist of five subscales: modeling the way, inspiring a shared vision, challenging the process, enabling others to act, and encouraging the heart. Other studies also utilized the Clinical Leadership Survey (Patrick et al., 2011), which also consists of five subscales: clinical expertise, effective communication, collaboration, coordination, and interpersonal understanding.

Programs and interventions varied in length and content, with common elements including: leadership classes, workshops, or modules (Al-Dossary et al., 2016; Chappell et al., 2014; Dyess & Sherman, 2010, 2011; Greer-Day et al., 2015; Jeffries & Acuna, 2016; Laut et al., 2018; Luger & Ford, 2019; Wilson et al., 2018); mentorship by an experienced nurse or nurse leader (Chappell et al., 2014; Dyess & Sherman, 2010, 2011; Jeffries & Acuna, 2016; Vatan & Temel, 2016; Wilson et al., 2018); opportunities to engage in leadership committees and activities (Dyess & Sherman, 2010, 2011; Jeffries & Acuna, 2016); participation in quality improvement initiatives (Jeffries & Acuna, 2016; Wilson et al., 2018); facilitated reflection sessions (Goudreau et al., 2015); and outdoor team-building exercises during which NGNs could bond with teammates and exercise their leadership skills

(Greer-Day et al., 2015). Interventions ranged in length from a brief 1.5 hour workshop (Laut et al., 2018) to one-year and two-year residency programs (Al-Dossary et al., 2016; Dyess & Sherman, 2010, 2011; Greer-Day et al., 2015; Wilson et al., 2018).

Eight studies employed a quantitative (5 studies) or mixed methods (3 studies) approach, with all eight reporting improvements in NGNs' leadership scores post-intervention. Leadership programs drove positive changes in NGNs' clinical leadership skills and behaviours (Al-Dossary et al., 2016; Chappell et al., 2014; Dyess & Sherman, 2010, 2011; Vatan & Temel, 2016), improved confidence in their leadership capabilities (Laut et al., 2018; Luger & Ford, 2019; Wilson et al., 2018), and improved NGNs' understanding of leadership (Luger & Ford, 2019). NGN leadership programs also contributed to improved retention of new graduates (Dyess & Sherman, 2010; Greer-Day et al., 2015). Notably, programs spanning less than six months to one year (Al-Dossary et al., 2016; Laut et al., 2018) and those delivered via online learning (Wilson et al., 2018) were also found to be effective in improving leadership skills and behaviours. However, a minority of studies reported little to no improvement to certain aspects of NGNs' leadership competencies post-intervention, including confidence in communicating feedback to others, leading improvement initiatives (Laut et al., 2018) and enabling others to act (Dyess & Sherman, 2010, 2011).

Qualitative study findings, drawn from three qualitative and three mixed methods studies, were also largely positive regarding the impacts of NGN leadership programs. Reviewed articles described successes in building internal leadership capacity (Dyess & Sherman, 2010, 2011), with NGN participants being spurred towards formal leadership roles within the organization, including preceptor, charge nurse, supervisor, and manager (Greer-Day et al., 2015; Jeffries & Acuna, 2016). NGNs described improved ability to think from a

more global and systems perspective, enhanced confidence to actively participate in interprofessional communication, and improved perception of their ability to drive positive change (Dyess & Sherman, 2010, 2011; Goudreau et al., 2015; Jeffries & Acuna, 2016).

Despite wide variation in the content, length, and method of delivery of NGN leadership development programs, results of this review indicate that such interventions play a valuable role in helping new nurses incorporate leadership skills into their daily practice (Al-Dossary et al., 2016; Laut et al., 2018). Providing bespoke support for NGNs' leadership competencies can proffer further advantages at an organizational level by contributing to improved NGN job satisfaction and retention, greater engagement of new nurses in quality improvement projects, and ultimately improved services and patient care (Al-Dossary et al., 2016; Dyess & Sherman, 2011; Jeffries & Acuna, 2016).

NGNs' Experiences of Leading

In contrast to NGNs' informal clinical leadership, comparatively limited research acknowledges NGNs as formal leaders in their practice environments. The literature review retrieved nine studies which explored the role of the RN as inherently one of formal leadership by virtue of the RN scope of practice (Allan et al., 2015, 2016; Da Silva et al., 2010; Ekström & Idvall, 2015; Johnson et al., 2015; Magnusson et al., 2017; Sundberg et al., 2021; Vilela & De Souza, 2010; Whitmore et al., 2019). Although NGNs in these studies did not hold an explicit leadership role title (such as charge nurse), their RN designation automatically conferred upon them a "team leader" role (Ekström & Idvall, 2015).

NGNs' Experiences as Leaders in Acute Care. Four qualitative studies by a UK-based team of researchers explored different facets of NGNs' experiences as they supervised and delegated to healthcare assistants (Allan et al., 2015, 2016; Johnson et al., 2015; Magnusson et al., 2017). The topic of NGN leadership was identified as particularly pertinent

to the UK setting, as the role of the RN in acute care has transitioned away from direct

patient care and shifted more towards the management of care undertaken by healthcare aides

or auxiliary staff (Johnson et al., 2015). Using an ethnographic case study approach, Allan et

al. (2015, 2016) found that NGNs struggled with the domains of time management,

delegation, and supervision. While such skills were thought to be learned by NGNs "on-the-

job", the study investigators suggested that NGNs actually engaged in "invisible learning" by

learning through their mistakes, learning from difficult experiences, learning informally from

colleagues, and "muddling through" uncertainty as they adjusted to their new role in

leadership (Allan et al., 2016). As part of the same wider study, Johnson et al. (2015) found

that ward cultures and individual working styles influenced the level of collaboration

between NGNs and those under their supervision. Supportive cultures involved NGNs and

healthcare assistants working successfully together; detrimental cultures worked "in

parallel", undermining the efficiency of the team. Another secondary analysis by Magnusson

et al. (2017) identified NGNs' delegation styles, including: the do-it-all nurse, who

completed most of the work individually; the justifier, who over-explained their decision-

making rationale, at times to the point of defensiveness; the buddy, who prioritized

maintaining friendships; the role model, who hoped that others would follow their lead; and

the inspector, who constantly checked others' work. The study investigators identified the

need for educational and organizational supports to foster NGNs' effective delegation and

supervisory skills, while avoiding suboptimal leadership styles that can negatively impact

patient care and staff wellbeing.

     Delegation and supervision, however, are only two aspects of team leadership.

Researchers from Sweden (Ekström & Idvall, 2015; Sundberg et al., 2021) and Brazil (Da

Silva et al., 2010; Vilela & De Souza, 2010) more broadly explored the experiences of NGNs

as team leaders by virtue of their RN scope of practice. Team leadership was described as a significant challenge by NGNs in each of these qualitative studies, particularly in high-acuity settings where participants often had not yet developed a solid foundation of clinical skills (Da Silva et al., 2010; Vilela & De Souza, 2010). Feelings of insecurity were a recurrent theme across these qualitative studies, with NGN participants describing feelings of inadequacy to lead care due to their lack of education and experience—particularly when assuming a leadership role in a team comprising of highly experienced auxiliary staff (Da Silva et al., 2010; Ekström & Idvall, 2015; Sundberg et al., 2021; Vilela & De Souza, 2010). Participants perceived difficulties in communication and a lack of integration with their team (Vilela & De Souza, 2010), as well as little support in their leadership role from others (Ekström & Idvall, 2015). Notably, Ekström and Idvall (2015) described participants' need to dissociate from their leadership identity to avoid confrontation, with one participant stating: "…the word "leader" can be slightly negative, like you are some kind of boss, and it has a negative connotation I think. You don't go around saying that you're a leader…" (p. 80). NGN participants also described feelings of uncertainty as they perceived a lack of clarity regarding which RN was responsible to lead in the moment, if multiple RNs were present on the team (Sundberg et al., 2021); as well as a lack of role clarity blurring the boundaries of their leadership responsibilities, resulting in an overwhelming sense of accountability for all aspects of the workplace (Ekström & Idvall, 2015).

Despite these challenges, NGNs nevertheless strove to be perceived as competent leaders by being attentive to the needs of their team, and by maintaining strong communication to support team functioning (Ekström & Idvall, 2015). While they experienced a great deal of stress, participants described experiencing feelings of meaningfulness as they felt needed and important as leaders in their workplace (Sundberg et

al., 2021). NGN participants described growing in leadership confidence with experience, humility, and support from team members and mentors (Ekström & Idvall, 2015; Sundberg et al., 2021). While participants across several studies described the inadequacy of their undergraduate education in helping them meet the demands of team leadership and people management upon entering practice (Da Silva et al., 2010; Sundberg et al., 2021), other NGNs expressed the importance of experiential learning: "…it's a practical matter …it's something you can't learn theoretically, but it's something you need to practice … it's hard, difficult to practice while in school" (Ekström & Idvall, 2015, p. 81).

NGNs' Experiences as Leaders in Long-Term Care. One study investigated the experiences of NGNs in leadership roles in long-term care. Whitmore et al. (2019) used a qualitative explanatory case-study approach to explore the experiences of seven NGNs during their transition to a nurse leader role in long-term care settings in Ontario. Both RNs and RPNs participated in this study, and were perceived as being in positions of leadership in their places of work due to a smaller ratio of registered staff in long-term care compared to nonregistered workers. Newly registered RNs faced additional leadership demands than RPNs, contending with more complex and acute patients as well as managerial, administrative, and supervisory responsibilities (Whitmore et al., 2019). Whitmore et al. (2019) identified five themes from interviews with NGNs as they described their transition into leadership roles in long-term care: struggling to meet expectations; practicing in isolation; relying on others; developing skills and confidence; and recognizing the complexity and value of long-term care nursing. NGNs struggled to meet expectations as they were rapidly appointed into a position of heightened responsibility and leadership in their workplace. As the small nurse-to-resident ratio largely precluded nurse-nurse interactions, participants described being forced to independently make and expedite

decisions in their work. Trust and reliance on nonregistered team members was identified as risky, but necessary to meet the daily demands of the workplace. Despite these challenges, NGNs displayed resilience by recognizing and focusing on their personal and professional growth, although feelings of inadequacy remained.

These qualitative study findings collectively highlight a need for greater support for NGNs as they contend with the demands of team leadership in both acute and long-term care settings (Da Silva et al., 2010; Ekström & Idvall, 2015; Whitmore et al., 2019). Supporting NGNs as leaders demands greater awareness and understanding within healthcare organizations regarding the experiences and challenges of leading nursing care as a novice nurse (Sundberg et al., 2021).

Summary and Gaps in the Literature

The literature demonstrates repeated calls for greater support for NGNs' leadership competencies from both educational and practice settings. Much of the available quantitative evidence addresses programs and interventions targeting NGNs' informal (non-role based) leadership behaviours and skills. Conversely, qualitative studies exploring NGNs' leadership experiences largely focus on the leadership role of the RN in relation to teams comprising mostly of healthcare aides, technicians, or other auxiliary staff in international settings. However, there is a dearth of research addressing NGNs' engagement in frontline leadership roles such as charge nurse, particularly within Canadian clinical contexts. As leadership expectations and demands will vary across nations and healthcare sectors, there is a strong need for Canadian-based research that explores NGNs' leadership on teams comprising of nursing and interdisciplinary members.

The review of the literature also retrieved no studies that explored NGNs' engagement in leadership roles during infectious disease outbreaks or other crisis situations.

This topic is particularly timely, as COVID-19 has driven large-scale redeployments and the attrition of senior nurses (Bodine, 2020), thrusting NGNs into a challenging position wherein they may be the only option for frontline leadership roles typically held by senior staff. This study aimed to address these gaps, as a comprehensive understanding of NGNs' experiences in frontline leadership roles during COVID-19 can help inform strategies to support NGNs as leaders during the remaining course of the current pandemic, as well as during future crisis situations.

Statement of Purpose

The purpose of this interpretive descriptive study was to explore NGNs' experiences of engaging in frontline leadership roles in hospital settings during the COVID-19 pandemic. This research aimed to develop knowledge that may help inform educational and organizational strategies to support NGNs as leaders in their practice settings, including during periods of crisis such as infectious disease outbreaks. For this study, frontline leadership roles encompass any role that represents clinical leadership of one or more patient care areas, including role titles such as charge nurse, team lead, lead nurse, resource nurse, most responsible nurse, in-charge person, or unit leader.

Research Questions

The research question guiding this study was: How do NGNs experience frontline leadership roles in hospital settings during the COVID-19 pandemic? The sub-questions were: a) What facilitated or challenged their engagement in a frontline leadership role?, and b) What changes in nursing education or practice do NGNs propose would have helped them to be more successful as leaders in their workplace during the COVID-19 pandemic and/or during future crisis situations?

Methodology

This study used an interpretive descriptive approach, an "inductive analytic approach designed to create ways of understanding clinical phenomena that yield applications implications" (Thorne et al., 2004, p. 1). Interpretive description is an approach both informed by practice, and which informs practice (Thorne et al., 1997). An interpretive descriptive approach to inquiry was used to focus on clinically relevant aspects of NGNs' experiences and perspectives. These aspects included the opportunities and challenges they perceived in frontline leadership roles, the factors they found supportive or unsupportive, and recommendations they felt would help support them as novice nurse leaders in hospital settings amid a global pandemic. This focus was intended to produce insights that could help inform educational and organizational strategies to support NGNs in frontline leadership roles.

An interpretive descriptive approach was selected for this study to maintain internal consistency between research aims, epistemology, and methodology. First, interpretive description honours the epistemological mandate of nursing as an applied discipline by driving the development of knowledge that has direct applications for the betterment of practice (Thorne et al., 1997); this aligned with the epistemological motivations underlying this study's goal of producing insights that could inform future supports for NGNs who engage in frontline leadership roles. Secondly, interpretive description's constructivist approach (Thorne et al., 1997) supported the in-depth exploration of NGNs' experiences and perspectives of engaging in roles of frontline leadership. By focusing on individual NGNs' subjective and contextual experiences, this interpretive descriptive study aimed to develop practice implications that were grounded in the complex realities of the clinical environment (Thorne, 2016).

Methods

Study Setting

The study setting included hospital settings across Ontario, including acute care and community or rural hospitals. This study focused on hospital settings as other healthcare sectors, such as long-term care and community care, were expected to possess unique leadership expectations and demands during COVID-19 that are distinct to those settings.

Sampling and Recruitment

Inclusion Criteria. The inclusion criteria for this study were: newly graduated RNs (with three years or less of experience as an RN); working full-time, part-time, or casual in hospital settings in Ontario; with experience engaging in a hospital frontline nursing leadership role during the COVID-19 pandemic (defined as March 2020 onwards, as announced by the World Health Organization [2020]); fluent in speaking and reading the English language; and consent to audio-recording for an interview.

The College of Nurses of Ontario (CNO) distinguishes RNs from RPNs by length of education and scope of practice (CNO, 2018). While RNs and RPNs study from the same body of disciplinary knowledge, RNs must achieve a baccalaureate degree (4 years) while RPNs must earn a diploma (2 years) (Registered Nurses' Association of Ontario [RNAO], n.d.). As RNs study for a longer period of time, the RN scope of practice encompasses greater foundational knowledge relating to clinical practice and leadership, including assuming the role of leader within an interprofessional team (CNO, 2018). As such, only RNs were recruited for this study.

The definition for NGN used in this study is based on previous studies exploring novice nurses' transition to practice, which have defined NGNs as possessing within three years of experience in nursing (Laschinger et al., 2010, 2019; Sparacino, 2016). The

Canadian Nursing Students' Association (2019) also defines NGNs as novice nurses within their first three years of practice.

Recruitment Process. The CNO maintains a database of College members who have consented to the release of their contact information for the purpose of research in nursing. Recruitment of participants for this study took place primarily through this database. The study investigators submitted the Home Mailing Address List Request Form (Appendix A) to the CNO. Upon approval of the request, the CNO released to the study investigators a list of names and home mailing addresses of nurses who met the eligibility criteria of possessing up to three years of experience, working full-time, part-time, or on a casual basis, in an Ontario hospital setting.

From the list provided by the CNO, a random sample of 300 RNs were sent a mail-out package containing the study Letter of Information (Appendix B) and Consent Form (Appendix C). The Letter of Information invited recipients who had experience engaging in frontline leadership roles in hospital settings during the COVID-19 pandemic to contact the Graduate Student Researcher (GSR) by email if they were interested in participating in the study. Participants were offered compensation in the form of an electronic Amazon gift card ($20.00 CAD) to thank them for the time investment involved with the study activities. An electronic gift card was selected by the study investigators as an accessible and convenient means for participants to receive compensation, as participants were from across the province of Ontario.

Fourteen individuals contacted the GSR in response to the mail-out. During initial contact, the GSR addressed any study-related questions and confirmed that the respondent met the inclusion criteria. Of the 14 respondents, 13 met the inclusion criteria and consented to participate in the study. One respondent did not have experience in a role representing

clinical leadership of a team in a patient care area (e.g., charge nurse), and was excluded from the study. One additional individual was referred to the study by a participant; this individual also met the inclusion criteria and provided consent to participate in the study.

Sample Size and Sampling Method. There is no set prescription for sample size for an interpretive descriptive study, although most are between five and thirty (Thorne, 2016). Rationale for sample size limits cannot be attributed to when data reaches "saturation", as the nursing epistemology underlining interpretive description would be inconsistent with the assumption that all variations of an experience have been encountered (Thorne, 2016). Instead, sample size should be justified with rationale consistent with the research questions and aims (Thorne, 2016). For this study, an adequate sample size was considered to have been reached when a variety of perspectives had been collected to inform a rich understanding of NGNs' experiences in frontline leadership roles during COVID-19, and when a level of understanding had been reached such that the findings could help inform educational and organizational strategies to support NGNs in frontline leadership roles. The final sample for this study included 14 participants, who were selected using a mix of purposive and convenience sampling.

Interpretive description as outlined by Thorne et al. (1997) contends that those who have experienced the phenomenon of interest are often the best source of knowledge about that phenomenon, and that the generation of nursing practice knowledge requires "purposeful selection of research participants whose accounts reveal elements that are to some degree shared by others" (Thorne et al., 1997, p. 174). Purposive sampling is a technique that facilitates the identification and selection of information-rich cases to allow for in-depth study about the phenomenon of interest (Patton, 1990). This study used purposive sampling to identify and select NGNs who were able and willing to speak to their experiences and

perspectives in frontline leadership roles in hospital settings during the COVID-19 pandemic, and who therefore possessed the requisite knowledge and experiences needed to help the study investigators answer the research questions (Bradshaw et al., 2017). The goal of purposive sampling was to develop a comprehensive understanding of a breadth of NGNs' experiences, while also searching for commonalities across experiences that had important applications for nursing practice (Thorne et al., 1997). This purposive approach to sampling was mixed with convenience sampling, as the study involved the recruitment of participants who also met certain practical criteria (i.e., being easily accessible through the CNO registry of College members who have consented to the release of their contact information for the purpose of research in nursing, as well as being available and willing to participate in the study) (Etikan et al., 2016).

Nurses as a study population present unique challenges for recruitment in research, and therefore multiple recruitment strategies are recommended (Luck et al., 2017). As snowball sampling has been shown to be of benefit to improve access to challenging populations such as nurses (Luck et al., 2017), opportunities to recruit through snowball sampling were also pursued. In these instances, the participant did not provide the study investigators with any identifying or contact information, but referred the potential participant to contact the GSR by email if they were interested in participating in the study.

Data Collection

Data was collected through in-depth semi-structured interviews, of approximately 60 to 90 minutes in length. In-depth interviews provided opportunity for rich discussion regarding NGNs' experiences and perspectives, facilitating a collaborative effort towards a greater understanding of NGNs' experiences in frontline leadership roles during the COVID-19 pandemic and the ways in which they can be supported (Drew, 2008). Interviews were set

at a date and time convenient to the participant and the GSR, and were conducted through

videoconferencing via Western's association with Zoom Video Communications (Zoom) or

by telephone, in accordance with participants' preferences. As participants were variable in

their narrative style and ability to articulate their experiences and perspectives (Thorne et al.,

1997), the 60- to 90-minute timeframe was open to flexibility according to participants'

preferences and needs.

At the start of a participant's interview, the GSR reviewed the contents of the Letter

of Information and Consent Form with the participant and addressed study-related questions.

Participants were informed that they could decline to answer any questions, could request a

break during the interview or cessation of the interview, or could choose to withdraw their

consent to participate in the study. Participants were advised that withdrawal of their data

from the study after data analysis began would not be possible, as identifying information

would be removed and all participants' data grouped for analysis.

The participant was then given time to choose to provide or withhold their consent to

participate in the study. For both Zoom and telephone interviews, the participant was asked

to sign their consent form prior to the start of the interview. Participants were then invited to

answer an optional demographic questionnaire (Appendix D). Demographic data that was

collected included age, gender, length of experience, employment status, highest level of

education achieved, and type of hospital and unit on which their experiences in a frontline

leadership role took place.

The GSR then commenced audio-recording for the semi-structured portion of the

interview. Audio-recording of interviews supported intersubjectivity during data collection,

as the GSR remained grounded in the moment with participants as opposed to being

preoccupied with notetaking (Drew, 2008). A Semi-Structured Interview Guide (Appendix

E) was used to help maintain focus on topics of interest, as guided by the research questions. However, the interview allowed for flexibility in pursuing areas of importance as identified by participants (Turner, 2010). Interview questions evolved as the study progressed to reflect adaptability to emerging findings and to contribute to the richness of collected data (Pailthorpe, 2017). Questions were worded in an open-ended manner and wide-scoping questions were included to prevent premature closure of topics (e.g., "Is there anything else you would like to share about your experiences or perspectives, that you think would be important for healthcare leaders, nursing schools, and/or organizations to know?"). Potential prompts and probing questions were also prepared to encourage greater depth of answers (Turner, 2010). The GSR created reflexive field notes immediately post-interview to note the context of the interview, the GSR's positioning, researcher-participant interactions, and the potential impact that these factors may have had on the data that became available during the interview (Koch, 2006).

Following the interview, participants were given the option to return their signed consent forms via mail or e-mail. The GSR also notified participants that e-mail was not a guaranteed secure form of communication, should they choose to return their signed consent form through e-mail. All participants chose to take a digital photo or scan of their signed consent form and returned it via email to the study investigators. Participants were also asked if they were open to an optional 15-minute follow-up interview through Zoom videoconferencing or telephone. The purpose of follow-up interviews was to review preliminary findings with participants, to discuss the extent to which they felt findings were an accurate representation of their accounts, and to allow for clarifying questions (Thorne, 2016).

Audio-recordings were transcribed verbatim, with the redaction of any identifying information, and stored electronically in the Microsoft Office OneDrive Cloud Storage associated with Western University (Western OneDrive) in a password-protected study specific folder. A numerical code was used in place of the participant's name. This same numerical code was also used for participants' demographic information, which was also stored electronically in a password-protected Western OneDrive study specific folder. A master list, which linked each participant's unique numerical identifier to their name, was kept separate from demographic and interview data and from the signed consent forms in a separate password-protected study specific folder in the Western OneDrive. De-identified transcriptions were re-read to confirm accuracy while listening to its corresponding audio-recording, after which the audio-recording was permanently deleted.

Data Analysis

An interpretive descriptive approach to data analysis was used to focus on the "bigger picture" as relates to clinical relevance to the nursing discipline, and the study investigators maintained sight on the disciplinary scaffolding of the study so as to distinguish the most relevant patterns during data analysis (Thorne, 2016, p. 165). As is essential to the mandate of interpretive description, emphasis was placed on the generation of "usable" insights that were meaningful and relevant to nurses in everyday practice (Jensen et al., 2018; Thorne et al., 2016). Thus, the goal of data analysis in this study was to become familiar with each NGNs' individual case while abstracting common meanings that could ultimately inform supportive strategies for NGNs in leadership roles, which may then be applied back to individual cases (Thorne et al., 1997). Thorne (2016, p. 168) recommends considering "borrowing" analytic approaches from other techniques to achieve this goal. In this study, content analysis as described by Erlingsson and Brysiewicz (2017) was used as it is a

flexible, naturalistic, and pragmatic approach to develop knowledge of human experience through analysis of the content or contextual meaning of text data, including that which may be obtained through interviews (Hsieh & Shannon, 2005). This approach to analysis involves the "systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon, 2005, p. 1278). Erlingsson and Brysiewicz (2017) report that their approach to content analysis is based on "conventional content analysis" by Hsieh and Shannon (2005), "inductive content analysis" by Elo and Kyngäs (2008), and "qualitative content analysis of an interview text" by Graneheim and Lundman (2004). Content analysis is appropriate for studies which aim to describe a phenomenon and when existing literature on said phenomenon is limited (Erlingsson & Brysiewicz, 2017). In keeping with Thorne's (2016) guidelines for analysis in interpretive descriptive studies, this approach to content analysis allows categories and themes to flow inductively from the data, allowing for the development of new disciplinary insights that are grounded in the clinical realities of the research participants (Hsieh & Shannon, 2005).

Data analysis for this study followed Erlingsson and Brysiewicz's (2017) pragmatic, hands-on guide to content analysis, which included four reflective and non-linear stages: 1) Familiarizing oneself with the data by reading the transcript multiple times with the research aim in mind, such that the GSR reached a sense of the meaning of the interview as a whole; 2) Dividing the text into meaning units, defined by Graneheim and Lundman (2004, p. 106) as "words, sentences, or paragraphs containing aspects related to each other through their content and context", and subsequently condensing these meaning units into a shortened text that maintained the unit's main message; 3) Formulating codes, which are short descriptive "labels" for meaning units that aided the GSR in reflecting on the data in new ways while maintaining focus on the larger clinical picture (Erlingsson & Brysiewicz, 2017; Graneheim

& Lundman, 2004; Hunt, 2009); and 4) Developing categories by appraising codes and grouping those that were related in content or context (Erlingsson & Brysiewicz, 2017). Categories are short names expressing manifest content in the data, which answer "who?", "what?", "when?", or "where?" (Erlingsson & Brysiewicz, 2017). In cases where study data proved rich enough to warrant further abstraction, the content analysis was carried on towards the development of themes—a further level of abstraction that grouped two or more categories together to express underlying latent content (Erlingsson & Brysiewicz, 2017). Themes answered the questions "why?", "how?", "in what way?", or "by what means?" (Erlingsson & Brysiewicz, 2017).

In keeping with the interpretive descriptive philosophy in data analysis described by Thorne (2016), these analytic processes were not linear, one-time events, but rather a continuous and recursive process of moving between increasing levels of abstraction and returning to raw data to reflect on one's initial interpretations and analyses (Erlingsson & Brysiewicz, 2017). The GSR also alternated periods of immersion in the data with periods of immersion in interviews, such that memos, reflexive journal notes, and preliminary analyses could be used to refine questions for subsequent interviews and to inform evolving interpretations of the data (Thorne et al., 1997). For example, the GSR modified existing questions and incorporated new lines of inquiry to pursue leads and linkages as they became apparent, drawing on the larger data set to ask increasingly complex questions and enable a richer collection of interview data.

NVivo 12 Qualitative Data Analysis Software (QSR International Pty Ltd., 2020) was used to support the coding, sorting, and organization of data. This data management software did not represent the process of intellectual inquiry, and it was the study investigators who ultimately determined the synthesis and conceptualizations of data (Erlingsson & Brysiewicz,

2017; Thorne et al., 2004). To drive intellectual inquiry, the GSR kept a set of analytic notes to facilitate their ability to ask increasingly complex questions about the disciplinary relevance and meaning behind the data (Thorne, 2016). The GSR used a blank notebook dedicated for posing questions about cases, taking note of emerging patterns, and engaging the self in repeated reflections to support greater clarity in drawing connections between participants' observations and reflections (Thorne, 2016, p. 170). The GSR at regular intervals attempted to apprehend the greater picture in these analytic notes by asking "What is happening here?" and "What am I learning about this?" (Thorne et al., 1997, p. 174). As recommended by Erlingsson and Brysiewicz (2017), the GSR also kept a paper with the research aim and questions nearby, and frequently referred to this paper to maintain focus during interviews and data analysis. Concept mapping was also used as a creative exercise to support inductive analysis and to assist in achieving greater clarity of the relationships between data sources, meaning units, codes, categories, and themes (Hunt, 2009; Thorne et al., 2004).

Evaluative Criteria for Authenticity and Rigor

This study followed Koch's (2006) adaptation of Lincoln and Guba's (1985) criteria for trustworthiness in qualitative studies. These criteria are credibility, transferability, and dependability.

Credibility refers to confidence in the "truth" of findings, referring to how well the researcher's presentation of findings accurately represents the participants' perspectives and experiences (Lincoln & Guba, 1985; Nowell et al., 2017). The GSR supported credibility of the research process by demonstrating transparency and self-awareness in the role of the researcher in the development of study findings (Koch, 2006), consciously avoiding "over-inscription" of the self in the research (Thorne, 2016). This was demonstrated through

reflexive field notes created shortly pre- and post-interview that documented the GSR's

positioning and presuppositions, researcher-participant interactions, the context of

interviews, and the potential impact that these factors may have had on the data that became

available (Koch, 2006). Reflexive notes were similarly documented by the GSR during data

analysis. Through these notes, the GSR sought to maintain an awareness of pre-

understandings and assumptions to avoid the pitfall of rejecting new perspectives and settling

into familiar and anticipated codes and categories (Erlingsson & Brysiewicz, 2017). The

GSR also strove to remain neutral during data collection and refrained from strong emotional

displays that could unduly influence participants' responses (Turner, 2010). Feedback

sessions were also performed for member-checking purposes during follow-up interviews to

further enhance the study investigators' analyses and interpretations (Farren, 2015;

Leininger, 1994; Thorne et al., 1997). During feedback sessions, the GSR discussed

emerging patterns and themes with participants, and explored the ways in which the

developing findings resonated with participants to inform the ongoing analysis (Koch, 2006;

Thorne et al., 1997).

Transferability involves demonstrating applicability of findings to other contexts,

which is dependent on a thick description with adequate contextual information such that

readers can interpret whether findings are meaningful to their own cases (Koch, 2006). The

GSR supported transferability by providing a thick description of participants' experiences of

engaging in frontline leadership roles during the COVID-19 pandemic, and relaying adequate

information of participants' clinical contexts such that readers may interpret how findings are

meaningful to their own cases (Koch, 2006; Thorne, 2016). The format of 60 to 90-minute

interviews, with one optional follow-up interview, was designed to allow time for this rich

level of detail to be explored and collected. Questions within the Demographic Questionnaire

(Appendix D) and the Semi-Structured Interview Guide (Appendix E) were also designed to obtain important contextual information to support a thick description of participants' accounts.

Lastly, dependability refers to the extent to which the research process is logically and clearly documented (Koch, 2006; Nowell et al., 2017). The GSR engaged in reflexivity and created audit trails to support the dependability of this study. An audit trail and reflexive journal were used to document analytic decisions, explicitly link findings to collected data, and provide a clear map of the GSR's rationale as they moved between the data, identification of recurrent patterns and emerging codes, development of themes, and finalization of findings (Nowell et al., 2017). The GSR also documented key examples of the progression from meaning units to codes and other increasing levels of abstraction to support the dependability of the study (Erlingsson & Brysiewicz, 2017).

Ethical Considerations

This study was approved by the Western University Health Sciences Research Ethics Board (see Appendix F for the Ethics Approval Letter). Study investigators safeguarded participant privacy and confidentiality by assigning a unique numerical code identifier to each participant, recognizable only by the study investigators. Identifying information was stored separately from interview data and all study-related information was kept in a secure location accessible only by the study investigators.

Destruction of study records will be done in accordance with Western University's Information Security Procedures/Guidelines to ensure that information cannot be retrieved and used. Identifiable data will be retained for seven years per Western University policy. Study data in paper form will then be confidentially destroyed through shredding.

Confidential destruction of electronic study data will occur through electronic erasure, followed by manual or automatic verification to ensure that the data has been removed.

Findings

Fourteen in-depth interviews were conducted with NGNs from across Ontario who had experience engaging in frontline hospital leadership roles during the COVID-19 pandemic. From these interviews, four themes were identified to address the research questions: 1) *Nominated and necessitated into leadership*, 2) *Managing diverse and demanding responsibilities*, 3) *A spectrum of factors that help or hinder*, and 4) *Reflecting on leadership as an impactful experience*.

Participant Demographics

The final sample consisted of 14 participants, including 13 female nurses and one male nurse. Six participants were between the ages of 20-24 years old; four were between the ages of 25-29; and the remaining four were between 30-34 years old. All 14 participants practiced in acute care hospitals, with two participants identifying as practicing in a community or rural context. Eight participants worked full-time and six worked part-time. All 14 had a baccalaureate degree as their highest level of education achieved. Half of the participants had between 2-3 years of experience as an RN (7); six participants had between 1-2 years of experience; and one participant had between six months and one year of experience.

All participants had experience engaging in a frontline leadership role during COVID-19 on a non-permanent basis (e.g., rotating into the role or providing sick coverage for permanent frontline nurse leaders). Frontline leadership roles were typically called charge nurse, although other titles included in-charge person, most responsible nurse, resource nurse, unit leader, and lead nurse. Nine participants had exclusively engaged in these

frontline leadership roles during the COVID-19 pandemic; the remaining five participants

had been engaged in frontline leadership roles prior to the pandemic, and continued to do so

during its course. Participants' length of experience as an RN before taking on a frontline

leadership role ranged from within two months to two years, with over half of participants (8)

having done so within their first year of practice. The most common areas in which

participants had frontline leadership experience were medicine (8), surgery (5), and

emergency (3) (note: several participants worked in multiple or mixed clinical areas).

Participants also had experience in frontline leadership roles in psychiatry/mental health (2),

cardiology (1), oncology (1), rehabilitation (1), and critical care (1).

Theme 1: Nominated and Necessitated into Leadership

The circumstances surrounding NGNs' frontline leadership experiences were often

emphasized by participants as a catalyst for their engagement into roles they might not

otherwise have taken on. From participants' accounts, five types of situations in which they

were placed into roles of frontline leadership were identified: *the placeholder leader*, *the hot-*

potato leader, *the senior-junior leader*, *purposeful rotation of leadership*, and *the right*

person to lead. These circumstances were non-mutually exclusive, and participants often

reported multiple factors leading to their engagement into frontline leadership roles.

Subtheme 1.1: The Placeholder Leader. Many participants worked in settings that

had designated RNs as permanent frontline leaders from Monday to Friday during the day; as

staff nurses, participants often took over frontline leadership roles during interim periods

when those permanent leaders were not present—namely, during after-hours and weekends.

Being "placeholder leaders" outside of regular business hours came with unique challenges

for participants, who perceived both heightened responsibilities and fewer supports due to a

lack of permanent leadership presence. One participant observed:

It makes it kind of worse for the charge nurse role… I know hospitals are 24-hour

businesses, but everybody's still very much Monday to Friday, during the day.

There's so much less support on nights and it just gets a little more chaotic. (P11)

In these cases, participants often reported feelings of uncertainty as they navigated decision-making without clear knowledge of how situations would be handled by permanent leaders.

Participants also shared situations in which they had filled in for gaps in frontline leadership coverage. One participant recalled how her initial engagement into a lead nurse role was spurred by a shortage of frontline leaders exacerbated by COVID-19:

There were a lot of holes and not enough coverage during certain shifts. A lot of the

senior staff had to be redeployed to different areas… to long-term care homes to take

on leadership roles there. A lot of the more senior staff volunteered to go to the ICU,

so we were being spread thin in a lot of different directions. (P7)

In this case, the participant was approached to fill in as lead nurse on their emergency overflow unit, and grew to take on the role on an increasing basis as the demands of COVID-19 required more and more experienced and senior staff to be redeployed to other critical areas.

Subtheme 1.2: The Hot-Potato Leader. A recurring phenomenon in participants' accounts was the offloading of leadership roles to participants by senior RNs. One participant quipped, "*I call it the hot potato. Nobody wants to do it, right? They don't mind seeing us in charge, because that means they don't have to do it*" (P14). Participants noted that their more senior peers would, at times, resist frontline leadership roles, despite likely being more qualified than their junior counterparts. One participant shared:

A coworker of mine has tons of experience. She's a fantastic nurse, she's my go-to for

anything. But she says that whenever she's in charge, everything goes wrong, so she

would prefer not to do it. She's always like, "You do it, and I'll help you, but I don't

want to take [it] *on…" Some people just prefer to not have that responsibility*. (P4)

Participants noted that frontline leadership responsibilities constituted considerable additions

to a nurse's workload and liability, contributing to fatigue and burnout. One participant

further commented on the challenging context of COVID-19: "*Especially right now, I think*

burnout is worse than ever… They're just done. They're like, "I've had so many crummy

shifts in a row, I don't want to have any extra responsibilities – so you do it this time" (P11).

While participants often shared similar feelings of burden, they rarely refused roles of

frontline leadership. As newer staff, participants felt reluctant to turn down roles that had

been assigned to them; as well, participants reported feeling fewer negative feelings towards

frontline leadership roles than their more senior peers.

Subtheme 1.3: The Senior-Junior Leader. Participants recounted situations where

they were defaulted into frontline leadership roles by virtue of being the most senior RN in

their clinical area. Factors contributing to these situations included staffing shortages

(exacerbated by COVID-19), high turnover rates and the continuous attrition of experienced

RNs, as well as a generally low number of RNs to RPNs or auxiliary staff. For example, one

participant explained, "*Especially on night shift, because my unit is not a large unit, there's*

only 1 or 2 RNs on at max. So, inevitably, you end up kind of being it, regardless of the

experience you have" (P12). Furthermore, participants also observed that chance segregation

of junior and senior RNs into separate shift schedules also contributed to recurrent conditions

in which they were the most senior RN for a given shift—and therefore, the "only option" to

be assigned to a frontline leadership role.

In the absence of other experienced RNs, the presence of experienced RPN team

members was often described as a source of comfort. Despite not engaging in frontline

leadership roles themselves, RPN team members were valuable sources of clinical expertise.

Yet, one participant also described feelings of guilt when relying on experienced RPN staff:

> *You start to feel guilty because you're getting paid more as a charge nurse, and then*
>
> *you're asking all these questions to the RPN, who's pretty much doing your job at*
>
> *that point because they're helping you with every single decision.* (P11)

In contrast, participants also described leading teams comprised entirely of less experienced

nursing staff. A participant likened this to "*the blind leading the blind – neither one of us*

knows what's right, we're just kind of bumbling along" (P14). Participants relayed feelings of

fear and anxiety in such situations, as there were no experienced nurses on the team to

consult for support or direction.

Subtheme 1.4: Purposeful Rotation of Leadership. Approximately one-third of

participants described leadership as a shared responsibility in their clinical areas, such that all

registered nursing staff experienced purposeful rotation into frontline leadership roles.

Purposeful rotation was pursued to increase leadership capacity amongst staff RNs and to

reduce the burden of leadership on senior nurses. These cases were characterized by an

intention to ease the participant into the role, with the planned presence of senior staff to

guide them. One participant explained:

> *The idea was, 'We're making you charge on this night shift. It looks like it's going to*
>
> *be a quiet night. Eventually you're going to have to be charge on a less quiet night,*
>
> *so we'll get you used to this and you can ask any questions you want to Coworker Z*
>
> *who has 20-plus years of experience on this unit.* (P6)

Another participant articulated the benefits of purposeful rotation over other models

of frontline leadership (i.e., permanent frontline leaders). Due to COVID-19 restructuring, a

new charge nurse role was created at this participant's workplace. She recalled:

Most people expressed that they would love to take on that opportunity, but they

didn't want to always be in that position. So, we tried different people taking on the

responsibility here and there, and it just seems to be working. It gives people

opportunity to have a break from charge, because sometimes it's a lot. (P4)

In this case, the participant noted that purposeful rotation of the charge nurse role allowed her

to "try on" a leadership role without requiring her to commit to a permanent formal

leadership title. The participant observed that this provided a valuable opportunity to develop

her leadership competencies in a flexible and approachable manner.

Subtheme 1.5: The Right Person to Lead. A subset of participants described their

engagement into leadership roles as stemming from skills and competencies that made them

fit to lead care. These participants described possessing personality traits, specialized skills,

and clinical competencies that prompted others to view them as strong candidates for

leadership. For example, one participant described her technological savvy in using a new

electronic health record as a key reason she was often nominated for the charge nurse role:

I think it's mainly because of the way I can deal with the system that we have now… I

was a super user. I got extra training on it, so I guess they pushed me to be in charge

because I can get things done faster. (P1)

Another participant reflected on her personal attributes and experiences that made her

confident to take on frontline leadership roles: "*I'm an assertive protagonist, so I'm a pretty*

strong leader. I'm a good people person. And before I was an RN, I was an RPN… so I'm

quite comfortable participating in codes or acting in emergency situations" (P5).

In some instances, participants acknowledged that seniority did not necessarily equal

effectiveness as a frontline leader. One participant shared, "*The most senior person*

sometimes is very checked out and is not the most invested person, so sometimes a little bit of

young blood or young fire, I guess, is good for it" (P14). The participant went on to recall how she was preferentially selected for the charge nurse role over a more senior staff member due to the initiative and energy she brought to the role.

Theme 2: Managing Diverse and Demanding Responsibilities

Participants revealed a diverse and demanding set of responsibilities they fulfilled while engaged in roles of frontline leadership: *overseeing unit function and flow*, *managing and supporting staff*, *communication and conflict management*, *knowing and accessing resources to solve problems*, *advocating for quality care and safe work environments*, and *balancing behind-the-scenes and bedside work.*

Subtheme 2.1: Overseeing Unit Function and Flow. Each participant described a responsibility for oversight of their clinical area by ensuring that unit-level operations were running smoothly. This oversight ranged from the minutiae of ensuring equipment was maintained and procuring resources required for care delivery, to monitoring and addressing potential safety issues, and making strategic decisions to manage patient access and flow. Participants often characterized their responsibility—and accountability—as a frontline leader as all-encompassing, with one participant commenting:

> *I feel like automatically when you come on and you're told that you're charge, your stress level just jumps. You're like, okay, I have to pay a lot more attention to everything. Whereas, when you're not in charge, you're very much more focused on the patients you've been assigned.* (P11)

Participants also shared how roles of frontline leadership demanded a working knowledge of all activities in their clinical areas, including care plans for each patient. This was a particular challenge for participants who worked in larger areas, with participants' span of control ranging from units with less than 10 patient beds to units with over 50 beds. One participant

described the lengthy process of acclimating to her clinical area as the appointed leader for her shift: "*I would have to go from room 1 all the way to bed 32, and I would talk to the previous charge nurse of the shift… like giving report for the entire unit*" (P2).

For many participants, the COVID-19 pandemic further compounded the challenges of overseeing unit resources and managing patient flow. Participants described contending with shortages of PPE and other essential supplies (e.g., sterile drapes). Bed management decisions were also highlighted as a significant challenge, particularly in the context of rising hospital admissions and increased isolation precautions. One participant described the complexity of managing the flow of patients in the context of the pandemic:

> *You're responsible for placing COVID-positive people in specific rooms, discharging other patients, and accepting admissions from any other part of the hospital that needs room for a critical patient. And I feel like the hardest part with that is, you're constantly looking at what patient has to stay where.* (P2)

Several participants commented that it was very difficult to stay up to date with rapidly changing policies outlining the criteria for testing, placing, and cohorting potential and confirmed COVID-19 cases. While participants often sought the input and advice of others, they felt ultimately responsible for ensuring that bed management decisions within their clinical areas aligned with safe practices per organizational standards.

Subtheme 2.2: Managing and Supporting Staff. Strategic and compassionate management of staffing was highlighted by participants as a significant responsibility of their frontline leadership roles. Participants described closely monitoring staffing levels and attempting to contend with frequent shortages by reaching out to the staffing office, frontline leaders from other clinical areas, and more senior levels of leadership. Challenging decisions regarding the allocation of staff were frequently recounted by participants, who emphasized

the need for decision-making that balanced the different strengths and qualifications of team members. These decisions included the design of appropriate nurse-patient assignments and the redeployment of staff to provide coverage for shortages in other areas within the hospital.

The creation of nurse-patient assignments was often described by participants as a laborious and complex process. Participants described attempting to create fair workloads for each nurse by strategically balancing a number of factors relating to the individual nurse, the acuity and social complexity of patients, and the geography of the clinical area. For example, participants avoided placing too many high-acuity or isolated patients in one nurse's roster, ensured critically ill patients were paired with nurses of appropriate skill, and refrained from assigning pregnant team members to patients with COVID-19. One participant emphasized the need to "*strategically make* [the nurse-patient assignments] *to help people succeed in their role*" (P5). However, participants were often challenged to do so when faced with a shortage of staff and an influx of patients requiring an increased level of care. As staffing shortages were hospital-wide, some participants were also required to redeploy staff to other units in need. Again, participants described a complex decision-making process in which they balanced multiple factors: scope of practice (e.g., RN versus RPN); degree of experience, training, and skill; individual preference and comfort level; seniority; and time since last redeployment. Despite making earnest attempts to reach logical and fair outcomes, participants expressed guilt over redeployment decisions, which were a source of consternation amongst nursing staff. One participant recalled:

> *We've had people end up going home because they're just so anxious about that decision and they could no longer work. Then you feel bad, because it's like, "I'm sorry, there was no other* [way]*" … If I could go over there, I would, but I can't.* (P4)

Throughout these decision-making processes and in their daily functions as frontline leaders, all participants continually emphasized their role in supporting their team members as best they could. Many participants eschewed their frontline leadership role as one of authority over others, instead framing the role as one of greater responsibility to support team members. For most, feelings of responsibility towards others stemmed from their personal philosophies regarding effective leadership. One participant shared her approach to the charge nurse role: "*I like to be a charge nurse that gets their hands dirty. Even though I'm a new charge nurse, I'll be quick to jump in and help when help is needed. I think that's being a strong leader*" (P5). Many participants shared the sentiment that the frontline leaders they had admired and aspired to emulate were those who had been highly visible and present to aid them when needed. Pressure to support team members also stemmed externally: "*Definitely when you're charge, you feel an added expectation for you to be an assistant to your coworkers*" (P4). As a result of these internal and external pressures, some participants reported foregoing their own work and even breaks to assist team members in patient care.

Subtheme 2.3: Knowing and Accessing Resources to Solve Problems. While engaged in frontline leadership roles, participants described being frequently called upon to solve unexpected problems and troubleshoot issues in their clinical areas. Some problematic situations described by participants included: the need to use or troubleshoot unfamiliar devices (e.g., chest tube or dialysis machine); acute deterioration of a patient's condition; fire and smoke in proximity to the unit; and challenging patient discharges. As new graduates, participants acknowledged that many of these situations were novel to them as well. Yet, they were able to provide direction and leadership to their teams in unfamiliar situations by demonstrating a sound awareness of, and ability to connect to, appropriate resources for information and support. For example, one participant described the multiple options that

were available to her while troubleshooting errant dialysis machines: "*There are other units that work with PD dialysis, and I'm always able to call them… There's a number on the machine as well, so if I had any technical issues, I can always call them*" (P1).

Participants described a need to establish a strong familiarity with a multitude of key contacts, specialized staff, and interdisciplinary resources, in order to address a broad range of issues. One participant shared the importance of both knowing who to communicate with, and how to communicate with them, to help her facilitate patient discharges:

> *I understood what phone calls I had to make, who can do the specific things for me that I need to get done before this patient can leave…. If I knew who I needed to call, I felt like getting the answer was a lot easier than asking who to call and then not knowing how to articulate what I need properly*. (P2)

Participants acknowledged the limitations of their knowledge and experiences as new graduates, but emphasized their resourcefulness in knowing where and how to access the information they needed to respond to the diverse and unpredictable issues that emerged in their clinical areas. For example, several participants described tapping into their hospital intranets or organizational websites, which listed resources and contacts within the hospital and housed up-to-date policies of direct relevance to issues encountered by participants and their teams.

Subtheme 2.4: Communication and Conflict Management. Participants emphasized the importance of maintaining open and transparent channels of communication to facilitate patient care, to foster positive relationships with team members, and to mitigate and manage conflict. Participants perceived frontline leadership roles as centralized hubs for communication between frontline staff, patients/families, interdisciplinary team members, leadership, and other clinical areas within the hospital. One participant likened the role she

played as a charge nurse to a "gatekeeper": "*Everybody brings the information forward, but you're the gatekeeper, because you have to pull that information from them, and make sure that they're responsible for their contribution into that patient's care*" (P5). In this case, the participant highlighted the role of the frontline leader in facilitating communication between team members to develop and enact a cohesive care plan.

As liaisons between senior leadership and the frontline, participants were also often responsible for communicating and implementing important COVID-19 policies in their clinical areas. One participant recalled the challenges she encountered in communicating with team members when lapses in tightened infection control precautions had occurred:

> *If you saw it, you had to go and directly address it right in the moment, and that was definitely difficult for me, because a lot of the times, it's the people I work with, my colleagues, people I'm friends with.* (P7)

Participants were also often challenged to field and respond to complaints from frustrated staff, patients, and families. One participant explained, "*Management is not always there to hear their problems, and that's why they always go to the charge nurse with the issue*" (P1). In particular, participants described issues with nurse-patient assignments and restrictive visitor policies (stemming from COVID-19) as points of frustration for staff and patients/families, respectively; as frontline leaders, participants were responsible for addressing and de-escalating these situations.

To prevent and address conflict in the workplace, participants favoured empathetic, transparent, and (where possible) democratic approaches in their communications with staff, patients, and families. One participant described her gentle communication style when addressing patients' families and attempting to reach a mutually agreeable solution: "*As the charge nurse, I did a lot of that – of just trying to talk to people, reassuring them and*

calming them and trying to find creative ways for them to be able to see their family

members" (P12). Similarly, another participant shared her relational approach to entering

difficult conversations with team members who had not adhered to heightened infection

control standards (e.g., zero tolerance for food and drinks in the nursing station):

> *I try to be more light-hearted, and not in a punitive way, like you're trying to scold*
>
> *the person. Because I also understand where everyone's coming from, because I am a*
>
> *staff nurse, too… It may be a bit easier if I can tap into that 'friendship' aspect of it,*
>
> *but then also deliver the message I need to deliver.* (P7)

Overall, participants highlighted the need for a lateral communication style to mitigate

conflict and promote understanding and cooperation from staff, patients, and families.

Subtheme 2.5: Advocating for Quality Care and Safe Work Environments.

Participants emphasized their obligations in frontline leadership roles to advocate for their

clinical areas and those within them. Again, participants downplayed their leadership roles as

ones of authority, instead underscoring their heightened responsibility to promote healthy

working conditions conducive to high-quality patient care. One participant drew this

distinction as she commented:

> *I think it's important to know that being in charge is not so much of a power move as*
>
> *it is an opportunity to reach out to the team, and to help create the best care for the*
>
> *patients by advocating for the team.* (P13)

Advocacy took many different forms for participants, including: collaborating—and at times,

conflicting—with leadership or other departments to ensure that patients were placed into

units that would best meet their needs; requesting temporary delays in admissions to ensure a

safe transfer of care; rallying staff to identify and address unsafe working conditions; and

campaigning for improved staffing to reduce burnout and support patient care.

Several participants commented on the degree of strength and effort required to advocate for one's clinical area amidst the competing interests present in a busy hospital environment. In some cases, participants described triumphs that led to improved conditions for staff and patients. For example, one participant shared:

> *I told them that adding another RN to the night shift staff would help alleviate the burnout and stress that these nurses are experiencing… It was a lot of work, but finally we got the extra RN onto our night shift line, and I feel like it really did benefit the nurses*. (P2)

However, other participants perceived that their advocacy efforts were met with apathy or resistance. One participant recalled her attempts to respond to frequent staffing shortages and pleas from her team to appeal for more nurses to be hired: "*You try and advocate and say those things, but at the end of the day… I don't feel like what I have to say makes that much of a difference in the grand scheme of things*" (P12). Despite holding a frontline leadership title (albeit on a non-permanent basis), participants at times felt they had little influence or power to drive positive change within the context of a complex hospital environment. Nevertheless, participants acknowledged that, while engaged in frontline leadership roles, they played an integral role as the voice of their clinical areas and the patients and staff within them.

Subtheme 2.6: Balancing Behind-the-Scenes and Bedside Work. When engaged in roles of frontline leadership, participants described a juggling act between working alongside their team members "at the bedside" and performing important administrative tasks "behind-the-scenes". While participants acknowledged the need to remain connected at the point of care, much of their time and energy was also commandeered by a wide variety of "behind-the-scenes" work, including: attending meetings wherein they represented their clinical areas

and received important information to communicate to their teams; making and receiving phone calls to maintain communication with leadership and other key contacts; and continually navigating the electronic health record to stay up-to-date with patient care plans, to input physician orders, and to facilitate patient access and flow. While some participants prioritized patient care, others felt that certain administrative tasks could not be delayed. However, participants were often conflicted in their decisions. One participant shared:

> *I feel like I'm constantly in meetings and constantly on the phone, constantly defusing situations, constantly in crisis. So in the end, patients come secondary, when they should always be the center of care, right? But because I have these competing priorities, I would get pulled away.* (P5)

Notably, most participants additionally managed their own patient assignment while engaged in frontline leadership roles. In some cases, frontline leaders were routinely expected to carry a patient load. However, some participants were required to take on a full patient assignment while engaged in a frontline leadership role due to a shortage of staff nurses. One participant articulated the compounded challenge of being a novice to both patient care and frontline leadership, while being expected to accomplish both concurrently:

> *When you're a new nurse, you're just struggling to keep up with your patients. So then when you have people coming and asking you questions, or coming to you to get help with their patients as well, suddenly you're way behind.* (P11)

Overall, participants described continual shifts in their focus from unit-level responsibilities and the needs of individual patients and team members. Despite endeavouring to adequately serve both, many participants acknowledged that they struggled to perform administrative tasks without sacrificing patient care to some degree (and vice-versa).

Theme 3: A Spectrum of Factors that Help or Hinder

Participants identified a range of factors that influenced their experiences as frontline leaders. These factors were categorized into five subthemes: *degree of role clarity and preparation*, *team culture and composition*, *manageability of workload, availability of interdepartmental and interdisciplinary supports,* and *leadership education and continuing education opportunities.*

Subtheme 3.1: Degree of Role Clarity and Preparation. Most participants identified that they did not receive a formal orientation or training for frontline roles of leadership. As a result, participants often described engaging into those roles without a clear understanding of their responsibilities or expectations. One participant recalled: "*I started my shift and then I realize I'm the charge nurse. What do I do as a charge nurse? I don't know! "I guess you guys don't have a charge nurse tonight!" – that's what I told them*" (P8). Participants who had been thrust into leadership roles with little preparation expressed surprise that they had been expected to do so, with one participant commenting, "*A lot of it is learning on the job, which is just mind-boggling. How are you in charge of a floor when you don't even know what the specs are?*" (P11). Participants shared that much of their understanding of frontline leadership was formed through informal avenues of learning— most frequently, by consulting experienced nurses or by observing other frontline leaders. Several participants expressed a wish that they had been warned ahead of time that they would be expected to take on a frontline leadership role, such that they could have better prepared on their own time if no training was to be provided. For example, one participant who received such advanced notice described arranging for her own informal learning opportunities: "*I approached one of the other leads and asked them for a rundown. Kind of like a mini-orientation, on my own time*" (P7).

For the minority of participants who received training, this most often constituted shadowing a nurse in the frontline leadership role. The length of this orientation ranged from one shift to two weeks. Overall, participants viewed shadowing as a helpful exercise, and those who did not have the opportunity to do so often perceived shadowing as an experience they wished they had been afforded. However, training opportunities were at times precluded by staffing and resource shortages, which had worsened in the pandemic environment. One participant recalled that, while her workplace offered shadow shifts to orient staff, she had nevertheless been required to take on the charge nurse role well before her shadow shifts were scheduled due to staffing issues. For many participants, however, training for frontline leadership roles was not routine organizational practice. One participant shared, "*I was told, "In your collective agreement, it doesn't state anywhere that training is to be provided." As an RN, it's a role that you're expected to take sometimes - that's part of your role*" (P14).

To obtain a better understanding of the responsibilities of their frontline leadership roles, participants described turning to their leaders for greater role clarity and direction. In the absence of formal training, several participants were gladdened to have leaders that were highly visible and available to answer their questions and provide clarification and support in complex situations. However, this degree of support was often not available during after-hours and weekend periods. Furthermore, some participants observed that COVID-19 had also increased the burden on their leaders as well, which may have adversely impacted the level of direction and support that leaders could offer them. Several participants also reported requesting a formalized list of role responsibilities and expectations from their leaders, although some struggled to obtain such resources. One participant reflected: "*I think they weren't anticipating people stepping into the role on an as-needed basis, so that's probably why they didn't prioritize making a resource for people that don't necessarily do those roles*

as often" (P7). As all participants engaged in frontline leadership roles on a non-permanent basis, several suggested that some form of standardized work would help them remain consistent with their full-time frontline leader peers.

Subtheme 3.2: Team Culture and Composition. Participants highlighted the significance of workplace cultures that were supportive of their on-the-job learning as they adapted to roles of frontline leadership. Participants expressed a need for latitude and understanding from others as they inevitably had to learn from their mistakes. For example, one participant shared the constructive approach taken by her workplace as she navigated decision-making in a leadership role: "*There were things that I maybe didn't make the best decision, but they were like, "Okay, so next time…" It's never being punished or told off, but just encouraged in a direction to go next time*" (P4). However, most participants reported challenges in securing the feedback they felt was needed to improve in their leadership role. Several participants recalled receiving hurtful comments which made them question their leadership and decision-making capabilities. One participant shared his reaction to such comments: "*You're not helping me make a better decision, you're just making me feel terrible for the decision I've already made*" (P11). Other participants reported being met with dismissiveness; for example, one participant shared the unhelpful feedback she received regarding the nurse-patient assignments she had created:

> *Just like, "Oh, it's fine. Don't worry about it. Yeah, they're going to be pissed off. They're always pissed off about their assignment." There's never, "This is what I would do," or "Yeah, your train of thought made sense," or "Maybe you should prioritize this more." Like they don't care enough to… they could be burnt out and all that, to offer any guidance in how to improve it for next time*. (P14)

In addition to constructive feedback, participants also expressed a desire for positive reinforcement from others: "*It's definitely nice when peers or leadership recognizes that effort and reassures that, you know, it's not easy, but it is a good job that you're doing… because that little bit would go a long way*" (P7). Participants whose efforts had been recognized reported feeling pride, relief, and affirmation in their role; others who lacked such feedback were at times left questioning whether they were right for the role or performing as expected.

Participants further expressed that much of their experiences as frontline leaders hinged upon the capacity of their teams to provide them with much-needed support. One participant stated, "*The two main things I would say can impact if I'm having a good day or a bad day: who I'm working with, and if we're fully staffed*" (P2). This sentiment was echoed by most participants: those who had adequately staffed teams, characterized by supportive cultures and comprising of experienced members, relayed more positive experiences in frontline leadership roles than those who did not. Many participants expressed gratitude towards their teams, who viewed effective unit functioning as a shared goal and who aided them in their leadership responsibilities. For example, one participant praised the supportive culture of her team: "*They're never like, "Oh, you're charge, it's your problem to deal with." Everyone's happy to jump in*" (P4). Participants further communicated feelings of relief and security when experienced RNs and RPNs were present, who could function with high levels of autonomy and who were rich sources of clinical and unit-based knowledge. However, a subset of participants acknowledged that high levels of team cooperation and collaboration were not always present, leading to increased pressure and feelings of isolation. One participant shared:

The way that I perceive [the charge nurse role] *and take it on is, it's all on me. And some days you feel that more than others, depending on the staff you work with… when you're working with newer staff or different staff that you don't fully agree with the way they do things, then I really feel it so much more.* (P12)

A subset of participants reported issues with more experienced team members who were not receptive to their leadership style or direction. In these situations, participants reported the added burden of having to defend, adjust, or compromise their plans (e.g., to admit a patient) to secure the cooperation of a reluctant team member. Overall, participants who led teams with a low capacity and/or willingness to provide support expressed perceiving a greater burden of leadership and were less apt to view their frontline leadership experiences in a positive light.

Subtheme 3.3: Manageability of Workload. Participants highlighted the need for reasonable workloads that allowed them time and energy to focus on their leadership responsibilities. Several participants identified that they felt more capable and effective in roles of frontline leadership when they did not have to "split" themselves between a patient caseload and their leadership responsibilities. One participant described the struggle to fully enact her leadership role when also caring for a patient assignment: "*I want to do a good job at both, and it's very difficult to. I don't like to half-ass being in charge*" (Participant 14). However, many participants were routinely expected to take on a patient assignment while engaged in frontline leadership roles. In contrast, one participant who was not expected to do so (unless her unit was short-staffed) shared, "*When I'm not having to take patients as well, I usually feel pretty good because I feel more in control of the situation and I have more time to deal with the stresses of the charge nurse role*" (P12).

Staffing was highlighted by several participants as one of the most significant factors influencing the quality of their experiences as a frontline leader during a shift. A participant shared the significant impact of staffing on their workload when engaging in a frontline leadership role:

> *The staffing piece is the biggest one, because that means you can actually take your full breaks, and not just trying to eat as fast as you can so you can get back out there. You can have a pee break or drink some water. Especially right now with PPE, it makes such a big difference.* (P12)

As participants were responsible for overall unit functioning while engaged in frontline leadership roles, participants reported feeling pressured to overextend themselves to fill gaps in care when their teams were short-staffed. Such shortages were noted to be all the more frequent in the context of COVID-19.

Subtheme 3.4: Availability of Interdisciplinary and Interdepartmental Supports.
Participants described reaching beyond their clinical areas and outside of their discipline for integral resources and supports. The availability of these supports and resources varied among participants' accounts. Experienced nurses and frontline leaders from other clinical areas were identified as key resources, particularly in situations where participants' own clinical areas lacked experienced staff. One participant described a culture of support and reciprocity between different units, stating, "*I was told to give other units a call, so that was always ingrained in me… They've always been really receptive, always willing to come over to give a hand or to have a second look at a patient*" (P9). Participants further described how specialized nursing staff from various units or teams could be called upon to help in difficult situations that were growing beyond their teams' knowledge or capabilities. For example, participants noted that nurses from the ICU or ER could be called upon to provide guidance

in critical patient situations. However, for some, procuring external help was not easy. One participant commented: "*We can draw on our ER and ICU nurses, but then you're taking them away from their roles… They're busy, and they're short-staffed, so it's hard*" (P12). In this case, the participant worked in a community hospital, which she acknowledged as possessing fewer staff and resources than larger urban centers. Some participants further described their interdepartmental peers as sources of stress as opposed to support, particularly when attempting to negotiate patient access and flow. One participant shared:

> *If other unit leaders that you're communicating with are angry or very frustrated – we've had some people be very critical of us, like, "Why is this bed not ready? We called so long ago!" And you're like, "We're dealing with 10 other things right now, we had someone almost coding!" Sometimes that makes it difficult and isn't helpful.*
> (P4)

Participants emphasized the need for interdepartmental cooperation and understanding, which was not always afforded to them in the context of considerable pressures to maintain patient flow.

Participants also highlighted the role of interdisciplinary resources in helping them fulfill the diverse responsibilities of their frontline leadership roles. Several participants noted that a working knowledge of different interdisciplinary roles allowed them to leverage various professions' unique talents. One participant shared:

> *I didn't understand how much the social worker is involved in discharging a patient, for example, or the dietician, or even the drug navigator. I didn't really understand what they do until I was in the role, and I needed their help.* (P2)

While interdisciplinary team members were valuable sources of support, some participants perceived communication barriers or a lack of interdisciplinary resources altogether. For

example, a participant who worked transiently across various units as a float nurse noted that a lack of familiarity with the medical team precluded efficient interdisciplinary communication: "*I don't know the physicians, so I don't have that relationship with them where I can just call up the surgeon, unless I'm floating to units I've worked on in the past*" (P5). Another participant working in a community hospital described challenges in managing critical patient situations during off-hours, as respiratory therapists were only available during the day. In contrast, participants who worked in larger hospitals and who were able to form positive working relationships with interdisciplinary peers expressed more positive experiences in being able to access key interdisciplinary supports.

Subtheme 3.5: Leadership Education and Continuing Education Opportunities. Participants were split with regards to the perceived value of their BScN educations in preparing them for frontline leadership roles. While some participants felt that their education had been lacking in that regard, others felt that they had received a solid foundation of skills and competencies that allowed them to further grow as leaders in their workplaces. Aspects of education that were perceived to be relevant to frontline leadership included interdisciplinary scopes of practice and collaboration, delegation, communication, critical thinking, and resilience. Participants also underscored the importance of a strong base of clinical competencies, which was often the focus of undergraduate education. While some participants recalled attending leadership courses, most felt that they failed to convey the realities of frontline leadership. One participant stated: "*It was very broad-spectrum, like if you're introducing a brand-new policy to a unit... But I feel like it's not common for you to implement a brand-new policy as often as dealing with colleague disputes*" (P2). Recurrent suggestions across interviews included a need for realistic scenario-based content, as well as opportunities to engage with frontline leaders (e.g., as speakers or preceptors) to bridge the

gap between education and practice. Many participants also described the need to correct an assumption that frontline leadership roles were reserved for experienced RNs, with one participant recalling:

> *Most things I read about or learned about either didn't discuss the timeframe that would take place before you could possibly be in a charge role - either stated or kind of implied it would be once you have a ton of experience.* (P11)

However, as frontline leadership roles were noted to differ across units and facilities, participants acknowledged that it would be difficult for nursing schools to develop specific content that could have directly prepared them for the diverse demands of frontline leadership. Furthermore, some participants reflected that they were not yet "ready" to benefit from frontline leadership education as students. One participant recalled, "*During school, you were so caught up in the skills… so, those roles, you're not really thinking about them as much. Maybe, sometime down the road - but it wasn't personally my first priority*" (P7). These participants expressed that greater undergraduate emphasis on leadership would not have necessarily helped them better engage in frontline leadership roles upon entering practice. Rather, opportunities for post-graduate education were highlighted as an area of importance. One participant reflected that she would derive much greater benefit from leadership education at the present stage of her career: "*If I took that leadership course I took in my BScN now, I'd probably understand it much more and take a lot more from it, for sure*" (P7). Participants expressed a desire for conferences, courses, or seminars to hone their leadership competencies. Courses to improve clinical competencies were also perceived to be beneficial to participants, such that they could better support acute patient care. Continuing leadership education was thought to be particularly timely in the context of COVID-19, as several participants felt that they had been prematurely thrust into leadership roles as a result

of redeployments and staffing shortages instigated by the pandemic. Yet, paradoxically, continuing education opportunities were noted by participants to be restricted due to social distancing measures and the funneling of resources towards essential healthcare services.

Theme 4: Reflecting on Leadership as an Impactful Experience

Participants described the professional and personal impacts stemming from their engagement into frontline hospital leadership roles. These impacts comprised four subthemes: *developing a big-picture perspective*, *experiencing a mental toll*, *experiencing growth and empowerment*, and *forming a leadership identity*.

Subtheme 4.1: Developing a Big-Picture Perspective. Participants described an expansion in their clinical perspectives as an outcome of their engagement in frontline leadership roles, frequently citing an enhanced understanding of the "bigger picture" as related to hospital and team functioning. For example, one participant described his broadened sense of responsibility to his unit and team:

> *It makes you really want to help everybody get everything done instead of rushing to get your patients settled, and then running away to chart or have a snack before anyone else has a chance to. I feel like once you've been in the charge role, you're more equipped to be helping other people as well as your patients.* (P11)

Participants further noted an expansion of their perspectives beyond their own clinical areas as they formed a system-level understanding of their complex hospital setting. This "big - picture" perspective was enlightening to participants who were otherwise accustomed to receiving only the information needed to provide care to their patient assignment. However, some participants found such knowledge to be disappointing at times:

> *You're seeing the more business side of the hospital, which is not always the nicer side to see. You see a lot of what is going on behind the scenes, and why things*

happen a certain way, which is helpful for sure. But it can be super frustrating

because you know that certain decisions were made for, maybe, not the best interests

of the nurses. (P4)

Nevertheless, participants appreciated the increased transparency in hospital functioning that they were privy to as frontline leaders, and felt that their broadened understanding left them better equipped to advocate for their patients and teams.

Subtheme 4.2: Experiencing a Mental Toll. Participants described heightened stress and anxiety as a result of their engagement into roles of frontline leadership. Participants who felt ill-prepared to meet the demands of the role conveyed feelings of personal inadequacy and guilt towards their teams, with one participant sharing:

It feels like you're not good enough. Like, why am I in this position? Definitely,

someone is out there that can do it better than me… it did take a toll on [my] *mental*

health. I would feel very burnt out after every single shift. (P2)

As frontline leaders, participants often felt pressured to please everyone on their teams; yet, most acknowledged that doing so was rarely possible. For example, one participant recalled recurrent situations in which her team was forced to work short-staffed:

The best solution is to find a replacement, but it's not always feasible. Then your

responsibility is to rearrange the assignment, but it is impossible to make everyone

happy because there has to be someone that takes a heavier workload. (P8)

Though participants made concerted efforts to make decisions and manage limited resources safely and fairly, they perceived that their efforts were not always valued. Furthermore, as the most proximal leader to the point of care, several participants perceived that they were targets for anger and frustration stemming from issues that were often intractable and systemic in nature—including nursing shortages, staff burnout, and the unprecedented impact

of COVID-19. One participant recalled, "*The* [COVID-19] *numbers were just through the roof… you could see that people were burning out. And it was hard, being in that position as a leader, and you don't really have a solution to that*" (P7).

In some cases, participants who experienced a mental toll from their engagement in frontline leadership roles questioned their commitment to the role and to future leadership opportunities. One participant described how her challenging experiences shook her resolve:

> *It's a lot of responsibility, and it's not glamorous at all. You have to fight with people and no one's happy, ever, and you have to deal with all this BS. And you get nothing for it, financially… you get peanuts for it. So it's kind of like, what am I struggling with this for? What am I putting all this effort in for?* (P14)

Notably, several participants found that the stress associated with their engagement into frontline leadership roles diminished with time and experience, and with a gradual acceptance that they could not reasonably expect to make everyone happy, know all answers, and solve all problems.

Subtheme 4.3: Experiencing Growth and Empowerment. The demanding nature of frontline leadership roles, while at times mentally and emotionally draining for participants, was also perceived as a catalyst for growth. One participant reflected on her overall experiences as a frontline leader: "*Despite it being stressful, I felt like I grew and I learned a lot*" (P7). Participants perceived that their leadership experiences accelerated the development of their professional competencies, including communication, critical thinking, decision-making, problem-solving, and conflict management. Participants also expressed a determination to address their limitations as leaders through opportunities for professional development. For example, one participant shared:

I was more willing to take on, even as a staff nurse, different assignments, different patients, and to go to more education events. I was interested in increasing my knowledge and learning about things I wasn't comfortable with. It made me feel like, if I'm going to be in that position, I should know what I'm doing. (P2)

For most participants, who did not self-identify as "natural leaders", engagement in frontline leadership roles also helped foster confidence and assertiveness. Several participants who described themselves as shy or indecisive expressed that their frontline leadership experiences helped them learn to "form a backbone" or "stand their ground". Participants further described feeling empowered to actively advocate for patients and team members, to readily step up to assist others, and to confidently act as full members of the interdisciplinary team. For example, one participant shared how being in a charge nurse role empowered her to address workplace violence (directed from a physician towards a nurse) in a way she felt she could not have done outside of a leadership role: "*I wasn't always that nurse who would have stood up to that doctor… But I felt like it gave me the responsibility, a power in a way, that I could speak up, because I had that role*" (P14).

Overall, participants emphasized the value of their frontline leadership experiences in spurring personal and professional growth. As such, most participants viewed rotation into frontline roles of leadership as valuable opportunities for NGNs to improve their clinical and leadership practice, provided adequate support is available to them.

Subtheme 4.4: Forming a Leadership Identity. Participants expressed that they had a greater sense of themselves as leaders in their practice settings as a result of their frontline leadership experiences. Engagement into frontline leadership roles prompted participants to overcome self-doubt and re-evaluate their leadership capacity. One participant, who had been obliged to provide short-notice coverage for a charge nurse who called in sick, reflected:

I probably wouldn't have become charge if that moment hadn't arisen for me… I feel like I would always just be in this circular mind, thinking I don't have that much experience, and I would always feel that way. But… when I kept doing it, I was like, okay, you know what? It's not that bad. (P1)

Another recurring sentiment among participants was a broadening of their perspectives of career possibilities, particularly to include other leadership roles. For example, one participant commented that her engagement into a frontline leadership role "*allowed me to see that I was able to do it*" and spurred an "*interest in being able to do it further, in a different level and different capacity*" (P7). While most expressed a heightened interest in other leadership roles, a subset of participants felt they still had much more to experience before they could consider further leadership opportunities. Conversely, others felt ambivalent about pursuing it any further, with one participant contemplating:

I've kind of grown to like it, but at the same time, there is this sort of hesitancy… I have to deal with this, for 8 hours every day, Monday to Friday. Do I want to have people yell at me every day? (P1)

In addition to a heightened personal awareness of their leadership identities, several participants noted an analogous change in their teams as well. One participant shared:

It kind of makes people think of you as a more capable nurse or somebody who can accomplish more than maybe they initially thought… maybe they appreciate working with you more after they've seen you successfully navigate a shift as charge nurse, or just appreciate how much you help them when you are charge. (P11)

Many participants felt that their frontline leadership experiences allowed them to build a leadership identity in their workplaces, such that coworkers continued to look towards them

for advice and support—whether they were actively engaged in a frontline leadership role or not.

Discussion

This interpretive descriptive study sought to explore the experiences of NGNs as they engaged in roles of frontline leadership in hospital settings during the COVID-19 pandemic. Four themes were identified from in-depth interviews with 14 participants: 1) *Nominated and necessitated into leadership*, 2) *Managing diverse and demanding responsibilities*, 3) *A spectrum of factors that help or hinder*, and 4) *Reflecting on leadership as an impactful experience*. By improving understanding of NGNs' experiences as frontline leaders, this research aimed to develop knowledge that could help inform strategies to support new and junior nurses in roles of frontline leadership.

Theme 1: Nominated and Necessitated into Leadership

The first theme, *nominated and necessitated into leadership*, illuminated the various circumstances that contributed to NGNs' engagement into frontline leadership roles. All participants engaged in such roles on a non-permanent basis, either as relief coverage for permanent frontline leaders or as part of a roster of RNs who rotated into a leadership role on a shift-by-shift basis (e.g., shift charge nurse). In many cases, participants identified that their engagement into roles of frontline leadership felt premature and unexpected, and that they likely would not have chosen to do so by their own volition; rather, they had been nominated into roles of frontline leadership by others or had been compelled to take on such roles due to their clinical contexts. Previous research has indicated that NGNs lack competence and confidence in leadership, including in areas such as delegation, prioritization, conflict resolution, and ability to anticipate potential risks (Bagnardi, 2014; Theisen & Sandau, 2013). Yet, there is a dearth of research that explores how and why NGNs may nevertheless

be called upon to fulfill frontline leadership roles that are ostensibly reserved for experienced

RNs who have achieved a high level of clinical and leadership expertise (Delamater & Hall,

2018). The findings of this study shed light on various clinical situations in which NGNs

have been called upon to engage in frontline leadership roles in hospital settings, including as

the placeholder leader, *the senior-junior leader*, *the hot-potato leader*, *purposeful rotation of*

leadership, and as *the right person to lead*.

As *place holder leaders*, participants took on frontline leadership roles when

permanent leadership was not present. Place-holding for permanent leaders during evenings,

nights, and weekends was accompanied by unique challenges for participants, who perceived

both heightened accountability and reduced availability of supports during these periods.

Similarly, an international study by Admi and Eilon-Moshe (2016) found that "responsibility

burden" and "lack of resources" were the most stressful factors experienced by hospital shift

charge nurses in Israel, United States, and Thailand. Notably, higher stress levels were found

among younger shift charge nurses (Admi & Eilon-Moshe, 2016).

Within Admi and Eilon-Moshe's (2016) study sample of 2616 hospital shift charge

nurses, approximately one-fifth had less than five years of nursing experience, with the

United States possessing the highest proportion of early-career shift charge nurses (28.4%).

These findings further tie into the second subtheme, *senior-junior leaders*, in which NGN

participants described recurrent situations in which they were the most senior RN available to

take on roles of frontline leadership. While previous research suggests that staff nurses are

selected for frontline leadership roles because of their experience and expertise (Homer &

Ryan, 2013), participants in this study shared situations in which they had been defaulted into

roles of frontline leadership because they were the only RN on the unit, or by virtue of a

marginal difference in seniority between themselves and other, newer RNs. The lack of

experienced and senior RNs noted by participants in this study may be attributed to multiple

factors, including: the aging RN population and the growing number of senior nurses retiring

(Canadian Institute for Health Information [CIHI], 2019); alterations to skill mix resulting in

a lower percentage of RNs to RPNs and auxiliary staff as a means to reconcile workforce

shortages and economic constraints with growing patient acuity, ultimately resulting in

greater supervisory responsibilities for RNs (Jacob et al., 2015); and the exacerbation of the

pre-existing nursing shortage, magnified by occupational infections, stress, and burnout

caused by the COVID-19 pandemic (International Council of Nurses, 2021).

Participants also described being unexpectedly thrust into frontline leadership roles as

hot-potato leaders—a phenomenon involving the offloading of leadership roles to NGNs by

more experienced RNs, who generally perceived those roles as undesirable. While this

finding is in line with previous research that explores the difficulties in recruiting nurses into

frontline leadership roles (Carlin & Duffy, 2013; Dillard-Henderson, 2018; Sherman et al.,

2011), the offloading of leadership roles to junior nurses has not been explored previously in

the literature. A study exploring newly qualified staff's perceptions of charge nurse roles by

Carlin and Duffy (2013) found that new nurses also viewed such roles as unattractive, with

lack of trust, responsibility, and negative feedback cited as the most off-putting factors.

However, while participants in this study similarly described an initial (and at times,

ongoing) aversion to roles of frontline leadership, few had refused their nomination or

placement into such roles. Study findings indicated that NGNs possessed a generally more

positive outlook towards frontline leadership than some of their more senior peers.

Furthermore, as new employees, NGNs were often hesitant to decline frontline leadership

roles that had been assigned to them, despite initially feeling unprepared or unqualified to

fulfill such roles.

The two remaining subthemes highlighted a more purposeful appointment of NGNs into frontline leadership roles: *purposeful rotation of leadership* and *the right person to lead*. Participants who were purposefully rotated into a frontline leadership role were advantaged by the planned presence of senior nurses to assist them, and were comparatively eased into leadership by a work culture that viewed frontline leadership roles as a responsibility to be developed and shared on a rotational basis amongst all staff RNs—NGNs notwithstanding. Purposeful rotation of frontline leadership roles can proffer advantages to both the NGN and the organization. Deliberate efforts to build leadership capacity amongst early-career nurses can contribute to a pool of future nurse leaders for much-needed succession planning efforts (Bard, 2018; Patrician et al., 2012; RNAO, 2013). Participants further highlighted other benefits of purposeful rotation, including reduced fatigue and burnout as the burden of leadership does not fall squarely on senior staff (who may be limited in number), as well as a generally more positive experience as beginner leaders due to the presence of planned supports.

In cases where participants were considered *the right person to lead*, participants were purposefully nominated into frontline leadership roles due to specific skills or competencies, including flexibility, personability, motivation, technological expertise, and clinical competence. Notably, all participants belonged to Generation Y (under 34 years old); this generation of nurses is characterized in the literature by their optimism about their ability to drive positive change in the workplace, their interest and motivation in pursuing higher education, and their incorporation of technology as a "sixth sense" (Dyess et al., 2016). Several participants noted that such qualities were part of the reason why they were perceived as being well-suited for leadership roles and were, at times, even preferentially selected to lead over other more experienced RNs.

Theme 2: Managing Diverse and Demanding Responsibilities

The six responsibility subthemes identified in this study (*overseeing unit function and flow*, *managing and supporting staff*, *communication and conflict management*, *knowing and accessing resources to solve problems*, *advocating for quality care and safe work environments*, and *balancing behind-the-scenes and bedside work*) echo some of the responsibilities identified by previous researchers attempting to define responsibilities of frontline leadership in acute care. For example, Eggenberger (2012) conducted an exploratory study with 20 charge nurses from acute-care facilities in the United States, and developed eight themes to describe the responsibilities of the charge nurse role: creating a safety net, monitoring for quality, showing the way, completing the puzzle, managing the flow, making a difference, putting out fires, and keeping patients happy. Similarly, Cathro (2016) conducted a grounded theory study with charge nurses on medical-surgical hospital units in the United States. The emerging theory was identified as *navigating through chaos*— charge nurses balanced multiple roles (educator, advocate, and resource), kept a watchful eye over the clinical environment, and led the team to maintain patient safety. Lastly, Dillard-Henderson (2018) identified key frontline leader responsibilities as organizing the unit, supervising nurses, and managing and assisting with patient care.

However, the present study may be distinguished from the aforementioned works by the exclusive recruitment of NGNs with less than three years of experience, as well as its unique positioning within Canadian clinical contexts and the COVID-19 pandemic. While the responsibility subthemes identified in this study in some ways align with findings of previous works (particularly as regards overall unit oversight, managing patient flow, solving problems, and acting as an advocate and as a resource for team members), the NGN participants in this study did not place as much emphasis on the "supervision" of staff, nor

the "monitoring" of work by others. Rather, as frontline leaders, participants expressed a strong sense of obligation to support their team members by being highly visible, available, and in-touch with their teammates at the point of care. These findings echo some of the principles of servant leadership, which is characterized by a sense of responsibility rather than possession towards followers (Greenleaf, 2005; Van Dierendonck, 2011). Aspects of authentic leadership were also reflected in participants' approach to fulfilling their frontline leadership responsibilities. Authentic leadership is characterized in part by self-awareness and relational authenticity (Wong & Cummings, 2009), which was demonstrated by participants as they described openly acknowledging their limitations as both novice nurses and novice leaders. Accordingly, participants emphasized the importance of knowing who and where to turn to for key supports and resources to aid them in novel and challenging situations—a key responsibility not highlighted by previous studies involving more experienced nurses in frontline leadership roles (Cathro, 2016; Dillard-Henderson, 2018; Eggenberger, 2012; Sherman, 2019).

While previous research has also identified the dual managerial and clinical roles of the frontline nurse leader, which contributes to a high level of responsibility burden (Admi & Eilon-Moshe, 2016), the participants within this study were uniquely challenged in that they simultaneously experienced both a transition to practice as a novice nurse learning to manage a full patient assignment, as well as a transition to practice as a novice frontline nurse leader. Both types of transitions have been explored in the literature: a vast amount of research has been conducted on NGNs' transition to practice in acute care, which is "fraught with fear and ambiguity" and which remains a global issue within the nursing community (Hawkins et al., 2019, p. 1). Similarly, transitioning into nurse leadership roles has been identified as a challenging process with the potential for dissatisfaction, burnout, and turnover—particularly

as new nurse leaders were often promoted into leadership positions without the advanced

knowledge, skills, and training needed for these complex roles (Chunta, 2020; Shifflet &

Moyer, 2010). The findings of this study contribute to this body of literature by illuminating

how NGNs experienced the compounded challenges of both types of transitions within acute

care settings during the COVID-19 pandemic.

Theme 3: A Spectrum of Factors that Help or Hinder

A range of factors were found to influence NGNs' experiences of frontline leadership

roles. In the subtheme, *degree of role clarity and preparation*, most participants highlighted

that they did not receive a formal orientation or training prior to their engagement into a

frontline leadership role, either in accordance with routine organizational practices or due to

significant resource constraints created by COVID-19. As such, they entered into those roles

with an incomplete understanding of their role responsibilities and accountabilities. This

concurs with findings from extant literature, which indicates that nurses are often thrust into

positions of frontline leadership without adequate training and preparation (Assid, 2010;

Patrician et al., 2012; Sherman et al., 2011; Wojciechowski et al., 2011). Inadequate role

preparation and delineation increases the potential for role confusion and stress, undermining

nurses' effectiveness as frontline leaders (McCallin & Frankson, 2010). These findings raise

potential concerns for staff and patient safety, particularly in the context of the COVID-19

pandemic.

In lieu of formal training or orientation programs, participants highlighted the

important influences of *team culture and composition, manageability of workload*, and

availability of interdepartmental and interdisciplinary supports. These subthemes reflect

some of the elements of structural empowerment as defined by Kanter (1993), which

identifies social structures within the organizational environment that enable nurses to

accomplish their work. These social structures include access to information, support, and resources necessary to meet the responsibilities of their roles (Kanter, 1993; Pineau Stam et al., 2015). In particular, participants highlighted a need for ongoing support, understanding, interest, and investment from others (both peers and leaders) in their leadership journey. While little research has been conducted on workplace conditions that support NGN leaders specifically, the themes identified in this study echo those highlighted by other studies investigating conditions conducive to NGNs' general transition to professional practice. Constructive feedback regarding participants' performance was key to understanding in what ways they were meeting expectations and in what ways they could improve in enacting their frontline leadership responsibilities. Previous studies exploring conditions favourable to NGNs' successful transition into practice similarly emphasized the need for supportive unit cultures that foster encouragement and constructive feedback (Kim & Shin, 2020; Regan et al., 2017). However, similar to the findings of this study, previous research has identified unanticipated changes to orientation length, heavy workloads, inadequate staffing, and unsupportive unit cultures as organizational barriers to NGNs' successful transition into a professional role (Regan et al., 2017).

While little has been published about frontline leadership role development and education programs (Normand et al., 2014; Schwarzkopf et al., 2012), findings relating to the subtheme of *leadership education and continuing education opportunities* shed light on current nursing leadership education practices in Ontario. Of the participants who received workplace training or education prior to their engagement into a frontline role of leadership, this most often constituted a shadow-shift with a frontline nurse leader; however, these shadow shifts could be as brief as one shift, and were at times precluded entirely by a lack of nursing resources due to the strain of COVID-19. Participants suggested that a protected

mandatory orientation period would have been vastly beneficial prior to their engagement into frontline roles of leadership. Evidence from the literature also indicates that post-graduate leadership education improves job performance and satisfaction (Delamater & Hall, 2018; Homer & Ryan, 2013). Notably, study findings emphasized the importance of post-graduate leadership education, as participants acknowledged that their frontline role responsibilities were often unique and specific to their practice environments. Furthermore, some participants recalled that their priorities "lay elsewhere" than nursing leadership as students—while most participants recalled some degree of leadership education within their undergraduate curricula, many had not anticipated that such content would be immediately relevant as new graduates. This finding supports that the nursing profession continues to be challenged to conceptualize leadership as inherent within the professional scope of the RN (Scott & Miles, 2013), and highlights the need to challenge an apparent disciplinary assumption identified by participants that frontline leadership roles are reserved for experienced RNs only.

To bridge the gap between frontline leadership practice and education, participants suggested opportunities for interactions with frontline nurse leaders. While nurse educators have previously espoused the benefits of internships with nursing administrators and executives as a means to introduce students to nursing leadership (May & Cutting, 2014; Metcalfe, 2010), little research has been conducted on nursing students' understanding of frontline leadership roles such as charge nurse or team leader. Exposure to nurses who engage in frontline leadership roles (e.g., via internships, placements, or as speakers) may be of greater immediate relevance to RN students, considering that over half of the participants in this study had been placed into such roles within their first year of practice.

Theme 4: Reflecting on Leadership as an Impactful Experience

The final theme of this study, *reflecting on leadership as an impactful experience*, revealed a range of ways in which NGNs had been impacted by their engagement into frontline leadership roles. These impacts included *developing a big-picture perspective*, *experiencing a mental toll*, *experiencing growth and empowerment*, and *forming a leadership identity*. The findings of this study suggest that engagement in frontline leadership roles can catalyze a rapid development of systems-level understanding in hospital settings. Participants revealed a consistent broadening of their perspectives as they were required to communicate with leaders from other clinical settings and at other levels within the hospital, in order to facilitate important decisions regarding patient flow, resource allocation, and staffing. The development of systems-thinking awareness (defined as the ability to recognize, understand, and synthesize the interactions and interdependencies of various components comprising the larger hospital setting [Dolansky & Moore, 2013; Moazez et al., 2020]) is particularly significant in this population, as previous studies have indicated that new nurses lack this skill (Novotny et al., 2021). Systems-level thinking has been shown to positively correlate with clinical practices that prevent patient harm and facilitate early detection of errors (Moazez et al., 2020).

This broadened perspective came at a cost, however. The subtheme, *experiencing a mental toll*, described the increased stress, anxiety, and burnout reported by participants as they navigated frontline leadership roles. In line with previous studies examining frontline leaders' role stress (Admi & Moshe-Eilon, 2010; Sherman et al., 2011), the findings of this study indicate that participants struggled with managerial decision-making, management of conflict, deficiency of staffing and resources, as well as overload of responsibilities. Participants further shared feelings of inadequacy and guilt when they felt they were failing

in the roles they had been entrusted with. This was particularly felt by participants who contended with systemic issues that had been magnified by the COVID-19 pandemic (including nursing shortages and staff burnout), which they felt they had little power to adequately address. Previous research corroborates the heavy burden of frontline leadership roles, which are paradoxically characterized by a high level of responsibility for quality outcomes, while possessing relatively limited formal leadership power (Sherman et al., 2011). Increased roles stress is associated with emotional exhaustion, job dissatisfaction, burnout, turnover, as well as negative impacts to health and wellbeing (Admi & Eilon-Moshe, 2016; Garrosa et al., 2011; Jones et al., 2015; Van Bogaert et al., 2014).

However, despite these adverse impacts, participants valued the growth and development that their leadership experiences had afforded them, as reflected in the final two subthemes, *experiencing growth and empowerment* and *forming a leadership identity*. Participants felt that their engagement into frontline leadership roles had shaped them into becoming more effective leaders, team members, and nurses. Roles of frontline leadership conferred on participants both an opportunity and an obligation to further enhance their clinical competencies, and empowered them to assert themselves in the workplace and to actively advocate for patients and staff. Notably, participants who had been "pushed" into roles of frontline leadership reported that they had previously been reluctant to view themselves as leaders. These findings are in line with previous research suggesting that NGNs enter the practice environment without a solid leadership identity or skillset (Al-Dossary et al., 2016; Curtis et al., 2011; Scott & Miles, 2013). The findings of this study indicate that NGNs' unexpected engagement into such roles prompted them to re-evaluate their leadership capacity and develop a leadership identity.

Most participants felt positively about a future in nursing leadership as a result of their experiences, and were open to pursuing further levels of leadership as a potential career path. These findings align with previous research investigating the potential role of frontline leadership roles in succession planning efforts. Such roles are considered a "starting point in a leadership career move" (Wojciechowski et al., 2011, p. E15), and nurses who perceive success in frontline leadership roles are more likely to be motivated to pursue further leadership opportunities (Sherman et al., 2011). While limited, research investigating the benefits of rotational leadership models suggest that rotating newer staff into frontline leadership roles can be an effective means of building leadership capacity amongst staff nurses, ultimately contributing to a large and diverse pool of future nursing leaders (Bard, 2018; RNAO, 2013). Conversely, negative experiences in frontline leadership roles can contribute to higher turnover rates and low job satisfaction, and ultimately deter potential nurse leaders from embracing a leadership career path (Schwarzkopf et al., 2012). Accordingly, some participants did express hesitancy and ambivalence about pursuing more advanced roles of nursing leadership. Overall, however, participants agreed that engaging in frontline leadership roles provided an unparalleled opportunity for growth and learning, while providing valuable exposure to other areas within the hospital and other leadership career opportunities. While they valued their experiences and felt that other NGNs should also have opportunities to engage in roles of frontline leadership, this did come with the caveat that NGNs should have adequate supports available to them to facilitate their success.

Strengths and Limitations

To the writer's knowledge, this study is the first to explore the experiences of NGNs who engaged in hospital frontline leadership roles during the COVID-19 pandemic. The findings of this study contribute to several under-studied areas of research, including NGNs'

engagement into roles of leadership, as well as frontline hospital leadership in the context of infectious disease outbreaks. A strength of this study lays in its interpretive descriptive methodology, which weaves together "lived experiences, new knowledge, and practical outputs" (Burdine et al., 2021). As such, the findings of this study captured individuals' subjective experiences while drawing on lessons from broader patterns, ultimately contributing to practical disciplinary knowledge with the potential to help inform and improve education, practice, and policy for NGNs who engage in frontline hospital leadership roles (Burdine et al., 2021; Thorne, 2016). An additional strength of this study was its broad recruitment strategy, which targeted NGNs across the province of Ontario. The demographics of the final study sample were comparable to provincial figures for gender and age: male nurses represented 7.1% of the study sample, compared to 7.6% in Ontario (CIHI, 2019). 42.9% of participants were between the ages of 20-24 years old, while 28.6% were between the ages of 25-29 and 30-34 years old each; this is consistent with the average age of newly graduated Ontarian RNs (26.9 years old [CNO, 2016]). However, a slightly greater proportion of the study sample (14.3%) worked in rural or community hospital settings, compared to the provincial percentage of RNs (5.3% [CIHI, 2019]).

Another strength of this study was the use of member checking, which allowed the GSR to check the accuracy and resonance of the emerging findings with participants (Birt et al., 2016). This validation technique is commensurate with the study's interpretive descriptive approach (Burdine et al., 2021). During member checking interviews with six participants, participants responded positively to the emerging study findings and felt that they resonated with their experiences. Participants also provided further clarification and critical commentary, which enriched the process of analysis and enhanced the final study findings (Burdine et al., 2021).

The limitations of this study include sole reliance on in-depth interviews for data collection. Interpretive description advocates the use of multiple data sources to avoid a "naïve overemphasis on interview data" (Thorne et al., 2004, p. 3), and to support a comprehensive and contextualized analysis of the phenomenon of interest (Thorne et al., 1997; Thorne et al., 2004). It is possible that participant observation (e.g., observing NGNs as they enact roles of frontline leadership) or interviews with other parties involved (e.g., participants' team members or leaders) would have revealed contextually relevant data and proffered a richer understanding of NGNs' frontline leadership experiences; however, such data collection methods were precluded as they could threaten participant confidentiality and due to time constraints surrounding this study. As participants were recruited from Ontarian hospital settings, the study findings may also have limited applicability to other geographical and clinical contexts.

Conclusion

This qualitative study used an interpretive descriptive approach to explore NGNs' experiences of engaging in frontline leadership roles in hospital settings during the COVID-19 pandemic. In-depth interviews were conducted with 14 NGNs across Ontario. Content analysis of these interviews revealed four main themes. The first theme, *nominated and necessitated into leadership*, described various circumstances that catalyzed NGNs' engagement into roles of frontline leadership. The second theme, *managing diverse and demanding responsibilities,* highlighted the diverse responsibilities fulfilled by NGNs in frontline leadership roles. The third theme, *a spectrum of factors that help or hinder*, outlined a range of factors that influenced their experiences in frontline leadership roles. Lastly, the fourth theme*, reflecting on leadership as an impactful experience*, illuminated the professional and personal impacts stemming from NGNs' engagement into frontline

leadership roles. These findings contribute to the limited literature on NGNs' engagement into formal roles of clinical leadership. Study findings provide insights into potential educational and organizational strategies to support new and junior nurses in roles of frontline leadership, both during the remaining course of the COVID-19 pandemic and beyond.

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CHAPTER THREE

IMPLICATIONS, RECOMMENDATIONS, AND CONCLUSION

Summary of Key Findings

The purpose of this study was to explore new graduate registered nurses' (NGNs')
experiences of engaging in frontline leadership roles in hospital settings during the COVID-
19 pandemic. Using an interpretive descriptive approach, in-depth interviews were conducted
with 14 participants. From these interviews, four main themes emerged. The first theme,
nominated and necessitated into leadership, described various circumstances that catalyzed
NGNs' engagement into roles of frontline leadership. Five types of non-mutually exclusive
circumstances were identified: *the placeholder leader*, when NGNs provided frontline
leadership coverage when permanent leaders were not present; *the senior-junior leader*,
when NGNs were nominated into frontline leadership roles by virtue of being the most senior
or only registered nurse (RN) present; *the hot-potato leader*, when frontline leadership roles
were offloaded to NGNs by more senior nurses; *purposeful rotation of leadership*, when all
staff RNs—NGNs notwithstanding—were expected to rotate into frontline leadership roles;
and *the right person to lead*, when NGNs were viewed by others as strong candidates for
roles of frontline leadership.

The second theme, *managing diverse and demanding responsibilities,* highlighted the
various responsibilities fulfilled by NGNs in frontline leadership roles. These responsibilities
spanned six subthemes: *overseeing unit function and flow*, *managing and supporting staff*,
communication and conflict management, *knowing and accessing resources to solve
problems*, *advocating for quality care and safe work environments*, and *balancing behind-
the-scenes and bedside work.*

The third theme, *a spectrum of factors that help or hinder*, outlined a range of factors that influenced NGNs' experiences in frontline leadership roles. These factors were categorized into five subthemes: *degree of role clarity and preparation*, *team culture and composition*, *manageability of workload*, *availability of interdepartmental and interdisciplinary supports,* and *leadership education and continuing education opportunities.*

Lastly, the fourth theme*, reflecting on leadership as an impactful experience*, described the professional and personal impacts stemming from NGNs' engagement into frontline leadership roles. Participants described *developing a big-picture perspective*, *experiencing a mental toll*, *experiencing growth and empowerment*, and *forming a leadership identity* as a result of their experiences as frontline leaders.

Overall, these study findings reveal opportunities to strengthen nursing education, practice, policy, and research, to contribute to improved conditions and enhanced supports for NGNs who engage in frontline leadership roles in hospital settings. Implications and relevant recommendations for education, practice, policy, and research, are detailed below.

Implications and Recommendations

Implications and Recommendations for Education

The findings of this study suggest that there may be a gap between the content covered in prelicensure education and the demands of frontline nursing leadership encountered by NGNs as they enter practice. During their undergraduate education, participants in this study recalled perceiving the enactment of leadership roles (including frontline leadership roles) as an advanced nursing competency rather than a core dimension of nursing practice. The study findings suggest that, while leadership concepts, theory, and pertinent skills such as communication and critical thinking are typically covered in undergraduate nursing curricula, roles of frontline nursing leadership are not necessarily

receiving their due priority. As a result, participants frequently recounted feeling discomfited and nonplussed when they were called upon to fulfill such roles. As study findings indicate that NGNs can and do enact frontline leadership roles quickly upon entering practice, a greater focus on frontline leadership in prelicensure education may encourage neophyte nurses to practice their leadership skills, foster their leadership identities, and improve their readiness to engage in roles of frontline leadership upon entry to practice.

Study findings indicated several strategies to help bridge the gap between the content covered in prelicensure leadership education and the day-to-day realities of frontline leadership roles. Participants in this study valued exposure to "real-world" examples and scenarios, such that they could conceptualize the application of broad leadership concepts and theories into daily practice (e.g., managing conflict between interprofessional team members, making strategic decisions to facilitate patient access and flow, communicating across departmental lines, or designing appropriate nurse-patient assignments). Previous studies support the use of simulated leadership scenarios in undergraduate courses to improve students' understanding of key charge nurse competencies, including communication, interpersonal and interprofessional collaboration, cooperation, delegation, time management, decision-making, critical thinking, and problem solving (Labrague, 2021). Opportunities to interact with nurse leaders across various settings (e.g., through visiting speakers, placements, or internships) may also afford nursing students a more practical understanding of frontline nurse leadership roles. Such opportunities may be arranged via educational partnerships between healthcare organizations and baccalaureate nursing programs (Metcalfe, 2010). Shadowing or mentorship opportunities with NGNs or nurses with more than three years of experience in frontline leadership roles can help students build an understanding of frontline leadership in action, and encourage students to conceptualize their leadership

development as a timely and relevant goal (Shinners et al., 2021). With education and

support, NGNs can also gain valuable experience in role modeling and mentoring individuals

who are at an earlier point in their career trajectories (Shinners et al., 2021).

Participants largely agreed that education and training for specific frontline leadership

roles may be more practical to arrange in practice rather than in undergraduate education,

particularly considering that such roles often vary across clinical settings (Admi & Eilon-

Moshe, 2016). However, previous research indicates that students' leadership identities

develop over time, building from awareness of leadership as a concept, to integration of

leadership within their identities (Komives et al., 2005; Scott & Miles, 2013); as such, early

emphasis on leadership in undergraduate nursing curricula is key. In supporting the

development of students' leadership identities, educators should also consider individuals'

varying levels of leadership capacity and experience upon entering nursing programs (Scott

& Miles, 2013). Nurse educators should also seek to uncover trends in frontline leadership

expectations in the practice environment, and ensure that students are well informed of the

demand for frontline nursing leadership both in the COVID-19 pandemic environment and

beyond.

Implications and Recommendations for Practice

The findings of this study challenge an underlying disciplinary assumption, described

by study participants and apparent in the literature (Delamater & Hall, 2018; Eggenberger,

2012; Spiva et al., 2020), that roles of frontline leadership in acute care settings are exclusive

to experienced or senior nurses. Participants revealed recurrent circumstances in which they

had been called upon to fulfill frontline leadership roles, both prior to and during the

COVID-19 pandemic. While often perceived as unexpected or premature by participants,

they nevertheless valued the professional growth and empowerment that stemmed from their

experiences as frontline leaders—including accelerated development of clinical and leadership skills, a broadened systems-level understanding of hospital functioning, and increased knowledge and interest in further positions of nursing leadership. Thus, engaging NGNs into roles of frontline leadership may serve as a valuable strategy to improve their practice and to build leadership capacity amongst frontline nursing staff. In particular, non-permanent engagement into roles of frontline leadership was perceived by participants to be beneficial in affording the novice RN a valuable opportunity to "try on" a leadership role on a shift-by-shift basis.

However, study findings highlighted that most NGNs had little to no formal training, orientation, or other form of preparation, prior to their initial engagement into a frontline leadership role. While this was at times attributed to a lack of human resources precipitated by COVID-19, study findings indicated that training for frontline leadership roles was often limited or nonexistent prior to the pandemic as well. Previous studies have also highlighted a lack of formal training and poorly defined role expectations for nurses who engage in roles of frontline leadership (Eggenberger, 2012; Patrician et al., 2012). Given the significance and complexity of frontline leadership roles, evidenced by the diverse responsibilities revealed in the study findings, it is critical that NGNs are oriented to the expectations of frontline leadership roles prior to enacting them. Thus, it is recommended that leaders clearly communicate and delineate their leadership expectations to NGNs who join their organizations, while continuing to invest in professional leadership development opportunities to support the success of NGNs in frontline leadership roles (Spiva et al., 2020) both during and beyond the COVID-19 pandemic.

Study findings highlight the need to develop more structured frontline leadership training programs which are sensitive to NGNs' simultaneous transition to practice and

transition to a role of nursing leadership. Given the social distancing constraints of the COVID-19 pandemic, organizations should prioritize the development of alternative methods for frontline leadership training and education, such as on-line or blended learning (Bateman & King, 2020; Kitto, 2020). Such methods may prove viable and even preferable in the post-pandemic environment due to their flexibility and convenience. Evidence from the literature supports the incorporation of continuing leadership education in improving frontline leadership competencies, job performance, and job satisfaction (Delamater & Hall, 2018; Homer & Ryan, 2013). NGNs who are well-supported as they engage in roles of frontline leadership can be applied in a greater capacity to support improved patient and organizational outcomes (Eggenberger, 2012), and may be more likely to pursue other advanced leadership roles within the organization (Greer-Day et al., 2015; Jeffries & Acuna, 2016).

Considering the mental toll of frontline leadership revealed in the study findings, adequate attention to the wellness and resilience of NGNs as they engage in frontline leadership roles is also recommended. Frontline leadership training programs should include content to help NGNs mitigate and manage the potential for role stress associated with frontline leadership roles (Admi & Eilon-Moshe, 2016). Leaders can build resilience in NGNs by offering ongoing mentorship and fostering positive unit cultures, in which NGNs are actively encouraged to seek feedback and support as they engage in roles of frontline leadership (Ekström & Idvall, 2015; Regan et al., 2017; Spiva et al., 2020). Study findings also highlighted further supportive factors and conditions which hospital organizations and senior leaders should endeavour to make available for NGN frontline leaders, including: adequate staffing to support realistic workloads; an appropriate balance of skill mix and experience levels across shift schedules, such that experienced nurses are available to provide support to NGNs as they adjust to roles of frontline leadership; a collaborative and collegial

interprofessional and interdepartmental work environment, in which NGNs may feel safe seeking support from a rich variety of resources; and high visibility and availability of senior leadership to provide reassurance, feedback, and direction in complex situations.

Implications and Recommendations for Policy

The findings of this study support the need for greater clarity and consistency in organizational policies concerning roles of frontline leadership. Study findings highlighted two main models of frontline nursing leadership employed in Ontario hospitals: permanent and rotating. Both types of models opened opportunities for NGNs to engage in frontline leadership roles on a non-permanent basis, either as relief coverage for permanent frontline leaders or as part of a roster of RNs who rotated into a frontline leadership role on a shift-by-shift basis. Thus, organizations and leaders should ensure that appropriate policies are in place to support NGNs who are expected to engage in frontline leadership roles. This is of particular significance for clinical areas with many new or junior RN staff.

Opportunities to strengthen organizational policies include the clear delineation of both permanent and non-permanent frontline leadership role responsibilities and accountabilities, which would contribute to role clarity and help provide the basis for frontline leadership role training programs. Study findings also indicate that NGNs' frontline leadership experiences often took place during off-hour periods when senior leadership was not present. As such, policies should clarify which roles are directly responsible for providing support to frontline leaders. This would help circumvent potential gaps in supports as NGNs navigate frontline leadership roles during nights and weekends. Lastly, study findings revealed the need for greater investment in the leadership development of nurses who engage in leadership roles on a non-permanent basis, as participants were often not afforded the same training opportunities that were offered to nurses in permanent leadership

roles. These findings corroborate previous research highlighting a lack of training for nurses in frontline leadership roles (Eggenberger, 2012; Patrician et al., 2012), and support that organizational policies should be developed to mandate a protected training period for nurses prior to their engagement—whether permanent or non-permanent—into roles of frontline leadership (Admi & Eilon-Moshe, 2016).

Implications and Recommendations for Research

Few studies have been conducted which acknowledge NGNs as formal leaders in their workplaces. This study contributes to the limited literature on NGNs' engagement into roles of frontline leadership in hospital settings. Study findings indicate the need for greater recognition of NGNs as a unique cohort of frontline leaders in their practice areas, both during and beyond the COVID-19 pandemic, in future research endeavours.

The findings of this study illuminate several directions for future research, including quantitative studies which may, firstly, seek to quantify the extent to which NGNs engage in frontline leadership roles in Canadian hospital settings. Wide-spanning surveys would provide important insights into the scale of the leadership demands and expectations encountered by NGNs in practice. Other potential areas for future research within the quantitative paradigm could supplement the findings of this interpretive descriptive study: for example, studies exploring the relationship between NGNs' experiences in frontline leadership roles and burnout, empowerment, or likelihood of pursuing further roles of nursing leadership. Future studies could also explore the impact of facilitative or challenging factors identified in this study on NGNs' leadership competencies, as well as patient or organizational outcomes. Such research endeavours would further contribute to the knowledge base that can inform evidence-based strategies to support NGNs in roles of frontline leadership.

As this study focused on NGNs' engagement in frontline leadership roles in hospital settings in Ontario, qualitative studies within other regions and clinical areas would provide further insights unique to those settings. For example, this study could be replicated in long-term care or home-care settings, or by sampling across other geographical locations. Additional qualitative research on this topic would further illuminate the diverse responsibilities of frontline leadership and how NGNs across care settings perceive, enact, and experience leadership roles. Such findings may further clarify ways in which NGN leaders might be similar or different from their more senior counterparts, and help identify potential strategies that are uniquely suited to provide support to NGNs in frontline leadership roles specifically.

Conclusion

This interpretive descriptive study has elucidated NGNs' experiences in frontline leadership roles in hospital settings during the COVID-19 pandemic. Study findings contribute to the knowledge base that can help inform strategies to support NGNs as frontline leaders. Insights gained from this study support the need to develop educational content that effectively conveys the day-to-day realities of frontline leadership roles. Greater support for NGNs who engage in such roles may be achieved through the promotion of collaborative and supportive unit cultures, the development of mandated leadership training programs, and the strengthening of policies to provide greater clarity and consistency regarding frontline leadership role responsibilities.

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APPENDICES

APPENDIX A

The College of Nurses of Ontario (CNO) Home Mailing Address List Request Form

Request
for Home Mailing Addresses

COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO
THE STANDARD OF CARE.

Guidelines and Instructions

1. Please complete all applicable sections.
2. Where applicable, the following documents must be received by CNO along with the completed form:
   - Project outline or research protocol
   - Sample copy of the information being sent to College members (e.g. questionnaires, cover letter)
   - Approval from relevant Ethics Review Board
   - Privacy and security policies associated with the project
3. Return the form by e-mail to [redacted] or mail or fax to:

   College of Nurses of Ontario
   Analytics and Research
   [redacted]
   [redacted]

4. CNO will acknowledge your request after receiving it. If you do not receive an acknowledgement within five business days, please contact us by e-mail at [redacted].
5. Please review the Privacy Code at www.cno.org/privacy to understand how your personal information will be used.

6. Requests for home address lists may be denied if:
   - CNO deems the request inappropriate
   - CNO is not able to provide the requested information
   - CNO does not receive all required documentation
   - The form is incomplete and/or
   - The request is made under false pretenses.
7. Once the request has been assessed and approved by the College, an agreement form will be e-mailed to you. Sign the form to confirm the request specifications, estimated time for completion and approximate cost.
8. The fee structure is as follows:

   For-Profit Organization:
   - $5,000 intellectual property charge
   - $300 flat rate (less than 2 hours)
   - $200 per hour in excess of two hours

   Not-For-Profit Organization:
   - $300 flat rate (less than 2 hours)
   - $100 per hour in excess of two hours

   Students Conducting Research in Nursing:
   - $300 flat rate

(If charges exceed the listed amounts, the actual charge will apply.)
Note: All fees are subject to HST (13%).

Section One: Requester Information

First Name: Justine	Mailing Address:
Last Name: Ting	
Organization/Affiliation: Western University	
Department: Arthur Labatt Family School of Nursing	Telephone Number: [redacted]
Position/Title: Graduate Student, RN, MScN Candidate	Fax Number:
Name of Professor/Principal Investigator (if applicable): Yolanda Babenko-Mould, RN, PhD, Associate Professor	E-mail Address: [redacted]

Section Two: Request on Behalf of Another Party (if applicable)

First Name:	Mailing Address:
Last Name:	
Organization/Affiliation:	Telephone Number:
Department:	Fax Number:
Position/Title:	E-mail Address:

Section Three: Home Address List Requirements

1. Select the criteria for your list. The College does not release any data apart from the name and home mailing address for members who have consented to such release. Check all that apply:

a) Type of Nurse(s)

- ☑ RN
- ☐ RN – Non-Practising*
- ☐ RPN
- ☐ RPN – Non-Practising*
- ☐ NP

b) Nursing Employer

HOSPITAL
- ☑ Acute Care Hospital
- ☑ Addiction & Mental Health Centre/ Psychiatric Hospital
- ☑ Complex Continuing Care
- ☑ Rehabilitation Hospital
- ☑ Other Hospital

COMMUNITY
- ☐ Blood Transfusion Centre
- ☐ Cancer Centre
- ☐ Children Treatment Centre (CTC)
- ☐ Client's Environment
- ☐ Community Care Access Centre (CCAC)
- ☐ Community Health Centre (CHC)
- ☐ Community Mental Health Program
- ☐ Diabetes Education Centre (DEC)
- ☐ Family Health Team (FHT)

b) Nursing Employer (cont'd)

- ☐ Hospice
- ☐ Nurse Practitioner Led Clinic
- ☐ Nursing/Staffing Agency
- ☐ Physician's Office/Family Practice Unit
- ☐ Public Health Unit/ Department
- ☐ Remote Nursing Station
- ☐ Other Community

LONG-TERM CARE
- ☐ Long-Term Care Facility
- ☐ Retirement Home
- ☐ Other Long-Term Care Facility

OTHER
- ☐ Colleges/Universities
- ☐ Correctional Facility
- ☐ Government/ Association/Regulatory Body/Union
- ☐ Health-Related Business/ Industry
- ☐ Industry (Not Health-Related)
- ☐ Schools
- ☐ Spa
- ☐ Telephone Health Advisory Services
- ☐ Other

c) Position in Nursing

- ☐ Advanced Practice Nurse – CNS
- ☐ Advanced Practice Nurse – Other
- ☐ Case Manager
- ☐ Clinical Educator
- ☐ Consultant
- ☐ Educator/Faculty
- ☐ Infection Control Nurse
- ☐ Informatics Analyst
- ☐ Middle Manager
- ☐ Nurse Practitioner (NP)
- ☐ Occupational Health Nurse
- ☐ Office Nurse
- ☐ Outpost Nurse
- ☐ Policy Analyst
- ☐ Public Health Nurse
- ☐ Researcher
- ☐ Sales/ Marketing Representative
- ☐ Senior Manager
- ☑ Staff Nurse
- ☐ Visiting Nurse
- ☐ Volunteer
- ☐ Other

d) Area of Practice

- ☑ Acute Care
- ☐ Administration
- ☑ Cancer Care
- ☑ Cardiac Care
- ☐ Case Management
- ☑ Chronic Disease Prevention/Management
- ☑ Complex Continuing Care
- ☑ Critical Care
- ☑ Diabetes Care
- ☐ Education
- ☑ Emergency
- ☐ Foot Care
- ☑ Geriatrics
- ☐ Infection Prevention/ Control
- ☐ Informatics
- ☑ Maternal/Newborn
- ☑ Medicine
- ☑ Mental Health/ Psychiatric/Addiction
- ☑ Nephrology
- ☑ Occupational Health
- ☑ Palliative Care
- ☑ Perioperative Care
- ☐ Policy
- ☑ Primary Care
- ☑ Public Health
- ☑ Rehabilitation
- ☐ Sales
- ☑ Surgery
- ☐ Telehealth Services
- ☐ Other

* Nurses in the Non-Practising Class are not permitted to practise nursing in Ontario. For more details about the Non-Practising Class, visit http://www.cno.org/en/maintain-your-membership1/nonpractising-class-faq/

2. Describe any additional criteria (e.g. sample size, sample distribution):

In addition to the criteria listed above, participants in the study must have been employed for 3 years or less as a registered nurse, with a designation of full-time or part-time or casual employment in a hospital setting. They must also possess experience engaging in a frontline leadership role (e.g. charge nurse, in-charge person, team/unit/shift leader, or unit/shift coordinator) in a hospital setting.

In keeping with an interpretive descriptive methodology, this study will aim for a sample size between 15 and 30. The researcher will send a mail-out package containing a Letter of Information-Consent Form for the study to potential participants. The Letter of Information-Consent Form outlines the study purpose and other study-related details, and will invite recipients who have experience engaging in a frontline leadership role in a hospital setting to contact the researchers by phone or email if they are interested in participating in the study.

Section Four: Project Details

1. Title of project:

2. Briefly state the purpose of the project. Attach the project outline or research protocol, and sample copy of any information being sent to members (e.g. questionnaires):

The purpose of this study is to explore the experiences of new graduate registered nurses (NGNs) to improve understanding of the challenges, facilitators, and factors that influence their ability to perform in frontline leadership roles in hospital settings during the COVID-19 pandemic. This research aims to contribute to educational and organizational strategies to support NGNs who engage in frontline hospital leadership roles, particularly during periods of crisis such as infectious disease outbreaks.

The research protocol is attached to this email. The Letter of Information-Consent Form and the Reminder Letter of Information-Consent Form that will be sent to potential participants are also attached to this email.

3. Describe the benefits to be derived from the completion of this project:

The findings of this study will contribute to strategies to support NGNs in frontline leadership roles, particularly during periods of crisis such as infectious disease outbreaks. Greater support for NGNs as leaders may lead to public benefits such as improved quality of care and patient satisfaction. Furthermore, as little research has been conducted on NGNs engaging in leadership roles, the findings of this study will contribute to greater public recognition of NGNs as leaders during COVID-19 in their practice areas, and may also lead to further research on this topic.

4. If the project involves a survey, describe the methodology used to design the survey and analyze the results:

This project does not involve a survey.

5. How do you plan to share the results of your project? What is the expected completion date?

6. Does this project require an ethics review and approval?

   ⊙ Yes →   Please attach a copy of the ethics approval with this form.
   ○ No →   Please explain why an ethics review is not necessary.

> Please see the ethics approval attached to this email from The Western University Health Science Research Ethics Board (HSREB).

7. What measures are in place to protect the confidentiality of CNO's Home Address List? (Where applicable, attach privacy and security policies with this form.)

> All data collected will remain confidential and accessible only to the study investigators. Personal identifiers of participants including full name, address, and postal code, will be collected from the CNO to allow for recruitment, scheduling of interviews, and mailing of study-related forms. A unique numeric identifier will be generated for each participant. A password-protected master list linking identifiers to the unique participant numeric code will be stored in a password-protected study specific folder in the Microsoft Office OneDrive Cloud Storage associated with Western University, which is separate from the study data folder. This folder will be accessible only to the study PI and GSR. Signed consent forms will be securely stored in a separate locked cabinet in the locked office of the study PI at Western University. De-identified and numerically coded transcribed data will also be stored electronically in a password-protected NVivo file and in a password-protected OneDrive folder. The password-protected and de-identified NVivo file with study data will only be accessible to study investigators.
>
> The Microsoft Office OneDrive Cloud Storage associated with Western University (through Western University's Microsoft Office 365 Campus Agreement with Microsoft) is password-protected. NVivo 12 Qualitative Data Analysis Software will require a separate password for access to de-identified data.
>
> All study information will be kept for seven years in a secure and confidential location after study completion per Western University policy, and then confidentially destroyed.

8. Is this project funded by an outside body?

   ○ Yes →   Please provide information about the funding source in the box below.
   ⊙ No

APPENDIX B

Study Letter of Information

Project Title:
New Graduate Nurses' Experiences of Engaging in a Leadership Role in Hospital Settings
During the COVID-19 Pandemic

Principal Investigator:
Dr. Yolanda Babenko-Mould, RN, BScN, MScN, PhD
Associate Professor and Associate Director – Graduate Programs
Arthur Labatt Family School of Nursing
███████████████████████████

Western University
London, Ontario, Canada
███████████████
████████████

Graduate Student Researcher:
Justine Ting, RN, BScN, MScN Student
Arthur Labatt Family School of Nursing
Western University
London, Ontario, Canada
███████████

Dear Potential Participant,

Frontline nurse leadership roles (often called "charge nurse", "in-charge person", "unit/shift
coordinator", or "team/unit/shift leader") are often rotated through staff registered nurses on
a shift-by-shift basis in Ontario hospitals. As a result, nurses may be expected to take on
frontline leadership roles very early in their careers. These frontline leadership roles have
become even more challenging, particularly for new nurses, in the context of the COVID-19
pandemic.

We are conducting a study to explore new graduate registered nurses' experiences in
frontline leadership roles in hospital settings during the COVID-19 pandemic. We are
looking to recruit registered nurses with up to three years of experience, who have engaged in
a frontline leadership role in a hospital setting (e.g., "charge nurse", "in-charge person",
"team/unit/shift leader", "unit/shift coordinator", or other titles representing leadership of a
team in one or more patient care areas) during or after March 2020. If you meet these criteria,
we would greatly value your participation in a one-to-one confidential interview for this
study. Participants will be compensated with a $20.00 (CAD) Amazon gift card.

We invite you to review the study information below, and if you are interested in
participating, please respond to the Graduate Student Researcher, Justine Ting, via email at
███████████. Please do not hesitate to contact the Graduate Student Researcher or the
Principal Investigator (contact information provided above) if you have any questions or
concerns regarding this study.

Invitation to Participate
You are being invited to participate in this study because you are a registered nurse with up to 3 years of experience, who may have experience engaging in a frontline leadership role in a hospital setting (e.g., "charge nurse", "in-charge person", "team/unit/shift leader", "unit/shift coordinator", or other titles representing leadership of a team in one or more patient care areas) during or after March 2020.

Why is this study being done?
With new nurses being called upon to fulfill frontline leadership roles in hospitals, there is an urgent need to develop a better understanding of new graduate nurses' leadership experiences, particularly during times of increased pressure and uncertainty like infectious disease outbreaks. By studying new graduate nurses' experiences in frontline leadership roles in hospital settings during COVID-19, this study aims to contribute to a stronger understanding of how to help new graduate nurses succeed as frontline clinical leaders during infectious disease outbreaks and other crisis situations.

Inclusion Criteria
You are eligible to participate in this study if: you are a new graduate registered nurse (defined as having 3 full years [36 months] or less of experience as a registered nurse) working full-time, part-time, or casual in hospital settings in Ontario, who possesses experience engaging in a frontline nursing leadership role (e.g., charge nurse, in-charge person, team/unit/shift leader, or unit/shift coordinator) in a hospital setting during or after March 2020; you are fluent in speaking and reading English; and you consent to audio-recording for an interview.

Exclusion Criteria
You are ineligible to participate in this study if: you have more than 3 full years (36 months) of experience as a registered nurse; you are not working full-time, part-time, or casual in hospital settings in Ontario; you possess experience in a frontline leadership role in non-hospital settings only (e.g., public health, but not hospital employment); you have not been involved in a frontline leadership role during or after March 2020; you are not fluent in speaking and reading the English language; or you do not consent to audio-recording for an interview.

What are the study procedures?
If you consent to participate in this study, please contact the Graduate Student Researcher by email. The researcher will verify that you meet the study's inclusion criteria. You will be asked to participate in an audio-recorded interview about your experiences in a leadership role, which may take place through Zoom videoconferencing, telephone, or in-person, depending on your preference and in accordance with potential social distancing measures that may be required due to COVID-19. The first 15 individuals who meet the inclusion criteria and wish to participate in the study will be scheduled for an interview by the Graduate Student Researcher. Only audio-recordings will be collected during interviews using an external digital audio-recording device; video-recordings will not be collected in any interviews. This interview will be set at a date and time that is mutually convenient to you and the Graduate Student Researcher. This interview will be approximately 60 to 90 minutes in length.

After the initial interview, the Graduate Student Researcher will ask if you are open to an optional 15-minute follow-up interview which will take place through Zoom videoconferencing or by telephone. The purpose of this follow-up interview is to share and discuss findings and allow for clarifying questions.

What are the risks and harms of participating in this study?
There are no known or anticipated health risks associated with participating in this study. However, you may feel uncomfortable in answering questions about your experiences engaging in a frontline leadership role during the COVID-19 pandemic. Please know that you may decline to answer any questions you do not wish to answer, may request a break and resume the interview when you feel ready, may request to reschedule the interview for a different date, or may stop the interview and not resume it at a later time if that is your preference.

There is also the risk for breach of privacy, as some identifying information is being collected as part of this study. Study investigators will do their utmost to safeguard your privacy and confidentiality by ensuring that identifying information is stored separately from interview data, and by keeping all study data in a secure location which is accessible only by study investigators.

What are the benefits of participating in this study?
You may not directly benefit from participating in this study, but you may benefit indirectly from potential practice changes that improve support for new graduate nurses' leadership, which may stem from study findings. This study intends to develop knowledge that can inform strategies to support new graduate nurses in frontline leadership roles during the COVID-19 pandemic. Greater support for new graduate nurse leaders may lead to public benefits such as improved quality of care and patient satisfaction. Furthermore, as little research has been conducted on new graduate nurses engaging in leadership roles, the findings of this study will contribute to greater public recognition of new graduate registered nurses as leaders during COVID-19 in their practice areas, and may also lead to further research on this topic.

Can participants choose to leave the study?
If you decide to withdraw from the study, you have the right to withdraw your consent to participate in this study and request withdrawal of information collected about you. If you wish to have your information removed, please let the Graduate Student Researcher or Principal Investigator know through phone, email, or in-person communication, at any point before, during, or after your interview. Withdrawal prior to data analysis will result in all traces of your information being destroyed from the study records. However, if you choose to withdraw after data analysis begins, the information collected prior to you leaving the study will still be used as identifying information will be removed from study data and all participants' data will be grouped for analysis; as such, the researchers will be unable to identify an individual participant's responses once data analysis begins. However, no new information will be collected without your consent.

How will participants' information be kept confidential?
All data collected will remain confidential and accessible only to the Principal Investigator and the Graduate Student Researcher of this study. Your full name, address, postal code,

telephone number, and email address will be collected to allow scheduling of interviews and mailing of study-related forms. Gender and age will be collected to allow for a description of the study sample. Voice recordings will be collected to allow for transcription of interviews and to ensure accuracy for data analysis. Audio-recordings will be shared with a professional transcriptionist and will be transcribed verbatim, except for the removal of identifying information as necessary. You will be asked to refrain from disclosing identifying information during your interview. Should identifying information be disclosed during interviews, this information will not be transcribed. The recording will be confidentially destroyed once transcription is confirmed. Your name, address, postal code, telephone number, email address, and voice recording, will never be used for published or presented materials. Quotes may be used in published materials, however, these quotes will not contain personal or identifying information. A numerical code will be used in place of your name. A master list linking your study number with your identifiers will be kept separate from your interview data. All hard copy materials will be kept in a confidential, locked filing cabinet in the locked office of the Principal Investigator. All electronic data will be password protected and encrypted.

Please note that representatives of Western University's Health Sciences Research Ethics Board may require access to your study-related records to monitor the conduct of the research. Study information will be kept for seven years in a secure and confidential location after study completion per Western University policy and then permanently destroyed.

Are participants compensated to be in this study?
You will be compensated with a $20.00 (CAD) electronic Amazon gift card for your participation in this study. If you choose to withdraw your participation in this study, this $20.00 gift card will still be provided to you. This gift card will be emailed to your preferred email address at the start of your interview. Please note that, if you consent to receiving the $20.00 (CAD) Amazon e-gift card, your preferred email address will be provided to Amazon for the purpose of sending you the Amazon e-gift card via email. If you do not consent to your email being provided to Amazon, a physical gift card will be mailed by the researcher to your home mailing address instead.

What are the rights of participants?
Your participation in this study is voluntary. You may decide not to be in this study. Even if you consent to participate, you have the right to not answer individual questions or to withdraw from the study at any time. You do not waive any legal rights by consenting to this study.

Whom do participants contact for questions?
If you require any further information regarding this research study, please contact the Principal Investigator, Dr. Yolanda Babenko-Mould by email at ▇▇▇▇▇▇▇▇▇▇ or by phone at ▇▇▇▇▇▇▇▇▇▇. You may also contact the Graduate Student Researcher, Justine Ting at ▇▇▇▇▇▇▇.

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Human Research Ethics ▇▇▇▇▇▇▇▇▇▇▇▇, email: ▇▇▇▇▇▇▇. This office oversees the ethical conduct of research studies and is not part of the study team. Everything that you discuss will be kept confidential.

Consent

A copy of the Consent Form is included with this Letter of Information. At the start of your interview, the Graduate Student Researcher will review the contents of this Letter of Information and the Consent Form with you. The Graduate Student Researcher will address any study-related questions you may have, and you will be given 10 to 15 minutes to review the material and choose to provide or withhold your consent to participate. This will include consent for audio-recording of the interview and use of de-identified quotes for published materials. If you complete a Zoom or telephone interview, you will be mailed another hard copy of the Letter of Information and the Consent Form with a return-addressed and stamped envelope. You will be asked to sign and return your Consent Form as soon as possible for your data to be included in the analysis for this study. You may choose to return this form using the return-addressed and stamped envelope provided to you, or you may choose to email an image of your signed form to the Principal Investigator. Please be aware that email is not a guaranteed secure form of communication if you choose to return your signed form by email. If you do not return a signed consent form, your data will be permanently deleted from the study.

Thank you for considering participation in this study. This letter is yours to keep for future reference.

APPENDIX C

Study Consent Form

Project Title:
New Graduate Nurses' Experiences of Engaging in a Leadership Role in Hospital Settings
During the COVID-19 Pandemic

Principal Investigator:
Dr. Yolanda Babenko-Mould, RN, BScN, MScN, PhD, Associate Professor and Associate
Director – Graduate Programs, Arthur Labatt Family School of Nursing, █████████████
█████, Western University, London, Ontario, Canada, █████████
███████████

Graduate Student Researcher:
Justine Ting, RN, BScN, MScN Student, Arthur Labatt Family School of Nursing, Western
University, London, Ontario, Canada, █████████

I have read the Letter of Information, have had the nature of the study explained to me **and I
agree to participate.** All questions have been answered to my satisfaction.

I agree to participate, and to have my interview audio recorded, in this research. **I
consent to the use of unidentified quotes obtained during the study in the dissemination
of this research.**
☐ **YES** ☐ **NO**

_____   _____   _____
Print Name of Participant   Signature   *Date (DD-MM-YYYY)*

**I consent to the study researchers providing Amazon with my email address for the
purpose of emailing me a $20.00 (CAD) Amazon gift card as compensation for
participating in this study.**
☐ **YES** ☐ **NO**

_____   _____   _____
Print Name of Participant   Signature   *Date (DD-MM-YYYY)*

**My signature means that I have explained the study to the participant named above. I
have answered all questions.**

_____   _____   _____
Print Name of Person   Signature   *Date (DD-MM-YYYY)*
Obtaining Consent

APPENDIX D

Demographic Questionnaire

This questionnaire is optional, and you may decline to answer any question you do not wish to answer. Please note that your answers to these questions will **not** be recorded on the audio-recording.

1. Age:
   - ☐ 20 to 24 years old
   - ☐ 25 to 29 years old
   - ☐ 30 to 34 years old
   - ☐ 35 to 39 years old
   - ☐ 40 to 44 years old
   - ☐ 45 or above

2. Gender:
   - ☐ Female
   - ☐ Male
   - ☐ Other; if you wish to, please specify: _____

3. Employment status:
   - ☐ Full-time
   - ☐ Part-time
   - ☐ Casual

4. Highest level of education achieved:
   - ☐ Bachelor's Degree
   - ☐ Master's Degree
   - ☐ Doctorate

5. Length of experience as a Registered Nurse:
   - ☐ Less than 6 months
   - ☐ 6 months to 1 year
   - ☐ 1 to 2 years
   - ☐ 2 to 3 years

6. Type of hospital where you engaged in a frontline leadership role during COVID-19:
   - ☐ Acute Care Hospital
   - ☐ Complex Continuing Care Hospital
   - ☐ Rehabilitation Hospital
   - ☐ Addiction & Mental Health Centre/Psychiatric Hospital
   - ☐ Other Hospital; please specify: _____

7. Since the start of the COVID-19 pandemic (i.e., during and after March 2020 onwards), approximately how often have you engaged in a frontline leadership role?

_____

8. Type of area(s) worked where you engaged in a frontline leadership role during COVID-19 (please select all that apply):
   - ☐ Medical
   - ☐ Surgical
   - ☐ Psychiatry or Mental Health
   - ☐ Emergency
   - ☐ Cancer Care
   - ☐ Palliative Care
   - ☐ Obstetrics
   - ☐ Pediatrics
   - ☐ Intensive/Critical Care
   - ☐ Operating Room
   - ☐ Post-Anaesthesia Care
   - ☐ Complex Continuing Care
   - ☐ Rehabilitation
   - ☐ Ambulatory/Outpatient Care
   - ☐ Other; please specify: _____

APPENDIX E

Semi-Structured Interview Guide

<u>Pre-Interview</u>
Prior to the start of the interview, the Graduate Student Researcher will review the Letter of Information and Consent Form with the participant. Study-related questions will be answered by the researcher, after which the participant will be given 10 to 15 minutes before choosing to provide or withhold consent to participate in the study. The researcher will prompt the participant to sign their Consent Form prior to the start of the interview. The researcher will remind participants that they may decline to answer any questions they do not wish to answer, or may request a break and resume the interview when and if they feel ready. The researcher will also remind participants that audio-recording will commence after the demographic portion of the interview. The participant will then be given the option to complete a brief optional demographic questionnaire.

<u>Interview</u>
The following questions will be used to guide the interview, but do not encapsulate all potential areas of discourse. The researcher will remain aware of participant cues and maintain flexibility in pursuing areas of inquiry which the participant deems significant in answering the research questions or meeting the research aims.

The researcher will also notify the participant at the moment when audio-recording commences. The audio-recording will begin with the researcher asking the first prompt in the Semi-Structured Interview Guide:

1. Please describe the frontline leadership role you have engaged in.
    a. Probe: What are the responsibilities of this role? What attributes and skills do you need in this role?
2. Tell me about your experiences in a frontline leadership role during COVID-19?
    a. Probe: How is it that you came into this role of frontline leadership?
    b. Probe: How has this role been impacted by the pandemic?
    c. Probe: Please share with me examples of memorable experiences you had as a frontline leader during COVID-19.
3. What would you say were the main challenges you encountered when fulfilling a frontline leadership role during COVID-19?
    a. Probe: In what ways did you feel prepared, or unprepared, in facing these challenges?
    b. Probe: How did you feel supported, or unsupported, in facing these challenges?
    c. Probe: Please discuss factors (people, resources, circumstances) that influenced your ability to address these challenges.
4. Please describe an experience where you felt you had really succeeded in your leadership role, amid the challenges of COVID-19?
    a. Probe: Share some factors in your workplace that helped, or that hindered, your ability to have these kinds of positive experiences?
5. In what ways have your experiences as a frontline leader during a pandemic situation impacted you?
    a. Probe: How did these experiences influence your view of yourself as a leader?

      b.   Probe: Do you feel you possess the skills and attributes needed to effectively fulfill a leadership role? Please tell me more about that.

      c.   Probe: Did these experiences impact your interest in other leadership roles? Please tell me more about that.

6. Do you think your nursing education prepared you for a frontline leadership role, particularly during a time of crisis? Please tell me more about that.

      a.   Probe: What kind of leadership education did you receive during your schooling?

      b.   Probe: What aspects of your nursing education do you think prepared you for a leadership role (both in general, and during COVID-19)?

      c.   Probe: What changes to your nursing education do you think would have better prepared you for a leadership role (both in general, and during COVID-19)?

      d.   Probe: Can you tell me about your leadership education or experiences outside of nursing?

7. Did you feel adequately supported in your workplace to have a positive experience in a leadership role in the context of COVID-19? Please tell me more about that.

      a.   Probe: What ways do you think your workplace or leaders could better support you as a new graduate in a frontline leadership role, particularly in a pandemic situation?

      b.   Probe: What supports at your workplace did you find most valuable in helping you have a positive experience as a new graduate in a leadership role?

      c.   Probe: Are there policies and/or procedures in place at your work, or that you think should be in place, to better support you as a new graduate in a frontline leadership role?

8. Lastly, is there anything else you would like to share about your experiences or perspectives, that you think would be important for healthcare leaders, nursing schools, and/or organizations to know?

Post-Interview

      The participant will be thanked for their participation and asked if they have any further comments, questions, or suggestions for future interviews. Participants will also be asked if they are open to a follow-up telephone interview or videoconferencing interview via Western's association with Zoom Video Communications at a future date. The Graduate Student Researcher will review the consent process with the participant. Participants will be reminded that their data cannot be used unless their Consent Form is signed and returned.

APPENDIX F

Ethics Approval Letter

Western Research

Date: 24 November 2020

To: Dr. Yolanda Babenko-Mould

Project ID: 116023

Study Title: New Graduate Nurses' Experiences of Engaging in a Leadership Role in Hospital Settings During the COVID-19 Pandemic

Application Type: HSREB Initial Application

Review Type: Delegated

Full Board Reporting Date: 15/Dec/2020

Date Approval Issued: 24/Nov/2020 06:37

REB Approval Expiry Date: 24/Nov/2021

Dear Dr. Yolanda Babenko-Mould

The Western University Health Science Research Ethics Board (HSREB) has reviewed and approved the above mentioned study as described in the WREM application form, as of the HSREB Initial Approval Date noted above. This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Demographic Questionnaire - New Graduate Nurses' Experiences in Leadership Roles	Other Data Collection Instruments	02/Oct/2020	
Research Plan - New Graduate Nurses' Experiences in Leadership Roles	Protocol	17/Nov/2020	2
Semi-Structured Interview Guide - New Graduate Nurses' Experiences in Leadership Roles	Interview Guide	17/Nov/2020	2
LOI and Consent Form - New Graduate Nurses' Experiences in Leadership Roles	Written Consent/Assent	17/Nov/2020	2
Reminder LOI and Consent Form - New Graduate Nurses' Experiences in Leadership Roles	Written Consent/Assent	17/Nov/2020	2

Deviations from, or changes to, the protocol or WREM application should be initiated without prior written approval of an appropriate amendment from Western HSREB , except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

REB members involved in the research project do not participate in the review, discussion or decision.

The Western University HSREB operates in compliance with, and is constituted in accordance with, the requirements of the TriCouncil Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2); the International Conference on Harmonisation Good Clinical Practice Consolidated Guideline (ICH GCP); Part C, Division 5 of the Food and Drug Regulations; Part 4 of the Natural Health Products Regulations; Part 3 of the Medical Devices Regulations and the provisions of the Ontario Personal Health Information Protection Act (PHIPA 2004) and its applicable regulations. The HSREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000940.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Ms. Nicola Geoghegan-Morphet , Ethics Officer on behalf of Dr. Philip Jones, HSREB Vice-Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

CURRICULUM VITAE

Name:	Justine J. Ting
Post-Secondary Education and Degrees:	McMaster University Hamilton, Ontario, Canada 2013-2015, BScN
Honours and Awards:	RNFOO Nursing Research Interest Group Award 2021 Western Graduate Research Scholarship 2019, 2020, 2021 Irene Nordwich Graduate Student Award 2020 Dr. Heather Laschinger Graduate Scholarship in Health Services 2019
Related Work Experience	Research Assistant Western University 2021 Teaching Assistant Western University 2019-2021 Registered Nurse London Health Sciences Centre 2015-present

Publications:

Ting, J. J., & Garnett, A. (2021). E-health decision support technologies in the prevention and management of pressure ulcers: A systematic review. *Computers, Informatics, Nursing*. Advance online publication. https://doi.org/10.1097/CIN.0000000000000780.

Ting, J., Garnett, A., & Donelle, L. Nursing education and training on electronic health record systems: An integrative review. *Nurse Education in Practice*, *55*, 103168. https://doi.org/10.1016/j.nepr.2021.103168