ORIGINAL RESEARCH

Building capacity to lead: Development implementation and evaluation of a leadership and management education program for nurse leader-managers

Sue Bookey-Bassett*[1], Heather Thomson[2], Janet Chee[3], Irmajean Bajnok[4], Victoria Miscio[3], Kim Cook[5], Donna Leybourne[3], Shanoja Naik[3]

[1] *Daphne Cockwell School of Nursing, Toronto Metropolitan University, Toronto, Canada*
[2] *Lawrence Bloomberg Faculty of Nursing, University of Toronto, Toronto, Canada*
[3] *Registered Nurses Association of Ontario, Canada*
[4] *Wounds Canada, North York, Canada*
[5] *Inspiro Healthcare Consulting Corp., Toronto, Canada*

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ABSTRACT

Background/Objective: Nurses in leadership and managerial roles require ongoing opportunities to develop their leadership knowledge and skills. Effective nursing leadership contributes to team functioning and healthy work environments, as well as improved outcomes for staff and patients. This paper reports on the development, implementation and evaluation of a Leadership and Management for Nurses Program (LMNP) in Ontario, Canada. The program was designed for novice nurse leader-managers to enhance knowledge and skills necessary to promote competence, confidence, and effectiveness in these roles.

Methods: A program evaluation framework was developed to evaluate the LMNP including the degree to which the program supported participants in achieving their leadership goals and the impact of the program on participant leadership and confidence. Upon completion of the program all participants were invited to respond to an electronic evaluation survey exploring both program processes and outcomes. Descriptive statistics were used to analyze survey data.

Results: Fifty-four participants responded to the survey. Results suggest that the program length and content were appropriate, contributing to the achievement of leadership learning goals and the development of leadership and managerial skills and knowledge, increased confidence and overall preparedness to lead.

Conclusions: Novice nurse leader-managers require support to develop and maintain leadership and managerial competencies, underscoring the importance of providing leadership development opportunities through programs such as the LMNP. Healthcare organizations should consider how best to support ongoing nurse leader-manager development through leadership training and mentorship programs.

Key Words: Leadership development, Management, Managerial leader, Capacity building, Education, Nurse manager

* **Correspondence:** Sue Bookey-Bassett; Email: sbookeybassett@torontomu.ca; Address: Daphne Cockwell School of Nursing, Toronto Metropolitan University, Toronto, Canada.

1. INTRODUCTION

Nurse managers play an important role within the healthcare system with functions such as leading, motivating and supervising staff, empowering teams, promoting shared decision-making, creating healthy work environments, managing change, problem-solving, strategic planning, as well as budgeting and procurement, among others.[1–3] As such, engagement and performance within the nurse manager role impacts nurse retention, empowerment, and job satisfaction, as well as patient satisfaction.[4,5] Literature suggests that nurse managers lack support in their roles, which ultimately impacts their performance, job satisfaction, as well as recruitment and retention.[2] A scoping review by Cave and colleagues[2] identified varying levels of organizational support received by nurse managers, with some studies reporting that nurse leaders experience limited orientation and job training.[6,7] Nurses in managerial roles desire support for leadership development and require education programs focused on content such as managerial and leadership competencies to allow them to be more effective in their roles.[2]

Informed by evidence from the literature, and data from a survey on work and wellbeing,[8] the Registered Nurses Association of Ontario (RNAO) initiated the development of a virtual synchronous leadership and management education program for novice managerial leaders. As the professional body representing Registered Nurses, Nurse Practitioners and nursing students across Ontario, Canada, the RNAO was well positioned to lead this work, aligned with their mission to advocate for healthy public policy, promote excellence in nursing practice, and empower nurses to actively influence and shape decisions that affect the profession and the public.[9] The RNAO survey on work and wellbeing was carried out during the third wave of the COVID-19 pandemic (May-July 2021), and findings suggested that nurses, particularly in the hospital sector, did not feel that their manager was highly visible or accessible.[10] Moreover, nurses in the hospital sector reported poor levels of support from nurse managers and supervisors.[10] However managerial leaders, stretched to the limit at this time, also expressed a lack of support, without perceiving the same needs among their staff. This apparent lack of synergy reinforces the need for nurse managers to better understand the pivotal nature of their role, for staff at the point-of-care. Evidence suggests there is a need to explore the support leaders have in their workplaces, how they enact their leadership role, and how continuing education at the nurse manager level can provide guidance to better understand the needs of front-line nurses, perhaps leading to greater retention.[10] The purpose of this paper is to describe the development, implementation, and evaluation of the first iteration of RNAO's Leadership and Management for Nurses Program (LMNP) informed by evidence and lived experiences of practicing nurse leaders.

2. METHODS

2.1 Program description & leadership framework

The LMNP is based on the premise that effective nursing leadership contributes to the delivery of high-quality patient care across all health sectors.[2,3,5] Effective nursing leadership helps shape the profession, contributes to the development of community, facilitates policy development, promotes mentorship and evidence-based practice, and supports staff in navigating change. Leadership extends beyond traditional roles and is important in all aspects of nursing — whether that nurse leader is an educator developing future leaders, a researcher mentoring new researchers, an administrator or manager providing support and guidance to staff, a point-of-care staff nurse providing exemplary care and sharing professional knowledge, or a nurse providing practice support through policy development.[3] Following a rapid scan of current models of leadership and management, the team selected the RNAO Conceptual Model for Developing and Sustaining Leadership[3] as a guiding framework. The RNAO leadership model was augmented with emerging managerial leadership concepts, particularly those related to leading in crisis and managing ever changing competing priorities.[3] The theoretical underpinnings of the RNAO Model for Developing and Sustaining Leadership[3] are reflected in the five transformational leadership practices shown to result in positive outcomes for patients, nurses, and organizations.[3,11] These practices include building relationships and trust, creating an empowering work environment, creating a culture that supports knowledge development and integration, leading and sustaining change, and balancing the complexities of the system, managing competing values and priorities.[3] Transformational leadership practices are influenced by organizational supports and personal resources within a context of external, sociocultural, and professional factors (see Figure 1).

2.2 Program development

Once the need for the leadership education was identified, the RNAO engaged the broader Ontario nursing leadership community to support the co-creation of this novel program. The first step in developing the LMNP was to establish a Curriculum Team that was responsible for formulating the learner application and selection processes, program goals, curriculum framework, curriculum delivery model and evaluation plan. The Curriculum Team included members of RNAO staff, and members of the executive committee of the Nursing Leadership Network of Ontario (NLN.ON). NLN.ON is an RNAO interest group of nursing leaders providing a

voice for nursing leadership in Ontario. NLN.ON was a key partner in co-creating the full curriculum and engaging Ontario's nursing leadership community in presenter and facilitator roles within the program. The curriculum was based on updated content related to each of the transformational leadership practices in the RNAO Conceptual Model for Developing and Sustaining Leadership. The updated concepts were drawn from the literature and reviewed against feedback from team members of NLN.ON, all actively engaged in leadership roles and/or teaching leadership to undergraduate and graduate nursing students. This partnership with NLN.ON nursing leaders served to ensure the program's theoretical components were enhanced with a strong focus on application. Collaboratively, the Curriculum Team developed the program over a four-month period using an iterative approach. To facilitate the development of content, the team met virtually on a bi-weekly basis to discuss content, program delivery methods, and evaluation. See Table 1 for the program timeline.

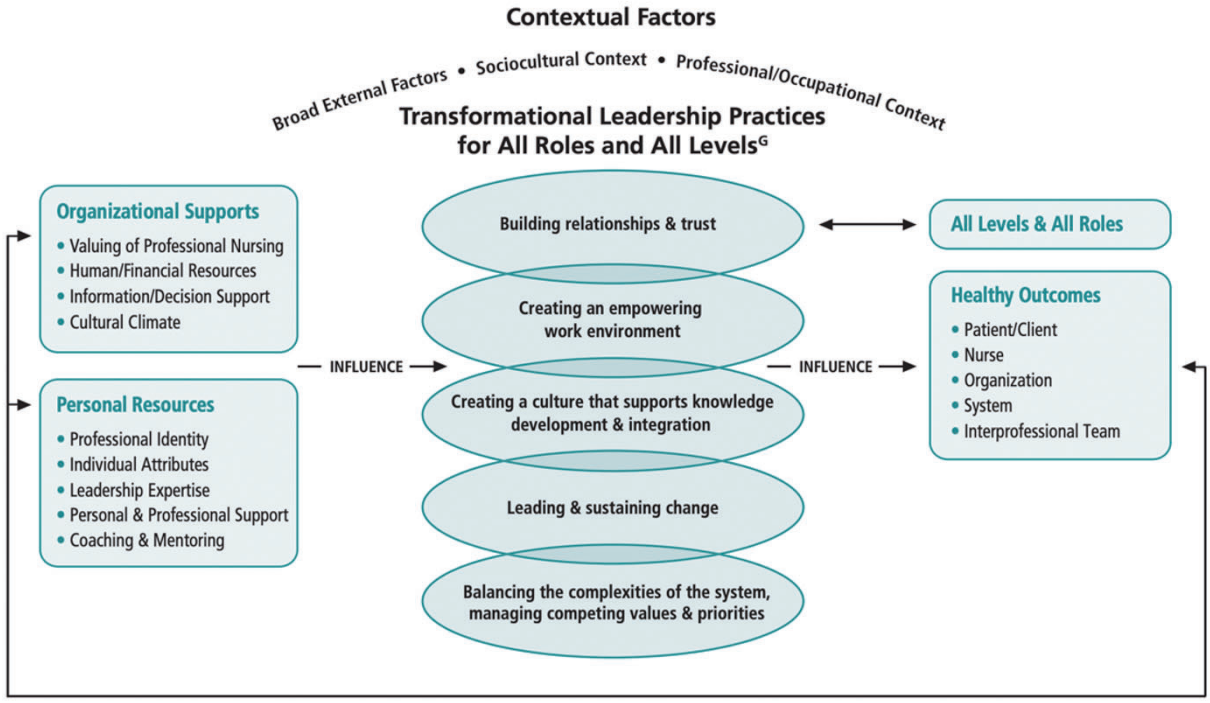

Figure 1. Conceptual model for developing and sustaining leadership
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Table 1. Program timeline and activities

Timeline	Activities
March 2022	• Development of LMNP format, goals, curriculum content outline, and evaluation framework
May 2022	• Nursing week – Launch of LMNP to begin in Fall 2022 for acute and long-term care sectors
May 2022-June 2022	• Engagement with NLN.ON • Content development including speaker and mentor recruitment • Weekly Curriculum team meetings
June- August 2022	• Applications and review processes
September 2022-December 2022	• Delivery of LMNP Program including monthly synchronous sessions • Debriefing after each session to review participant feedback and modify LMNP based on feedback and observations as required
December 2022	• Celebration the graduation of 63 participants • Summative evaluation
January 2023	• LMNP session focus group

2.3 Program audience and admission/eligibility requirements

Nurses in managerial leadership roles are critical to motivating and inspiring effective nursing teams.[1] The LMNP was designed for novice nurse leader-managers to enhance knowledge and skills necessary to promote competence, confidence, and effectiveness in these roles. The first cohort of the LMNP was aimed at leader-managers in the hospital and long-term care sectors, as leaders in these roles were seen as critical during the early phases of the pandemic. Leader-managers included those in a variety of leadership roles with admission being open to Registered Practical Nurses (RPNs), Registered Nurses (RNs), and Nurse Practitioners (NPs) in Nurse Manager, Assistant Director of Care, Director of Care or other formal leadership positions. Aspiring nurse leaders were also encouraged to apply for consideration if space permitted. Program participants required the support of their direct supervisor, along with funded release time for the duration of the program, enabling access to program resources and support, preparing for and attending sessions, meeting with their mentor, and completing a leadership project. In addition to organizational support, applicants were asked to submit supporting information as outlined in Table 2. To promote capacity building, the program was offered free of charge, facilitating broad access.

Table 2. List of application requirements

- Letter of intent indicating career goals as a nurse manager and overall leadership and management learning goals
- Identification of a unit-based leadership project to be developed/completed as part of the program
- Agreement to self-select a mentor (as required)
- Letter of support for the program from direct supervisor, agreeing to provide 2 full days of release time once a month for duration of the program (4 months) and to provide necessary support to applicant to enable success as a nurse leader-manager

2.4 Program content & delivery methods

The LMNP consisted of evidence-based content, case studies and storytelling to promote application of theory, collaboration and networking with peer leaders, and transfer of theory to practice through a project supported by a skilled mentor. Given that nurse leader-managers are adult learners, the program was further designed in alignment with Knowles'[12] principles of andragogy. These principles include experience-based learning, orientation to learning and respect for learner autonomy.[13] As such, the program was intentionally designed to provide learners with opportunities to apply learning to real world scenarios, while also having the freedom to work on a project of their choosing. Moreover, principles such as readiness to learn and self-directed learning were promoted through self-directed learning activities including reflective journaling and support from the mentor.

While relationship-focused skills such as managing conflict and motivating staff are critical to the nurse manager role, nurse leader-managers also require knowledge of finance, human resources, and leadership theory.[2] Concepts discussed within the context of the LMNP included: key leadership behaviours; transitioning from staff nurse to a leader-manager; the context of leadership; day-to-day management skills and personal supports critical to becoming an effective leader-manager. These concepts were expanded to include a list of key themes that formed the basis of each learning module. See Table 3 for a complete list of topics.

Table 3. LMNP module topics

- Leadership and management concepts and realities
- Critical perspective and skill shifts occurring as one transitions to leadership management roles and across the management leadership continuum
- Communication and trust as a seminal skill for leaders and managers
- Empowering staff and teams and cultivating learning systems
- Leading change incorporating knowledge to action and social movement action frameworks
- The environment of nursing and health and community care embracing the quadruple aim in the context of the United Nations sustainable development goals
- Incorporating personal strengths and resources in your leadership and management style
- Going forward as a leader, sharing growth and next steps

2.4.1 *Delivery methods*

The LMNP was offered through synchronous virtual sessions (via the Zoom platform) offered once a month over a four-month period. During each monthly session, two modules were covered, each one 3.5 hours in length. Modules consisted of a 1-1.5-hour synchronous webinar aimed at delivering program theory, two 30-minute sector specific presentations, and small group discussions. Small group discussion topics varied by module and included case studies and stories to highlight application of theory, while also providing time to discuss leading through day-to-day challenges and realities. Small group discussions were led by expert facilitators who further engaged participants in developing their individual projects. Participants were able to raise questions about day-to-day challenges they were experiencing to receive advice from facilitators and peers.

The curriculum included an electronic workbook which served as a guide for participants in completing preparatory reading, follow up activities, as well as reflective journaling. Aligned with the principles of andragogy, learning activities and reflections included in the workbook supported individual participant growth and learning needs, and were not

submitted for assessment. To support self-directed learning,[13] course resources including slides and the workbook were added to the RNAO's electronic learning management system, which participants could access at any time.

2.4.2 *Program faculty*

Program faculty included members of the Curriculum Team, plenary speakers (e.g., researchers, nursing faculty, healthcare leaders), sector specific speakers (e.g., hospital and long-term care) and facilitators. Targeted recruitment campaigns distributed by NLN.ON were used to identify potential speakers and facilitators. Interested applicants completed an online form indicating their preferred sessions as well as their experience and role. Program faculty participating in the delivery of content and facilitation were all in current /active leadership roles in hospital, long-term care, and academic settings. Invited faculty were provided with an orientation by a member of the Curriculum Team which included an overview of the program, discussion of relevant objectives, and a brief virtual training session prior to participating.

2.5 Mentorship

The role of mentorship has been highlighted as a critical support for nurse managers.[2, 14] As such, all LMNP participants were required to have a mentor in a leader-manager role to guide clinical application of the leadership content. For the first iteration of the program, participants had the option of self-selecting a mentor or receiving support from RNAO in being matched with a mentor. Mentors were required to be experienced nursing leaders from the participants' corresponding health care sector, either hospital or long-term care. Once matched, mentees met with their mentors early in the program to review the role, expectations, and resources available to both mentors and their mentees. Mentor-mentee relationships were built on a solid foundation of collaboration, knowledge sharing, mutual respect, constructive feedback, and professionalism. The dyads were encouraged to sign a mentor and mentee agreement to identify mutually agreed upon goals and parameters that served as the basis for the mentoring relationship. Mentors and mentees had access to documents on RNAO's electronic learning management system that provided direction for their roles, meetings and suggested areas of focus to ensure alignment with program theory and application. Mentee-mentor dyads were encouraged to meet monthly; the frequency and meeting mode (in-person, virtual or phone) was ultimately determined by the mentor-mentee dyads. Participants were encouraged to utilize their mentors to discuss not only course content, but also progress on their projects and current day-to-day challenges they were experiencing in their roles. Any sensitive issues that were discussed were to be held in the strictest of confidence and the relationship was to be evaluated monthly and any necessary adjustments made as required.

2.6 Participant projects

As part of the application process, all participants had to identify a leadership project to be completed over the duration of the program. Projects focused on specific clinical areas of concern, implementing best practices, staffing issues, models of care, continuous quality improvement, creating a healthier work environment, and team building. Projects were targeted at micro, meso and macro levels. Further details of the project examples can be seen in Table 4. Providing participants with hands-on opportunities to apply their learnings was an important component of the LMNP, aligned with principles of andragogy.[13] As participants worked through their individual projects, they were supported by program facilitators and their mentors who provided suggestions and advice about program planning and implementation. Opportunities for sharing project ideas and challenges among program participants were also provided during small group breakout sessions, this allowed participants to receive constructive feedback from their peers. To recognize the accomplishments of participants, at the end of the program, projects were presented to the cohort, including peers and program faculty.

2.7 Program evaluation methods

A program evaluation framework was developed to evaluate: (1) the various components of the LMNP program, (2) to what degree the program supported participants to achieve their leadership goals; and (3) the impact of the program on participant leadership attributes. The evaluation process was intentional and multimodal with a combination of formative and summative evaluation approaches used. Formative participant surveys were completed immediately after each module. The purpose of formative surveys was to gain feedback on program delivery, content and suggestions for improvement. Summative participant surveys completed at the end of the program served to evaluate both program processes and outcomes. This survey included twenty-nine questions related to program logistics, participant goals and goal attainment, leadership behaviours, knowledge and confidence levels, preparedness to lead, mentorship and overall impressions and feedback about the program. Questions were developed by the RNAO and scored using 5-Point Likert scales with responses ranging from strongly disagree to strongly agree or very unsuccessful to very successful. Additional items included demographic questions such as age, gender, work status, work setting, experience in nursing leadership and mentorship experience. Participants also had the opportunity to provide qualitative feedback through an open-ended

question at the end of the survey. The electronic surveys were developed and disseminated to participants through the standard RNAO survey tool accessed through a secured portal with a single sign-on through the RNAO platform, accessible only to course participants. Descriptive statistics were used to analyze survey data. Focus groups held with participants one month after the completion of the program garnered further information about the integration of program content into practice and subsequent changes in leadership behaviour. A one-year follow-up survey was distributed to participants consisting of similar questions found in the summative evaluation. As the final component of evaluation, participants' leadership trees were analyzed. This innovative data collection method consisted of an analysis of participants' leadership attributes related to the leadership model which was the framework for the curriculum. Quantitative data were analyzed using descriptive statistics, results of the summative participant survey are reported below. Results of other components of the evaluation will be published at a later time.

Table 4. LMNP project examples

Level	Examples of Projects
Micro (individual level)	• Developing staff at the front line related to decision making, ownership of practice and voicing concerns. • Enhancing team functioning through supporting staff development in the areas of self-reflection, developing solutions for issues and having difficult conversations. • Developing education for staff, in particular first responders on compassion fatigue, vicarious trauma and workplace safety.
Meso (unit/department level)	• Improving surgical services experience using a patient portal for patient education, communication and post-operative follow-up. • Implementing evidence-based mental health practice in the emergency department. • Transitioning staff from paper to electronic charting in long-term care.
Macro (organizational level)	• Developing and implementing a new model of care including the development of a new "patient care aide" role to support registered staff amongst a nursing shortage. • Improving overall morale in the organization with a focus on staff appreciation models. • Planning, educating and implementing supports to assist long-term care homes to adopt a palliative approach to care according to regulations. • Developing a program that supports RNs and RPNs to practice to their full scope.

Given that this was a program evaluation, research ethics board approval was not required, however, the team took steps to ensure that participant confidentiality and anonymity were maintained. Participants provided formal consent prior to participating in data collection methods including surveys and focus groups. Limited identifying information was collected, and all results were kept confidential. Data are presented in aggregate format to protect participant identities.

In addition to formal evaluation, the Curriculum Team relied on continuous quality improvement methods to evaluate the implementation processes. Debriefings were held immediately following each virtual day-long session with the program leads, speakers, and facilitators to review what went well and opportunities for improvement. Verbal feedback received from participants throughout the day-long virtual sessions was collected by RNAO team members and shared during this time. During weekly/biweekly meetings with NLN.ON, as well as in meetings with facilitators and the RNAO team, members reflected on feedback received and integrated it into future sessions. For example, based on participant feedback, the pace of presentations was reduced, and more time for questions was incorporated to support processing of concepts. Results from the formative evaluations were also reviewed with the Curriculum Team and used to inform changes such as availability of speaker slide decks, timing of breaks and electronic learning management system access.

3. RESULTS

A total of 110 individuals applied to the program of which 68 met the inclusion criteria and were accepted to participate, including 34 from the hospital sector and 34 from long-term care. Five participants withdrew either before or during the program for various reasons including workload and inability to attend sessions, resulting in a total cohort of 63 participants.

All 63 participants were matched with mentors, the majority of whom were from the participants' organizations. While most mentors were nurses, other members of the health team in leadership positions also served in this role. Faculty includ-

ing a total of 32 session speakers, 25 small group facilitators, and 63 mentors contributed to the delivery of the program.

3.1 Participant summative evaluation results

3.1.1 *Participant demographics*

A total of 54 participants (84% response rate) completed the summative program survey with one survey partially completed. The age of participants varied from 20 to 75, of which twenty-two percent (22%) of participants were less than 40 years of age, and 74% between 41 to 69 (inclusive) of age. Eighty-four per cent of participants were Registered Nurses, 14% were Registered Practical Nurses and 2% were Nurse Practitioners. Eighty-two percent (82%) of participants had less than five years of experience in nursing leadership positions, of which 35% had one to five years' experience and 47% had less than one year in a nursing leadership role. Nursing leadership roles included director of care, nurse clinician, nurse educator, education lead, public health nurse, resource nurse/charge nurse, nurse manager, and assistant director care.

3.1.2 *Program length and course components*

Most participants reported that the length and monthly spacing of the sessions helped in meeting their learning needs (70%, 83% respectively). Monthly spacing of the sessions enabled participants to complete the workbook activities (80%) and apply the knowledge in the workplace (83%). The length of the day-long sessions helped to enhance nurse leader manager skills (74%); and the 4-month length of the program helped to enhance nurse leader manager skills (89%). Participant responses to survey questions related to program content and assignments are presented in Table 5.

Table 5. Survey results of participants' experience with course content

Items	Percent of participants who selected 'agree' or 'strongly agree'
The sector specific sessions were relevant to my nursing leadership and management	96% (N = 54)
The small group breakout sessions were relevant to my nursing leadership and management	93% (N = 54)
The pre-assignments/readings supported the content of the day-long sessions	91% (N = 54)
The plenary session content was relevant to my nursing leadership and management	91% (N = 54)
The workbook content helped to guide my learning experience and activities	87% (N = 54)
The website content was easy to access	85% (N = 54)
Assignments were straightforward and clear	85% (N = 54)
The program content helped me to develop my project	80% (N = 54)
The opportunities for me to present my project and receive feedback were helpful to me in developing my project	78% (N = 54)

3.1.3 *Goal achievement*

Related to program goal achievement, 67% of participants agreed that they were successful or very successful in achieving goals of enrolling in the program. The goals that were most successfully attained included strengthening: skills in nursing leadership (96%), knowledge in nursing leadership (94%), and both knowledge and skill in nursing management (94%). See Figure 2 for additional results.

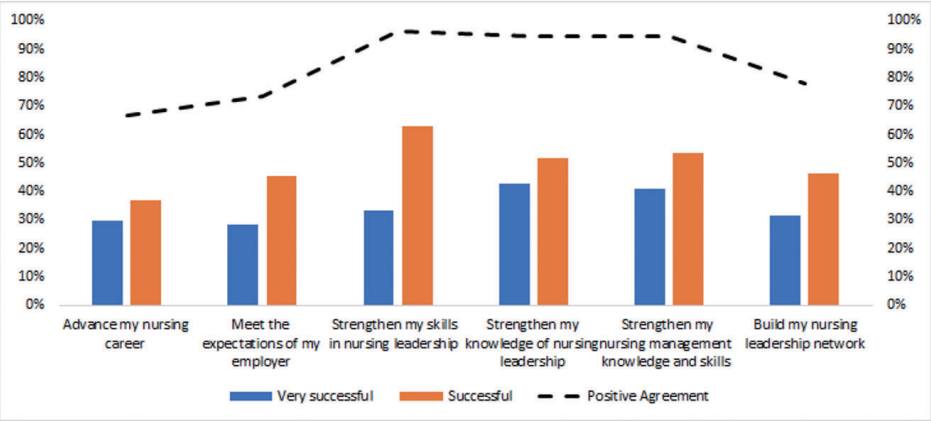

Figure 2. Agreement with achieving goals of program enrolment

3.1.4 *Program impact on learning outcomes, confidence & leadership behaviours*

Most participants (90%) indicated that they were either very successful or successful in meeting their learning goals for the LMNP. More than 80% of participants noted that the program enhanced their understanding of leadership and management concepts, while more than 75% reported increased confidence related to leadership and management abilities. Notably, 87% reported that the program enhanced their overall preparedness to lead. Survey results suggest that participants understood the importance of advocating for staff and giving them a voice (96%). Thirteen percent indicated moderate confidence, while 52% of participants agreed that they are somewhat confident, and 35% agreed that they were not at all confident in being an advocate for staff and giving them a voice. Ninety-three percent of participants agreed or strongly agreed that the program positively impacted their confidence in implementing workplace policies. Additional results pertaining to the program impact on participant leadership behaviours are presented in Table 6. Qualitative comments provided in the open-ended question indicated that participants felt more energized by learning about solutions that could be used to address real-world challenges.

3.1.5 *Participant projects*

Participants reported their projects enabled them to apply theory to practice and provided them with opportunities to work on a topic meaningful and relevant to their professional goals. Eighty percent of participants agreed or strongly agreed that the program content helped them develop their project. Seventy-eight percent agreed or strongly agreed that the opportunity to present their project and receive feedback was helpful to the development of their projects.

Table 6. Program impact on leadership behaviours

Leadership behaviours	Percent of participants who selected 'agree' or 'strongly agree'
Understand importance of being an advocate for staff giving them a voice	96% (N = 54)
Better understand how I can influence workplace policy	94% (N = 54)
More confident in implementing workplace policies	93% (N = 54)
Better understand value of my presence to the staff I lead	93% (N = 54)
Enhanced ability to engage with stakeholders	83% (N = 54)
More aware of how interprofessional colleagues value nursing	83% (N = 54)
More aware of how workplace values nursing	80% (N = 54)
More aware of how workplace values nurse manager/leader role	76% (N = 54)
More aware of how interprofessional colleagues value the nurse manager/leader role	76% (N = 54)

3.1.6 *Mentor-mentee relationship*

Fifty-nine percent of participants self-selected mentors whereas 41% had a mentor selected by RNAO. Participants indicated the frequency of mentor meetings during the sessions: monthly (13%); bi-weekly (9%); weekly (19%); as needed (43%); other (2%) and not at all (15%). In addition, participants used various methods to engage with their mentors: virtually (44%), in-person (43%) and a combination of both (13%). The most significant finding was that sixty-nine percent of participants agreed that their mentor helped them to achieve their leadership goals and the style of the mentorship relationship worked to help the mentee achieve their goals. Additional results related to mentorship activities are presented in Figure 3.

3.1.7 *Relationships & networking*

A key component of the program was the social aspect of learning where participants had opportunities to connect with their peers, program facilitators and mentors. Seventy-eight percent of participants indicated that they were successful in building leadership networks. Participants also reported that they felt less isolated as a result of making connections with like-minded leaders.

4. Discussion

The overall aim of the LMNP was to enhance competence, confidence, and effectiveness of nurses in managerial leadership roles through the development of leadership and managerial knowledge and skills. While there is mixed evidence about the components of leadership focused educational interventions that are effective,[14] this program evaluation results suggest that the LMNP was successful in building nurse leader manager capacity. Through the innovative and interactive LMNP program, participants in this program had the opportunity to engage in theory, discussion, application sessions and one on one mentoring with an experienced leader. Sector-specific learning opportunities were a unique aspect

of the LMNP that promoted learning and the development of skills and knowledge by providing participants with leadership experiences, examples and case studies unique to their respective sectors (e.g., acute or long-term care). Leadership capacity development and confidence were important outcomes of the program.

Figure 3. Mentorship relationship & activities

At the program outset, many participants shared they lacked confidence in their abilities, often termed "imposter syndrome". At the end of the program, participants reported that they felt more competent and confident in their nurse manager-leader role based on their newly acquired knowledge and skills. Similarly, literature suggests that educational interventions related to leadership development that are adapted to the needs of participants and include evidence-based content may contribute to improved nursing leadership.[11] To support participants, mentorship was included as a key component of the program. Almost all participants were matched to a mentor and as expected, most participants benefited from the advice and guidance provided by their mentors. The need for mentorship among nurse leader-managers has been highlighted in several studies, where mentors contribute to increased confidence and leadership competence.[2, 11, 15, 16] Mentor-mentee dyads where mentors were identified by mentees seemed to be the most successful due to their existing relationship. This underscores the importance of mentees self-selecting committed mentors and providing training and development opportunities in the mentor role, as being in a formal leadership role was not necessarily sufficient preparation.

One of the primary facilitators of the success of the LMNP was collaboration and engagement between the RNAO and NLN.ON, which represents the larger nursing leadership community. Collaboration with NLN.ON provided access to recruit engaging leaders from practice and academic settings across the province to share their collective wisdom as speakers, facilitators and mentors. This collaboration further resulted in the framework[3] to develop a theory and practice-informed education program that was beneficial to both participants and faculty. Literature suggests that partnerships such as those between academic and service organizations may result in benefits such as capacity building, access to shared resources and curriculum improvement.[17]

Beyond the collaboration between RNAO and NLN.ON, partnerships with program faculty (speakers and facilitators) and mentors contributed to the richness of the program. Nursing leaders were asked to participate in this program as faculty and mentors during the pandemic when they were experiencing increased workloads. Despite these demands, faculty and mentors were willing to candidly share their experiences and learnings with participants. While the program was built on theoretical foundations, the lived experiences and stories of program faculty were essential to ensuring that content was relevant to nursing leadership in the current context. Storytelling has been used in leadership education to promote the development of mutual understanding and to allow learners to visualize themselves in various situations.[18]

The concept of Professional Learning Communities has been used in educational literature where participants share learning, leading to enhanced competency and practice.[19] Developing a learning community among program participants contributed to the success of the LMNP. Participants were able to build relationships and their leadership networks through program activities including opportunities for discussion and small group work. Notably, these relationships

and networks were formed both within and across sectors (e.g., hospital and long-term care).

The use of the RNAO Model for Developing and Sustaining Leadership,[3] underpinned by transformational leadership theory, was effective in guiding the development of the program content and contributing to the overall learning outcomes. Two key strategies further supported participant learning about transformational leadership practices and program authenticity: 1) augmenting the theoretical content with real-world, context-specific practice examples;[20] and 2) having sessions facilitated by current practicing nurse leaders. Findings from this work confirm transformational leadership practices are important and relevant in leading in today's complex healthcare environments.[1]

4.1 Implications

There are several implications arising from the development and evaluation of the LMNP. While academic programs prepare future nurse leaders with theoretical content and skill development opportunities, healthcare organizations should consider how best to support ongoing leadership development among both experienced and novice nurse leaders. Achieving leadership excellence is a lifelong endeavor, best realized through ongoing knowledge development, safe environments for reflective application, and networks of leaders for maximizing individual and collective growth. Leveraging professional associations to support program development is one strategy to ensure that content is relevant and reflects the current context. By leveraging adult learning principles and blending theory with practical application, multi-modal leadership development programs can be responsive to a variety of different learning styles. Mentorship was an integral program component, there is a need to provide mentorship opportunities, particularly to novice nurse manager-leaders to ensure that they are equipped with the necessary knowledge and skills required to lead. Healthcare organizations should seek out new leaders and create a plan for their learning and mentorship. New leaders are also advised to request training and support from their organizations, especially when engaging in new roles. Other opportunities for leadership development include participating in communities of practice for leaders, leveraging the social aspects of learning and promoting exposure to a variety of approaches to address leadership challenges.

While the LMNP program was a success, sustainability of leadership development programs needs to be considered. Implementing such programs are resource intensive, requiring subject matter experts, skilled facilitators, supporting resources and possibly release time for staff. For organizations that do not have resources to support program development, they may consider leveraging individual program components that are more feasible to sustain, for example, online learning modules and one-to-one mentorship. Sustainability should also be integrated early on in the planning process when developing new leadership programs.[21]

4.2 Limitations

There were several limitations associated with the evaluation of the LMNP. While data were collected longitudinally, participant attrition increased as time progressed. As such, the ability to draw conclusions about the sustainability of program learning is limited. Moreover, all data collected were subjective and prone to potential bias due to the self-reporting nature of data collection. Despite these limitations, the structured and multi-component program evaluation plan was a strength. It was comprehensive, ensuring that at each stage of program development and delivery, participant feedback was sought to allow for adaptation as needed. Given that this was an inaugural program for the RNAO, this multifaceted input was essential to developing a program that was responsive to participant learning needs. Following the first iteration of the LMNP, the team reflected on opportunities for improvement for future iterations. Building on the success of the program, a second iteration of the program was offered in the home and community sectors. There are future opportunities to expand the reach of the program to include other health and social care sectors. In addition, future considerations to adapt the program could include creating asynchronous and virtual modules, allowing for more flexibility and possibly less participant attrition.

5. Conclusion

Nurse leader-managers have experienced challenges such as role changes and increased workload because of the pandemic.[1] This has left little time for professional development opportunities, exacerbated by a lack of organizational support for these initiatives. Nurse leader-managers require ongoing professional development opportunities to develop and maintain leadership and managerial competencies. This paper highlights how collaborative development of the LMNP while engaging leaders in the field enhanced the currency and relevance of the content, and delivery methods resulting in a reality-based curriculum. The applied nature of the program included tailoring leadership content by sector and use of case studies providing opportunities to test evidence informed approaches to leadership. The LMNP is one example of a leadership development program that contributes to capacity development among novice nurse leaders, allowing them to increase their confidence and improve their leadership practice.

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AUTHORS CONTRIBUTIONS

SBB, HT, JC, SN drafted and revised the manuscript with input from all authors. All authors read and approved the final manuscript. JC, IB, SBB, HT, SN were responsible for the overall project design. JC, SN were responsible for data collection and analysis.

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The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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No additional data are available.

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