UK Nurses' and Midwives' experiences of healthful leadership practices during the COVID-19 pandemic: A Rapid Realist Review

NAME AND EMAIL ADDRESS OF CORRESPONDING AUTHOR

Caroline AW Dickson Prof Doc MSc BA RN DN RNT

Senior Lecturer, Division of Nursing and Paramedic Science; Member Centre for Person-centred Practice Research,. Queen Margaret University, Edinburgh Scotland; Fellow of Queens Nursing Institute Scotland.

Caitlin Davies BSc RN

Graduate Research Assistant

Division of Nursing and Paramedic Science

Queen Margaret University Edinburgh Scotland

Prof Brendan McCormack (RCN Fellow)

Head of School & Dean

Susan Wakil School of Nursing and Midwifery | Sydney Nursing School

Faculty of Medicine and Health

President Omega Xi Chapter Sigma Global

THE UNIVERSITY OF SYDNEY

Level 8 East, D18 Susan Wakil Health Building, Camperdown| Gadigal | NSW | 2050

Dr Liz Westcott

NMC Test of Competence Assessor and Coach

Sigma, Europe Regional Coordinator

Sigma, President Phi Mu Chapter

Oxford School of Nursing and Midwifery

Faculty of Health and Life Sciences

Oxford Brookes University, England

Prof Joy Merrell

Emeritus Professor,

Faculty of Medicine, Health and Life Science

President Upsilon Xi at Large Chapter of Sigma, Wales

Swansea University, Wales

Prof Sonja Mcilfatrick (RCN Fellow)

Head of School Professor of Nursing and Palliative Care

School of Nursing

Ulster University, Northern Ireland

Prof Jan Dewing

Head of Graduate School & Centre for Person-centred Practice Research

Queen Margaret University, Edinburgh Scotland

Abstract

Aim: To explore healthful leadership practices in nursing and midwifery evident within the Covid-19 pandemic in the UK, the contextual facilitators, barriers, and outcomes.

Background: Globally, the health and care sector are under pressure and despite nurses and other professionals demonstrating resilience and resourcefulness in the COVID-19 pandemic,

this has negatively impacted on their health and wellbeing and on patient care.

Evaluation: Two searches were conducted in July 2021 and December 2021. Inclusion/exclusion criteria were identified to refine the search, including papers written since the beginning of the pandemic in 2020. A total of 38 papers were included principally from the USA and UK. 10 were research papers, the others were commentaries, opinion pieces and editorials. MS Teams literature repository was created. A unique critical appraisal tool was devised to capture *contexts, mechanisms* and *outcomes* whilst reflecting more standardised tools i.e., the Critical Appraisal Skills Programme and the Authority, Accuracy, Coverage, Objectivity and Date tool (AACOD) tool for reviewing grey literature to refine the search further.

Key Issues: Six tentative theories of healthful leadership emerged from the literature around leadership strategies which are relational, *being visible and present; being open and engaging; caring for self and others; embodying values; being prepared and preparing others* and u*sing available information and support.* Contextual factors that enable healthful leadership practices are in the main, created by leaders' values, attributes, and style, as well as the culture within which they lead. The literature suggests leaders who embody values of compassion, empathy, courage, and authenticity create conditions for positive and healthful relations between leaders and others. Nurse and midwives' voices are however absent from the literature in this review.

Conclusion: Current available literature would suggest healthful leadership practices are not prioritized by nurse leaders but the perspectives of nurses' and midwives' about the impact of such practices on their well-being is missing. Tentative theories are offered as a means of identifying healthful leadership strategies, the context that enable these and potential outcomes for nurses an midwives. These will be explored in phase two of this study.

Implications for nursing management: Nurse leaders must be adequately prepared to create working environments that support nurses' and midwives' wellbeing, so that they may be able to provide high quality care. Ensuring a supportive organisational culture which

embodies the values of healthfulness may help to mitigate the impact of the COVID-19 pandemic on nurses' and midwives' wellbeing in the immediate aftermath and going forward.

AIM

This Rapid Realist Review (RRR) sought to answer the following questions:

1. What leadership strategies and interventions did nurses and midwives find effective in the COVID-19 crisis?

2. How do contextual factors facilitate or inhibit leadership strategies and interventions?

3. What are the outcomes for nurses and midwives from effective leadership strategies?

This review forms the first phase of a realist evaluation which explored the differences in contexts that made the mechanisms (leadership strategies and interventions) work and the outcomes during the pandemic, generating tentative programme theories (Pawson et al. 2004). These theories will be tested in the second phase of the study by inviting nurses and midwives to share their experiences of leadership practices that promote healthfulness during the Covid-19 pandemic. Following theory refinement, it is anticipated the results from the study will inform future nursing leadership and leadership preparation.

BACKGROUND

Health and care sectors across the globe, although shown to be resilient and resourceful during the pandemic, are under tremendous pressure. Across all four UK nations, this has impacted on the NHS and care services ability to deliver safe and effective care (Bailey & West, 2020). Healthcare professionals are rapidly adapting to population health needs whilst addressing a host of urgent issues including essential resource shortages e.g., personal protective equipment (PPE). Authors (Hoernke et al. 2021; Jai et al. 2020) suggest that when resources are stretched, healthcare professionals are left to decide who receives treatment; resulting in the increasing provision of unanticipated end-of-life care. UK Nurses and midwives have, and continue to, face changing practice considerations, including role redeployment, increased work pressures and strained interdisciplinary team-working (Rosa et al. 2020). Due to prolonged physical contact with patients, nurse's risk increased COVID-19

viral transmission, leaving them bare to the emergent suffering of patients and families, as stringent infection control and visiting policies have overhauled communication and dynamics (Rosa et al,. 2020; Royal College of Nurses [RCN], 2020a). The intersection of these elements are causing accumulative high stress, producing debilitating mental, emotional, and spiritual exhaustion, increasing rates of burnout and moral distress (Rosa et al., 2020). In England and Wales, increasing rates of absenteeism in doctors, nurses and midwives have been attributed to psychiatric illness e.g. anxiety, stress and depression (Just include citation to statistics). In Scotland, latest stress and absenteeism rates were published via a freedom on information request in 2017. Whilst in Northern Ireland no statistics were found. In 2020, Public Health Wales (2020) surveyed 1642 nurses, midwives, and healthcare support workers revealing 62.1% reported work-related stress and 13.6% having difficulty in feeling relaxed. Therefore, Rosa et al. (2020) suggest, nurses and midwives require distinct leadership considerations to protect and sustain them throughout the pandemic.

Unsurprisingly, pandemic aberrance has multiplied and intensified the requirements of nurse leaders and created new complexity. Thus Bailey & West (2020) posit nurse leaders must sustain their own motivation despite uncertainty, through ensuring their own mental wellbeing; contending this will enable coping and focus, to meet core nursing/midwifery needs. Contemporary leadership theories e.g., compassionate leadership (West et al. 2017) emerging from transformational leadership (Burns 1978), focus on relationships, communicating a vision, involving others and autonomy. However, these negate leader wellbeing as a contextual factor. Cardiff et al. (2018) produced a new model of leadership using the person-centered framework (2017) as a theoretical lens; identifying authenticity of a leader, including showing vulnerability, as highly valuable. Their model suggests the reciprocal leader/associate relationship enables mutual and fundamental personal growth and development. Contrastingly, NHS hierarchy amidst pandemic, adopted an emergency, command and control, style of leadership and management. Despite being effective in teams where status quo exists, directive leadership is ineffectual and unsustainable in times of change, risking increased emotional fatigue, when compared to empowering leadership (Manzanares et al. 2020; RCN 2020b; Rudolph et al. 2022). Unsustainable directive leadership, risks alienating the very staff who require engagement and motivation during the COVID-19 pandemic, the longevity of which, is yet to be determined (Rosser et al. 2021).

Rosser et al. (2020) suggested the following core aspects of leadership during the pandemic that need to be addressed, visibility; collaboration; and advocating for personhood. They suggested that in order to meet the needs of and support nurses, it is crucial to identify how to make leadership more visible. They contend, ensuring the nursing voice is heard and recognising nurse well-being is paramount in all future decision making (Rosser et al. 2020). The Kings Fund report 'Courage of Compassion' (West et al. 2020) highlighted the ways in which nurse wellbeing must be supported. The longstanding issues of chronic excessive work pressures and inadequate working conditions have only been exacerbated by the COVID-19 pandemic. They suggested nurse leaders and management should focus on meeting the three-core nurse needs of I) autonomy- giving nurses control over their work lives, enabling them to act consistently with their values; II) belonging- the need to be connected, cared for, and caring of others around them at work, to feel valued, respected and supported and; III) contribution- the need to experience effectiveness in what they do and deliver valued outcomes. In response to this report, The RCN Foundation has commissioned this realist evaluation that explored nurses' and midwives' perspectives and experiences of effective leadership strategies during the Covid-19 pandemic.

The aim of this review brings healthful leadership practices to the foreground to make recommendations for how these practices can be incorporated into future leadership strategies within nursing and midwifery beyond the pandemic. Healthful practices reflect nurses' core needs as highlighted in the Kings Fund report (West et al. 2020). McCance and McCormack (2020) describe healthful practices as collaborative, featuring shared decision-making. They suggest when leadership is transformational and innovative staff feel supported and able to maximise their potential in line with their values. They proffer that establishing healthful practices has the potential to create healthful cultures where everyone is able to flourish. They argue that attention needs to be given to practice environments which support person-centred practices. Person-centred processes that enable person-centred practice identified in the framework are working with the *person's beliefs* and *values, engaging authentically, sharing decision-making, being sympathetically present and working holistically* (McCormack and McCance 2017). This paper reports on a Rapid Realist Review (RRR) of

current evidence as part of a larger realist synthesis study exploring healthful leadership during the pandemic.

EVALUATION:

In this review we aim to understand what is known in the literature about healthful leadership practices, the intended outcomes of these and different contexts that enable these practices to happen. The review question was based on the definition of a healthful culture developed by McCormack & McCance (2021 pg29):

> *"A healthful culture is one in which decision-making is shared, staff relationships*
>
> *are collaborative, leadership is transformational, innovative practices are supported*
>
> *and*
>
> *is the ultimate outcome for teams working to develop a workplace that is person-*
>
> *centred".*

This definition has emerged from McCormack and McCance's (2017) ideas on personhood and person-centredness, central constructs to the practice of nursing. RRR, which according to Bulley et al. (2021) is an accelerated form of realist review or synthesis. As a review methodology, 'rapid review,' usually used to inform policy has different meaning s in the literature.   As rapid reviews follow systematic review guidance (usually Cochrane Collaboration), decision-makers place value on the evidence reviewed and quantify any bias to inform policy (Kelly et al 2016). However, this is not the intention of this review. Pawson and Tilley (2008; Wong et al.(2013) propose realist synthesis as an alternative systematic method, as it can rapidly generate theories to explain why a particular intervention is likely to work, how, for whom and in what circumstances. Recognising complexity of interventions, Lavis et al (2005) concur, citing this method as a means of informing healthcare management and policymaking. Using the expedited form of realist synthesis as used by Bulley et al. (2021) therefore,, we contend RRR is a legitimate and innovative approach to conducting literature review. To ensure a systematic approach, we have used the RAMASES I Quality Standards for Realist Synthesis https://www.ramesesproject.org/

The RRR approach enabled the identification of the important contextual factors (C) that facilitate or inhibit desired interventions (M) (leadership), and the (healthful) outcomes

achieved (O). Contingent relationships expressed as C,M,O configurations, therefore show how particular contexts or conditions trigger mechanisms to generate outcomes (Rycroft-Malone et al. 2012). According to Hewitt et al. (2021) mechanisms are the pathways from resource to reasoning and response. Thus, identified healthful outcomes will depend on contextual factors e.g. leader attributes and/or leadership styles. The research questions were jointly agreed by the project commissioner and research team through an initial scoping of evidence and were then translated into a realist review question (Figure 1). An initial scoping of the literature is required before determining the area of focus (Kent and Ajjawi 2022)

[Insert Figure 1]

The systematic, iterative approach as directed by Wong et al. (2013), involved collaboration with a panel of experts contributing to each of the three phases undertaken. Preliminary screening of the literature was conducted by two reviewers CDi and CDa, to identify what literature existed surrounding this topic and to assist in the development of the search strategy. Screening produced limited research and thus scope was expanded to include specific international and grey literature to increase results. The terms *well-being* and *resilience* were also included as keywords as in initial searches it was noted that this terminology was used frequently in articles of relevance to this review. The search strategy was refined, key words and inclusion and exclusion criteria identified (Figure 3).

[Insert Figure 2]
Figure 2: Three stage search strategy of the Rapid Realist Review

[Insert Figure 3 here]
Figure 3: Inclusion/exclusion criteria.

Appraisal
As suggested by the RAMESES guideline (2013), realist reviews do not lend themselves to a technical protocol but require unique consideration during appraisal and inclusion/exclusion cannot be based solely on an assessment of document quality; but more depends on

relevance and robustness of the evidence to answer the research question. Thus, a unique critical appraisal tool was devised to capture *contexts, mechanisms* and *outcomes* whilst reflecting more standardised tools i.e., the Critical Appraisal Skills Programme (CASP) structures and the Authority, Accuracy, Coverage, Objectivity and Date tool (AACOD) tool for reviewing grey literature. Wong et al. (2013) recognise that this is challenging but necessary.

The search, conducted in July 2021 by CDa generated 52 papers which on first reading met the inclusion criteria. Abstracts were scrutinised by CDi and CDa independently. Following discussion and debate, 19 papers were excluded as they did not meet the inclusion criteria. Initially a total of 36 papers meeting the inclusion criteria were downloaded and collated into a shared excel table via Microsoft Teams. Decisions about inclusion/exclusion were documented with clear rationale in shared MS Teams literature repository. Areas of contention or concern occurred for several reasons e.g., papers not offering insight into leadership, lacking an evidence-base, not addressing the review question. Leadership strategies and interventions proposed were opinions from experts, often without basis in current clinical practice, lacking supporting evidence or explicit intended outcomes produced by interventions. As a result of these discussions, a further 3 papers were excluded, leaving a total of 33 papers included in the initial review.

Papers in this initial search (Figure 4) were mainly from the USA (n= 16), The UK (n=11), the European Union (EU) (n=2), Australia (n=3) and one a review of the literature. The majority of papers were written either for or from the perspective of nurses in recognised leadership positions. This is with the exception of Boykin et al. (2021) who emphasised the informal leadership demonstrated by 'frontline' nurses using storytelling. There was also an emphasis on situational management or the management of COVID-19 disease and little evidence of nurses' voices, and even less of midwives or other care workers. The missing narrative surrounding what works for nurses and midwives and what has made a difference to them, and their wellbeing amplifies the need for this programme of research. This is further augmented by only three of the papers reporting research, one mixed methods study, two qualitative and one survey. The other papers were commentaries, opinion pieces and editorials.

[Insert Figure 4: Prisma 1: Initial search]

For completeness, a second level search in December 2021 was again conducted to identify leadership strategies and styles (mechanisms) that impacted positively on nurses/midwives' well-being, and the context within which the leadership was displayed (figure 5). This search included papers from June 2021- December 2021 focusing on research only to address the gap in the first search I.e., to better understand the experiences and hear the voice of "frontline" nurses. This updated search yielded a total of 45 articles which following independent scrutiny by CDi and CDa revealed 5 articles meeting the inclusion criteria. Research was conducted in the EU (n=2); UK (n= 1); NZ (n=1) and USA (n= 1). Thus the total number of papers included in the review was 38. The literature table can be found in ==Suppl Doc 1).==

[Insert Figure 5 Prisma 2: Second level search]

Data Extraction

Each manuscript was coded for CMO configuration and for its potential to inform programme theory as per RAMASES protocol. Six key factors of healthful leadership emerged: *being visible and present; being open and engaging; caring for self and others; embodying values; being prepared and preparing others* and; *using available information and support.* Scrutiny of the chains of inference has led to the The generation of tentative theories within each of these domains by identifying the chains of inferences (Table 1), has given some insights into the review questions posed. Further data synthesis in the following section identifies from the literature, what leadership strategies work, in what circumstances and why.

[Insert Table 1 Theories and Chains of inference]

Being visible and present

Throughout the literature there was an increased emphasis on the importance of having visible, available, and present nurse leaders, who listen, identify the challenges of the pandemic and needs of individuals or teams (Allen 2021; Brodrick et al; 2020 Markey et al. 2020; Quinn et al 2020). Allen (2021) in his paper offering advice from senior nurses on

preparing and assisting depleted staff to cope during the pandemic suggested the benefit of having an open-door policy and being visible was to hear any concerns or problems. This was supported by Quinn et al (2020; Brodrick et al. 2020). In the UK study by Quinn et al (2020) focus groups were used to interview five UK final year student nurses. They described ineffectual leaders who were absent from the clinical environment during the pandemic and effective nurse leaders as those who were available and who were able to provide support and advice. Brodrick et al. (2020), surveyed 106 nurses in New York. They found visibility enabled nurse leaders to be supportive and able to communicate consistently and meaningfully. In their small study, they found this ensured nurses felt supported and could work in collaborative partnerships. Fortgang (2021) and Rosa et al. (2020), scholars from the USA reviewed a range of evidence which emphasised the importance of visibility of nurse leaders throughout organisations. They found being visible enabled connection with staff not only enabling them to hear nurses' voices and needs as suggested by other authors (Allen 2021; Brodrick et al. 2020; Quinn et al. 2021) but this enabled them to relay these vertically up the organisational structure to be heard by senior management. Rosa et al. (2020) suggested this allowed staff to be acknowledged, validated feelings and built trust and engagement with the organisation.

Both Quinn et al. (2020) and Rosa et al (2020) described the outcome of having open communication as the creation of supportive environments where nurses felt heard and valued and that fostered well-being. This involved strategic advocacy, available mental health services, availability of fora to discuss ethical decisions and dilemmas. The review of evidence by Rosa et al (2020) described such environments as ones where staff are not readily re-deployed; and there are regular updates and an established feedback loop. However, Raderstorf et al. (2020) in their guidance based on experience of leading through previous crises, argued that although maximising their presence is crucial for nurse leaders, this is often made impossible by the increase in formal leadership responsibilities in a crisis. They argued this does not have to mean a lack of connection with colleagues, but availability and connectivity can be maintained through the intelligent utilization of multiple horizontal communication methods. Similarly, others (Yoder-Wise 2021; Abbu 2021; Ernst 2020) have reported on leaders innovating in the pandemic by using social media platforms, zoom meetings, team huddles and Schwartz Rounds to best hear staff voices, provide support and

encourage self-compassion as well as compassion towards staff, colleagues and patients (Allen 2020 Dimino et al. 2020; Hofmeyer and Taylor 2020; Ernst 2020).

Being open and engaging

Leaders using openness, honesty, positivity and facilitative approaches as a means of promoting collaboration and transforming practices were themes found by Holge-Hazelton et al. (2021) in their qualitative descriptive study. Data were collected from 13 ward managers in one Danish hospital using surveys and follow-up interviews. Using person-centredness as a theoretical framework they found the pandemic made best practice difficult for nurse leaders as they had to adapt their leadership. Some thrived and innovated to new ways of working whilst others struggled with a crisis of leader identity. They concluded nurse leaders required support themselves to be able to provide good leadership and hence quality care. Markey et al. (2020) advocated similarly in their guidance drawn from literature and using Lawton and Paez Gabriunas' (2015) integrated ethical leadership framework. Viewing evidence from previous pandemics through a lens of resilience and learning lessons from previous pandemics, Duncan (2020) advocated mentoring relationships which she suggested develops individual's resilience and builds positive and nurturing professional relationships. The intention of mentoring was identified as practising healthy coping strategies to support their self-efficacy, promote camaraderie and resilience, develop emotional awareness, autonomy and empowerment. The techniques mentors used included positivity, writing reflective journals and debriefing. Holge-Hazelton et al. (2021) and Crooke 2020; Dimino et al. 2020; Hofmeyer and Taylor 2020) offering leadership advice during the pandemic to promote well-being in their commentaries, suggested through positivity, nurses experienced an enhanced sense of wellbeing, improved team working and increased commitment to organisational goals. This was achieved by leaders who had leadership knowledge, were role models and resilient, through strategies such as having clarity of values and beliefs, utilising feedback from staff to innovate and solve problems together, hope huddles and celebrating successes. They posit this would lead to higher quality patient care and the involvement of staff in decision-making and co-design.

Dimino et al. (2020) reported that nurse leaders who can provide supportive engagement cultivate a caring culture where high quality patient care is the norm. In their paper offering

advice for leaders, they suggested leaders can promote psychological capital, by being 'emotionally available'. Interventions such as 'hope huddles', providing teams with inspiring quotes, celebrating success, reframing negative experiences as creating social persuasion (the conditions for success), optimism, encouragement and a supportive environment they claim are means to achieving this. Positive emotional environments were also highlighted by Harrington (2021) in her paper examining leadership styles she considered to be most effective during the pandemic. She suggested such environments are compassionate, values based, where the team know each other. In such environments the connection between patient and nurse experiences are kept visible and the leadership is values-based. She proffered it as a means of transmuting negative emotions into positive ones by providing an empathic response to distressed teams or individuals. In their commentary examining values-driven leadership in challenging times, James and Bennett (2020) suggested leaders can inspire others by channeling passion, motivation, and their emotions towards the achievement of set goals. Duncan (2020) suggested leaders can develop emotional intelligence through sharing and reflecting on experiences of vulnerability which can enable the development of personal resilience although resilience did not feature prominently in the literature. James and Bennett (2020) described emotional intelligence as exhibiting self-control and self-awareness. An aspect of emotional intelligence identified by Quinn et al. (2021) in their study exploring final year students' experiences of working during the COVID 19 pandemic, is being open to learning from others and in doing so, being perceived as more approachable and better equipped to connect with and inspire teams.

Caring for self to care for others

Authenticity is a recurring theme in the commentaries written by nurse leaders from the UK and the USA. Authenticity is viewed as vital to enable leaders to convey the realities of the stressful nature of the pandemic. Yonder-Wise et al. (2021) suggested that leaders who practice with agility and grace would be calmer and more authentic during crises, whereas Ernst (2020) and Quinn et al. (2021) reported that leaders able to express their own vulnerability can build authentic relationships and connectedness with their staff. In their commentary, Cathcart (2020) and Moore (2020), both academics from the USA, offered advice to leaders, suggesting calm or equanimous leaders who control their emotions during uncertainty, would be able to reduce fear, instill confidence in others and create feelings of

safety. Although authenticity and equanimity must exist alongside 'other-centered' intentions to care, compassion can be reciprocal (Howell 2021; Moore 2020; Dimino et al. 2020). In their paper advocating means of supporting staff during the pandemic, Vogel and Flint (2020) highlighted the self-care feedback loop that exists whereby nurse leaders who care for themselves demonstrate the importance of self-care in the nurses. They claimed this would lead to better recognition and value of self-care generally within the clinical environment.

Both Duncan (2020) and Foster (2020) advocated for an environment of self-care, but they suggested it is reliant on nurse leaders displaying respect of personhood in their caring intentions However, in their commentaries Hofmeyer et al. (2020) and Croke (2020) emphasised that resilience and self-care are the dual responsibility of the individual nurse and the wider organisation. The need for nurse leaders to prioritise 'self-'and self- nurturing is highlighted as a particular need during the pandemic (James and Bennett 2020; Yonder-Wise et al. 2020). A self-nurturing leader is resilient, and a role model according to several opinion leaders (Croke 2020; Dimino et al. 2020; Merchant 2020; Yonder Wise 2021; Duncan 2020; Raderstorf et al. 2020). They suggested this would promote resilience in staff and foster well-being, whereas   Hofmeyer et al. (2020) and Raderstorf et al. (2020) specified outcomes of increased morale, engagement and job satisfaction for nurses. Hofmeyer et al (2020) offered strategies and resources for nurse leaders to use to lead with empathy and prudence through the COVID-19 pandemic. They suggested empathic conversations, specific clinical learning and resources, providing mental health resources, personalised self-care plans, compassionate action and Schwartz Rounds.

Embodying values

Leaders who embody their values was another contextual factor featured in the literature. Yonder-Wise et al. (2021), Hofmeyer et al. (2021) and Moore (2020) emphasised that leaders must know themselves to be able to explicitly share their beliefs and values with staff, and that they must also be aligned to organisational values. Moore (2020) drew on theoretical ideas from Klann (2003) in her review of evidence to offer suggestions of leading during a crisis. She advocated embodying values to give insight to others' suffering. This would enable them to offer decompression strategies such as adequate breaks, flexible working, chats to keep in touch, as well as triaging and allocating resources effectively. Hofmeyer et al (2021)

also offering advice to avoid burnout specifically suggested offering organisational interventions would promote engagement. These interventions are supported by others (Harrington (2001; Vogel and Flint 2021; James and Bennett 2020). They framed this as compassionate action and suggested it would not be possible without first hearing and being 'alive to the suffering of others' linking the two concepts.

Other commentators highlighting values as contextual factors enabling effective leadership were courage, openness and honesty (Boykin et al. (2021) and advocacy which emerged in Rosa's (2020) review of evidence of leadership during crises. Three commentators (Holge-Hazelton et al. 2021; Moore 2020; Merchant 2021) suggested authentic nurse leaders would be able to share what they know and what they did not know about the pandemic. Openness and honesty would allow nurse leaders to demonstrate their vulnerability, making it possible for others to share their own vulnerability (Holge-Hazelton et al. 2021; Ernst 2020; Eldridge 2020; Kellish 2020) and boosting their credibility as leader. Duncan (2020) found communication principles have the potential to relieve others' stress in her review of evidence. Eldridge (2020) also promoted communication i.e., concise, consistent, timely and open messaging, regular updates which are research and evidenced based; credibility, honesty and openness. They also highlighted leaders who are respectful are valuable to nurses as they promote calm and co-operation in times of increased stress and vulnerability. Holge-Hazelton et al. (2021), Kellish (2021), Vogel and Flint (2021) suggested respectfulness They described healthful cultures being built around recognising the significance of human-to-human connection where all individuals are valued equally. In a culture such as this, nurses would be able to contribute to discussions, learning, innovation and shared decision-making (Holge-Hazelton et al. 2021; Allen 2021; Raderstorf et al. 2020). Hence, a healthful flourishing culture is one dependent on an authentic leader who communicates well and embodies their beliefs and values including openness, honesty, compassion and empathy.

Being prepared and preparing others

Certain leadership styles, for example, authentic, compassionate and transformational leadership, are widely referenced throughout the literature as means of maintaining morale and ensuring staff feel supported (Harrigton 2021; James and Bennett 2021; Catania et al. 2020). During the pandemic, the supportive nature of these styles places an emphasis on the

wellbeing of nurses according to Rosser et al. (2020) and James and Bennett (2020). Preparedness of leaders was evident only in two papers (Duncan 2020; Cook et. Al. 2021) although others identified experience and knowledge of 'self' as important in being a prepared leader The role of propositional knowledge developed through role experience, was echoed by several authors (Quinn et al. 2021; Harrington 2021; Ernst 2020). So too was recognising the value of inherent leadership characteristics and attributes in nurses. Once again, the precursor is understanding themselves as leaders, as well as propositional knowledge. Learning lessons from a qualitative study exploring experiences of Italian frontline nurses (n=23) during the pandemic, Catania et al (2020) particularly highlighted the need for appropriate training opportunities for nurses particularly where they found themselves in unfamiliar clinical environments after re-deployment. Drawing on a review of research conducted in previous pandemics, Moore (2020) also advocated conducting formal mandatory training, during circumstances of high stress, although acknowledged caution as this might increase nurse workload and therefore stress.

The importance that prepared leaders in turn would ensure preparedness of nurses who can in turn practice flexibly and foster trust was reported by Holge-Hazelton (2021), Hofmeyer and Taylor (2020) and Fortgang (2021). Fortgang (2021) advocated joint provision of appropriate training and leader preparedness as well as the formation of learning spaces may empower nurses to become involved in decision-making. The importance of learning spaces, despite no clear definition, was a recurring theme in the literature. They are repeatedly referred to as informal spaces where nurses can discuss and reflect on clinical challenges, increasing the pool of nursing knowledge and collaboration and creating opportunities for creativity and innovation (West et al. 2020; Howel 2021; Fortgang 2021). However, in Hofmeyer et al's. (2020) commentary, they expressed concern that these spaces may have been eroded by the worsening conditions of the pandemic and mandated physical distancing, affecting the cultivation of a 'community at work'. Leaders who are themselves prepared are able to maintain an environment of learning appears to be integral to the development of a healthful culture.

Using available information and support

It is widely reported in the literature, whether through research or commentary that nurse experiences of caring during the COVID-19 pandemic pose a serious risk to nurses' psychological wellbeing and there is a need for information and support because they are forced to provide sub-optimal care with limited knowledge and resources and; the prevalence of end-of-life care for patients with poor outcomes (Hofmeyer and Taylor 2020; Crooke 2020; Catania et al. 2020; Merchant 2021; Hofmeyer et al 2020; Allan 2020; Abbu 2020). Moreover, the practical implications of the COVID-19 pandemic and the associated stresses may be compounded by financial instability through furlough, particularly in the USA or issues with childcare (Digby et al. 2020; Abbu 2020; Hofmeyer and Taylor 2020). Risks to psychological wellbeing raised in the literature included an increased risk of burnout, moral injury, distress and other mental health disorders (Croke 2020; Merchant 2021; Rosa et al. 2020; Duncan 2020). To reduce stress, the availability of relevant and reliable clinical information to 'frontline nurses' should be disseminated in a timely manner (Moore 2020; Brodrick et al. 2020; Digby et al. 2020). Fortgang (2021) and Abbu (2020), both offering advice as leaders in the USA to clinical leaders, posit in addition to reducing stress, it would build trust between nurses and leaders. However, reporting conversations with senior nurse leaders in the UK Allan (2020) emphasised that rather than being the only form of emotional support available to nurses, leaders need to be able to signpost staff to available institutional support services. They can implement supportive measures e.g., ensuring safe staffing and adequate breaks (Croke 2020; Catania et al. 2020; Allan 2020) and are well placed to disseminate available support available within organisations. The importance of resources such as wobble rooms, open forums, emotional hygiene programmes, counselling, and mindfulness, were highlighted throughout the literature as necessary to support nurses transitioning from a prolonged state of crisis to a new normal (Croke 2020; Hofmeyer et al. 2020; Rosa et al. 2020; Markey et al. 2021). The reduction of nurse psychological harm has benefits not only for individuals but for the wider organisation, as nurses with negatively impacted mental wellbeing will be unproductive, burnt out and unable to provide the best possible care (Merchant 2021; Hofmeyer and Taylor 2020; Croke 2020).

KEY ISSUES:

The larger HeaLiN project will use qualitative and quantitative data to synthesise and further refine the identified theories. Data sysnthesis within the scope of this RRR has revealed

mechanisms or interventions leaders are encouraged to use that contribute to healthful outcomes are varied. They use multiple means of communicating with nurses both in-person and remotely. By being engaging, motivating and using facilitative practices, they can be responsive to individuals and teams' needs. They ensure nurses are prepared for their role through training and creating learning spaces and have the practical support they need. According to the literature these mechanisms contribute to supportive environments that promotes autonomy, well-being, learning and collaborative practices. The contexts that enable leaders to employ these strategies are concerned with who they are as leaders, their self-awareness and the attention they give to their own well-being. The attributes of healthful leadership emerge as authenticity, embodying values such as compassion, honesty, openness, humility, respect, vulnerability and courage and these are aligned with organisational values.

Despite the call from prominent nurse leaders (Rosser et al. 2020; West 2020) at the beginning of the COVID-19 pandemic for nurse well-being to be at the centre of decision-making, the literature suggests leaders appear not to have promotion of healthfulness as a core intent, although it is implicit in the findings. This may be due to the absence, in the main of any theoretical frameworks to guide interpretation of leadership strategies required during the pandemic. There is also little acknowledgement of the role of the macro culture and context that helps leaders to practice in these ways, rather the emphasis is on leadership attributes. According to Cardiff et al. (2020; McCance and McCormack 2020) this is only one level of context, supportive, learning environments are also key. A new attribute, vulnerability is a new finding which may be linked to courage and of relevance during crises. Although not explicit, Theory 2 suggests emotional intelligence, demonstrated by equanimity.

Healthful strategies identified in the literature include It also highlights being facilitative which leads to collaborative practices. According to McCance and McCormack (2020) collaborative practices and shared-decision-making are healthful strategies, rather than outcomes, although shared decision-making may be embedded in facilitative practices as in Theory 2: Being open and engaging. Cardiff et al. (2020) in their action research study identified practices of sensing (what is going on), presencing (authentic attentiveness and responsiveness), balancing the needs of all persons and contextualising, concerned with

understanding the others' personhood. Presencing may be embedded in visibility (Theory 1) which has the intention of understanding the team's needs, resonating balancing, Theory 4: Embodying values resonates with the work of West et al (2020) who contended that key to healthfulness is nurses feeling they have autonomy which enables them to work consistently with their values. This theory however also identifies being sympathetically present and creating learning spaces as interventions consistent with Cardiff et al's (2020) model but adds responsiveness as a leadership strategy. Other leadership strategies such as advocacy at a strategic level, finding different and multiple ways of communicating in timely ways, innovative resources e.g., wobble rooms and signposting well-being service to nurses are also new findings in this review. Whilst healthful leadership strategies, reflecting relational leadership are identified in the literature, there was an emphasis on the need for leaders to understand self and be adequately prepared. Theory 3 focusing on leaders only being able to care for others if they care for themselves also resonates with West et al. (20202). They suggest this enables others to feel valued and that they are making a valued contribution to their work, whilst the findings in this review suggest this enables nurses to engage in well-being practices. Innovation as an outcome of healthful leadership has emerged in the literature but nurses being able to maximise their potential in line with their values has not explicitly (McCance and McCormack 2020). This may reflect a more pragmatic approach advocated by nurse leaders at the beginning of the pandemic ensuring nurse preparation and learning but this had less intention of enabling nurses to flourish, although autonomy is a suggested outcome. The lack of nurse voice makes this difficult to ascertain: Healthful outcomes appear to be less focused on nurses flourishing and more concerned with reducing psychological harm, promoting resilience and boosting morale. We therefore acknowledge a limitation of this review as the nature of current evidence means that there is a degree of assumption about the important mechanisms which are enabled when contextual factors are at play and the range of outcomes this leads to. There is a paucity of research evidence. Much of the literature is opinion-based and prominently from North America. However, convergence of findings in the literature have provided indicators to develop tentative theories as to the factors which may promote nurses and midwives' well-being and healthfulness during and after a pandemic and these will be explored in phase two of this study.

CONCLUSIONS:

A gap in the literature are the perspectives of nurses' and midwives' regarding the influence of nurse leadership on their well-being and healthfulness This review found leaders do not make healthful practices a specific leadership intent, nor do they give context full attention as an enabler of healthfulness. The literature does not address the role of the macro context on healthful leadership practices, rather relies on leaders' attributes and attention to promoting well-being of nurses and midwives. Healthful outcomes do consider context for nurses and midwives as they aim to create supportive environments that promotes autonomy, well-being, learning and collaborative. Leaders however need to adapt their leadership practices to influence healthful outcomes.

IMPLICATIONS FOR NURSING MANAGEMENT:

The findings from this review have highlighted several factors that may promote nurses' and midwives' wellbeing and healthfulness. In addition to providing adequate resources, for example, in terms of staffing levels and learning spaces, the literature suggests that nurse leaders need to be adequately prepared to facilitate a healthful working environment to support nurses' and midwives' wellbeing, so that they may be able to provide high quality care. Ensuring a supportive organisational culture which embodies the values of healthfulness may help to mitigate the impact of the COVID-19 pandemic on nurses' and midwives' wellbeing in the immediate aftermath and going forward.

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Figure 1 Research Questions

Programme theory questions:

1. What leadership strategies and interventions do nurses and midwives find effective in the COVID-19 crisis?
1. How do contextual factors facilitate or inhibit leadership strategies and interventions?
1. What are the outcomes for nurses and midwives from effective leadership strategies?

Realist review question:

'What works in leadership that promotes healthful outcomes in nurses and midwives in the current pandemic, in what circumstances and why?'

Figure e 2: Three stage search strategy of the Rapid Realist Review

Phase 1: Initial Scoping	Phase 2: Search 1	Phase 3: Theory testing	Phase 4: Theory Refinement
• Literature scope using provisional key words • Development of research question • Development of inclusion and exclusion criteria • Refined key words established	• 1st searchers of literature as per PRISMA diagram of search 1. • Appraisal of literature using adapted AACODS tool • Data analysis and MCO development	• Researcher working group • Development of tentative theories from the literature based on the M,C,Os • Tentative theories tested with expert panel	• Theories refined post expert panel meeting • Search 2 conducted for completeness and to retrieve more research evidence • Theories refined for further realist evaluation

Figure 3: : Inclusion/exclusion criteria

Inclusion/exclusion criteria	Key words
Inclusion criteria Full text available English language Published 2020-2021 Has focus on nursing/midwifery leadership Health and/or social care context identified Set within the context of the Covid-19 pandemic UK, Europe, USA, Canda, Australia and New Zealand Research and commentaries from nurse leaders **Exclusion criteria** Subjects focus on other healthcare professionals Commentaries with no evidence-base	Leader* OR "leadership interventions" OR "leadership strategy*" AND nurs* OR midwife* OR "student nurs*" OR "student midwife*" OR "healthcare support worker*" AND Covid-19 OR pandemic AND person-centred* OR personhood OR healthful* OR well-being OR resilience OR wellness

Figure 4- PRIMSA Initial search

Identification of studies via databases

Identification

Records identified from:
Databases CINHALplus with full text, MEDLINE, PscyhInfo, ASSIA, SCOPUS
(n = 901)

→

Records removed *before screening*:
Duplicate records removed (n = 4)
Inaccessible records removed (n=12)

Screening

Records screened based on title
(n = 885)

→

Records excluded**
(n = 774)

Records screened based on abstracts
(n = 111)

→

Records excluded which did not meet inclusion criteria
(n = 59)

Records critically appraised by CDa and CDi
(n = 52)

→

Records excluded based on:

1) Inability to meet inclusion criteria

2) Distinct lack of rigour

3) Inability to answer research question

(n=19)

Included

Records included in review and added to overall rapid review findings
(n = 33)

→

Figure 5- PRISMA 2 Second level search

Identification of studies via databases

Identification

Records identified from*:
Databases CINHALplus with full text, MEDLINE, PscyhInfo, ASSIA, SCOPUS
(n = 199)

Records removed *before screening*:
Duplicate records removed (n = 52)
Inaccessible records removed (n= 13)

Screening

Records screened based on title
(n = 134)

Records excluded**
(n =37)

Records screened based on abstracts
(n = 97)

Records excluded which did not meet inclusion criteria
(n = 52)

Records critically appraised by CDa
(n = 45)

Records excluded by CDa based on;
1) Further inability to meet inclusion criteria, which now included original research (n = 30)
2) Distinct lack of rigour (n= 3)
3) Inability to answer research question (n= 4)

Included

Records examined by CDa and CDi
(n = 8)

Records excluded based on CDa and CDi consensus
(n = 3)

Records included in review and added to overall rapid review findings
(n = 5)
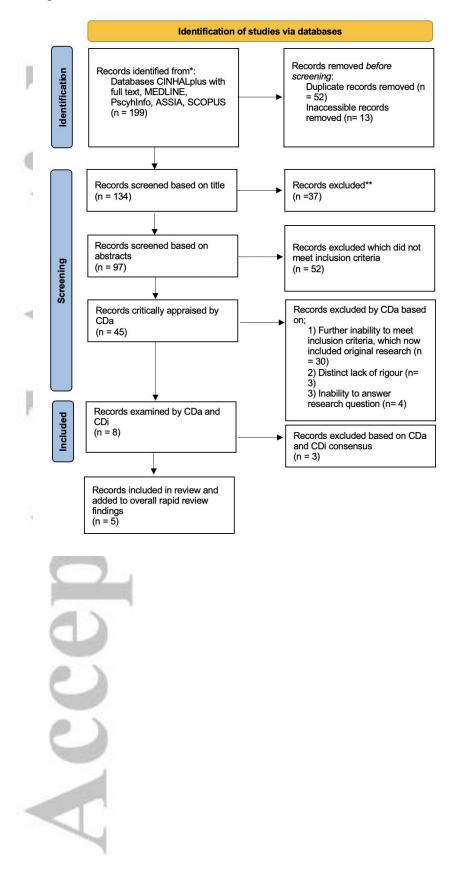
Table 1 – Theories and Chains of inference

Working Theories what is each about?	Themes	Chains of inference (Evidenced)
Theory 1: Being visible and present Nurse leaders who are visible and available (C) to nurses use multiple communication methods (M) to understand and respond to individual and team need that promotes their wellbeing (O) and creates a safe supportive work environments (where people feel heard, valued etc.) (O) This means they are also able to be advocate at a strategic level (M).	Visibility Multiple communication methods (Horizontal and vertical) Safe, supportive work environment	**C: Visibility/availably as part of a safe supportive work environment** (Markey et al. 2021, Allen et al. 2020, Digby et al. 2021, Brodrick 2020, Fortgang 2021, Moore 2020, Quinn et al. 2021, Raderstorf et al. 2020, Vogel and Flint 2021, Rosa 2020, Rosser et al, 2020) **M: Multiple communication methods (listening, being present, team huddles, protocols, emails, zoom, Schwartz rounds, collaborative dialogue, horizontal and vertical communication** (Rosa 2020, Vogel and Flint 2021, Catania et al. 2021, Howell 2021, Hofmeyer et al. 2020, Merchant 2021, Abbu 2021, Moore 2020, Ernst 2020, Fortgang 2021, Yoder-Wise et al. 2021, Croke 2020, Brodrick 2020, Hoffmann et al. 2020, Holge-Hazelton et al. 2021, Digby et al. 2021, Hofmeyer and Taylor 2020, Allen 2020, Markey et al. 2021, Dimino et al. 2020)

		Advocacy (Hoffman et all. 2020, Brodrick 2020, Rosa 2020) **O: Feeling heard** (Markey et al. 2021, Howell 2021); **Compassionate culture** (Vogel and Flint 2021, Croke 2020, James et al. 2020, Hofmeyer and Taylor 2020); **Authentic relationships** (Dimino et al. 2020, Holge-Hazelton et al. 2021, Fortgang 2021); **Environment of trust** (Brodrick 2020, Abbu 2021, Cathcart 2020); **Caring culture** (Dimino et al. 2020) **Feeling valued** (Kellish 2020, Hofmeyer et al. 2020, Harrington 2021, Holge-Hazelton et al. 2021).
Theory 2: Being open and engaging Emotionally intelligent leaders are person-centred facilitators who are reflexive and open to learning from others (C). they foster engagement, motivate, and empower nurses (M) to engage in collaborative working practices and transform practice (O)	Person-centred facilitators Facilitation interventions Collaboration/collaborati ve working practices Transformation of practice	**C: Emotional intelligence** (James et al. 2020) **Reflexivity** (Duncan 2020, Kellish 2020); **Learning from others** (Quinn et al 2021, Foster 2020) **M: Facilitation** (Dimino et al 2020, Markey et al. 2021, Harrington 2021, Boykin et al. 2021, Brodrick et al. 2020, Croke 2020, Fortgang 2021, Moore 2020, Merchant 2021, Hofmeyer et al. 2020, Quinn et al. 2021, Kellish 2020, Foster 2020, Raderstorf 2020, Catania et al. 2021, Vogel and Flint 2021, Rosa 2020, Rosser et al. 2020, Duncan 2020). **Engagement** (Foster 2020, Vogel and Flint 2021, Hofmeyer 2020, Fortgang

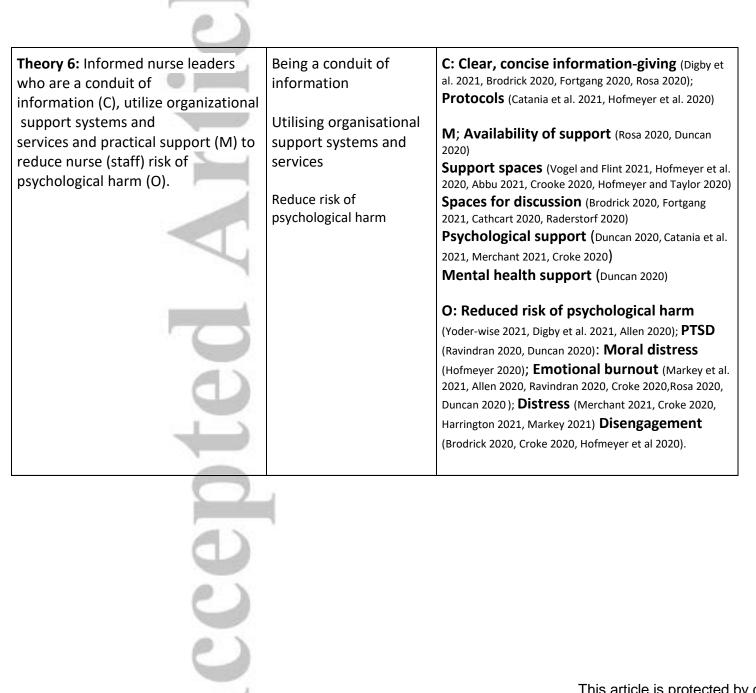|		
		2021, Croke 2020, Rosemary et al. 2020, Holge-Hazelton 2021); **Giving feedback** (Moore 2020, Rosa 2020) **co-design** (Raderstorf et al. 2020); **mentorship** (Vogel and Flint 2021, Markey et al. 2021); **transformative practices** (Harrington 2021, Catania et al. 2021, Rosser et al. 2020). **O: Collaborative working practices** (Abbu 2021, Ernst 2020, Brodrick 2020, Rosemary et al. 2020) **Transformative practice** (Harrington 2021, Catania et al. 2021, Rosser et al. 2020).
Theory 3: Caring for self to care for others Self-nurturing practices of leaders creates conditions for expression of authenticity and equanimity (C) enabling nurse leaders to be resilient, other-centred and caring (O). This acts as a catalyst for nurses and teams to engage in well-being practice, thus promoting their own resilience, increasing morale and job satisfaction (O).	Self-nurturing Leadership attributes Self-care Resilience-building Job satisfaction	**C: Self-nurturing** (Dimino et al 2020, James et al 2020a, Harrington 2021, Croke 2020, Yoder-wise 2021, Merchant 2021, Hofmeyer et al.2020, Quinn et al. 2021,Howell 2021, James et al. 2020, Raderstorf et al. 2020, Vogel and Flint 2021, Duncan 2020) **Equanimity** (Moore 2020, Abbu 2021, Cathcart 2020, Howell 2021) **Authenticity** (Dimino et al 2020, Holge-Hazelton et al. 2021, Brodrick 2020, Ersnt 2020, Quinn et al 2021,Kellish 2020, Cathcart 2020, Howell 2021, Catania et al. 2021); **Self-care of leader** (Dimino et al. 2020, Markey et al. 2021,

		Hofmeyer and Taylor 2020, Holge-Hazelton et al. 2021, Merchant 2021);
		M: Other centred and caring (Dimino et al. 2020, Digby et al. 2021, Boykin et al. 2021, Croke 2020, Moore 2020, Hofmeyer et al 2020, Kellish 2020, Cathcart 2020, Howell 2021, Foster, Raderstorf 2020, Rosa 2020, Rosser et al. 2020); **listening** (Dimino et al. 2020, Markey et al. 2021, Allen 2020, Ravindran et al. 2020, Digby et al. 2021, Yonder-Wise et al. 2021, Moore 2020, Howell 2021, Vogel and Flint 2021, Rosa 2020); **Being present** (Dimino et al. 2020, Holge-Hazelton et al. 2021, Brodrick 2020, Croke 2020, Moore 2020, Abbu 2021, Merchant 2021).
		O: Self-care of staff (Dimino et al. 2020, Markey et al. 2021, Hofmeyer 2020, Holge-Hazelton 2021, Harrington 2021, Abbu 2021); **Resilience** (Dimino et al. 2020, Markey 2021, Hofmeyer and Taylor 2020, Digby et al. 2021, Hoffman et al. 2020, Croke 2020, Fortgang 2021, Vogel and Flint 2021, Duncan 2020) **Increased morale** (Markey 2021, Harrington 2021, Hofmeyer 2020, Kellish, Howell 2021); **Job satisfaction** (Haque 2021,Catania et al. 2021, Boykin et al. 2021, Harrington 2021

Theory 6: Informed nurse leaders who are a conduit of information (C), utilize organizational support systems and services and practical support (M) to reduce nurse (staff) risk of psychological harm (O).	Being a conduit of information Utilising organisational support systems and services Reduce risk of psychological harm	**C: Clear, concise information-giving** (Digby et al. 2021, Brodrick 2020, Fortgang 2020, Rosa 2020); **Protocols** (Catania et al. 2021, Hofmeyer et al. 2020) **M**; **Availability of support** (Rosa 2020, Duncan 2020) **Support spaces** (Vogel and Flint 2021, Hofmeyer et al. 2020, Abbu 2021, Crooke 2020, Hofmeyer and Taylor 2020) **Spaces for discussion** (Brodrick 2020, Fortgang 2021, Cathcart 2020, Raderstorf 2020) **Psychological support** (Duncan 2020, Catania et al. 2021, Merchant 2021, Croke 2020) **Mental health support** (Duncan 2020) **O: Reduced risk of psychological harm** (Yoder-wise 2021, Digby et al. 2021, Allen 2020); **PTSD** (Ravindran 2020, Duncan 2020): **Moral distress** (Hofmeyer 2020); **Emotional burnout** (Markey et al. 2021, Allen 2020, Ravindran 2020, Croke 2020, Rosa 2020, Duncan 2020); **Distress** (Merchant 2021, Croke 2020, Harrington 2021, Markey 2021) **Disengagement** (Brodrick 2020, Croke 2020, Hofmeyer et al 2020).

Theory 4: Embodying values An authentic leader that embodies values of compassion, honesty, openness, humility, empathy, respect, vulnerability, and courage (C) works with peoples' beliefs and values whilst aligning organisational values (M). They strive to create a healthful culture where people can be sympathetically present in spaces for discussion, learning, innovation, (O).	Leadership values Shared values and beliefs Healthful cultures Communicative action	**C: Leaders empathy** (Hofmeyer 2020, Harrington 2021, Brodrick 2020, Yonder-Wise et al 2021, Ernst 2020, Hofmeyer 2020, Quinn et al. 2021, Kellish 2020,„James et al .2020b, Foster 2020, Raderstorf et al. 2020, Vogel and Flint 2021, Rosa 2020); **Compassion** (Hofmeyer 2020, James et al 2020a, Harrington 2021, Hofmeyer et al. 2020, Cathcart 2020, Howell 2021, James et al. 2020, Vogel and Flint 2021); **Honesty** (Hofmeyer 2020, Holge-Hazelton et al. 2021, Boykin et al. 2021, Fortgang 2021, Moore 2020, Merchant 20201, Howell, 2021, Eldridge 2021, Duncan 2020); **Openness and transparency** (Holge-Hazelton et al. 2021, Brodrick 2020, Ernst 2020, Moore 2020, Abbu 20201, Merchant 20201, Quinn et al.. 2021, Eldridge 2020, Rosa 2020, Rosser et al. 2020); **Authenticity** (Dimino et al 2020, Holge-Hazelton et al. 2021, Brodrick 2020, Ersnt 2020, Quinn et al 2021,Kellish 2020, Cathcart 2020, Howell 2021, Catania et al. 2021)); **Courage** (Boykin 2021, Fortgang 2021); **Humility** (Boykin 2021, Fortgang 2021, Abbu 2021); **Resilience** (Fortgang 2021, Vogel and Flint 20201); **Grace** (Yoder-Wise et al. 2021); **Vulnerability** (Ernst 2020); **Love** (Kellish 2020) **Respect** (Kellish 2020, Catania 2021)

		M: Working with people's beliefs and values (Eldridge 2020, Hofmeyer 2020, James et al. 2020, Markey et al. 2021) **Clarity of beliefs, values, and vision** (Abbu 2021, Moore 2020, Fortgang 2021, Croke 2020, Boykin 2021) **Alignment of organisational values** (Yonder-Wise 2021, Hofmeyer 2020, Eldridge 2020) **O**: **Reduced uncertainty** (Digby 2021); **Increased morale** (Markey 2021, Harrington 2021, Hofmeyer 2020, Kellish, Howell 2021); **Feeling supported** (Harrington 2021, Croke 2020)**; Increased resilience** (Dimino et al. 2020, Markey et al. 2021, Hofmeyer 2020, Digby 2021, Rosemary 2020, Croke 2020, Fortgang 2021, Vogel and Flint 2021, Duncan) **Feeling empowered** (Dimino et al. 2020) **Trust** (Brodrick 2020, Fortgang 2021, Moore 2020, Kellish); **Promotes healing** (Cathcart 2020); **Improved health of leaders** (James et al. 2020); **Job satisfaction** (Haque 2021,Catania et al. 2021, Boykin et al. 2021, Harrington 2021) **; Improved QOL** (James et al. 2020); **Connectedness** (Duncan); **Learning spaces** (Fortgang 2021, Hofmeyer et al. 2020, Howell 2021, Rosa 2020, West et al. 2020).

Theory 5: Being prepared and preparing others A prepared leader is able to foster trust through developed leadership expertise and understanding of themselves as a leader, and their preferred approach (C). They ensure teams have adequate preparation and practical support, creating learning spaces (M) which promotes innovation and indicative of a learning environment (O)	Preparedness of leader Preparedness of staff Learning environment	**C: Knowing self as a leader** (Allen 2020, Yonder Wise 2021, Moore 2020, Abbu 2021, Quinn et al. 2021, Cathcart 2020, Howell 2021, James et al. 2020, Duncan 2020) **Leadership expertise** (Holge-Hazelton et al. 2021, Boykin et al. 2021, Hoffman et al. 2020, Eldridge 2020, Rosser et al. 2020, Duncan 2020) **Leadership preparation** (Howell 2021) **Leadership styles** (Dimino et al. 2020, Harrington 2021, Ernst 2020, Hofmeyer et al. 2020, Fortgang 2021, James et al. 2020, Catania et al. 2021, Vogel and Flint 2021, Duncan 2020, Rosser et al. 2020) **M: Availability of training** (Catania 2021, Hofmeyer 2020, Merchant 2021, Abbu 2021) **Learning spaces** (West et al. 2020, Rosa et al. 2020, Howell et al. 2021, Hofmeyer et al. 2020, Fortgang 2021) **Giving feedback** (Moore 2020, Rosa 2020) **O: Innovation** (Foster 2020, Howell 2021)