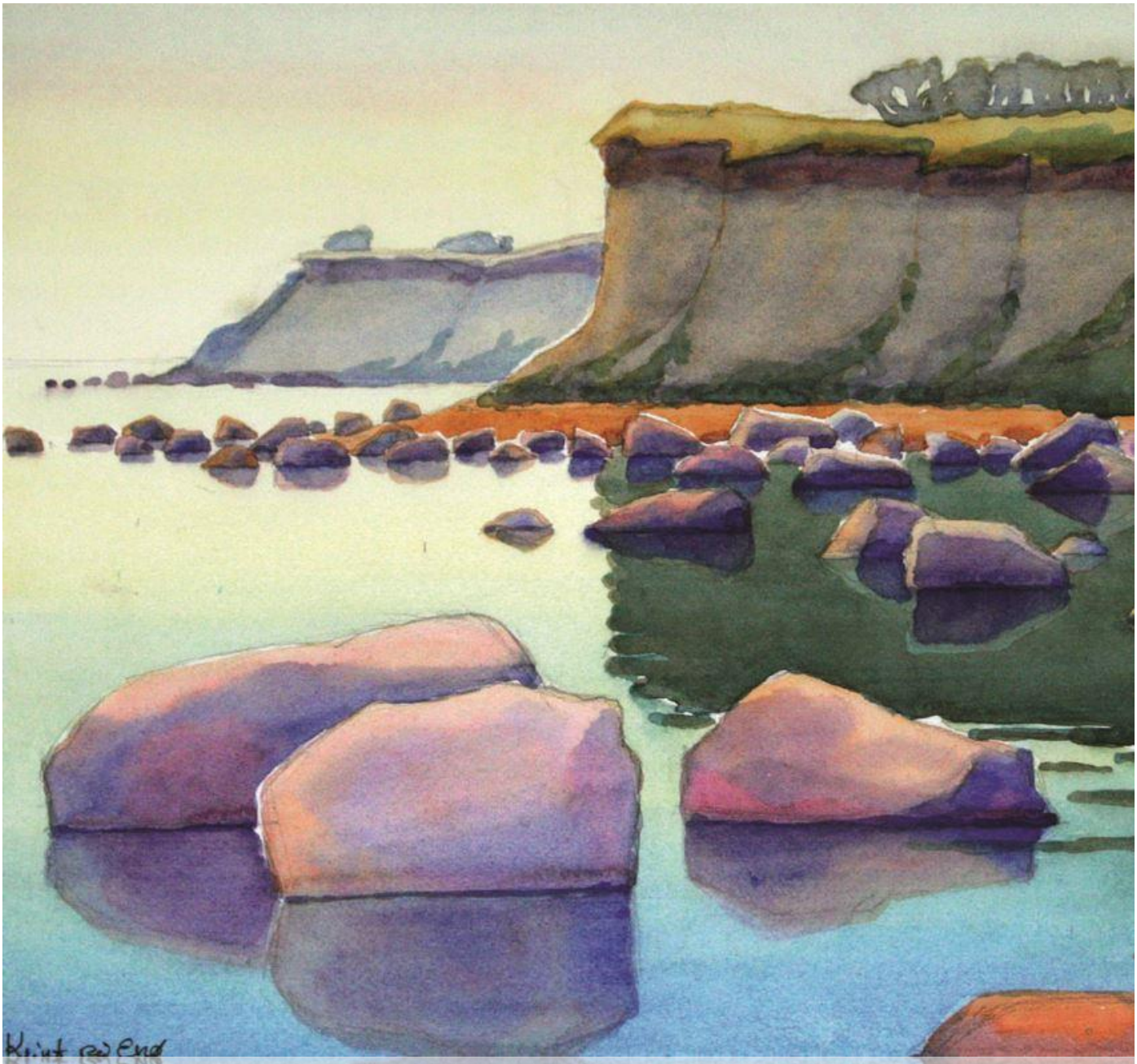

RESEARCH AND DEVELOPMENT CULTURE

LEADERS WITH DETERMINATION AND COURAGE

2nd Edition

Forewords by Brendan McCormack and Shaun Cardiff

Edited by
Bibi Hølge-Hazelton &
Mette Kjerholt

REGION ZEALAND

Research and Development Culture - Leaders with Determination and Courage

2nd Edition

Bibi Hølge-Hazelton & Mette Kjerholt (ed.)
Research and Development Culture - Leaders with Determination and Courage

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EDITORS

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Nurse, DpL, MLP, MSc, PhD. Since 2011 Head of Research in the Department of Hematology & Unit of Nursing Research/Development at Zealand University Hospital. Since the 1980s, employed in various nursing management positions at different levels, but always with clinical practice as a starting point and focus area. In terms of research, the focus is also clinical practice and applied research (primarily action research), where problems at both an organisational, health professional and patient-oriented level are the subject of research.

FOREWORD BY BRENDAN MCCORMACK

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Brendan's research focuses on person-centredness with a particular focus on the development of person-centred cultures, practices and processes. He has engaged in this work at all levels from theory development to implementation science and through to instrument design, testing and evaluation. He is methodologically diverse but is most at home in participatory/action research. Whilst he has a particular expertise in gerontology and dementia practices, his work has spanned all specialities and is multi-professional. He also has a particular focus on the use of arts and creativity in healthcare research and development. Brendan has more than 600 published outputs, including 240 peer-reviewed publications in international journals and 12 books. Brendan is a Fellow of The European Academy of Nursing Science, Fellow of the Royal College of Nursing, Fellow of the Royal College of Surgeons in Ireland and Fellow of the American Academy of Nursing. In 2014 he was awarded the 'International Nurse Researcher Hall of Fame' by Sigma Theta Tau International. Most recently, Brendan was featured in the Wiley Publishers 'Inspiring Minds' short films series https://www.youtube.com/watch?v=13c5C-tbcT4. In 2022 Brendan was selected as a member of The Academia Europaea.

We are certainly living through strange times when it comes to nursing and the nursing profession! On the one hand we come up against an overly romanticised 'heroes and angels' image of nursing where a good 'training' in clinical skills and a big heart are all we need to provide good care; whilst at the same time, the evidence of the impact of a highly educated registered nursing workforce on patient experience and outcome is irrefutable (see the collection of papers addressing this topic here https://www.nursing.upenn.edu/chopr/). We know that nurses around the world are battling to have their unique nursing knowledge, skills and expertise recognised, adequately remunerated and supported through funded continuous professional development. In addition, and probably equally troubling is a desperation by many nursing executives to fill vacancies, resulting in a dilution of the registered nursing workforce and replacement with a variety of 'nursing assistant' roles, or as I have witnessed first-hand, recruitment conversations that go along the lines of "we just need pairs of hands to cover these shifts!"

And so, a book like this one comes along! The courage shown by the co-authors of this book can never be under-estimated, as they have shown the kind of leadership that is needed in a health system for nursing research to be advanced. For most of my career, I have been employed in clinical-academic positions – from lecturer/practitioner roles through to Director of Nursing/Professor of Nursing positions and everything in between. I know first-hand, the challenges that are faced in ensuring that nursing research has the recognition and respect it should rightly have in a health system, especially an academic health system, such as a university hospital network. I know the 'fights' I have needed to have to get a professor of nursing employed in a system that employs (quite literally) hundreds of professors of medicine, and the challenges associated with establishing secure employment contracts for such roles that reflect their academic level and expertise. In 2022, The Journal of Clinical Nursing published a special issue dedicated to clinical academic careers in nursing

https://onlinelibrary.wiley.com/toc/13652702/2022/31/3-4. The collection of papers illuminated the variety of roles that nurse researchers hold in clinical practice, highlighted the impact of their work on patient experience and care outcomes, as well as shining a light on the multitude of barriers that are placed in the way of clinical-academic nurses by healthcare organisations and universities. In that special issue, Avery et al (Avery et al., 2022, p. 406) highlighted the need for clearer career paths and greater integration across clinical and academic departments, but also cited the most common barriers to successful clinical-academic careers related to insecure research roles, lack of availability of positions and funding for such roles. In my current position as a Nursing Dean in a School of Nursing & Midwifery that is highly committed to clinical-academic research positions, it concerns me the efforts that my colleagues and I need to go, to demonstrate the worth (financial and care outcome) of a Professor of Nursing in a health system and the extent of the impact expected from one position.

The co-authors of this book show us how we can get beyond these sterile and unproductive processes, by adopting a whole system approach to the integration of nursing research in a health system. They bring complementary styles of leadership to research and evidence in practice and in the process show how their own research and inquiry expertise has grown in the process. As someone who has focused my research career on the development of cultures that can enable all persons to flourish, then this book serves up many lessons that can be translated into practice in other organisations. Why is this so important, beyond the issue of clinical-academic roles themselves?

The use of the 'pairs of hands' phrase is insulting and demeaning, but more significantly it dehumanises the personhood of registered nurses and their expertise. Ironically, many nursing executives who use such language, will continue to drive forward a person-centred care agenda for patients, as if somehow the two (the personhood of the nurse and the

personhood of the patient) are not connected! The concept of personhood is core to all our being. It is what distinguishes humans from other species. Personhood in its simplest form means being able to reflect on my being in the world – being with my values (what I stand for), being in time (why I respond like I do), being in place (where I am most at ease), being in the social world (how the context influences my behaviour) and being in relation (people I am most authentic with). Reflexively understanding my being in the world helps me to know myself as a person and in the context of nursing practice, helps me understand how I can provide person-centred care.

Why does this matter? A study by Berlin et al. (2022) showed that the work environment was the most important factor in influencing nurses' decisions to stay in their current role. Top of the factors that impacted on that decision was 'having trusted colleagues' but was closely connected with the meaningfulness of the work, a sense of safety and feeling valued by the organisation – fundamentally, nurses want colleagues and organisations to respect their personhood! As registered nurses providing care, if we are to do so from a person-centred perspective, then we need to work in workplaces and organisations where our personhood is equally valued to that of the patient and other healthcare staff. To suggest otherwise is to devalue the humanity of registered nurses and compromise their personhood. The importance of person-centred care can never be under-estimated, and we should never take for granted its focus in nursing practice. There is ample evidence demonstrating the importance of the existence of a person-centred culture if we are to espouse person-centred care for patients. For more than twenty years, I have been working with a whole systems framework in the development of person-centred cultures in healthcare. Through those years of experience and associated evidence, I am clear that if the practice context is not conducive to person-centred practice, then person-centred care cannot be sustained. The leaders through their writing in this book show us how in a busy, unrelenting, demanding and complex world of everyday practice, striving

for these ways of being, doing and becoming make the difference between registered nurses 'doing practice' and being 'engaged with practice'. They also show us what a 'healthful culture' (the outcome from the implementation of these organisational and practice constructs) can look and feel like when this kind of leadership is shown – qualities such as, shared decision-making, collaborative staff relationships, facilitative leadership, and the implementation of innovative practices. Ultimately, they show us how nurses can be helped to flourish in their work.

Nursing is facing many global challenges and now is not a time to turn our backs on the big agendas of recruitment and somehow think that we can dismiss the need for nursing expertise or ignore the evidence that clearly shows the need for person-centred organisational cultures. This is a time however for all nursing leaders to join forces and develop integrated strategies for advancing the implementation of the evidence that clearly shows the impact of registered nursing on patient outcome and the impact of organisational culture on nursing retention. Adopting a person-centred focus enables us to consider the wellbeing of all persons and ensure we are proactively developing workplace cultures that are respectful of all persons. There is no hierarchy of privilege when it comes to respecting persons, and any workforce strategy that does so is at serious risk of compromising its espoused goal – having knowledgeable, expert and person-centred teams who have as their central focus, the delivery of evidence-informed person-centred care.

Brendan McCormack

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FOREWORD BY SHAUN CARDIFF

Author: *Shaun Cardiff, senior lecturer and researcher, Fontys University of Applied Sciences, Eindhoven, the Netherlands*

Shaun started nursing in London, UK. Moving to mainland Europe, living in Belgium whilst working in The Netherlands, taught him the importance of culture and that that what we perceive is not necessarily all that there is. He believes that whilst there are multiple powers constantly influencing our thinking, being and becoming, both individually and collectively, we also possess the potential to influence others and the environments around us. He believes moral nursing leadership is all about finding and enabling these potentials, within self and others, for the greater good.

As a senior lecturer and researcher at Fontys University of Applied Sciences (The Netherlands), specialising in person-centred practice and nursing leadership, I am frequently enthused, surprised and sometimes troubled by the stories front-line nurse leaders tell of how they handle everyday opportunities and challenges. I frequently admire their resilience as they try to balance often conflicting demands from higher management and team members. Currently it seems as if, post COVID-19, higher management and development departments presume it's all 'business as usual' whilst the reality is that the pandemic only accelerated the forewarned shortage of qualified nursing staff (Heinen et al., 2013). Unfortunately, all too often I hear dedicated nurse leaders and nurses struggling to meet demands to innovate and provide excellent care whilst simultaneously being confronted with staff shortages on every shift and often with more temporary than permanent staff. The nursing shortage is a wicked problem with numerous interconnected factors and there is

no one solution. However, first-line nurse leadership has a crucial role to play (Cardiff et al., 2023). This is certainly illustrated in the narratives of nurse leaders from Zealand University Hospital (ZUH), Denmark.

Reading the narratives of these passionate, transformational and person-centred leaders reaffirmed by belief that good leadership needs a supportive context if positive sustainable change is to be achieved. I observed it during my own doctoral study and have recently witnessed it whilst facilitating Dutch and Belgian charge nurses wanting to improve nurse retention. Leadership at all levels in an organisation needs to be addressed if the shortage problem is be resolved. All leaders, regardless of their position in the hierarchy or organisational organogram, need to be reflexive, person-centred, participative, inclusive and collaborative so that whole system transformation can create healthful (workplace) cultures where service-users AND staff can flourish and come into their own i.e. where person-centred care (McCormack et al., 2021) and person-centred leadership (Cardiff et al., 2018) can be practiced. In the rest of this foreword, I would like to explain a little more what I mean by this last statement.

In The Netherlands the phrase ‘excellent care’ is usually used to denote person-centred, evidence-based and safe healthcare. ZUH clearly has this same ambition too. The narratives in this book show how translating such ambition into everyday professional care usually requires fundamental changes to workplace structures and processes, alongside changes to embedded ways of thinking, being and doing. It also requires transformational leadership i.e. leaders who model the way, inspire a shared vision, challenge the status quo, enable others to act and encourage the heart (Kouzes & Posner, 2007). Very often change agents primarily look at structures and processes claimed to foster safe, evidence-based care e.g. educating nurses in research appraisal skills; setting up journal clubs; developing specialist and advanced nursing roles; developing, disseminating

and translating clinical guidelines and protocols; holding multi-disciplinary treatment meetings etc. Whilst these are valuable 'interventions', the way they are implemented and led/facilitated is also of vital importance if they are to foster person-centred practice too. Leader and leadership development are key to sustainable person-centred practices.

At ZUH we read how the transition from general to university hospital status was a major influence in stimulating visionary nurse directors and nurse managers to establish a clinical professorship and an organisational strategy for excellent nursing care. Their strategic work set the pathway for enabling the development of new research roles as well as structures and processes at the micro-/unit-levels. Luckily, there was also the realisation that just 'saying it' would not necessarily make it 'happen'. The narratives are therefore testament to the importance of leader and leadership development when management want to lead nurses towards delivering excellent care. This reminds me why I frequently ask leaders four fundamental questions before inviting them to describe how they lead: What do you lead? Who do you lead? Where do you want to lead them towards? Why you and why there? The organisational/nursing strategy seems, to me, to be an important tool for ZUH leaders to answer these four basic questions and consequently give meaning (and motivation) to their leadership work. The active learning sets and journal clubs were a valuable source of support, but the way they were facilitated is probably of greater importance. Creating safe, critical and creative learning environments is extremely important for leader development. I often hear leaders tell how valuable and supportive they find these spaces, as they often feel very lonely in their everyday practice. What the work at ZUH also shows, is how important the inclusion of first-line leaders to collaborate and participate in the strategy development is if the translation into local workplace/unit structures, processes, roles and practices is to become a reality. The collection of narratives is a fine example of the CIP

(Collaboration, Inclusion & Participation) principles of practice development (Manley et al., 2021), being employed to guide organisational transformation.

In their endeavour to foster a nursing research culture, the nurse leaders at ZUH created new research roles and positions within hospital units and departments. This developmental journey has been challenging, but progress is evident in the narratives. Differentiating nursing work is a current challenge in The Netherlands too. A Master of Science in nursing science didn't emerge until 1979, and the number of nurse professors and directors of nursing/nurse directors has only really started to increase since the turn of the millennium. A professional master in advanced nursing practice for the nurse practitioner role has contributed to the growth of more academically educated nurses, but not without critique, suspicion or resistance. Many attempts to foster differentiation within nursing work have failed, often due to strong resistance within the nursing community itself. However, times are changing and a recent RN2BLEND project (https://rn2blend.nl/en/over-rn2blend) is uncovering examples of (university) hospitals successfully introducing and developing differentiation in nursing work alongside employment of doctoral nurses in clinician-researcher roles. Like ZUH, they too are finding that success is not just a case of putting ideas onto paper. The active support of people in strategic positions within the organisation is needed to lever resources, a clear vision for clinical nursing research is also needed alongside resilient nurse researchers committed to collaborating with bedside nurses and other allied healthcare staff (Martini et al., 2021). What the RN2BLEND project doesn't explicitly highlight, is the role hierarchical nurse leadership plays in this transformation process. Lessons can therefore be learnt from reading the ZUH leader narratives.

From my reading of the ZUH leader narratives, these leaders needed to be catalysts and facilitators of change. They needed to understand the theoretical underpinnings and frameworks for person-centred, evidence-

based and safe nursing care, even if they themselves were not actively engaged in hands-on nursing. They also needed to comprehend the skills needed to generate funding and execute clinical nursing research, alongside knowledge sharing, even if they themselves were not active researchers. In other words, leaders need to understand what is needed within the context if they are to lead the actors (professional nurses of all educational level and multiple roles) realising the desired vision. The narratives show how the leaders learnt by doing, by themselves researching how to lead a nursing culture of research and excellent care. Again, the facilitation by a clinical professor and director of nursing who role modelled the way, inspired a shared vision, challenged the status quo, enabled them to act and encouraged their hearts, should not be underestimated. What the narratives also reveal is that leadership should be both person-centred and transformational. A person-centred approach to care and leadership is based on a fundamental belief in mutual and reciprocal respect of personhood and right to self-determination. Whilst healthcare practitioners can find support an inspiration in the person-centred practice framework (McCormack et al., 2021), there are also conceptual frameworks to support them in becoming person-centred leaders (Cardiff et al., 2018) and/or leading nurses in becoming person-centred practitioners (Lynch et al., 2011).

Person-centred leadership is a relational approach to leadership where leaders focus more on enabling practitioner coming into own than on care efficiency and effectiveness. Many of the ZUH leader narratives speak of the importance of building strong relationships, and Britta Louise Schack's narrative in chapter 8 describes many of the leader attributes and processes found in the person-centred leadership framework (Cardiff et al., 2018). When leader and co-worker come into their own, they both experience a sense of wellbeing within the workplace, feel empowered to exercise influence over their work and realise their full potential. To achieve this, leaders continuously work on building relational connectedness by reading self, the other and the context in order

to respond appropriately. They are constantly gathering information through: using all one's senses to gather information about the current state of being of the other person, and verifying interpretations (*sensing*); *balancing* the needs of the other person with one's own needs; seeing and understanding how being embedded in multiple roles and contexts is affecting a person's current state of being (*contextualising*); being there for the other person and thinking with them rather than for them (*presencing*), and engaging in action-oriented dialogues (*communing*). The information gathered is used to determine how best to position oneself in relation to the co-worker (*stancing*). The chosen stance may be leading from the front (offering to role model the way) or leading from the side line (offering instructions whereby the co-worker feels confident to act alone). Sometimes, leading from alongside is needed (working closely together, balancing high challenge with high support) and at other times leading from behind is the right choice (stepping back and observing what happens). A person-centred leader is constantly moving between all four stances as they respond to changes within the co-worker, self and/or the context. This constant movement makes leadership feel more like a dance than a task to be completed. As they dance, the leader and co-worker(s) will influence and be influenced by the surrounding contextual factors such as the organisational culture, the needs of other stakeholders (other professionals and service users alike), evaluations of care and leadership as well as the content of safe, critical and creative communicative spaces such as journal clubs, action learning sets and teambuilding workshops. Being aware of such dynamics and responding appropriately is complex and the following leader attributes are extremely helpful: being authentically other-centred and caring; knowing self and understanding relational dynamics; being patient, open and positive; being willing to show one's own vulnerability; being reflexive (aware of how oneself influences situations). Ultimately, person-centred leaders want to cultivate healthful cultures.

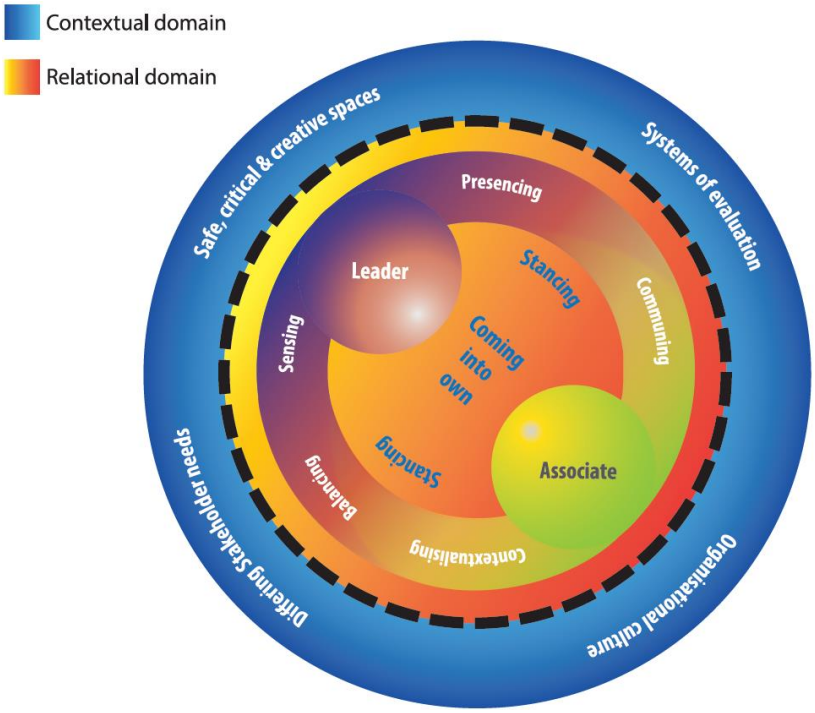

Figure 1 Framework for person-centred leadership (Cardiff et al., 2018)

Workplace cultures (the way things are done within the workplace) are powerful influencers of practice development and staff recruitment and retention. Ideally workplace cultures should value: person-centred, evidence-based and (holistically) safe care with lifelong learning and positive attitudes towards change; ways of working that include open communication, high challenge/high support, collaborating, including and participation of stakeholders, teamwork and leadership development (Manley et al., 2011).

These values should not only be documented in a shared vision and mission, but enabled through formal structures and processes for learning, evaluation and shared governance. When trying to cultivate such cultures, first line leaders should focus on: developing collective leadership whereby everyone can use their talents or learning needs to take the lead on something; explicitly promoting and revisiting the meaning of the values associated with effective workplace cultures; creating and facilitating safe, critical, creative and active learning spaces; focusing on, and framing

proposed change in terms of that what matters to staff and service-users, what they consider 'change for good' (Cardiff et al., 2020). Whilst this book does not reveal the narratives of staff and service-users (which would make a nice trilogy!), the leader narratives do show how they are trying to, and achieving success in, developing nursing research cultures alongside healthful workplace cultures i.e. cultures where staff and service-users are "supported and enabled to maximise their potential in line with their values" (McCormack et al., 2021, p. 29).

So what are my concluding thoughts? I take my hat off to the ZUH leadership team. To the work they have done, the work they continue to do and the sharing of their narratives in this book. Whilst the change in status from a general to university hospital may have ignited a movement within the nursing culture, it is clear that system-wide reflexive nurse leadership development is key to cultivating cultures of excellent care and workplaces where nurses want to nurse and research nursing.

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GLOSSARY

The following table contains concepts, which appear in this book. The list can be used for foreign readers to understand organisation and titles used in Denmark or Zealand University Hospital. Besides, the Danish titles are listed in brackets for Danish readers to review the English translation.

Figure 1 is an illustration of the hierarchy for nurses at Zealand University Hospital.

Concept *(Danish designation)*	**Explication**
Assisting ward manager *(Souschef)*	A nurse who holds the position of deputy head of a ward. Refers to the ward manager.
Associate professor *(Lektor)*	A researcher with a university position where the working hours are divided between clinical work and research (often 10-50% for research). The title is protected.
Auxiliary nurse *(Social- og sundhedsassistent)*	A healthcare professional that focuses on direct patient care.
Clinical development nurse *(Klinisk udviklingssygeplejerske)*	A RN who specializes in clinical development and implementation of new nursing practices and holds a Master or MSc degree.
Clinical nurse specialist *(Klinisk sygeplejespecialist)*	RN with special competencies/responsibility, Master, MSc or Ph.D. degree.
Clinical research nurse *(Projektsygeplejerske)*	RN employed in clinical research/trial units
Head nurse *(Oversygeplejerske (nu chefsygeplejerske))*	Nurse head of the department. See Figure 1.

Head of research (nurse) *(Forskningsleder)*	RN responsible for nursing research at department level. Holds at least a Ph.D. The title is not protected.
Heads of department *(Afdelingsledelse)*	Team consisting of the head nurse and the chief physician
Master (degree) *(Master)*	An academic qualification acquired after completing a bachelor's (60 ECTS + work experience). For instance: Master of Clinical Nursing, Master of Business Administration Master of Public Management.
Master of Science (MSc) *(Kandidatuddannelse)*	An academic qualification acquired after completing a bachelor's degree (120 ECTS). For instance: MSc in Nursing, MSc in Health Science
Master thesis *(Kandidatspeciale)*	Final written assignment for Master of Science.
Master's thesis *(Masteropgave)*	A scientific paper written at the end of a Master degree
Midlevel manager *(Mellemleder)*	For instance, ward manager. See figure 1
Nurse research assistent *(Sygeplejefaglig forskningsassistent)*	A nurse who engages in nursing research and supports scientific studies.
Nurse with special competences *(Sygeplejerske med specialistfunktion)*	RN with special interest and competencies within a clinical area for instance nutrition.
Nurse/Allied Health (AH) *(Mellemlang videregående uddannelse (MVU))*	A level of education that typically lasts three to four years and includes both theoretical instruction and practical training. Nursing/AH programs are often career-oriented and prepare students for specific professions or advanced studies, such as nursing, physical therapy, midwifery, and radiology.
Nursing deputy director (*Sygeplejefaglig vicedirektør)*	Top level nurse, head of nursing at hospital level. See Figure 1.

Professional Master *(Erhvervskandidat)*	Master of Science programs for nurses who work and study part time.
Registered nurse (RN) *(Basissygeplejerske)*	In Denmark, the nurse education is a full-time education of 3½ years and 210 ECTS points.
The Electronic Healthcare Platform *(Sundhedsplatformen)*	Hospital software documentation system (EPIC).
The post-basic school of Nursing at Aarhus University *(Danmarks Sygeplejerskehøjskole)*	An educational institution that educated nurses postgraduate until 2003.
Ward manager *(Afdelingssygeplejerske (nu oversygeplejersker))*	A nurse who oversees a ward in a hospital. Often at diploma or master level. See Figure 1.

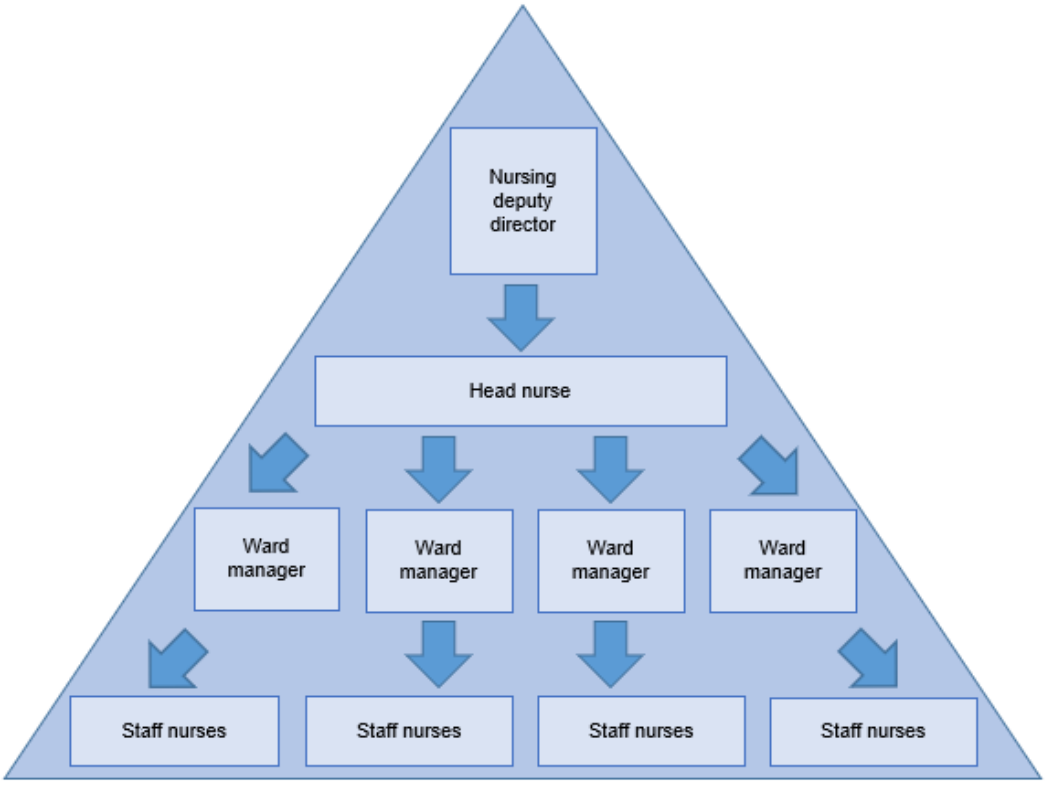

Figure 1 Illustration of the hierarchy for nurses at Zealand University Hospital.

CAPACITY BUILDING ACROSS AN ENTIRE HOSPITAL – WITH A MANAGEMENT AND LEADERSHIP FOCUS


Authors: *Bibi Hølge-Hazelton, Professor and Head of Research &*
Mette Kjerholt, Head of Research

Editors' Reflections in 2025

Working with culture and cultural changes is a demanding and ongoing process. This is evidenced by the content of this book and the interest in it. We are often contacted by and collaborate with colleagues both domestically and internationally about the way we work with capacity building. From our perspective, however, there is still a significant issue: how to establish an interdisciplinary development, innovation, and research culture that recognizes and rewards a broad understanding of what good knowledge/evidence is, and how and by whom it is produced and implemented.

The future therefore calls for leadership with the kind of will and courage that the nursing leaders in this book demonstrate. Our hope is that more healthcare leaders will take on the task together and recognize that the perspectives of different professional disciplines strengthen research and development cultures in clinical practice.

In 2022, the first version of this book was published in Danish. The book quickly became popular in Denmark, and we were encouraged to translate it into English, launching the English edition in 2023.

The conditions and frameworks for leaders are constantly changing, and therefore we (the editors) decided to publish an updated version of the book, in which the authors had the opportunity to add to their original chapters. Additionally, we invited two international nursing experts in person-centered leadership, Brendan McCormack and Shawn Cardiff, to read the book and contribute their reflections. Leadership expert Søren Barlebo has also written the new afterword for the book.

CONTEXT OF THIS BOOK

At Zealand University Hospital (ZUH), we have been working strategically on building a research and development culture within the field of nursing and Allied Health Professionals (AH) since 2010. From the first Ph.D. student with a nursing background being employed in a 'patchwork compromise' between many different departments, to today, where all departments either have or are in the process of hiring researchers with nursing/AH backgrounds in clinical practice.

From the beginning and through all the work of developing a research and development culture there have been two principles: First, capacity building must be action- and practice oriented and focus on a positive development of the care and treatment offered to patients at ZUH. This includes a broad understanding of what counts as evidence in clinical practice, in this case the best available knowledge, understood as knowledge - or evidence - that derives from research, development, patients, relatives and health professionals (Berthelsen, 2019; Sackett et al., 1996; Thomsen, 2014). Secondly, the capacity building must contribute to promoting and creating a developing environment for employees and managers by being constructive, creative, inclusive and visible at all levels (Hølge-Hazelton, 2014).

One of the principles we have consistently worked with is that we must be strong in documenting the results of our specific projects while also sharing our organizational cultural experiences. We have done this, among other things, by establishing an e-book series where, over the years, we have described the process of supporting a research and development culture in clinical practice. The books consist of chapters, all written by employees at ZUH. Some of the chapters were first published as professional or scientific articles elsewhere, but the majority of the chapters are written by authors with very little or no previous professional

writing experience, and that has its own key point. The books are primarily intended to inspire others to do the same by showing that it is not impossible or reserved for the few to describe and reflect on their practice. We have also chosen to make the books freely available to everyone because we did not want to limit access for those who can use our experiences, and because it has given us full freedom to determine the content ourselves. Based on the feedback we have received from authors as well as readers from both Denmark and abroad, it is a good strategy because it is useful and inclusive.

Until 2022, we had published four books in Danish, including the book you are holding in an English version here (Hølge-Hazelton, 2014; Hølge-Hazelton & Kjerholt, 2022; Hølge-Hazelton & Thomsen, 2015, 2018). This has been the book we were most excited to initiate, edit, and publish because it was the first book written exclusively by leaders. When we started the process with the book, we knew there was a need for it because we often met leaders who expressed a lack of concrete and realistic inspiration on how to support a research and development culture in a busy everyday life. And how to pick up the thread again if it failed the first, second, and maybe third time, because it *is* a difficult task - as all change and cultural work is. What we did not realize was that the book would also be interesting outside Denmark.

KEY CONCEPTS

Before we briefly review the chapters, it is appropriate to introduce some of the terms used by several of the authors in the chapters: Person centred practice and CAPAN. These concepts will be familiar to many leaders and employees at ZUH, but not necessarily to others.

PERSON-CENTRED PRACTICE

At ZUH we have a dynamic vision for nursing/AH staff (Vision, mål og strategier for MVU-området, frem mod 2025 [Vision, goals and strategies

for the nurses/AH area, towards 2025], 2021), which is based on a person-centred approach to practice. This approach is established through care and treatment related associations between all health professionals, patients/citizens and relatives. A person-centred approach to care and treatment is supported by values such as mutual respect and understanding, respect for the individual and the right to self-determination. The approach, inspired by Professor Brendan McCormack and colleagues work (McCormack & McCance, 2016)[1], becomes possible when a culture that supports continuous development of practice is present. Several departments at ZUH work with the approach in a concrete manner, which will be evident in some of the book's chapters.

CAPAN

CAPAN is an abbreviation of *CAPAcity Building in Nursing*, and the name of the 5-year research program that was initiated in 2017 in reference to the establishment of the first professorship in nursing in Region Zealand. The overall aim of CAPAN is to strengthen a culture of curiosity and thoughtfulness among nurses/AH parallel to the transition from a local hospital to a university hospital (Hølge-Hazelton & Lønborg Friis, 2016).

CAPAN has the following points of impact, all of which are documented and implemented on an ongoing basis: Nursing clinics, development of a generic reflection tool and management of nursing care (Hølge-Hazelton, 2019; Thomsen et al., 2019; Pleh et al., 2021).

In addition, CAPAN consists of a survey including all nurses at the hospitals of Region Zealand. Results from the survey, which focuses on the nurses' perception of and experiences with research, development and the framework for person-centred work, is primarily intended as a tool for development in the individual department/hospital. The survey has

[1] Professor Brendan McCormack was appointed as a guest professor at the University of Southern Denmark, Oncology Department and Palliative Units, as well as the Hematology Department at Zealand University Hospital in 2021.

been developed by researchers, leaders and clinicians from ZUH, combined with a translated, internationally validated questionnaire, the Context Assessment Index/CAI (Hølge-Hazelton et al., 2019).

Several chapters of this book refer to the CAPAN study, and some of the authors write that they are excited about the results from the study's third round in 2022, which was underway when the chapters were written. This tells us that leaders regarded CAPAN as a tool that is also applicable, exactly as intended.

CHAPTERS OF THE BOOK

The book has two forewords, both written by renowned nursing researchers with extensive knowledge of person-centered leadership in international contexts: Professor Brendan McCormack and Senior Lecturer Shawn Cardiff.

The book consists of 11 chapters written by leaders at ZUH. In addition, is an appendix which is a scientific article published in the Journal of Nursing Management. This article concerns experiences in developing a journal club for leaders, where focus was developing leaders' competencies to support a research and development culture in their departments (Kjerholt & Hølge-Hazelton, 2018).

Chapter 1 outlines the background to the work with the book and introduces the remaining chapters.

Chapter 2: Here Professor Bibi Hølge-Hazelton describes the establishment and continuation of Action Learning Sets (ALS) for senior nurses/AH. These groups focus on the leaders’ roles and tasks in supporting research and development. The leaders themselves took the initiative to create these groups, which have been in continuous operation, with changing participants, for five years. The chapter describes in detail how the groups have developed and function.

Nurse leaders[2] from ZUH wrote the following nine chapters:

In chapter 3, nursing deputy director at ZUH, Susanne Lønborg Friis sets the overall and strategic agenda by describing the first ambitions, visions and strategies to the current situation. This chapter can beneficially be read as context for the remaining chapters.

Nurse leaders who have focused on research and development for many years have written the following three chapters:

In chapter 4, head nurse Helle Gert from Department of Oncology and Palliative Care describes the learning processes, managerial priorities and reflections in the construction of a nursing research culture in a large clinical department. She also describes some of the barriers when integrating different research traditions in the department. Finally, it is emphasized to choose research methods, which are identifiable to core values of nursing, if these must be preserved.

Head nurse Ole Toftdahl Sørensen from the Department of Surgery, advocates in chapter 5 for increased postgraduate specialization to match health care development. He describes how he, as a leader, specifically works to increase the number of academically trained clinical nursing specialists, and how these are integrated into the clinical work, while at the same time giving them opportunity to use and develop their academic skills.

Head nurse Lotte Kragh Nielsen from the Department of Ear, Nose, Throat and Maxillofacial Surgery uses in chapter 6, three specific and significant impact points to describe the journey towards an organisation development including a transparent nursing development and research-oriented foundation. These impact points are: having a common overall

[2] The fact that the book exclusively contains chapters written by nurses is attributable to the unavailability of other leaders with AH backgrounds to contribute. This limitation is, of course, regrettable.

strategy for development and research in nursing, organising a professional nursing theme day, establishing the department's development and research foundation, and finally the significance of having participated in an action learning set group and a journal club for leaders[3].

Two chapters written by ward managers follow this. These chapters describes perspectives on development and research from the angle of mid-level managers.

In chapter 7, ward manager Patricia Vallebo Lindhardt from the Department of Medicine reveals her thoughts on her role as a leader and knowledge sharing, respectively. Basis of the chapter is a master's thesis in Business Administration with a focus on knowledge sharing and on which conditions are needed to promote knowledge sharing at a university hospital. The thesis is linked to the experiences from the COVID-19 pandemic, inter alia, by reflecting on the relationship between the concepts leadership and management.

In chapter 8, ward manager Britta Louise Schack from the Department of Haematology describes how she has worked both mentally and concretely creating a learning, development and research culture in the department based on an actor-involving and person-centred approach. Besides which positive significance this has and has had for both patients and health care staff.

Three leaders, each with individual starting points, have written the last three chapters of the book.

In chapter 9, head nurse Birgitte Mortensen from the Department of Neurology shares her reflections on how she, first as a clinical nurse specialist

[3]For more information about this initiative, please read the Appendix, a scientific article published in the Journal of Nursing Management. The article describes our experiences in developing a journal club for leaders, with the purpose to support a research and development culture in the departments.

and then as leader, has worked with the department's development culture. The tool has been reflection talks, for the purpose of competence development and retention, with newly employed nurses.

Chapter 10 is the contribution of head nurse Jytte Hykkelbjerg Bruhn from the Department of Cardiology. The chapter is based on her master's thesis in Public Governance, in which she asked the question: Are we in the Department of Cardiology ready for development and research, and what does it require of me in terms of management?

In chapter 11, the last chapter of the book, head nurse Karen Marie Ledertough, from the Department of Plastic Surgery and Breast Surgery, describes her considerations before and subsequent reflections on hiring the first research-trained nurse in a department that is in its research infancy. The process is described with great enthusiasm as "a pilgrimage on the Camino", and specific examples of how the department's learning environment is developed are explained, as well as personal considerations about hiring a sparring partner.

The book is capped off by Søren Barlebo Rasmussen, managing partner at the consulting firm Mobilize Strategy Consulting, who has worked internationally with strategic leadership in the knowledge sector for decades and is, among other things, responsible for research leadership programs in Denmark, Norway, and other parts of Europe.

We wish to thank our brave and reflected authors for their contributions. We know that it has been a major task that time has been short, and that some of you have never written in this way before. However, it is such an important book because it can inspire other leaders to take similar initiatives. With this book, it becomes so clear and concrete that when leaders dare to set a professional direction, join forces and be open to innovative thoughts, then quite a lot is possible to the benefits of patients, staff and the leaders themselves.

Also thank you to all of you, for agreeing to and pay for translating your book chapters so this book can become freely available to an international audience: You are truly generous leaders!

Enjoy your reading!

Bibi Hølge-Hazelton og Mette Kjerholt

Roskilde 2025

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ACTION LEARNING SETS FOR HEAD NURSES/ALLIED HEALTH PROFESSIONALS

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Photo: Thurid van Steenwijk

A COMPLETELY NEW TASK FOR LEADERS

Leading staff with research background and supporting the development of a research culture in clinical practice is a relatively new task for many nurses/allied health professionals (AH) leaders (Hølge-Hazelton et al., 2015). Even though most of the leaders involved are educated at master levels, they have rarely received any training or education in how to lead researchers, or how they as a leader can support a research culture. Therefore, they may experience this task as difficult and challenging, even when they are leaders in departments with established research units. Most of these units are usually centred around the physicians because they HAVE to conduct research if they are to progress in their careers. For this reason, most departments have medical students and physicians who are conducting research, but this is rarely something the nurse leaders experience that they are directly involved in. Still, it is not uncommon, that nurses in the same departments, as part of the established culture and without asking questions, assist the physicians with research by identifying or recruiting patients to studies, handing out material, participating in information situations, examinations, caring for patients after research related procedures, etc. At leadership level, many head nurses/AH are co-responsible (together with a chief medical physician) for large budgets including guaranteeing salary for Ph.D. students and/or direct support to research projects or research units.

When we strategically began to focus on establishing a research and development culture at ZUH, an employment of PhD students or PhD graduates with nursing/AH background was formulated as a clear part of the overall strategy. This was in line with the regional research policy, which in several versions emphasized the need for the development of research capacity within nursing/AH, but it was a completely new task for nursing/AH leaders.

INTEGRATING RESEARCHERS IN CLINICAL PRACTICE IS A DIFFICULT LEADERSHIP TASK

When we began this voyage, we quickly realized that the hiring of PhD students was not the right first step. Firstly, only one person with nursing/AH background had the formal qualifications to supervise PhD students, but even more important, no culture was in place to include PhD students in clinical practice. Therefore, we choose to encourage the chief nurses to employ research graduates in positions as postdocs or assistant professors, whose roles were concerned with establishing research cultures in clinical practice including conducting practice relevant research.

The first experiences with these appointments showed that it was crucial that nursing managers themselves have the opportunity to develop, train and participate in the leadership aspects of research and development (Hølge-Hazelton et al., 2015). Therefore, in 2016 we implemented two journal clubs for leaders based on literature on the management of research (Kjerholt & Hølge-Hazelton, 2018). The evaluations of the held journal clubs showed that the managers experienced a great need for further exchange of experience.

This learning was further underlined by an e-mail, from a head nurse, who had employed a nurse researcher. The e-mail was sent to me as director of nursing research in spring 2017:

Dear Bibi

I have the need and desire for the establishment of a network group at head nurse level who leads researchers at post-doc/associate professor level. Would you recommend me to take an initiative myself, or would you/can you facilitate such a network???

Establishing the first action learning group

The fact that a head nurse took this initiative could be seen, as an expression of the managers were now ready to develop this part of their management space. In our overall strategic approach to building a research and development culture, we were grounded in action learning and action research and were therefore interested in supporting practice relevant initiatives (Hølge-Hazelton, 2014). I therefore gladly accepted the invitation and offered to facilitate a group, as I had facilitated many other groups before. I suggested that the group was organized as an Action Learning Set (ALS), based on Action Oriented Research and Action Learning (McGill & Beaty, 2001).

The specific aim of the ALS was to assist managers to lead, support and enhance practice development and research activity, including the use of evidence in their area of speciality. At the same time, I emphasized that any group would have to be documented in terms of research on an equal footing with our other practice development initiatives, for example journal club facilitation courses (Faebo Larsen et al., 2015), writing courses (Thomsen & Hølge-Hazelton, 2014), journal clubs for leaders (Kjerholt & Hølge-Hazelton, 2018) and integration of researchers in clinical practice (Hølge-Hazelton et al., 2015; Hølge-Hazelton & Thomsen, 2018).

Based on my experience with facilitation and supervision I suggested a framework with six to eight participants, and using reflective teams as a method. I also suggested that we could include articles that focused ex-

plicitly on leading researchers and building a research culture as inspiration. The group began for a start with four times of two hours with approximately six weeks apart. After this, we should evaluate and decide on a possible further process. The most important issue was that the content and form was meaningful to the leaders, and that the initiating leader herself brought the idea forward to the rest of the nursing/AH leader forum to recruit participants. The leader then discussed the idea with another head nurse who was struggling with similar questions, and after a few adjustments, they presented the idea to their colleagues.

The purpose of the group was formulated in collaboration with the initiators, so that participation for the individual manager in the ALS group for research and development should be:

- To become aware of what I do well
- To let myself be inspired by the others to do something better
- To a greater extent, to become clear on my own objectives for nursing research
- To get inspiration for, and concrete knowledge about, further development of nursing research in my own department and at ZUH in general

After this, we announced the first group and within a few days, a group consisting of seven head nurses and one head of physiotherapy was established.

Structuring the first action learning set

The two initiating head nurses had assessed that it was realistic for the leaders to participate in group meetings lasting two hours. It was therefore essential to establish a clear structure and clear rules. These were reviewed and handed out to all the participants in connection with the first meeting. The rules were formulated as follows:

1. We start and finish on time
2. The content of the meetings is confidential
3. No cell phones

The participants were encouraged to arrive in good time, so that everyone was ready precisely at 9:00 when the meeting started. Meetings never ended later than 11:00 a.m. so the leaders could be sure that deadline was kept.

The process itself was described as follows:

- Bibi is the meeting facilitator.
- We start with a round where each participant gets approx. 5 minutes to talk about the managerial experiences, reflections and problems linked to today's theme.
- It is the meeting facilitator's job to keep time.
- When the round is finished, one or two are selected to go more in-depth. Here we work with a reflective team as a model.
- It is important to try to avoid giving advice but instead share experiences and reflections. Offer ideas, not solutions. Ask about "what and how" instead of "why". Remember to say ”I”, and not ”you”.
- We finish with a round, where each participant answers a simple question: "what will I take back home today that I can use for my own development?"

THE CONTENT OF THE FIRST FOUR MEETINGS IN THE GROUP

All the meetings in the group were themed in collaboration with the participants. Each theme was supported with selected articles that could be read either before or after the meetings for inspiration.

The first theme was "To change identity from a regional hospital to a university hospital. The participants' experiences with management opportunities and challenges". The background for choosing this theme was due to the great focus ZUH had received in relation to having become the region's flagship when it came to research, medical education, the adoption of specialized treatments, and the building of the new super hospital. Part of this change of identity was to be found in the new strategy for the hospital "The patient is everything", but also in the strategy and vision for the nursing/AH, which had placed research and development high on its agenda. Two articles were recommended (Hølge-Hazelton & Lønborg Friis, 2016; Johansen, 2014).

The next theme was "To support profession-oriented research and development culture in clinical practice. The participants' experiences with leadership opportunities and challenges". This theme was chosen with the aim of sharpening the participants' attention to what research culture is, and how it can be established and supported managerially, and how different professional cultures can interact and react in such a process. Two articles were recommended (Berthelsen & Hølge-Hazelton, 2017; Staugaard, 2017).

The third theme was "Integrating researchers into clinical practice, the participants' experiences with leadership opportunities and challenges". The theme was what had initially given rise to the establishment of the group, but was placed here in order to include the concrete discussions of strategy, culture and profession that had taken place at the first two meetings, and furthermore until the participants knew each other better. Two articles were recommended (Hølge-Hazelton et al., 2015; Olsen & Hølge-Hazelton, 2016).

The last theme was "Forward-directed leadership of research and development culture at Zealand's University Hospital, competencies and de-

velopment needs". Here, the participants took as a starting point a management model for supporting research in clinical practice (Harrington, 2010). The model was intended to sharpen the participants' attention to the importance they themselves have for the development of the research culture in their department, including what could be done in practice, for example how important it is that the managers themselves articulate and demonstrate the importance of the development of evidence in nursing/AH practice.

EVALUATING THE FIRST GROUP

The participants in the group were informed from the start that they would be asked to evaluate the meetings continuously, and that they would be asked to provide a written evaluation at the end.

After the last group meeting, the participants gave an oral evaluation of the overall process. The participants had been happy to come to the meetings. Monday morning was a good time for most people. The group emphasized the importance of making it a priority to come all four times, and to be there all the time. However, there was also an understanding that something urgent could arise that meant you were late. However, there was an agreement that once you had arrived, you should not leave before time. The group size had been fine. In addition, the participants indicated that they would very much like to see the group continue with a further round of four thematic meetings.

Finally, the group exchanged ideas for strengthening the general research and development culture across the entire hospital. Here they indicated that they would like to contribute concretely to the implementation of the ideas, which included, among other things, a proposal to host a management conference with a focus on research and development within the nursing/AH area, as well as a proposal to develop offers for mid-level managers with a focus on development (and research).

In addition to the oral evaluation, all seven participants were asked to answer a short questionnaire, which can be seen below in Box 1:

Box1 Questionnaire for ALS Group 1

EVALUATION OF ACTION LEARNING SETS, GROUP I

You have been a member of an Action Learning Set for leaders with the aim of developing yourself professionally through the exchange of experience and knowledge sharing about leadership of researchers and the establishment of a research and development culture in your department. To what extend have your expectations been fulfilled.

1. My expectations for participation in the group were fulfilled
    - Beyond expectation
    - Greatly
    - Somewhat
    - To a lesser degree
    - Not at all
    - Elaborate your answer if necessary:
2. Describe what you got most out from participating in the group:

3. If a new round of ALS meetings is established, describe what expectations you have for your own professional development:

4. If you have other reflections in connection with the groups, you are welcome to write them here:

Six participants answered that their expectations had been largely met, and one participant answered beyond expectations.

When asked what the participants found had been the best outcome of the meeting (benefits of the meetings), it was highlighted that it was important to have a network, that there was confidentiality, and that the participants did not experience themselves alone with the challenges associated with tasks related to leading research and development. A participant with 10 years leadership experience wrote:

“ It has been fantastically fruitful to have a small, confidential network, where it has been possible to raise issues in complete confidentiality, issues that have been or are difficult to solve and furthermore in the network finding great sparring for how to move on, and likewise have seen what you should have done - or should go home and do - to be able to solve the problem. It has been followed up on whether it was possible to solve the problem. It has been in a safe environment and in a format where everyone had their say. And no problem was too small or too big.

The most important thing has been that it has been confidential, so that speech has been free.

When the group and the entire hospital are in a difficult situation, it is important to have a network where you can talk about the problems and get advice and help.”

Another leader with +twenty-five years of leadership experience wrote:

“To feel that you are not alone with your doubts and challenges, hopes, and ambitions. Good to be inspired by those who have made it further. It was also a big plus to experience so clearly that regardless of expertise, there is a community that goes beyond any professional differences. “

Finally, a participant with 18 years leadership experience wrote:

“I got confirmation that the considerations and actions I take regarding the management of the area are good and profitable. A clarity that researchers, with their different profiles, like others, must be lead differently, not surprisingly. But also how important it is to make clear which researcher profile meets the department's current needs in the best way, and which matches the development strategy you want to promote.”

On the question of what a possible new round of ALS meetings should ideally contain, most participants commented that they were primarily interested in further development, feedback and inspiration to move forward with research in their own departments.

Finally, the participants had the opportunity to send me further reflections. Here, someone who had only participated twice wrote that it was difficult that the group's process was also included as part of research, and consequently, that twice was not enough to feel like a member of a group that was in a course. Another wrote that the composition of the group had been very harmonious and that this was probably why the yield had been so great. Sometime after the evaluations were received, one of the participants sent me an email and wrote:

> *"Thinking back what happened was that we got a little closer to each other and broke a facade where we all walk around thinking we should be able to manage everything.*
>
> *We are not good at sharing challenges. We are each other's guardians and super competitive. There is also a lot of backbiting and gossiping about each other, which keeps someone from being open.*
>
> *However, it is not only relevant in relation to the evaluation of the specific network. Maybe it says something more about the culture in the overall leadership group?"*

Establishing a new action learning group?

After the first ALS round was completed, two of the participants were no longer employed at ZUH, one had retired, and one had found another job. Therefore, I decided to send out an email, to get a general expression of interest from the entire leadership group, whether they wanted to participate in an ALS group, before we decided whether to create one or two groups. If there was a single person or two who wanted to participate, these persons could be offered to join the "old" group.

It was as if some of the other managers were just waiting for this opportunity when I sent out the email, and five new ones signed up within the first day. After discussing it with the initiator of the first group, we therefore agreed to create two groups. One was a brand-new ALS group, and the other was a group consisting of the five participants from the first group who all wanted to continue, as well as a newly hired leader who wanted very much to join the group, which was accepted by all the participants.

Based on the experiences we had gained from the first group, a form was drawn up which the participants in the new group had to fill in before the start. The members of the first group had answered similar questions in their final written evaluation. The questions dealt with participants' expectations of the group and specific issues that they would like to bring into play. A participants answered:

" I expect that I will get a better foundation in relation to the management of people employed with research as the main purpose. To get a nuanced picture of how I best lead the employee. I find that my employee is invisible to the care team and would like help on how to help her become more visible in the department.

I would like to focus on:

- *How do I best lead these employees?*
- *How do I make the other employees see the researchers as a strength in the department?*
- *How do the researchers become part of the clinic and at the same time se-cure time for development and research?*
- *What can I as a leader expect from these new employees?"*

The new group followed the same procedure as the first, i.e. the same four themes, literature and evaluation methods. At the end, the participants expressed that their expectations had been met. Besides, that they had ideas for what they would like to work on if the group could continue which all, but a single participant wished. Therefore, the participants were offered a continuation of the ALS with a second round of four meetings. After the first meeting the group, who were familiar with each other from the first round, decided to bring up topics that they were more concerned with right now to get feedback and inspiration to solutions to problems related to research and development they were concerned about. This development in the group is consistent with the general aim of participating in ALS: joint learning and reflection on specific issues for which solutions should be found (McGill & Beaty, 2001).

Perspectives of development of Action Learning Sets

At the time of writing (2022), there are two ALS groups in progress. One of these is consolidated as a permanent group, which has scheduled meetings a year ahead. The form is still 2-hour meetings, on Monday mornings, with an overall focus on the management of research and development. It is decided in advance who will present. The group wants facilitation as before and does not want to lead the group itself. Literature can be included on an ongoing basis, where it is relevant, or if something comes up that can be shared in the group, but it is not a fixed component. The group's members have several times taken up a theme for discussion, which they have agreed to take up in the large Nursing/AH leadership forum.

The second group is smaller and consists exclusively of leaders who have several years of experience with research capacity building. The framework is also 2-hour meetings, and an agreement is made ½ year into the future. Here the focus is on specific problems brought up from meeting to meeting.

THE REFLECTIONS OF THE FACILITATOR

In all the years I have been a research leader at ZUH, I have acted as a sparring partner for many head nurses/AH on an individual level. Some have contacted me when they needed to discuss appointments and expectations for some of the more than 40 PhD students, postdocs, associate professors and international visiting professors who are employed at the hospital. Here I have participated in recruitment committees, helped formulate advertisements and job descriptions. Some have contacted me for discussions of a more strategic nature. I have always offered mentor-groups for the researchers, but not before the head nurse, as described in this chapter, did contact me, have I had supervision with groups of leaders. At the beginning I interpreted is as an expression of our organisational culture had shifted towards being more oriented and ready to work with practice development and research within nursing/AH. I regarded this as a very important step, because the initiative came from the leaders themselves, not from me.

The fact that the group, which was established in 2017, still functions with a core group of leaders who have been there from the beginning underlines its importance. Had it not been important, the leaders could have prioritised their scarce time on many other and essential tasks. The core of action learning is that, the starting point is the participants' issues and concrete experiences, and from this, the participants generate relevant knowledge for use in practice (Hølge-Hazelton et al., 2021; Kjerholt & Hølge-Hazelton, 2017; Olsen & Hølge-Hazelton, 2016; Revans, 1997; Wilson et al., 2008).

I have observed several times that participants from the ALS groups have brought up topics of a more relational nature at leadership meetings, topics that were not previously discussed in larger forums. I have also several times experienced my research colleagues saying, "We can feel you have been working with our leaders"; because they have experienced leaders who have become clearer in relation to research and development work.

I have no doubt that it is the framework, the structure, and the community that emerges among the leaders that makes a difference for the individual and for those who participate in an ALS. It is probably also important that I, as the facilitator, am both an insider and outsider in the sense that I know the organisation and that I am part of it, and simultaneously I am not employed in a single department or have anything at stake in relation to the individual leader.

As far as I know, there is nowhere else in Denmark where hospital employed leaders are offered ALS with a focus on research and development culture in clinical practice. Likewise, it is also not common practice outside the country's borders. However, based on dialogues with colleagues from abroad, I have good reason to believe that the approach described in this chapter can be used in other contexts, if the leaders themselves ask for it.

UPDATE 2025

Based on the positive feedback over the years, the new version of the hospital's vision and strategy includes the addition that all new head nurses/AH should have the opportunity to participate in an ALS group. In this way, the development initiative has been implemented in practice.

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CHAPTER 3

FROM A COUNTY HOSPITAL TO A UNIVERSITY HOSPITAL

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I am a nursing deputy director at Zealand University Hospital. I became a nurse in 1983, and after that acquired a Master of Public Management from University of Southern Denmark. I have also participated in the Leadership Challenge, Senior Executive Program and Scottish Quality and Safety Fellowship Program. My clinical background is mainly from surgical wards, where I have worked as a ward manager or head nurse for 22 years. My interest in management and education and in the development of the clinical practice have been the focal points of my entire career.

In recent years, Zealand University Hospital (ZUH) has gone through a deliberate development facilitated by the management group's cooperation, working determinedly and systematically on vision, strategy and goals.

This chapter describes the strategic considerations at a general hospital level regarding how we can develop nursing and other treatments provided by nurses/Allied Health Professionals (AH) to make research and development an integrated part of everyday life and the operation of the hospital. Furthermore, the chapter describes how we have succeeded in increasing the awareness of leaders on working evidence-based and share knowledge about results.

INTRODUCTION – WHAT HAS HAPPENED IN 15 YEARS?

About 15 years ago, Roskilde and Køge Hospitals, which they were called back then, were county hospitals. Roskilde was a bit more ”sophisticated”

than Køge, as this was the place where the specialised treatments were gathered, and Roskilde had a tradition of medical research.

The hospitals had a joint budget of approximate DKK 2.2 billion (5.3 billion now), had a total of approx. 700 beds (600 now) and well over 3000 employees (now 7000). The hospitals had a high productivity performance, one of the highest in Denmark, and a strong focus on productivity.

Regarding nursing, some of the wards worked methodically on nursing development, but none of them did research, and very few worked intentionally and systematically with nursing evidence. Furthermore, no nurses or AH had completed or were completing a research education.

Back in 2008, the managing head nurses decided to convert a nurse at hospital level with responsibility for the pre-graduate study programmes to a nurse with skills and knowledge within research. This was the beginning of a determined and systematic approach to establishing an evidence-based nursing practice.

Moreover, Roskilde and Køge Hospitals changed their status and name to Zealand University Hospital on the 4th of March 2016. This was of great significance to the hospital, particularly regarding education and research.

The hospital was obviously not a fully-fledged university hospital from day one. Building a university hospital is a process – and a laborious, yet interesting, task. The ability to offer specialised treatments needs to be acquired. People with the right skills need to be employed and trained to carry out new treatments. New technological equipment for supporting the treatments is required, as well as expanding the physical surroundings. The hospital needs to employ researchers and establish and develop research environments. The pre-graduate education needs to be updated. Concurrently with the establishment of the university hospital, the new super hospital in Køge has been planned, and it is currently under

construction. In 2024, ZUH merged with Nykøbing Falster Hospital, and efforts are now being made to integrate the many initiatives across the new ZUH

Thus, a lot has happened in the last 15 years. We now have 43 nurses/AH researchers at ZUH. Most of the researchers are nurses, but they also include physical therapists and one midwife.

Table 1 Selected information about nurses/AH researchers at ZUH as of the 1 January 2024

Number of employed researchers	**43**
Professors	2
International adjunct professors	3
Associate lecturers	11
Postdoc/assistant lecturers/senior researchers	11
PhD students	16
Number of publications (2023)	**216**

Our clinical nursing professor is employed as the research director of the nursing/Allied Health (AH) research as well as the manager of ZUH's research support unit.

This chapter describes how we have worked at strategic hospital level to achieve the current results, where our number of researchers has improved from zero to 43 and more coming.

WHAT DOES IT TAKE?

A whitepaper from Institute for Healthcare Improvement (Nolan, 2007) describes three things that are particularly important in order to achieve results: Will, Ideas and Execution. Will is required at all levels, but it is particularly important in top management, as they are responsible for establishing new working procedures and abolishing old ones. New working

procedures require new ideas. Ideas create alternatives for the status quo. New ways of doing things result in new cooperative relationships that involve patients in their care and treatment. These change processes are facilitated by looking beyond your own hospital, region and country and being inspired by the experiences of others for the purpose of creating new methods and processes adapted to the local situation. All this requires managers that can convert ideas, goals and plans into action. Managers that can execute.

Thus, will, ideas and execution are vital when working on creating change and improvements. Particularly in identifying where and how to act if the plans do not progress as intended.

In our situation, the head nurses, the head of research and the nursing deputy director all had the will, ideas and drive to develop the nursing field and work towards an evidence-based practice. The primary purpose was to provide nursing for patients that could match the best in the country. Another important factor was to ensure that the professionals were given the opportunity to develop and improve their field, as this contributes to ensuring job satisfaction and pride within the field and in the workplace (Hølge-Hazelton, 2014; Hølge-Hazelton & Thomsen, 2015, 2018). Furthermore, good opportunities for professional growth contributes to better recruitment and staff retention (Hølge-Hazelton et al., 2020).

To ensure progress in implementing a more evidence-based practice, we worked with a deliberate strategic focus on the following three things:

- Ensuring research capacity and competency
- Developing a vision, goals and actions
- Maintaining focus on management and the culture in individual wards to supplement the productivity focus with an added focus on research, development and education.

After a few years' work among the head nurses, the group was expanded to include the other nurse/AH managers. Thus, the work on the three outlined focus areas targeted all nurse/AH employees.

RESEARCH CAPACITY AND COMPETENCY

An important prerequisite for creating research capacity was to hire a senior researcher at least at associate lecturer level to provide guidance for PhD students, participate in the employment of further researchers, and thus contribute to starting the food chain of new researchers.

Unlike our medical specialist colleagues, we prioritised hiring an associate lecturer at hospital level as the research director for the entire nurse/AH group. It was our assessment that within this group, there was a significant need for a person in a senior position with research competence to support and establish research across the entire hospital within the entire field. As we all know, nurses/AH do not have a long research tradition with experience in doing research in clinical practice. We initially noticed a lot of uncertainty and lack of knowledge regarding how to initiate research projects. Furthermore, there was significant uncertainty and concern about how to acquire research funding. A research support unit was established around the newly employed senior researcher, where all wards could seek support and assistance in their efforts to carry out research and potentially hire researchers themselves. Initially our research director was an associate lecturer, but management and the employee worked determinedly towards establishing a professorship.

It was important to ensure that all the individual wards were aware of the new research support unit. Therefore, when hiring new managers, we planned an introduction to the research unit on equal terms with an introduction to the hospital's information system with an overview of finances and sickness absence etc., among other things. This helped ensure knowledge of the research director, and it highlighted the hospital's strategic focus on research within nurses/AH.

Our research director was soon assessed qualified to be a professor, and in cooperation with University of Southern Denmark, we established a professorship in clinical nursing. In 2016, our first professor with a background as a nurse and the first female professor in the region was hired.

When establishing the professorship, the research programme CAPAN was initiated. CAPAN stands for CAPAcity building in clinical Nursing. CAPAN is focused on strengthening the curiosity and contemplation culture among nurses for the benefit of developing patient-centred nursing. CAPAN is the first research programme of its kind in Region Zealand. All wards and nurses were included in the research programme, and every few years, the nurses have received questionnaires about the research programme. This data has been processed and made available to the individual wards, who have subsequently been able to use this information in their own efforts to build and develop a culture research and development[1].

THE COLLABORATION

From the beginning of the development process, it was evident that close collaboration between the research director and the nursing deputy director was necessary to achieve the desired progress. This collaboration has been expanded and strengthened further over the years, which has been a great advantage and has contributed to our progress in this area.

From the beginning, the research director has reported directly to the nursing deputy director. This has contributed significantly to maintaining management focus on – and interest in – the task of establishing a research culture. Monthly meetings were booked, where strategic focus areas, challenges as well as anything and everything were discussed. Plans

[1] Read more about CAPAN in Chapter 1 as well as in Chapters 4, 6, 10 and 11, where leaders from Zealand University Hospital describe how they use the results from the programme in their strategic work on supporting research and development in their wards.

have been made, ideas for development have come up, and meetings have been reviewed and planned.

This close collaboration, in which the nursing deputy director has had someone with research competence close at hand to ”pave the way”, has been of great significance to the progress and implementation. Furthermore, the head nurses and eventually, the nurse/AH mid-level managers, became pivotal in the work to create a research culture, as described below.

A STRATEGIC TOOL – VISION, MISSION, GOALS AND ACTIONS

The work on vision, mission, goals and actions is a useful management tool if you – like we did - intend to change the current situation.

Throughout my career in management, I have often used these tools, and always in close collaboration with the relevant managers. Commitment in the management group is important for things to change and to achieve results. Furthermore, goals and actions ensure that everyone works specifically on the agreed tasks.

In the head nurse group, we agreed to work on vision, goals and actions. A task group was set up, and this group created the first draft for a vision paper to be discussed. This has been our way of working throughout the years. These days, when we need to revise the vision work, we set up a task group to work on a revised vision, which is then to be presented for discussion and decision-making. After this, the vision is put up on the website and sent to the managers. Some of the managers also use the vision work to draw up a vision and goals for their own ward.

The vision includes four elements: Mission, vision, strategy/goals and actions/action plan.

The ***mission*** describes the organisation's reason for existing - why the organisation or function exists. We have described our mission in the following way:

"The mission is the patient. Excellent cooperation, nationally as well as internationally, is vital to good continuity of care. ZUH works together with the other hospitals in Denmark, general practitioners, specialist physicians and municipalities for the purpose of giving our patients/citizens the best health professional results within:

- Diagnostics
- Treatment
- Care and nursing
- Rehabilitation and palliation
- Health promotion and prophylaxis"

The ***vision*** is a future image of the organisation's wishes, dreams and ambitions, often expressed through long-term goals. It is a guiding ambition for where the organisation wishes to succeed and how the organisation wishes to be perceived.

Our vision is: "Zealand University Hospital at the top". With this statement, we express our ambition to measure up to the best hospitals in Denmark.

Strategy/goals describe the long-term intentions, ideas and plans for how the organisation is going to implement the vision.

One of our goals is related to development, research and evidence-based practice, and it is phrased in the following way: "That the practice regarding the nurse/AH field at ZUHis based on the best documented knowledge from research and development and clinical experience as well as from patients and relatives. The care and treatment should be person-centred

and adapted to the local context". This goal is fundamental for the development of the research culture at Zealand University Hospital. To be precise and clear about where we are going and what we want to achieve, we have formulated subsidiary goals within this field.

***Action plan**:* This plan specifies goals, activities, time and responsibilities required to implement the strategy.

Actions are important to reach our goals. We have described several actions under each goal. For example, we have specified 23 actions for the goal related to research and development. Example: "There will be a masterclass regarding research and development for interested persons 1-2 times a year carried out by Zealand University Hospital's own nurse/AH researchers or our visiting guest professors. Person responsible: The nursing research director."

Throughout our work on the vision, we have been through six revisions, where we have added new goals and accomplished others. However, in all the years, we have worked on goals for development, research and evidence-based practice. This has been pivotal for how far we have come today. Furthermore, we found it necessary to establish a job structure, as more nurse/AH were given positions with tasks and responsibilities within research. It was important for us to define and highlight career paths, enabling our current and future employees to see a future career opportunity with opportunities within research and development, the education field as well as management. In addition to this, the job structure is an important management tool that clarifies the expectations for competence and organisation within a ward.

The work on vision and goals has primarily been a management tool to help determine the strategic direction for developing nursing and the other AH fields. The managing head nurses etc. have used vision, goals and strategies on their own ward, and in addition to this, several have

formulated specific goals and strategies for the ward based on the hospital's vision. In 2021, there was also a theme day for mid-level managers and specialist nurses to disseminate knowledge about the vision.

Today, all wards work systematically and determinedly on research as well as development of nursing/AH. Among other things, the work is made visible at the annual symposium for all nurses/AH as well as through research publications. Furthermore, all wards endeavour to support research by hiring PhD students, postdocs, associate lecturers, professors and international adjunct professors.

MANAGEMENT FOCUS – FROM A PRODUCTIVITY CULTURE TO A DEVELOPMENT CULTURE

ZUH has been known for being highly productive, and for many years, it was among the three most productive hospitals in Denmark. The Ministry of Finance estimates productivity at the hospitals in Denmark each year using a simple method where activity is compared to the expenses incurred to create this activity. Basically, how much health you get for a buck.

Having high productivity used to be the main goal of our hospital. This affected development efforts, which often had to yield for productivity reasons. Therefore, an active effort was required to ensure balance between productivity, development and research as well as education. We wanted to create a shift in the culture: from only focusing on productivity to also include efforts within research, development and education.

Therefore, we worked deliberately on creating more management focus on the research and development effort as well as developing managers' competence when it comes to initiating local research projects in their own ward. For several years, each meeting in our nurses/AH manager forum included a fixed item on the agenda regarding development of the

research effort. Here, initiatives, difficult problems and new research projects were discussed. At these meetings, the research director and the nursing deputy director had an important role, and the research item was planned carefully with the participation of relevant researchers.

Furthermore, various supporting efforts were initiated, such as writing courses, establishment of networks for researchers as well as exchange of experience groups[2] and journal clubs[3] for head nurses, just to mention a few examples. These efforts, which are regularly revised and expanded (through our vision work), have contributed to our current competence and awareness regarding research, development and education.

Another significant and pivotal factor for how managers and employees are now working on research, development and education, is that the hospital was given the status of university hospital back in 2016. An important event and a big day for the hospital and its future. The title of university hospital helped and is still helping raise the bar, particularly in the research and education field.

Obviously, the title alone is not enough. Substance is required to meet the expectations for a university hospital. At a strategic level, we therefore worked determinedly on supporting and developing the hospital as a university hospital. At the hospital level, we formulated a strategy called ”The patient is everything”. This strategy included visions, goals and strategies, and in all wards, we appointed strategy ambassadors, who were either nurses or physicians. We developed a basic narrative about the country's youngest university hospital, we formulated a professorship plan, and we established the hospital’s research committee. There was also a significant focus on establishing medical/medical specialist professorships within all areas of specialisation, and funds were allocated to the

[2] Read more about exchange of experience groups (ALS) in Chapter 2
[3] Read more about journal clubs in the Appendix

establishment of five postdocs within the nurse/AH field, just as our first professorship within nursing became a reality.

The establishment of the university hospital and the associated obligations and expectations to ensure education, both pre-graduate and post-graduate, as well as research were also of great significance to the nurse/AH field. All wards established interdisciplinary research units, and it was required for all wards to continuously work on developing this area regarding the nurse/AH field as well.

Deliberate explication of expectations and provision of equal status for the education, development and research field compared to the productivity field have resulted in the fact that we now have a great balance between all fields and a great development of the research field.

WHAT DIFFERENCE DOES RESEARCH MAKE?

As healthcare professionals – in my case as a nurse – it is our foremost duty to always ensure that the patients are given the best possible care. The patients and their challenges are our core task, and we have a duty to provide the best evidence-based nursing and to ensure a high-quality continuity of care. As a university hospital, apart from working in an evidence-based way, we also need to contribute to developing new knowledge for the benefit of the patients. This sounds simple, but as described, it has required a deliberate choice, both due to the nursing profession's and the hospital's traditions in this field.

There are several added bonuses of ensuring an environment where research comes naturally. It has a positive effect on staff retention and recruitment, it results in professional pride and job satisfaction, and not least, it has a positive impact on the hospital's profile, both as a place for treatment, but also as an attractive workplace. It is important to give

healthcare professionals the opportunity to become immersed and involved in professional issues and thus contribute to developing the professions.

Important prerequisites for establishing a research culture

It is an extensive and demanding change to go from a hospital that focuses solely on productivity to a hospital that prioritises productivity, research, development and education equally, and where there is an expectation that all wards work on all four things. There have been many challenges along the way.

In the time perspective of 15 years described in this chapter, there have been three different hospital directors with different perspectives on what matters the most when running a hospital. A prerequisite for developing a research environment in a new group – in this case, nurses/AH – is that the hospital director agrees that this development is necessary and valuable to our patients. Developing a culture is difficult work that requires the entire hospital management to work in the same direction and show with their actions and words that the development of the research culture is important. Schein et al describes culture in the following way:

> *"Culture is the deeper level of basic assumptions and beliefs that are shared by members of an organization, that operate unconsciously and define in a basic 'taken for granted' fashion an organization's view of its self and its environment."*
> *(Schein et al., 1985)*

Therefore, it is vital for all members of the hospital management to be aware of the hospital's culture and thus work determinedly on changing the culture in the desired direction. In our organisation, examples of this include visibility on the hospital's website, culture being explicitly men-

tioned in the hospital's values (and, as such, it becomes part of the 'narrative of the hospital'), and that the topic is discussed in meetings among managers and the research committee.

Furthermore, it is also important to have a regional strategy in the research field describing the significance of research across subject areas. It is not enough to have a nice strategy; regional actions and interventions must be carried out to ensure that the strategy is converted into real change.

FUTURE PERSPECTIVES

ZUH is experiencing rapid development in the research field. All wards have established research units. Many wards have already hired researchers with a nurse/AH background and others are planning and preparing the employment of researchers. The cooperation between wards and researchers in the hospital works well and is under continuous development, including collaborative research projects and knowledge sharing.

Better research collaboration across the region's hospitals is being established, and close cooperation between the nursing deputy director and research directors of the individual hospitals has been initiated to strengthen research in the nurse/AH field in the entire region.

Furthermore, the regional research council is working on establishing financial support for the nurse/AH field, which means that in time, we will achieve equal terms and circumstances for all researchers in the region regardless of their professional background.

The establishment and development of the country's youngest university hospital (Zealand University Hospital) will continue in the years to come. In 5-10 years, all wards will have researchers, and the main areas of specialisation will have professors.

An additional initiative to support this development is the establishment of a program TECS (Team Professional Master in Clinical Nursing) focusing on part-time academic education of nurses at master's level (professional master degree). The ambition is to educate nurses for the increasingly complex tasks they encounter in clinical practice, thereby strengthening evidence-based nursing.

As the nursing deputy director, it is crucial for me to work on developing the clinical practice to continuously be at the forefront of development. This means that I need to provide inspiration from management level to hospital level and help provide the framework for developing the clinical practice in the individual wards.

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MANAGEMENT PRIORITISATION OF RESEARCH CREATES A COMMON DIRECTION

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Photo: Thurid van Steenwijk

I became a registered nurse in 1989 and was subsequently employed as registered nurse, assisting ward manager and ward manager in medical departments. In October of 2000, I became ward manager in the Department of Oncology, and after having finished my Master of Clinical Nursing (MCN), I was employed as head nurse in the Department of Oncology in Roskilde. I further hold a Master of Public Governance (MPG) from 2016. The Department of Clinical Oncology and Palliative care has a total of 472 employees across five oncology units, a palliative ward, five palliative teams, a late complications clinic and a clinical research unit.

Nursing research environments are currently being established in most hospitals, but the intensity and pace is varying. As head nurses, we are often directly involved in the decisions and processes, but we move within a field, in which we are also responsible for managing knowledge workers and processes, and it is even a field about which we ourselves have limited knowledge and experience.

This chapter describes my experiences, reflections and actions as to establishing a nursing research environment in a large clinical department. The process has been equally exciting, educational and relevant, but also long, frustrating and difficult! You could ask me, why I stayed on and continued working with the process? The question can be answered in many

ways and the answer that initially comes to mind, is that I believe that nursing research is necessary for our healthcare system. Patients demand it and it contributes to recruiting and retaining clinical employees. Another significant driving force in the process has been my wonder about why it has been – and still is – so difficult to establish a nursing research environment? The objective of this chapter is to suggest what is at stake, when you establish nursing research and what barriers you risk running into along the way. Diving into this perspective of nursing research has further delivered the answer to why the process at times has felt long, difficult and frustrating. By doing so, I hope to inspire and help others who consider taking on or are in the middle of a similar process. The chapter is further an acknowledgement of nursing research as being relevant and complementary to traditional medical research, and as being equal in an interdisciplinary research direction, regardless of whether it is budding or already integrated.

THE MEDICAL TRADITION AND CULTURE – A SHORT REVIEW

During the process of establishing a nursing research environment, I quickly gained interest in the medical tradition and culture - the origin of medical research. I hoped that it would provide me with some understanding of the barriers, which I ran into.

Modern medical science experienced a budding breakthrough in the early 1800s, where the university faculties were already rooted (Jacobsen & Larsen, 2017). Thus, the medical tradition and culture have a long history, characterised by being powerful and well founded. The physician was one of three societal professions together with the lawyer and pastor. The physician had the power of life and death, and due to his profession and power, he was an esteemed and important citizen.

The medical development throughout the 19th and 20th century was tremendous. The ability to prevent, examine, heal and relieve was rapidly

developing and medical science was regarded to be a recognised and necessary effort. No citizen would question medical science, as it was a prerequisite for a well-functioning healthcare system. Medicine as profession, the physician as ruler over life and death and medical research as a prerequisite for this became manifested and commonly accepted and recognised by society. Physicians were recognised and so was medical science.

Nursing research started developing in Denmark during the 1990s. The first team of graduate students was established at the post-basic school of Nursing at Aarhus University in September 1991, and the educational institution further received the right to assign PhD scholarships to nurses. This marked an important milestone in nursing research. The first nursing professor started in 2002; the next in 2007 and more pioneers have since followed (Bydam & Glasdam, 2008). Today, research within the field of nursing is becoming a well-integrated part of the Danish healthcare system. Unfortunately, I do not see research within the field of nursing experiencing the same tradition, recognition and power as within the medical field. Different fields of research and research methods within the two professions may be explanations for the difference in power and recognition, more than historical and social considerations. Medical research is often based on quantitative data with extensive data material and with treatments and examination methods being fields of research, resulting in more generalizable and evidential research results. The research levels vary, and the research evidence is dominated by a positivistic perspective of natural science, which is for instance expressed in medical science. This leaves medical science in a stronger position (Hamer & Collison, 1999). Nursing research is largely based on qualitative data, less data material and “softer” fields of research such as welfare, communication, care, rehabilitation etc. The data is not as generalizable and the level of evidence is in some cases lower. Medical research results are often published in international journals, whereas nurses often convey their research results verbally and as posters on both professional

and scientific conferences, or as articles in national or Scandinavian journals. None of these forms of communication of knowledge or publications are registered as having impact in the official documentation in our region (Kjerholt, 2020).

This is, from my perspective, a natural consequence of the professional differences and the applied research methods. However, it makes a difference for the connection and comparison within the two professions.

I believe that it is of importance to the way, in which nursing research is perceived and accepted as both legitimate and necessary, by society and the healthcare system. Moreover, there is a lack of common knowledge about the strengths and weaknesses of the research methods - especially in terms of how they can complement each other and thereby be of benefit to both professions. I assume that it altogether contributes to building barriers for establishing nursing research in our department. However, I do not think it can stand alone. The nurses' own view of nursing research, lack of knowledge about research methods and terms as well as poor understanding of the legitimacy and necessity of research, may explain why it is so difficult. In order to provide a deeper insight into this, I will briefly account for a survey conducted amongst the nurses of the department as part of the research project CAPAN[1] by nursing professor Bibi Hølge-Hazelton (Forskningsstøtteenheden, 2019).

CONDITIONS OF NURSING RESEARCH IN THE DEPARTMENT – THE RESULT OF A CAPAN SURVEY

The nurses employed in the department have different levels of experience and knowledge. Several nurses have been working within the specialist field for many years, but the department is also recruiting newly educated nurses and nurses from other fields. Most of the nurses are

[1] Read more about CAPAN in chapter 1

basic registered nurses, but the department also includes nurses with additional training, special training and academic training.

The CAPAN Survey II provided the opportunity to gain insight into the knowledge and perspectives of the nurses in terms of nursing research during the establishment of the nursing research environment in the department. Below is an excerpt of the final report for the department. The total response rate was 48%; however, the results should be taken with caution, but they may set a *pointer* as to the knowledge and position of nursing research in the department.

In short, the result of the survey showed that 49% of the respondents had knowledge about the department strategy for development and research, 15% did not know the strategy and 36% responded, "I do not know". Forty-nine percent of the respondents completely or mostly agreed that the general research activity had increased within the last year. Of those, who stated that the research activity had increased, 60% stated that it had affected their function in the department positively. About a third (37%) of the respondents answered that one or more nurses in the department have conducted nursing research within the last year. Of those, 50% stated that they knew the subject of research, and 54% answered that they completely or mostly agree that research was relevant for their everyday nursing practice. To the questions, whether new knowledge within the professional areas of the respondents is easily accessible and easy to understand, 53% and 68% of the respondents respectively completely or mostly agreed (please contact the author for a copy of the complete report).

The results of the survey, even though they should be taken with caution, supported my personal experience of the research culture in the department. The demand for results of nursing research is very limited, several nurses lacked knowledge about and insight into research, and not everyone found it relevant for their clinical practice. I came across statements

like: “What is wrong with doing things the usual way?” or “It would be better if we were more staff to handle patient care” or “I just want to take care of the patients” - just to name a few.

Addressing the need for more employees to handle clinical tasks seemed conspicuous. From earlier discussions, for instance within the management group, I knew that the increasing pressure on department operations collided with the prioritisation of resources for development and research, especially with nursing practice. This also meant that the possibility for both leaders and clinicians to take time to learn about and engage in research was extremely limited and at times non-existing, which was consistent with the results of the CAPAN Survey II. The cross-pressure between daily operations and research became apparent.

Despite the many apparent barriers, I decided to continue my work on establishing nursing research in the department. Deeper insights into the field, combined with development within the healthcare system, aroused my curiosity and motivation - and I was lucky to rely on the help of wise nursing researchers in my network.

NURSING RESEARCH IS ESTABLISHED

In connection with a merger between the department and a unit from another department, we received the funds to employ a postdoc nurse. This became the big turning point in establishing nursing research. At that time, the department included a clinical development nurse and a clinical nursing officer, and by employing a postdoc, we were able to unite the academic nursing skills that enabled knowledge, feedback and strategic considerations related to nursing research. The hospital’s nursing professor further established a network for head nurses interested in research[2]. This resulted in visibility, attention and legitimacy in regard to nursing research, both in the department and throughout the hospital. Looking back, it seemed like the doors to nursing research were opened and it

[2] Read more about ALS for head nurses in chapter 2.

marked the beginning of a process full of obstacles and frustrations because the level of knowledge was low and the lack of experience on department and organisational level high. From my management perspective, three elements became obvious: knowledge, experience and culture - all of which required development when setting a new direction for nursing research in the department.

The heads of department decided to be clear about the future prioritisation of research as a general application area in the department. We wanted to make clear that clinical practice and research go hand in hand and that it is not either-or. We therefore planned a theme day for leaders and researchers from the department to put research on the agenda of the leaders. Moreover, make them aware that we as heads of department expected increased attention to the field, increased prioritisation of resources to the field and targeted communication on the topic to employees, backed up by the heads of department.

Managing employees with academic skills and formulating research strategies were all new tasks. We needed structures, routines and well-defined objectives, both on hospital and department level. However, this changed over time and a budding organisation of nursing research was born, resulting in formal structures for recruiting nurses with academic skills, wage adjustments, job descriptions, objectives for the number of publications, nursing research networks, national and international networks - all on hospital level. It created direction and legitimacy for nurse leaders and researchers in the department.

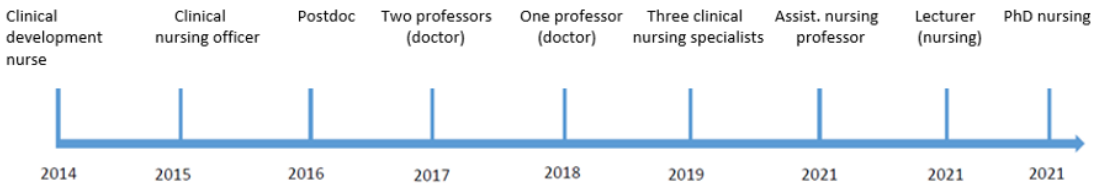

Figure 1 The timeline illustrates the employment of central research employees in the department during the period 2014-2021

At the same time, the department's Clinical Research Unit (CRU) went from being a unit for logged research, initiated by the pharmaceutical industry, to being a unit also conducting own research and run by three new medical professors. Of course, medical research played a central role in the department as also in the other hospital departments. On hospital level, an ambitious professor plan and a research council was established, both dominated by medical research. The same tendency was observed on regional level and the development of the research field took off rapidly with the establishment of national and international research networks that resulted in both financial means and publications.

It would be fair to assume that we were close to having a well-established research environment. However, it was predominantly medical networks and not so much nursing and interdisciplinary networks. It further turned out that the formal structures of CRU and those of the hospital's nursing research were out of sync, that the medical and nursing research tradition did not seem homogeneous and that expectations for a common research environment as the basis of nursing and interdisciplinary research were unaligned. The lack of harmonisation was a solid barrier and resulted in misunderstandings in the department; both because it was not addressed in time, but especially because of the inadequate focus on solving it.

THE CHANGE OF DIRECTION BROUGHT RESULTS

It became clear that the department had to change direction and create common ground for research. The heads of department agreed that interdisciplinary research is important to the department, for instance offering an assembled view of the possibilities and needs during patient care. At Zealand University Hospital (ZUH), nurse leaders and researchers had for years worked on creating well-developed and clear settings and structures for nursing research. They could not stand alone but served as a well-established platform for expanding and developing interdisciplinary research in our department. A strong mono-professionalism and culture is an important basis in order to be able to contribute to interdisciplinary research (Berthelsen & Hølge-Hazelton, 2017). At ZUH, there was a strong conception and addressing of nursing as a profession and field of research, but the conception and addressing within our department was not consolidated in the same manner. I was therefore uncertain to what degree nursing research would be accepted as legitimate and necessary, once we made a change of direction to be coordinated with the medical and other interdisciplinary research within the department. However, I could see that the harmonisation, cooperation and common direction would open to new opportunities and new strength for nursing research. In other words, the arguments were many to change direction and create common ground for research in the department.

The change of direction brought results! A common and clear direction and a common language and management prioritisation of research contributed to the change of direction. It resulted in a will to cooperate between nursing and medical research - a will that was especially the result of the conducted development process and a will also in me as the department's nurse leader, but also in the heads of department and among the three medical professors. Being aware of this as well as making the

decision to use the skills of the whole group of researchers in the department to strengthen nursing research, was crucial for the change of direction.

Today, research in the department has been expanded significantly and is thriving - this also applies to nursing and interdisciplinary research; however, it is a bit more limited. The overall research within CRU is illustrated in the umbrella with also nursing and interdisciplinary research (see figure 2). A lecturer (former postdoc employee in the department) is head of the nursing research, which is continuously expanded with focus on clinical practice. As a result, a clinical specialist nurse with research tasks and two clinical nursing specialists with development tasks were employed. All clinical nursing specialists hold a Master of Science or master's degree. The latest addition is a nurse as PhD graduate. From January 2021 and three years on, the department will in cooperation with another hospital department, have assisting nursing professor Brendan McCormack affiliated, known for his theory of Person-Centred Practice (PCP). The objective is to strengthen and support implementation of PCP through the nursing research environment (Kjerholt et al., 2020). PCP is ideally interdisciplinary anchored, but it is important that our ambitions remain realistic, and PCP is therefore initially implemented in the nursing environment. We find it important to create a strong mono-professional platform to be able to conduct solid argumentation on a well-founded basis for interdisciplinary PCP implementation. Within the team of nurse leaders and nursing development and research employees, we find it important that PCP is part of the ambition of Personal Medicine, a strong development tendency within the field of treatment. We also use this argument for why we believe that PCP is relevant in an interdisciplinary context and is a common issue in the long term. We experience that having a professor affiliated is a positive thing and it is accepted among the other research employees in the department.

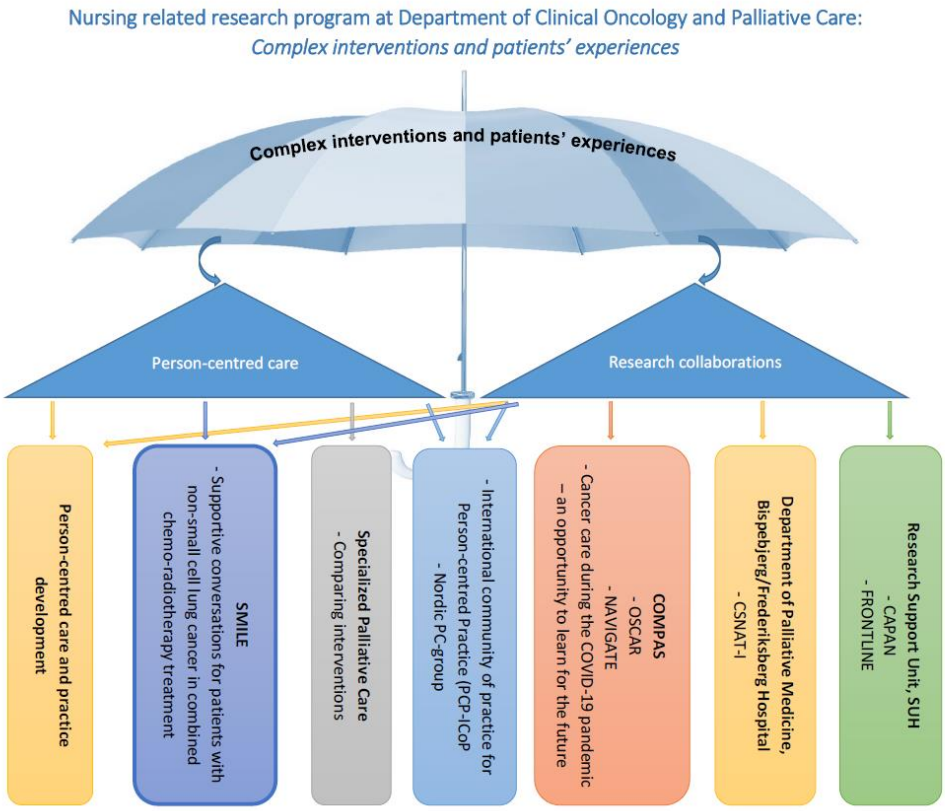

Figure 2 The umbrella illustrates the department research programme for nursing within the Department of Clinical Oncology and Palliative Care, Zealand University Hospital

Establishing the nursing research environment has generated results on several levels, both in terms of the number of nursing publications and presentations on conferences, and in terms of the creation of networks. Nursing research has a solid national network with numerous examples of relevant nursing partnerships, including interdisciplinary research partnerships; further, international networks and partnerships. It has also resulted in a research environment in the department; with for instance the university affiliation to University of Southern Denmark as an important factor in career processes. The research environment also makes a difference locally in the department. Employees ask for feedback on development and research projects and the same goes for guidance on individual career paths. We experience interest in development and research results among our clinicians as well as the addressing of clinical issues. Especially the interest of clinicians is significant. We need to develop and maintain the nursing research environment by means of the

clinicians' interest and addressing of issues on patient level. I strongly believe that nursing research finds its true legitimacy in this context.

Apart from the common direction creating implications for nursing research in the department, it has also resulted in improved research partnerships across professions. It has made access to a strong medical research environment easier, enabling guidance and help, regardless of research methods, research areas or level of researcher knowledge and experience. This is significant for both the quality of the research work and for the support for application of financial means for nursing research. Further, it has provided methodically width to the overall research in the department, and it has created stronger networks. The medical research, including the logged research with medicine testing, can be supplemented with nursing research, creating a mix of research methods and research competences, leading to a more nuanced basis for results. The allocation of competences can strengthen the research environment and propagate research methods and networks, resulting in a basis for development within the field.

THE PROCESS GENERATED KNOWLEDGE

The process generated knowledge on several levels. Personally, I learned that breaking down structures and conditions may be necessary when it concerns an important cause. We learned that professional differences are not always rational, but rooted in history, traditions and cultures. The understanding of your own profession is strong and the encounter between research traditions and methods can be challenging. We also learned that it might be a display of strength to meet and learn from the conditions and structures of medical research, even though it in some areas may tone down nursing as a profession, and that battling the current professional identity may be required. The synergy effect of the research community may, in the long run, be leveraging for nursing research – it has therefore been important to maintain a long-term view of the development of the nursing research culture. I have learned that integrating

nursing research in other department research requires focus on research partnerships and the use of research methods to maintain the unique relational and person-centred aspects, which are nursing core values. If we want to maintain nursing core values, we must select research methods that speak to them. This is a task, which both nurse leaders and nursing researchers must solve. We have further gained relevant knowledge about nurses' knowledge on and perception of nursing research in the department - and we have gained a viable basis to continue development. It will be interesting to see the results of the next CAPAN survey.

Finally, we have learned that the road to the goal of establishing a nursing research environment can be exciting, educational and relevant, but also long, frustrating and difficult – exactly like the road to research results.

Afterword July 2024

Since I wrote the book chapter titled "Management Prioritisation of Research Creates Common Direction" in 2022, the development of the department's research culture in general, and the development of nursing research specifically, has been in progress. In the following section, I provide both a retrospective, a forward-looking, and a reflective view on the department's nursing research.

A look back at the department's nursing research since 2022 confirms that there has been solid development and progress, which can be measured on several parameters. Based on nursing research, the number of articles and posters presented nationally and/or internationally has increased significantly, with a total of 9 publications and 10 posters presented in 2023. All sections of the department have employed staff with a master or master's degree, who participate in clinical practice 80% of the employment norm. In addition, a research assistant has been employed, both as academic support to the department's associating professor in nursing and as part of the strategy to continuously have one or more Ph.D. candidates in the department. This helps to create a solid foundation for qualifying, supporting, and further developing nursing research.

At the same time, the department's nursing researchers have been integrated into both national and international networks and groups, including networks and groups where person-centred practice is the foundation for research. Additionally, a collaboration has been established with Absalon University College and the University of Southern Denmark regarding pre- and postgraduate education, and cooperation with national and international research centres has been expanded.

Prospectively, the ambition is a continued increase in the number of articles and posters related to nursing research. We believe it is important to create evidence for our nursing practice, and being able to document nursing research is an integral part of the department's overall research profile. We also expect to have a clearer profile in nursing research across ZUH and in collaboration with national and international research centres.

We aim to consolidate the research environment and culture in the department's nursing/allied health area, including the number of Ph.D. students, postdocs, and academics in clinical practice, partly through a professorship in nursing. Culture creation is a long-term process that continuously requires leadership focus, but it is important to create an understanding that nursing research has a rightful place in the overall research profile – and thus also in the allocation of financial resources.

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We are experiencing an increased barrier for nursing researchers to secure the necessary funding to conduct research. This creates insecurity and uncertainty for the researchers when the funding only covers a few months ahead, and there is not necessarily a prospect of more funds. This is a barrier that both researchers and leaders need to take seriously.

Leading nursing research is an ongoing reflection process that places me in a field of tension between nursing research and the leadership of research in general. Besides reflecting on what organisation and decisions will mean to nursing research, I am concerned with which organisation and decisions will be the wisest from a general leadership perspective. It is important for me to act loyally to my function as a leader, where an overall leadership view on the organisation of the department's total research is necessary, while at the same time maintaining a professional view on the necessity of strong organisation and prioritisation of nursing research. It is a constant dilemma where direction must be set for the long-term possibilities and the value the organisation brings to research – and nursing research in particular.

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CONTINUOUSLY EDUCATED NURSES – WHY AND HOW IN CLINICAL PRACTICE

Author: *Ole Toftdahl Sørensen, Head Nurse, Department of Surgery*

I started working in my first management position as ward manager in 2001 and have ever since worked with nursing management within different departments, both medical and surgical, where I have gained broad experience as head nurse. For two and a half years, I was employed as head of profession in the Danish Nurses Organization, and I then returned to the clinical field in my current position. Since my nursing education, I have obtained a diploma in leadership and a Master of Public Policy.

At all times, the profession itself and development of the profession have been the centre and driving force of my leadership approach. I have for instance worked with interdisciplinary task management between nurses and therapists and have as head nurse always used the competences of academically trained nurses, for instance for clinical supervision, initiation of development and research and establishment of a research unit. For several years, I have been actively involved in the Danish Nursing Association, both within the research council and board.

THE NEED FOR CONTINUOUSLY EDUCATED NURSES

More and more nurses choose to continue education and constitute a resource, which we must use in the clinic. In this chapter, I reflect on what I believe may contribute to further development of practical nursing, including how strengthened competences and strong managing nursing skills are crucial to ensure sustainable development of nursing in line with the expectations of society.

Many nurses are driven by the desire to make changes and improvements - to gain knowledge through education and practice to do the best possible for people around them. It is my experience that nurses have never resisted professional improvements for the benefit of patients. New initiatives have often been obstructed by terms and conditions such as standardizations, vacant positions and activity requirements.

Specialised nursing requires competences on multiple levels; competences well founded in nursing practice. The need for evidence-based and specialised nursing practice is increasing because of its importance to admission times, mortality, patient satisfaction and costs (Aiken et al., 2014; Woo et al., 2017).

I have written this chapter based on twenty years of experience as head nurse. I have been responsible for nursing on a daily level, and for developing the field in line with development of society. I do not question the fact that nursing is founded on a strong professional identity and solid general education. However, we need to increase specialisation postgraduate to be able to match development within the healthcare system. We should, by means of an increased competence level, ensure that development of the profession is controlled by its own logics in line with the social task. By increased competence level, I mean the need for academic thinking and clinical skills to be able to match the context of nursing and patients.

In this chapter, I use my everyday experiences to describe how we within the department of surgery work on increasing the number of academically educated clinical nurse specialists, and how we integrate them in the clinical work, while they also get to use their academic competences.

WE STILL NEED QUALITY AND KNOWLEDGE WITHIN THE FIELD OF PRACTICE

An article in the Danish nursing journal, "Profession and Research" (Fag og Forskning), describes that nurses around the world are unable to provide the required nursing quality to an adequate extent (Sørensen et al., 2017). A high number of annually reported unintended events related to insufficient nursing supports this (Styrelsen for Patientsikkerhed, 2016). The article suggests that we as professionals and leaders must make a conscious choice to prioritise the professional foundation within every department or hospital (Sørensen et al., 2017).

Quality development and assurance has always been a cornerstone in nursing, and we have constantly worked on ensuring a minimum level of quality, both in individual situations as well as overall patient care. Unfortunately, it is generally known that we fail to provide the required quality of nursing. As early as 1980, Doris Christensen described nursing as being insufficient and characterised by coincidence and a need for development and improvement of the clinical practice (Christensen, 1980). Doris Christensen introduces the term "clinical nurse specialists" and thinks that they may contribute to fulfilling the need for professional development (Jensen et al., 2010).

To accommodate the dilemma between operations and the profession, we need to convey knowledge about the importance of nursing on a daily basis, and local argumentation of when and for whom nursing is crucial. We have during busy times seen a tendency to lose track of our professional perspective, and the professional foundation of the department is often regarded to be associated with the individual and not a professional characteristic (Kjerholt & Sørensen, 2014).

BEING A UNIVERSITY HOSPITAL ENTAILS NEW NURSING REQUIREMENTS

As Zealand University Hospital continues to establish itself as a university hospital, requirements for further specialisation in terms of care and treatment continue to increase. Being a university hospital requires that we as nursing leaders promote environments that contribute to nursing on an evidence-based foundation (Sackett et al., 1996), and not only as a ritualised practice, built on habitual thinking and individual comprehensions. We can do this by conducting research focusing on nursing, and by ensuring that some nurses conduct research and that other nurses implement the evidence at hand.

Concurrently with this development, there is a tendency to relocate nursing tasks from the secondary to the primary sector. The intersectional transition of patient/citizen has long been a challenge: The patient's situation is another during admission, where only patients severely affected by illness - requiring care - are hospitalised (Berthelsen & Hølge-Hazelton, 2018). Nursing and treatment are not necessarily completed at the time of discharge. The situation of the patient is stable, but treatment and nursing/rehabilitation takes place at home, possibly with outpatient follow-up. The criterion for success has been short, effective admissions, and a transition from bed-based activities to outpatient activities seems to be the organisational mantra (Sundhedsstyrelsen, 2009). We know that admission and inactivity are non-promoting for the recovery of surgical patients. This has meant that patients stay in hospitals for shorter periods, and that admitted patients are increasingly severely affected by illness and therefore require more intensive care.

Development entails new requirements for the nurse, who assesses and plans patient care during admission. The nurse must be able to identify the needs of the patient accurately along with the expected development and intervene by means of knowledge and experience. The nurse further

has to include both the patient and relatives in the process and prepare them for the time to come (Thaysen et al., 2019), which may be in the patient's own home. In other words, the nurse must be able to determine when the nursing situation requires admission and when it does not.

Vision and strategy for nursing

At Zealand University Hospital, we have for years worked on a strategy and vision for nursing with the objective of developing a person-centred practice based on research and development. This vision includes suggestions and objectives for supporting structures, learning, quality, development and research for the benefit of our patients (Hølge-Hazelton et al., 2021) based on the person-centred nursing framework (PCP) (McCormack et al., 2011)(see Box 1). Developing person-centred nursing is not a unique event; it requires constant efforts from organisations for ongoing facilitation of development as well as dedication from both clinical teams and across of organisations. Developing person-centred nursing rests on three factors, which affect the practical context: workplace culture, learning culture and physical environment (McCormack et al., 2011). The development process requires constant leadership focus, facilitation and a team of individuals with the right skills - in this context, nurses able to work methodically and with both experience-based and professional academic knowledge.

Box 1: Person-centred practice (PCP)

Person-centred practice (PCP) is a reference frame focusing on individuals (patients, relatives, healthcare professionals, primary sector etc.), cooperating with the purpose of providing optimal support and nursing/treatment for individual human beings. This requires incorporation of evidence in four parts: knowledge from patient/relatives, science, the involved professional groups and the contextual framework. With PCP, the resources and competences of the involved persons are utilized and collectively create the relations that form the foundation of decisions and patient care planning.

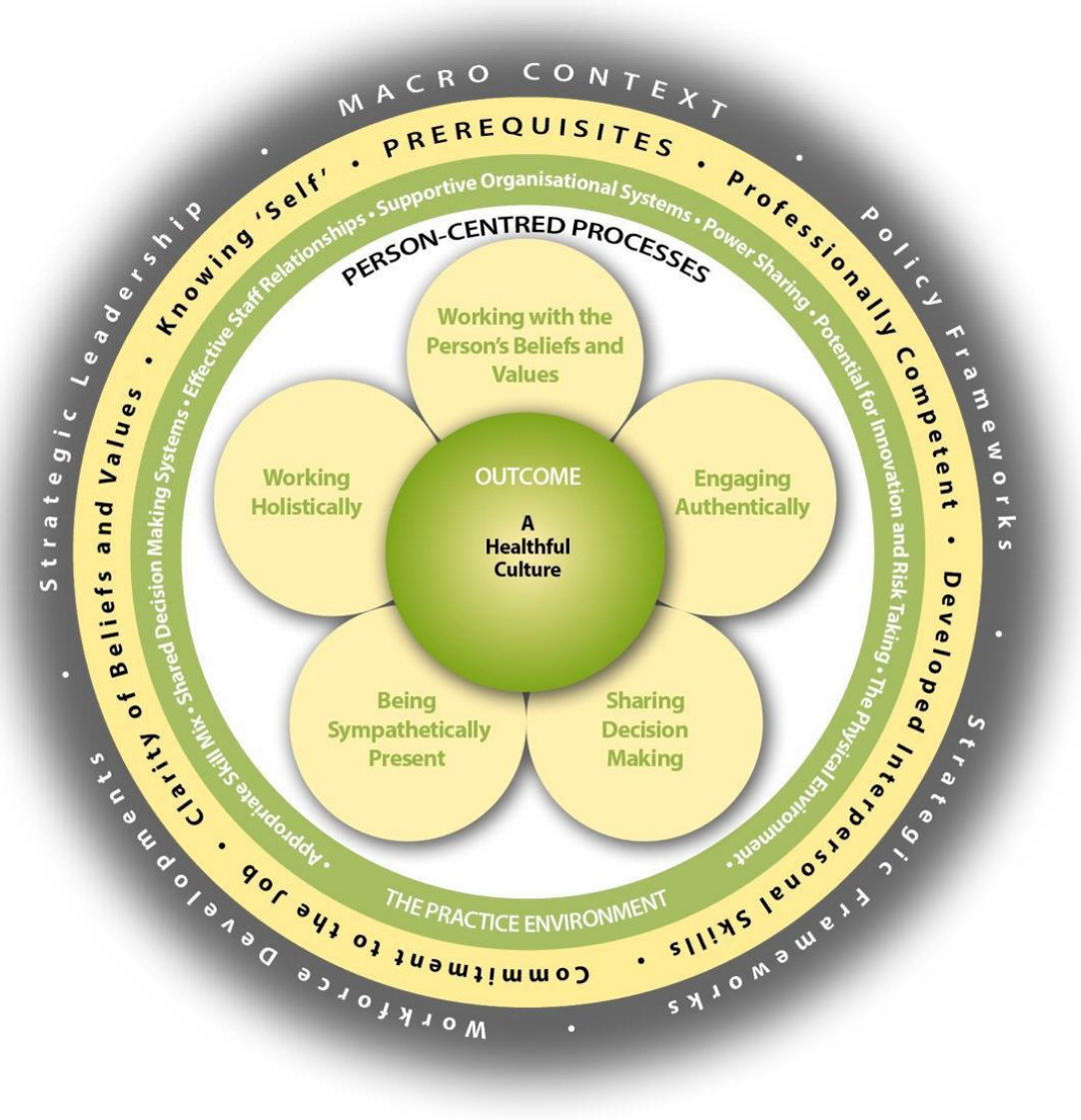

Figure 1 Person-Centred Nursing framework (McCormack et al., 2021).

The nursing strategy changes with development, and we therefore work in periods of three to four years. A current strategy is at hand, with very specific objectives of how we want to increase capacities within the nursing group at the hospital. The strategy is approved by the hospital administration, enabling legitimacy for local nurse leaders to initiate actions to meet the objectives. The specific objectives are identified by means of discussions among the head nurses of the hospital in cooperation with researchers and specialists; we have for instance created a plan for what we think is necessary for the development of nursing, as illustrated in the PCP framework above. In accordance with the PCP framework, the strategy focuses on leadership and facilitation as well as a structure to ensure the presence of the required competences.

The administrative area, which this chapter focuses on, is about starting by creating a supportive structure to support the use of academic competences within the field of practice. As a professional group, we are inexperienced with academically educated nurses employed on department level under the ward manager, and where the continuously educated nurse works both clinically and academically and reports to the head nurse. This challenges our managing skills and focus as well as our everyday work planning. For instance, is it legitimate to conduct development work while also trying to handle everyday tasks? Or what individual differences do we face in the competences and fields of interest of clinical nurse specialists (Kjerholt, 2018).

In our previous position structures, we did not take the increasing number of academically educated nurses into account, nor how to integrate them in clinical everyday life. The incentive to continue education is the wish to continue work within and with nursing, but with more perspectives than a practicing nurse. However, this does not seem to be possible in regular nursing positions, because we prioritise and demand skilful nursing. The vision and strategy of Zealand University Hospital therefore points out new possibilities of creating positions on department level for

academically educated nurses, partly to increase the competence level within the practice field and provide new options for exploiting this increase in competence, and partly to present new career paths as well as ways to retain and recruit employees.

THE VISION IMPLEMENTED WITHIN THE SURGICAL DEPARTMENT

POSITION STRUCTURE

Within the Department of Surgery, we have implemented the strategy to a plan of how we want to use the academically competences within the clinic. So far, we have created 14 new nurse specialist positions for continuously educated nurses, and in the summer of 2021, ten of these were occupied.

Within the Department of Surgery, the first objective is to have two specialists in the fields of each of the ward managers. We currently have two positions in each ward and one in our stoma outpatient clinic, with plans of further positions in the outpatient and endoscopy department. We work with a ratio of 80% clinical work and minimum 20% for development and research work. The nurse is employed in accordance with this ratio, and it constitutes the common foundation of the whole department, enabling uniform conditions for all clinical nurse specialists. We know from experience that the ward manager occasionally may need to prioritise differently, for example in the ratio 60/40. Such agreements should be clarified between the ward managers and specialists (Kilpatrick et al., 2016). Weekend work and other shift work is part of the positions to ensure that the academic competences are used during all the shifts. Nursing is primarily conducted within direct patient care, and we want to strengthen patient care in this encounter. The specialists should therefore be present, where patients require them to be. Experience shows that presence in clinical practice is significant to the function of clinical nurse specialists. It is crucial for the function to be part of the practice environment and observe; both to be able to identify issues, but also to

stay updated on the clinical practice. By participating and being present in practice and by communicating with nursing colleagues, the specialist gains deeper insights in the practice, which essentially is a big help in prioritisation of initiatives that should be implemented, and are of relevance, realistic and of importance for everyday life (Kilpatrick et al., 2016).

Within the Department of Surgery, we work with two employment levels: one on department level and one in staff function reporting to the head nurse. On department level, the clinical specialists come from a background with a relevant Master of Science (MSc) or master degree.

The group of master degree graduates primarily focuses on development tasks based on research literature. The other group with a relevant MSc degree focuses on research, development and implementation of evidence. Both groups have knowledge of research literature, research methods and design as well as experience with reading research literature. However, it has become clear that specialists with an MSc degree often are far better equipped in literature search and assessment of research literature.

Doctorate level specialists work 100% with research and the tasks connected to this field. However, we have decided that doctorate level specialists and training officers continue to report to the head nurse, since they - apart from in their daily work - also contribute to leadership feedback with the head nurse and connect strategic lines with operational actions (Kjerholt & Sørensen, 2013; Petersen, 2018). As to research and development projects, the doctorate level specialists work as mentors and advisors for the specialist group.

The education specialists are primarily responsible for planning and implementing our pre-graduate education obligation as well as for establishing and implementing skill and simulation training of permanent

nurses. Some of the clinical specialists participate as trainers in these séances. The education specialists also conduct interdisciplinary learning séances and are main players in the departments learning strategy. They further receive and process feedback from both head nurses and ward managers.

Placing the clinical specialists in combination positions means that the specialists are better equipped for staying updated on clinic observations and practice wondering and achieve a more natural knowledge base regarding the context of clinical nursing. It is often the case that collective wondering over the existence of a phenomenon leads to uneven handling of problems, and that the selected nursing actions depend more on personal preferences than on the evidence at hand. The competences of the clinical specialist may then work as a bridge between theory and practice and contribute to maintaining an evidence-based approach and culture. A study conducted in 2016 showed how newly educated nurses quickly lose their academic competences for the simple reason that they adjust to the practice, which newly educated nurses become part of (Voldbjerg, 2016). This could be interpreted as practice not being aware of and not being explicit in the use of evidence.

THE DEVELOPMENT OF NURSING AS TO EVIDENCE-BASED PRACTICE AND A HIGHER LEVEL OF SPECIALISATION

Good quality nursing entails requirements for the professional competences and skills of nurses to navigate organisational in a complex healthcare system. There are many challenges for professional logics. Specialisation and efficiency have on several occasions challenged the classic holistic approach of nursing to the patient situation, since specialisation is often connected to the current illness and specific admission process, whereas the holistic approach of nursing also includes a before and after, and you must think across sectors.

Within the Department of Surgery, we work within a person-centred framework with an individualised patient approach. We go from standardised care to conscious differentiation of preventive and follow-up care. We work target-oriented with nursing as to becoming explicit on when, why and on what background we differentiate between planned and provided care. This entails requirements for the professional nursing assessment and subsequent planning prioritisation. To differentiate between standard and individual nursing needs requires extensive, exact knowledge about patient groups, illnesses and nursing. This knowledge is gained by examining and documenting the effects and importance of the conducted care. As initially described, we are still quite an immature professional research group, and our clinical practice is characterised by this new tradition.

We know from experience that despite the increasing needs, it is challenging to implement evidence in everyday practice (Kjerholt & Sørensen, 2014). We know all the excuses about the lack of time and resources - including the presence of the right competences. The ordinary nurse often has no experience with implementation of evidence and is lacking role models, who can lead the way. Missing leadership support and prioritisation may also contribute to slow implementation. The academic role models struggle, not only with the aforementioned barriers, but also with an "anti-academic" nursing culture and acceptance from interdisciplinary partners, for instance physicians (Berthelsen, 2020).

Before we can declare evidence-based nursing existing in practice, nurses have to be aware of what evidence-based nursing means and includes, and what continuous processes and academic approaches are required in order to use and develop evidence in practice (Berthelsen & Hølge-Hazelton, 2017; Scott & McSherry, 2009).

Further, other factors are of significance to evidence-based work, for instance the access to literature in the form of professional nursing and

medical journals as well as practice-near office facilities and computer access for easy access to scientific literature. Inhibiting factors may on the other side be that the most important knowledge sources base on experiences of colleagues or intuition (Eizenberg, 2011; Kilpatrick et al., 2016).

THE ROLE AND TASKS OF CLINICAL NURSE SPECIALISTS

The function as clinical nurse specialist has been a matter of intense debate. In literature, there seems to be consensus on the areas of work of a clinical nurse specialist (Fulton, 2014; Jokiniemi et al., 2021). The Danish Health Authority defines the function as follows:

> *"Clinical nurse specialist is prepared at the masters – or doctorate level as a clinical nurse specialist and is an expert clinician in a specialized area of nursing practice. The specialty may be a population, a setting, a disease or medical subspecialty, a type of care or of problem" (Sundhedsstyrelsen, 2009).*

Within the surgical department, the clinical nurse specialist function is divided into four function areas based on existing literature:

Table 1 Overview frame inspired by Fulton, 2014, Jokiniemi et al., 2021

Clinical Expert	Clinical Development	Clinical Education	Clinical Research
• **Expert nurse** • **Identify clinical issues** • **Clinical management** • **Bed-side teaching** • **Role model** • **Holistic** • **Quality developer** • **Cooperation, network with other clinical environments** • **Management feedback**	• Manage development tasks • Facilitate and implement evidence • Management feedback • Facilitate quality development/assurance • Facilitate professional development • Cooperation with other practice developers/institutions	• Identify competence requirements • Plan and implement educational activities • Develop education programmes • Assess nursing competences • Cooperation with education institutions • Management feedback	• Duty of research • Distribute research results • Facilitate the use of research results • Cooperation/network with research environments • Management feedback

The expectation for the function of the clinical nurse specialist within the department is that the nurse is actively performing within patient care, behaves as a role model for nurses, teaches nurses/patients/relatives,

has an advisory role for nurses and other professional groups, facilitates development and education, and participates and initiates research.

Clinical specialists seem to be driven by the desire to make changes and improvements, gain knowledge through education and practice, develop competences, receive support and feedback as well as cooperate on developing practice within practice (Rasmussen et al., 2012).

IMPLEMENTATION OF CLINICAL NURSE SPECIALISTS

An implementation process is a change that includes organisational learning processes, which may involve new knowledge and skills on both an individual and organisational level. The process of change within the organisation takes place by means of interaction between the players of the organisation and their values as well as subjective understanding of tasks and roles (Kjerholt & Sørensen, 2014).

For implementation of the role as clinical nurse specialist, direct patient contact and participation in the team around the patient as well as patient work seems to be a significant catalyst (Eizenberg, 2011). Participation in the clinical work promotes acceptance of the role within the team and the clinic-near administrative workplace ensures visibility and easy access to the nursing specialist (Berthelsen & Hølge-Hazelton, 2018; Kilpatrick et al., 2016).

Understanding and support by the leader is crucial. A clear responsibility relationship between the clinical nurse specialist and the direct superior in relation to the tasks of the specialist is an important leadership prioritisation that promotes both clinical leadership (Munksgaard, 2017), organisational clarity and the opportunity of implementing projects. The leader may in this context establish dialogue forums, in which both parties participate in order to initiate discussion and anchoring of new ideas and change (Kjerholt & Sørensen, 2014).

PROFESSIONAL DEVELOPMENT MANAGEMENT

Visible nursing leadership is crucial for clinical nurse specialists to be able to meet the expectations embedded in the function. Implementation of academic thinking in practice requires leadership support, both on an everyday as well as a strategic level (Berthelsen & Hølge-Hazelton, 2018).

Leaders play a significant, facilitating role in succeeding with creating a development and research culture within the department. Leaders should actively initiate new development measures to legitimate that these are prioritised daily alongside regular operations. Bellman suggests that strong clinical leaders should identify, develop and implement initiatives, and that they need to have a background in nursing in order to ensure that the supporting values of nursing are reflected in plans and actions (Bellman, 2002). They can do so, because they are so deeply rooted in nursing because of practice, leadership experience and science. As leaders, they should aspire to create the best possible environment for nursing practice and ensure that all the required competences are at hand within this context in the form of clinical nurse specialists for the mission to succeed. They themselves do not have to master the specific practice, but their background should reflect insight into the profession and framework of possible practice with a research and development culture.

This active leader role may challenge the nursing leaders in terms of their knowledge about research competences. Leaders often have a general leadership education, and general leadership has for recent years been more in demand than professional leadership. Nurse leaders should ensure a process, in which the content and expectations for the specific role as clinical nurse specialists are mutually clarified and adjusted to fit individuals. The nurse leaders should also be aware that researchers have different research profiles, interests, academic ambitions and personalities. These differences may be significant for the continued process of

integrating the function. The role as clinical nurse specialist implicitly includes a high level of autonomy, requiring a more facilitating leadership style. The nurse leader should dare to make room for professional autonomy in order to succeed with the function (Bellman, 2002; Harrington, 2010; Hølge-Hazelton et al., 2016).

It is my experience that the same applies to employment of clinical nurse specialists with a master or MSc degree, meaning that leadership and organisational factors also matter in this regard. The leader is responsible for presenting a professional approach and act as facilitator of development. This way, the leader enables the clinical nurse specialists to transform their newly acquired academic knowledge to work methods within the function as clinical nurse specialists. However, the expectations - and the framework for- individual, specific tasks also seem to be of significance for how the usability of academic competences are experienced.

Employing clinical nurse specialists in the functions above may ensure a culture characterised by research and development in departments for the benefit of patients, since this culture - supported by professional nursing values and systematic methods - may provide nursing with validity. These types of positions are indispensable in conveying of what nursing means to patients and the organisation. If we want to go from the fact that only experienced knowledge controls development, to making control base on combined knowledge based on both research and experience, we as leaders must create the opportunity to develop research-based knowledge generated based on experience from the current practice. To be able to generate research, we as leaders must create positions that require academic competences. The competences must be near the practice to participate in establishing and incorporating the required and relevant research in practice development. The nursing leadership is forced to take part in this development and decide to create such opportunities.

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CHAPTER 6

STRATEGY FOR, EXPERIENCE FROM AND REFLECTIONS ON THE ESTABLISHMENT OF A NURSING DEVELOPMENT AND RESEARCH ENVIRONMENT

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I have worked as head nurse in the Department of Ear-, Nose-, Throat- and Maxillofacial Surgery (ENTMS) at Zealand University Hospital since 2002. In 1987, I became a nurse and furthermore I am holding a diploma degree in nursing with management as area of specialisation from the post-basic school of Nursing at Aarhus University, besides a Master of Public Management from the University of Southern Denmark. The department has gone from being one of several ENTMS departments in Region Zealand to becoming one overall department in 2013. The department merged with the Dental, Oral and Maxillofacial Department (DOM) in 2014, covering several specialist areas and sub-specialities. The department includes a ward, an ENTMS outpatient clinic, an ENTMS operating ward, a DOM outpatient clinic and a DOM operating room in a central operating ward as well as a sleep apnoea clinic and an audiology centre with clinic on four locations across Zealand.

WHERE ARE WE NOW?

In the Department of Ear-, Nose-, Throat- and Maxillofacial Surgery (ENTMS), we have established an organisation based on a strong foundation of nursing development and research. We have employed clinical nursing specialists in every ward; we have employed a nursing head of development and research and a nursing PhD student, working on a research project, and more will follow. This puts us at the forefront of research potentials and opportunities. We have for instance applied for and

received grants for a large international project with both mono-professional and inter-professional research. The description above indicates the status.

How did we get here?

In 2014, the hospital went from being one of Region Zealand's four hospitals, Roskilde and Køge Hospitals, to becoming a "*ground-breaking university hospital with unique focus on patients"*. The hospital had ambitious visions, including the ambition of strengthening research "*… in order to produce significant new knowledge for the benefit of patients and to strengthen the professional insights of employees"* (Sjællands Universitetshospital, 2014).

As we went from being one of several regional hospitals to becoming a university hospital, research gained importance on several levels - also within nursing. It therefore became necessary to create new strategies. The initial strategy for nursing after Zealand University Hospital (ZUH) became a university hospital, "Vision, objectives and strategies for nursing - First-class nursing"(Roskilde og Køge sygehuse, 2015), also included increased focus on development of new knowledge and under the heading *Development, research and evidence-based nursing* the overall objective was that:

> *"Nursing in Roskilde and Køge Hospitals should be founded on the best documented knowledge from research, clinical experience as well as patients and relatives. Treatment and care are patient-centred and based on the local context"*

Further, *"that the required competences for development and research are found within clinical nursing".*

The strategy resulted in increased focus on development and research within the field of nursing and led to employment of several nursing researchers throughout the hospital.

At the same time, the Danish Nurses Organization, created a research proposal called "Knowledge develops nursing" (Dansk Sygeplejeråd, 2012). Here, it says, "*research within the field of nursing contributes with the required knowledge to develop new and improved health services*". It describes that research within the field of nursing is socially relevant and for the benefit of patients, relatives and health professionals, and that research within the field of nursing is a vital part of health research. We need to generate this knowledge and keep developing to strengthen our competence areas and the field as a whole.

Both the regional development at ZUH towards becoming a university hospital and the national focus on strengthening professional competences indicate that professional development and research is here to stay.

The Department of ENTMS has kept a close eye on this development, and back in 2014, I already felt strongly about contributing in a manner that made sense to patients and nurses, both at the hospital as a whole and within the department. In addition, it has been a rocky road to get to where we are now in the department. We had to stop along the way and take detours, and the steps have been quite steep.

In the following sections, I will describe our journey up to this point. Moreover, I will focus on three points of impact that show when we in the department felt like we were seriously progressing.

The first point of impact describes what it meant when the senior nurses (head nurse, ward manager and head of research) of the hospital created a strategy for nursing development and research (Sjællands Universitetshospital, 2020). It was not the first strategy for nursing at the hospital, but indeed the first strategy with a clear research ambition. The next defining thing in establishing the development and research foundation of the department was a nursing theme day that brought together the nursing staff from the different units within the department. The purpose of

the day was "*to create a culture with nursing development and research as an integral part*"(Roskilde og Køge sygehuse, 2015). The last point of impact is about my personal development of preparedness, including the significance and effect of Journal Club[1] and the professional network such as participation in ALS (experience exchange) groups for leaders[2].

The chapter ends with a description of significant challenges along the way; what I have learned from the overall process until now as well as a perspectivation on the continued development of nursing development and research in the department, which of course is a never-ending process.

STRATEGY FOR NURSING DEVELOPMENT AND RESEARCH

When the two Departments of Ear, Nose and Throat merged in 2013, a development nurse was employed. At the time, the department was extremely focused on working with Den Danske Kvalitetsmodel (The Danish Quality Model). Simultaneously, ZUH employed a nursing research manager, and it became clearer and increasingly legitimate to change from primarily focusing on quality work towards gaining greater awareness about nursing development and research. This required a different prioritisation and subsequently a new department organisation. We implemented several good improvement and development projects, but we still needed structured and targeted work on development and rooting of an actual development and research culture.

During the transition process of focusing on quality work towards establishing a development and research culture, I was as head nurse inspired by colleagues at ZUH and other hospitals, who were going through the same process. Different management networks gave me the opportunity to exchange experiences that provided inspiration for moving on. This resulted in me establishing a nursing steering group in cooperation with the

[1] Read more about Journal Club in the appendix
[2] Read more about ALS groups for leaders in chapter 2

four charge nurses at the time, the nurse responsible for education and two development nurses. In the group, we discussed how we based on inspiration and experience from others in the department could establish, root and strengthen a systematic approach to development and research. With the steering group, we wanted to create a solid foundation in the department to be able to meet the hospital's vision for development and research.

In 2015, we created the "Strategy for development and research in nursing within ENTMS". We agreed that in order to establish a real development and research *culture*, the nurses of the department should "feel it" (Manley, 2017). It should be possible for individuals - by means of personal reflections - to provide ideas and be part of the creation of projects as well as their implementation and still be a practical nurse in the department.

In the following section, I will describe how the nurses in the department reacted to the initiatives planned by the steering group.

NURSING THEME DAY IN THE DEPARTMENT

The vision was the basis for establishing a development and research culture in the department. It was launched during a nursing theme day in October 2015, whereupon it was adjusted and published in its final form.

The nursing steering group created a schedule for the theme day; we started with a presentation of the department's strategy, followed by a lecture about possibilities and challenges within the field of nursing development and research. A nursing researcher who at the time had been employed in another department at ZUH for a few years and was able to contribute with practical experience held the lecture. She presented a well-tested project description template that included a research question and project background.

The overall idea of the day was based on the defined strategies: W*hy*: describes how the work as to fulfilling the strategic objectives could be conducted. H*ow:* with a presentation from the nurses of the department. W*ho:* with a presentation of projects implemented by the nurses of the department; all to demonstrate to the nurses of the department that we are well on the way, and it underlined that development and research is indeed possible while also working in clinical settings. It further became apparent that it did not require a completely new culture - the foundation was already at hand.

The schedule then made it possible for the nurses of the department to brainstorm ideas for development and research projects; thereupon, they selected two or three projects to work on. The purpose of brainstorming was to show the nurses that their ideas had development potential, to make them want to work with development and start systemising ideas into the generic project description template, which the nursing researcher had presented to us. We have since continued working with the project description template, and we continue to use it as a tool to ensure that we cover all aspects: from curiosity to examination and effective mediation of the acquired knowledge.

The room was full of energy all day long, visualised by reflections and discussions on nursing and wondering as well as wishes for improvements. The evaluation further indicated a distinct positive development in terms of motivation for working with nursing development within the department, and the nurses were looking forward to working on the projects, which they had contributed to defining during the day.

In the future, we wanted to work on the areas and tools presented during the day – for instance a common template for project descriptions. The nurses of the department quickly accepted the template; they regarded it to be a great help when creating drafts for project descriptions. Presentation in front of colleagues within the department was a challenge for

some, but they still saw it as a safe place to mediate the knowledge generated by a project. They took on the task of conveying their knowledge by means of posters and verbal presentations with humility and pride. It gave a fantastic sense of community and the experience that we also could 'contribute with something', which was extremely important for the development and research foundation and culture that was growing fast within the department.

It became clear that the foundation for developing culture in the direction of development and research already existed in the department. The nurses used the day to inspire each other. The synergy created has been an invaluable source for "going back" when everyday life became difficult. The desire to improve and develop grew and unfolded. Later, we had to practice not to launch too many projects at once, and we had to learn how to evaluate and implement our new knowledge. The subsequent changes to work processes became an integrated part of the process (Manley, 2017).

The department participated at the Interdisciplinary Symposium at ZUH in 2016 with three posters and a presentation. We further participated with both lecturers and posters at the ENTMS symposium as well as the annual meeting for ENTMS nurses. All this underlined the development, which the department was undergoing.

As nursing development and research within the department took off, I realises that I lacked specific competences in terms of development and research management, and no other staff member was qualified. Over time, it became clear that we needed someone capable of being both a catalyst as well as a facilitator.

In the following section, I will describe how I became aware of what and whom we needed to make sure that the department gained the required competences.

ORGANISATIONAL DEVELOPMENT OF PREPAREDNESS

The third point of impact, which has been of great significance to management decisions, was my participation in Journal Club (JC) in 2016 with other managers of the region with focus on *management of research and development* (Kjerholt & Hølge-Hazelton, 2018).

It made me understand that continued education within the department did not require "a researcher to be" but the skills of a professional researcher. It further became clear what type of researcher the department needed.

After participating in JC, addressing my network of other managers and after discussions within the management and nursing steering group in the department, it became clear that a person currently training to become a researcher already had plenty of work in terms of education, and such a person would not be able to handle the department's needs. We needed a person capable of facilitating development and research projects and processes. The department was in need of a person capable of driving development and research, as well as creating change in practice and document knowledge. My many reflections made it clear that we needed a professional head of research with a person-centred approach who could focus on practice development and patient inclusion and had experience with project fund application.

Apart from our need for a head of research, we also needed development and research to take place among our clinical nurses who worked close to patients. The strategy therefore included a plan for employment of nurses with academic backgrounds as clinical nursing specialists, with about 50–60% clinical work and 40-50% development and research work. Being academically trained nurses, they can read and understand the relevant literature and develop projects etc.

This process changed my own and the heads of department's perception of the need for professional skills within this field. We decided to create

a position as manager for nursing development and research, once we had the opportunity and we created a position as clinical nursing specialist in each unit.

Even though we now had a plan for strengthening nursing development and research, we knew that challenges would arise along the way and a head of research must be able to face them. The following section describes some of these challenges.

CHALLENGES

Of course, challenges arise along the way, and especially three types of challenges affected the progress as to the department's vision for nursing and the work of integrating development and research in the culture: budget adjustments, staff changes and vacancy handling on manager level.

We experienced budget adjustments (savings) several times - each time, they would result in reduced nursing staffing, which naturally made us focus on staff reactions and changes - not only among nurses but also throughout the department. It has a severe impact on the work environment, employment safety and task procedures etc. It takes a long time, and everyone focuses on figuring out and accepting the new department situation.

Staff changes among ward managers also affect the progress of the nursing development and research culture. During staff changes, some employees will have to take the lead as to focus areas, as new employees do not have the same knowledge of visions and strategies as former employees. The community feeling created within the leader group is gone and must be re-established.

It is important that you as head nurse know you must support your ward managers in different ways, since they have different competences. As a

new head nurse, you will primarily focus on your own unit and less on the department.

I have due to vacancies for longer periods during the process been responsible for handling several management roles, for instance during a long period without a chief physician, resulting in a lack of focus. The focus of employees follows the focus of their leader.

All these challenges change focus to holding everything together; management becomes increasingly operational and less strategic.

It requires persistence, risk-taking and courage to maintain the strategy of employing a head of research, when new head nurses and ward managers insist on nurses for handling patient care. However, if we as a university hospital department want to succeed in meeting the visions of the region, ZUH and the department, we need to hold on.

The heads of department and the nursing steering group participate in the upholding of the strategic objectives - an important tool to ensure focus on the specific task, which the department also has to succeed with: nursing development and research.

LEARNING

In 2016, we employed our first clinical nursing specialist. In 2018, the first nurse started a PhD project and in 2019, we employed a nursing head of research responsible for development and research. In 2021, we were granted several millions for a large international project with our head of research in charge.

Employing clinical nursing specialists and a head of research is not the answer to everything. We employed a nursing head of research at a time of change in the department. It was not an easy period for her to establish relations and acceptance within the department. The position as head of research may therefore be somewhat lonely, since the staff in a clinical

department consists of very few persons and the employees do not have any significant work groups. It required several discussions to ensure a collective understanding, close relations and a consensus on the direction of the department.

We are still working on creating the right organisation and optimal work routines. I believe that we must tread the path together and create and learn from experience.

However, I am convinced that we have created the right model, with clinical nursing specialists in the units who also have clinical patient care tasks and not just play a department staff role. We still need to see the full potential, but we work with the awareness of coherence between units and the department, as we acknowledge that some projects require inter-unit cooperation, and some projects relate to individual patients.

We have worked on finding proper solutions for how to utilise the competences of the clinical nursing specialist optimally. We know that we in some situations will feel uncertain as to what the head nurse is to decide and what the head of research is to decide. We are therefore testing whether it makes sense to formulate questions such as ’what’, ’when’ and ’how long’ for the head nurse, and discuss questions such as ’how’ and ’why’ with the head of research. We see the value in collective focus on maintaining coherence between our steering group and the units, and in incorporating the improvement and quality competences of all clinical nursing specialists for the benefit of the whole department. This results in interesting discussions, including disagreements that require resolving. It is about being part of a great team – and about development.

We have established a solid foundation and are climbing a solid ladder, which supports and manages the nursing development and research culture. Further, we have the ambition of “building a bridge” to other professional groups in terms of development and research. We hope to make this become reality in the upcoming international project.

Where can it lead? I will describe this in the next section.

PERSPECTIVATION

We are currently focussing on the professional strategies for nursing development and research, but the next natural step will be strategies for the department. How, when and what influence it will have, will be interesting to see. The department will gain a great deal of experience in the time to come. However, I am sure that with the establishment of a sound mono-professional network, we will have plenty to offer in terms of an inter-professional strategy.

The next important step on the road of nursing development and research is for the clinical nursing specialists in the units to facilitate more development tasks, including some of the interdisciplinary projects to give the research manager time for research tasks as well as guidance and mediation of knowledge in publications and at national and international conferences. The objective is to affiliate more nursing PhD students with the department, since we need more knowledge about more fields within nursing. Moreover, we want to and can contribute to this.

Finally, I want to point out that the work of implementing new knowledge and the learning, in which it results, is a task that requires continued focus. The knowledge generated should always be of benefit to the patient and this is only possible upon implementation.

New perspectives and challenges will continue to arise. It is a kaleidoscope: movements break with old patterns and create new, beautiful colours and patterns that continue to change.

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CHAPTER 7

THE ROLE OF A WARD MANAGER IN KNOWLEDGE SHARING IN A UNIVERSITY HOSPITAL

Author: *Patricia Vallebo Lindhardt, Ward Manager, Medical Department*

I became a nurse in 1998 and have experience from the geriatric, cardiology and endocrinology departments. I have been a ward manager since 2005; I got my Diploma in Management in 2011 and my Master of Business Administration in 2018.

In this chapter, I will concentrate on my master's thesis from 2018 and relate it to my everyday practice during the period from 2020 to 2021. The overall objective is to describe my management reflections, actions and visions in terms of developing a practical research and development culture. I chose the period from 2020 to 2021, since COVID-19 represented a challenge to the field of management in a completely new way, partly due to the extreme time pressure and partly to the pressure on employees who did not necessarily choose to work with patients with COVID-19. COVID-19 also became a new context to me, in which I had to work as a ward manager.

WHY IS IT IMPORTANT TO ME TO WORK WITH KNOWLEDGE SHARING?

During my master studies, I became interested in management - especially in how human interactions influence organisational objectives. In my master's thesis (Lindhardt, 2018), I devoted myself to knowledge sharing and the conditions required to promote knowledge sharing in a university hospital from a management perspective. My workplace

changed and went from being a local hospital to being a university hospital. Being an employee in a university hospital, you expect an approach based on development and research as well as application of the best and newest knowledge. The amount of available knowledge is vast, so how do you ensure a wide awareness of new knowledge among management employees, to create everyday inspiration and support practice development and maybe even research?

While working on my master's thesis, I was a ward manager in a ward with an outpatient clinic and my team worked in shifts. This may constitute a challenge in terms of effectively ensuring knowledge sharing and conveying relevant nursing knowledge and developments to everyone. Something, which I will describe later in this chapter.

On this background, I decided to examine what knowledge sharing really is, how knowledge is best shared and what management considerations you should make in this regard. In my master's thesis, I worked theoretically, but in this chapter, I want to focus on a specific kind of knowledge - knowledge within a department in form of instructions, guidelines and strategic objectives - knowledge systematised by others as in the case of COVID-19. Not the knowledge, directly demanded by employees but knowledge, which the organisation requires implemented in practice. I do so, because this form of knowledge and application of this knowledge form has been highly topical in terms of handling knowledge during COVID-19, where an important management dimension is the ability to act as facilitator of new knowledge to ensure best practice that is essential in terms of patient care and treatment.

The structure of the chapter:

I. Knowledge roles

II. Knowledge sharing as a process

III. Barriers in knowledge sharing

IV. Further reflections on my role as ward manager

Where it makes sense, the chapter will draw on my experience as ward manager during the first wave of the COVID-19 pandemic. Theoretically, I refer to Christensen's book *Bedre Videndeling* (Better Sharing of Knowledge) (Christensen, 2016). For those interested in further references, please refer to my master's thesis (Lindhardt, 2018).

I: KNOWLEDGE ROLES

Knowledge is a complex concept and can be broken down into different roles: the professional, coordinated and social role (Christensen, 2016). The knowledge role is important to identify what and where the knowledge sharing is required.

Within the professional role, knowledge is based on experience and most often characterised by being implicit knowledge, which can be converted to explicit knowledge by using the right social relations (Christensen, 2016). As part of my master's thesis, I examined the factors required for employees to be able to convert implicit knowledge to explicit knowledge. Terms such as confidence, comfort and knowledge of each other are consistent to activate the professional knowledge role. The existence of a social relation is crucial for employees to use their professional role.

The coordinated role includes knowledge about work tasks and processes within the smaller units of the organisation, and it has to be structured in

order to ensure that the tasks of individuals make sense to individuals as well as the unit as a whole (Christensen, 2016).

The social role of knowledge is to ensure a sense of belonging between colleagues and leaders, and should further ensure that employees are informed about the objectives and strategies of the organisation (Christensen, 2016).

I use the professional role in everyday interaction with employees and colleagues, where my experience becomes explicit knowledge through supervision and training. In relation to employees, I use the professional role while observing nursing and asking about professional nursing considerations. It is reflection on their and my own nursing practice.

During COVID-19, new instructions were almost issued daily. I used the professional role for these instructions in my supervision of the nurses in the department, and of both permanent and temporary nurses. I also experienced how the professional role was used, when I received instructions for new equipment, whereupon I instructed the department staff. These instructions related to knowledge on work tasks and how to solve them by using the coordinated role. We would for instance create a task description for the reception of COVID-19 patients, ensuring that everyone knew what to do and when - from blood pressure readings to swabs for tracheal suction. We focused on optimisation of the interdisciplinary cooperation on patients with COVID-19 to utilise everyone's resources optimally.

I applied the social role by conducting staff and team meetings, where we focused on cooperation and a common culture, and conveyed strategic messages. The social relation is strengthened during staff and team meetings, making use of this role of knowledge to increase knowledge sharing within the organisation. During COVID-19, I introduced a common presentation round during shift changeover, where everyone would state

their name, education, place of employment and experience. This was of great importance to cooperation during the shift and the entire period, and it invited for dialogue between all parties involved. During COVID-19, I experienced that my ability to use these three roles made sure that all employees received the relevant knowledge.

II: Knowledge sharing as a process

Knowledge sharing is a process, which takes place between people. Technologies can promote and support knowledge sharing, since knowledge is easy to copy, and technology can help distribute knowledge to many people simultaneously. Knowledge is an important resource and knowledge sharing helps increase organisational efficiency, since the organisation achieves its objectives by means of community and cooperation. It is therefore important that employees cooperate in sharing best practice knowledge. Knowledge sharing is about the knowledge of the organisation and individual as well as about how the individual and the organisation can benefit from that knowledge. Knowledge sharing therefore requires efforts from all individuals within the organisation. These efforts especially depend on the motivation of all employees. Psychological factors that increase internal motivation include meaningfulness, responsibility and feedback (Christensen, 2016; Mullins & Rees, 2013).

Knowledge sharing includes three processes: Identification of knowledge, transfer of knowledge and use of knowledge.

Identification of knowledge

As to the form of knowledge described here, this process means that I as ward manager must be aware of and reflect on the knowledge I have acquired when I am informed about new guidelines. Will the staff or patients benefit from the knowledge? Can it be of importance to others? And who could these others be? My staff, colleagues or my superior?

When I receive new information such as guidelines, I read it through repeatedly to identify the purpose, process and target person of the specific guideline. This enables me to assess, whether it will result in changes of the current practice, and if so - how and for whom it is of importance.

TRANSFER OF KNOWLEDGE

In my everyday life, transfer of external knowledge, for instance in the form of guidelines, depends on the kind of knowledge and who these guidelines are meant for. My mediation of knowledge is based on my identification of the knowledge. A specific example is from spring 2020, where COVID-19 hit the country and new guidelines were issued regularly - sometimes even daily. It was crucial that this knowledge was quickly conveyed to the employees at a time where everyday life meant that employees did not have time to read their emails. At the beginning, I therefore described new guidelines in a common forum during shift changeover in the morning and afternoon for everyone to be able to ask questions, and to make sure that everyone was informed. Later, I started delegating the task. I made knowledge adjustments, meaning that I identified the new knowledge and transferred it by means of different mediation methods, including comprehensive newsletters containing the relevant knowledge, verbal transfer and possibly visualisation of equipment use. This way, I made sure that everyone was informed at the right time and in the correct manner. I was also able to determine, whether the knowledge required further clarification, and possible misunderstandings were quickly resolved.

It is my experience that knowledge sharing with other managers can often be transferred unprocessed, whereas transfer of knowledge to employees requires considerably more considerations for knowledge to be used in the specific context and converted into operational practice.

USE OF KNOWLEDGE

In terms of the process related to use of knowledge, it may be difficult, since it can be hard to make things work alike everywhere. It may lack adjustment possibilities, since knowledge is complex, and it will be impossible to expect that "one size fits all" (Brown et al., 2010; Christensen, 2016; Rycroft-Malone et al., 2004).

I believe that in the sense of the use of knowledge, it is important to be critical as a manager in terms of what knowledge is useful in the specific department. Local adjustments may often be required for knowledge to make sense. If it does not make sense, it may result in decoupling of employees; the employees will stop taking in new knowledge and ignore it consciously, if they do not see the sense in it. This will leave new knowledge unused in practice.

New knowledge such as guidelines and instructions are affected by the values and competences of the individual nurse in combination with patient values and preferences, when nursing is based on the patient's need for care. It is all about the internal motivation and sense-making of nursing in everyday life, which managers can stimulate by providing the nurse with feedback on the implementation of nursing tasks (Brown et al., 2010; Rycroft-Malone et al., 2004).

In relation to COVID-19, every shift could require demonstrations of the practical use of equipment, protective measures and the like. The demonstration involved all three processes of knowledge sharing. Practical demonstrations were used as an effective supplement to knowledge sharing. This also ensured that all employees received the newest knowledge, regardless of whether they just had time off or were on shift.

It is my belief that when sharing knowledge about guidelines, instructions etc. with employees and other managers, I get the opportunity to contribute positively to the process of knowledge sharing for the message to

be facilitated in practice based on the competences and needs of the recipient. Especially when I have completed the three processes of knowledge sharing well, I experience the success in the actions of employees and colleagues. I hope that this approach to knowledge sharing will cause a ripple effect and inspire other effectively to share knowledge based on a reflective approach for facilitation of "best practice", since it is important for us as an organisation to succeed in providing our patients with the best care and treatment.

III: Barriers in knowledge sharing

According to theory, knowledge sharing holds three barriers to be aware of: individuals, management and technology (Christensen, 2016).

Individual barriers include personality traits, meaning that introversion and extroversion are of importance to knowledge sharing. The manager must be able to understand and consider the personality traits of employees in the planning of organisational knowledge sharing. Individual barriers also affect the relation between employees of the organisation, and the relation can constitute a barrier for organisational knowledge sharing (Christensen, 2016). Introvert individuals may for instance see extrovert individual as forceful and insistent, which may affect the relation and result in less ideal knowledge sharing conditions.

The process of knowledge transfer further includes mediation of knowledge. I try to be attentive of the personality traits of my employees. My extrovert employees respond instantly to knowledge and mediation, whereas my introvert employees are more reluctant in stating their opinion and perceiving/understanding. I therefore often go back to these individuals to make sure that they fully understand the message.

I further include the assessment of the personality traits of my employees in the task assignment, for instance in terms of colleague training, where extrovert employees feel comfortable in the role as mediator. Introvert

employees will often prefer peer-to-peer training. I regard this process to be important for a manager to support employees optimally in knowledge sharing.

Management barriers in knowledge sharing are in theory described as missing mental resources for practical reflection, for seeking new knowledge, for sharing new knowledge or for creating new knowledge (Christensen, 2016). As managers, we are responsible for fulfilling specific operational objectives. Many tend to range fulfilment of operational objectives in line with optimal resource exploitation. I also used to have this somewhat biased approach. However, in the last few years, I have started to see the world in another way to be able to create a room for knowledge sharing and thereby an interest and passion for development and research. This new way of thinking has evolved in line with my development as ward manager with management experience and education.

It is my responsibility as a ward manager to plan/provide the required settings for knowledge sharing among employees to make it possible for the organisation and employees to fulfil specific objectives. A ward manager must dare take on this task. I try to plan regular meetings to provide the settings for knowledge sharing, where knowledge includes treatment strategies and work processes.

Knowledge sharing should be considered an investment, meaning a cost right here and now, but with the possibility of creating greater value in the future for the organisation as well as the individuals within it.

The management challenge is in other words the ability to balance between leadership and management. Leadership focuses on development, employee motivation, social relations and facilitation of knowledge sharing, making the task solving in line with the organisational strategy (Christensen, 2016). Management focuses on day-to-day operations and meeting deadlines as well as ensuring that all the required resources are at

hand to solve the tasks (Christensen, 2016). Management indicates measurable parameters, but knowledge and knowledge sharing are not measurable parameters, since it is impossible to measure the quality of knowledge sharing, which I as ward manager must be able to contend and uphold the importance of, even though the quality of knowledge sharing is not objectively measurable.

Technological barriers include the use of IT systems and the lack of training, which may contribute to reluctance against IT systems. We often overestimate the possibilities of knowledge sharing by means of technology. It is important to establish a social environment and knowledge groups that encourage knowledge sharing. Forwarding emails does not automatically mean that the email is read and understood as intended. It requires critical assessment of the use and transfer of knowledge (Cabrera & Cabrera, 2002; Christensen, 2016).

The technological barriers became apparent during COVID-19, when new temporary nurses faced new screen displays used for patient care processes. However, the barriers were quickly eliminated, because the nurses were eager to learn a new way of documentation and finding information.

IV: Further reflection on my role as ward manager in knowledge sharing, including how it can support the development culture within my department

As ward manager, I provide the settings for how external knowledge such as guidelines and instructions are shared on an everyday basis and across shifts. I regard technology to be part of the solution, since it can ensure that everyone receives the same knowledge/information simultaneously. However, technology can as described not stand alone.

Experience has taught me that subsequent verbal discussions and/or peer-to-peer training, depending on the recipient should support written

knowledge sharing. It requires that you know your employees well. Employees, who feel safe and comfortable with each other, will also tend to discuss new knowledge with each other in terms of interpretation and common understanding.

The importance of interpretation became clear to me during my master's thesis. It became clear that my staff felt insecure about the difference of the terms nursing research and nursing development, and whether research could be separated from development.

This resulted in me initiating discussions about the terms, which have contributed to everyday reflections among employees and colleagues. I experienced that this led to increased attention to nursing development including knowledge sharing as well as evidence-based knowledge. Some of my nurses now come to me with ideas for patient care development-projects. We have further established a nursing conference, where nurses present patient cases and incorporate relevant treatment guides and guidelines.

As a leader, you must be aware of your wishes for the research and development culture in your department. You should know how to incorporate employees in research and development, since this will result in increased dedication, professionality and work satisfaction. As ward manager, I have leadership responsibility and must ensure coherence between employees and the organisational vision for research and development, and I should contribute to creating a meaningful research and development culture. I find this work incredibly exciting, challenging and in line with strategic management.

Afterword July 2024

It has been 3 years since I wrote my book chapter on the role of the ward manager in knowledge sharing at a university hospital.

The foundation for knowledge sharing is security and relationships, where the role of facilitator varies depending on where in the operation you, as a leader, find yourself. During COVID, there was a lot of knowledge sharing directly in the daily operation (direct interaction with all employees).

Now, under normal circumstances, with the same staff group and familiarity and security in the tasks, it is about facilitating and creating increased security. This creates the capacity to be curious about other ways to approach nursing tasks and to share knowledge across the region and the country instead.

It is largely about creating the framework for establishing meetings, and time has made the virtual meeting room a natural part of our everyday life. This makes it easier to create and maintain relationships across Region Zealand and the other regions. Virtual meeting rooms and webinars have indeed gained ground in recent years in terms of knowledge sharing, which gives new considerations for managing knowledge sharing in the virtual world. However, physical communities remain very important for knowledge sharing, and virtual communities should be used as a supplement.

My leadership focus will be to maintain an overview, as knowledge is now shared much faster than three years ago. At the same time, I want to use the enormous virtual knowledge, which is more easily accessible, constructively in our local communities and relationships to ensure that everyone participates in the knowledge sharing.

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CHAPTER 8

LEADERSHIP – LET EMPLOYEES SPEAK AND BE HEARD

Author: *Britta Louise Schack, Ward Manager, Department of Haematology*

I work as a ward manager in the Department of Haematology, section M. I became a nurse in May 2002 and started working as a nurse in the Department of Haematology at Rigshospitalet. It was my dream job, and I often said that "they have to carry me out with my boots on". However, I decided to move on to new challenges, when I was presented with the unique opportunity of participating in the development of a newly established Department of Haematology in Region Zealand in June 2011. As the chief physician said: "It's like building a new Great Belt Bridge" and that is just what we did. In 2011, I started working as assisting ward manager and one and a half years later, I became a ward manager for what was going to be - and today is - section M. The section includes 40 employees within an in-patient ward, outpatient clinic and a day unit. I hold a Diploma in Management from 2015 and am currently finalising my Master of Public Governance.

"Aesthetic/expressive rationality is about understanding. Understanding yourself, other people, the outside world and social coherences. It is not aimed at achieving results, but towards mutual understanding and in conversation" (Scheel, 1994)

INTRODUCTION

This story is about how I as a ward manager - and person - was inspired by Merry Scheel's theory of "interactional nursing practice" (Scheel, 1994) and of practicing an actor-involved and person-centred approach to leadership, research, development and learning. It is also about how I

incorporated and used this approach in the establishment of a learning and development culture within the department.

Merry Scheel's theory of "interactional nursing practice" is a practice discipline, meaning that theory and practice are closely connected and affect and develop each other. The theory is based on practice and practice can change theory, making it a circular process. Practice is therefore theoretically justified practice = interactional practice (Scheel, 1994).

An actor-involved and person-centred leadership approach is a unique opportunity for practical development. However, it is also a challenging and difficult approach, since the leadership framework is versatile and unpredictable. Mistakes are interesting with this approach, and vulnerability and openness are strengths. In nursing - or at least within nursing leadership - we are often used to the opposite. Mistakes are considered signs of failure, and vulnerability, openness and the lack of knowledge are results of poor and faulty leadership. In my opinion, it is the other way round, since this approach promotes responsibility, commitment, learning, development, work satisfaction, community and well-being. I see it in my own department in the form of few resignations, high social capacity, extremely low absence rate (1.74%), high professionalism and extremely high patient satisfaction. The approach has taught me a great deal and I will gladly share my experiences. But first, we must go 11 years back - back to 2011, where it all began.

My background & the beginning

I started working in the Department of Haematology in what was then called Sygehus Nord and later became Zealand University Hospital, Roskilde on 1 June 2011 – initially, as assisting ward manager and subsequently as a ward manager for nine years. Prior to this, I worked as a registered nurse in a hospital in the Capitol Region of Denmark. My everyday life was structured and quite predictable. Values, strategies and visions were developed and written down by the leadership team. Further, the

leadership team got ideas for development, made all the decisions and organised the structure. I did not question the organisation of the workflows, since I was not aware that it could be different.

When I came to Roskilde, the department did not have any written nursing values or strategies. I kept asking the head nurse at the time, what we/I was to do, and he answered: "We will find out together". I remember that I found his answer strange. He should find out. He was in charge and was supposed to tell us what to do. But he wanted us, the nursing group, to create a person-centred, actor-involved and innovative culture of learning, development, research and practice together (Kjerholt & Sørensen, 2013; Sørensen & Kjerholt, 2013). We were to develop a practice culture based on humanism, in which individual opinions, values, wishes and needs were acknowledged and incorporated in decisions concerning care and treatment. At the same time, we also were to develop an inspiring culture that would make employees feel that they have influence on their working conditions and feel responsible for developing their own practice (Kjerholt & Sørensen, 2013). Practice should be relevant for the actor/employee, patients etc. and it was therefore essential that ideas for development and research arise from and in practice and by practitioners, and that we together qualified, created and challenged the processes along the way.

However, we could not do it alone. We needed knowledge. A nursing researcher/postdoc focusing on action research and practice development was therefore employed (Kjerholt & Sørensen, 2013).

Upon employment, several common dialogue meetings with the complete nursing group were conducted with presentation and discussion of the background, purpose and reference frame of the desired practice development. For instance, we discussed how to establish the desired practice culture collectively, what the individual terms meant, what reference frame meant to us individually etc. Together, we created a logo for the

establishment and development of the actor-involved practice culture, which we wanted to build.

Figure 1 Logo for Unit for Nursing Research/Development (Kjerholt, 2020)

The logo illustrates that "together, we will find the way". It further illustrates that while finding and following the way, we will face unforeseeable events (illustrated with rain, clouds, hills and rainbow), which we collectively will address and act upon (Kjerholt, 2020). Today, we proudly use the logo on all project reports, annual reports, posters, presentations etc.

I remember thinking "this is nonsense, it does not work. It seems too laissez-faire" when I first was introduced to the terms of action research, learning and development and actor-based leadership. I did not understand it and was afraid of the unknown, since it was uncontrollable. What if I had to say, "I don't know"? I would look ignorant and make myself vulnerable.

In the beginning, it was very hard when I had to "let go" and accept that I did not know everything and was not supposed to know everything. The

leader is an actor as well, and the actors collectively shape reality (Kjerholt & Sørensen, 2014). Weekly one-on-one interviews with the head nurse and several dialogue meetings in the nursing group quickly taught me that it is the "right" leadership approach for me.

It is easy to control and make decisions for others. It is more difficult to share responsibility and leadership, be vulnerable, delegate tasks and wait for others to act. Today, I am dedicated to actor-based leadership; it has become part of my DNA. It is still very difficult. It may even be the most challenging leadership approach ever. I learn something new every day, because I make mistakes and do not know everything. Yes, I even make a fool of myself, drop a brick, am totally wrong and every time, I become wiser.

Nursing leadership and current challenges

Leadership and the concept of leadership have over the past 100 years developed from an authoritarian concept, meaning that the owner of a company, typically a man, had the sole leadership rights. They did their job - made the machinery run and assigned tasks. Employees were the means to an end. It was not possible to study Management, but only to learn from your "master". Otherwise, work was done as usual. Today, we have a democratic leadership concept, allowing employees to have more influence, and qualities like respect, equality, community, involvement are of value. Today, leadership is considered a land of milk and honey – and, for some, a labyrinth of different leadership styles/directions, leadership tools, theories etc. as well as vast educational possibilities (Johnsen, 1999). It further seems that being a leader is a challenging task, due to the transformation of the public sector with New Public Management (NPM) - that many do not consider "dead" - and because leadership over time has become increasingly more complex. Leadership often entails frustrations about the fact that all the knowledge in the world cannot prepare you for the challenges of leadership and the complexity, which you face every day as a leader. It is often difficult and it requires courage

to be a leader and have the guts to stand by the leadership style and leader you want to be (Dencker & Viereck, 1999).

According to Dencker, we live in the age of spectator awareness, characterised by life being perceived as a film. Future nursing leaders must be able to participate in "improvisational theatre" and be able to handle sudden and unforeseen changes to the organisation (Dencker & Viereck, 1999).

New Public Management (NPM) has for the last 30 to 40 years been the preferred governance regime within the public sector in Denmark - and it probably still is. It was established to create increased efficiency, quality and enable strategic leadership and more transparency (Gjørup et al., 2007). However, have we got that? According to Rasmus Willig, we are being weighed and measured in all we do, and everything not according to standard or within a specific frame, is criticised. But what about individuals? What happened to the voice of employees, patients and relatives? Today, we have standards for the sake of standards and they are in charge, telling us how to do our job (Willig, 2012). With NPM, the public sector has been tied up with control measures, and constructive criticism has become a mean of control, which seems strange, since the initial idea of NPM was to create innovation within the public sector.

The challenges, which society and the public sector face today, are almost the same challenges as those, which NPM was to solve. There are countless ideas for solving these "new"/old challenges, for instance by means of LEAN and performance management[1]. Kenneth Jørgensen does not regard LEAN to be the solution (Jørgensen, 2007):

[1] The big news of the day was Monday, 5th January 2015 in Politiken "performance management". Minister of Finances, Bjarne Corydon praised the new initiative, which meant that the police, schoolteachers and government employees were to be weighed and measured, and that salary and promotions should match performance levels. It was all about "carrot and stick".

"However, it seems unlikely that LEAN can contribute to fundamental changes. LEAN requires standardisation of objectives, procedures and operations (…) Yes, it may just be a tool, but it is still a poor tool" (Jørgensen, 2007, p. 3)

Instead of thinking of standards, Jørgensen suggests that public organisations ask themselves, what it takes to solve complex and unique situations.

Leadership is the crucial factor in ascertaining satisfactory implementation of new initiatives of change and development. This means that we need to rethink leadership within the public sector and that we think about individuals before the organisation and not - like today - about the organisation before individuals. When thinking about the organisation before individuals, we forget that organisations are made up of individuals with individual interests and intentions. Leadership in the combination of an actor-based approach and a positivistic approach meets the interests and intentions of individuals, which promotes innovation and results in motivated, responsible and competent employees (Jørgensen, 2007).

According to Kenneth Jørgensen, you cannot lead…

"(…) if you don't feel sympathy and care for the people you are supposed to lead. It will just be leadership in the formal sense, and it will be conditioned by primitive exercise of power. " (Jørgensen, 2007, p. 7)

I work trustfully and appreciative with individual assessments of the actors (= employees) on how to handle changes and development of a specific process and let this be the foundation of the required changes. Nurses are dedicated and ambitious on behalf of their profession, placing me under an obligation as a leader to listen, see and hear them as well as to creating the best possible environment for individuals to unfold in

terms of fulfilling external requirements as well as the individual professional ambitions of the nurses.

Organisation of the department of haematology

"Practice is not about isolated, individual skills, but a socially organised common activity" (Scheel, 1994)

I work as a ward manager across the department, meaning that I have leadership responsibilities for the in-patient ward, outpatient clinic and day unit. This segmentation is a conscious decision by the heads of the department. The structure should support and secure continuity for patients, relatives and employees. Integrated units make it possible for a nurse to follow a patient throughout the whole process. This flexibility is for many nurses a different way of being organised and requires training and innovation, both in terms of roster planning and a sense of belonging of individual nurses. All nurses, whether they are employed with a primary function in the in-patient ward, outpatient clinic or day unit, are trained to handle all functions throughout the department.

The patient and "the cancer nurse"

Patients with haematological malignancy have complex symptoms, characterised by life-threatening physical, psychic, social and mental problems. Everyday life often changes suddenly and very distinctively. Daily routines are often replaced by fears for the future and the unknown. Natural things, routines and habits of everyday life are broken, and daily life suddenly becomes unpredictable because of disease, treatment, side effects and (late) complications. We need to focus more on rehabilitation measures against late complications (Sundhedsstyrelsen, 2017).

To meet all patients with cancer - or in fact all types of patients - with high professionalism, requires a lot from nurses in terms of professional, social and organisation competences, and in terms of development of these competences.

The nurse does not have to be an expert within all areas but should have the appropriate knowhow and skills to be able to “figure out” the symptoms of the patient and subsequently the multifaceted needs of the patient.

Let nursing speak and be heard

As many other departments, we have created competence programs, we conduct haematological basic courses, mono and interdisciplinary conferences, have experience exchange groups etc. To support the professional development of the nursing group, we have established different kinds of dialogue “rooms”, in which nurses meet to reflect and create learning in and about their own practice. These dialogue rooms are important, since they help strengthen the insights of individual nurses to their own field of competence. Further, they are valuable from a leadership perspective, because they ensure that the required competences are at hand in the department.

The conscience about individual fields of competence provides the nurse with the opportunity to occupy a key position in the tension field between standardised and individualised procedures. It requires professional nursing and organisational skills to create continuity within this field and further extensive knowledge about the individual patient to create coherence. To make all this happen, it is important that you as a leader have the courage to let your employees speak up, while listening humbly, acknowledging and curiously to what they say.

To organise, structure and develop nursing for patients with cancer, it is important that you as a leader alongside your employees are curious about finding out what the vision, mission and objective is in terms of nursing development. What do the employees dream about? How should the development process be prioritised? Who has which skills and what are we lacking? What resources are available? Who can (and should) help

implement the task etc.? It is also important that planning, processing, evaluation and implementation take place in common practice.

If you as a leader want to develop or change existing practices, you can use the competence bridge as a method of creating the vision, control the process and stay on top of current activities and progress (Danelund & Jørgensen, 2002).

In the competence bridge, the central dimension is the future scenario and the focused now situation, where you place yourself in the future and look at the present in past tense and start building piers and spans to end up with a complete bridge. Another central element of the competence bridge is competence relations, where you by means of different conversation positions for instance address silent knowledge and preconceptions, and focus on resource thinking and future orientation instead of lack-based thinking (Danelund & Jørgensen, 2002).

When working with the competence bridge, it is important constantly to stay in the future - to see the future as the present and the present as the past - also as a leader, and maybe especially as a leader. As a leader, you must stay on top of things, be motivating and lead the way. It may be challenging in busy everyday life, but by constantly acting in the future, you are not controlled by the limitations of the present when you come across obstacles and resistance. No work on changes or development comes without “bumps in the road”.

Working this way makes it possible to hold on to the vision collectively created for the future and makes it possible to stay on top of tasks/subsidiary objectives and activities required to reach the goal. Working on developing the vision includes acknowledging dialogue and reflective questions. The employees must be involved in the work on reaching the goals; this makes them feel responsible, take ownership and it conveys community and insights into how to work on processes in order to achieve a specific vision or process (Danelund & Jørgensen, 2002).

During the winter of 2012/13, I introduced the term “competence bridge” to the nursing group. We talked about the different terms, what they meant and how we as individuals understood them. Everyone was excited about the idea of creating a collective dream for “our” department. It was a warm spring day in 2013. We decided to have a staff meeting in the garden of one of the employees. Again, I presented the theory, and we just started dreaming. However, it was not easy at all; it was in fact difficult, initially at least. In nursing, we are not used to dream. When we do, or when we try, we are often limited by immediate frames or limitations. This was also the case here. For the first 20 minutes, several said: “I dream of… but that will probably not be possible, because we lack/because there is not enough room/because, because…”

Each time, I dug deeper and was curious about their dreams. This way, all employees started dreaming and forgot the limitations. There were small dreams and big dreams. We dreamt for about two hours, we laughed and started to feel safer as we went along. All employees contributed with their dreams, thoughts and visions on how our department should develop. I then categorised the dreams under relevant captions: competence development, working environment, communication, interdisciplinary cooperation etc. The employees then made a prioritised list of what they would like to work on first.

A picture of a bridge between the future and the present started to emerge… And yes, there was a huge gap between the things we were dreaming about and our current everyday life. However, we were on fire. All the categorised captions were inserted in the bridge as piers. It was then about making the piers strong for us to walk on the bridge together. We agreed that competence development should be the first pier to work on. However, how should we proceed? Who was going to help us? What could others contribute with? How? How many? When would we reach the finish line?

We called it the “Dream of Section M” and we still work on and in accordance with it. At every staff meeting - four times a year - or whenever we feel that the nursing group is about to go off on a tangent, we bring out the dreams to achieve an acknowledging and reflective dialogue on where we are, what we work on and how we do it. What requires adjustment? What internal and external partners participate? Is anyone missing? Do we have the required knowledge? If not, what to do? How should we proceed?

Consciously and unconsciously, we work through the dreams that we categorised in the spring of 2013. Everyone takes responsibility and ownership. The dreams have developed and have become more, for instance numerous exciting development projects concerning home-treatment of patients with haematological cancer diseases. This chapter is also part of the competence bridge.

The employees often forget that everything we do is a step towards fulfilling our dream. When we talk about it during staff meetings, nursing meetings, interdisciplinary meetings and white board meetings etc., they often say “yes, that’s right” and see the connection and meaning. Especially during busy times, where we may feel that we are a “factory” and nothing really makes sense, we bring out the dream and say, “*Look, what does it mean? Do you see where we are headed?”.* It gives us energy and shows us the way.

The employees have taken ownership and everyone, including the patients, their relatives and myself clearly feel their commitment. If something is missing, things are ambiguous, wrong or the like, the employees themselves act, share experiences, seek new knowledge and try to solve the tasks. This process is both demanding and rewarding, and it constantly contributes to the organisation, structuring and development of highly specialised cancer nursing of patients with haematological malignancy.

When creating a vision, it is important to take the obstacles along the way into account. There will always be bumps in the road, both externally and internally, and it is crucial that you overcome these bumps, or you will never fulfil the vision and mission: the dream will fail and result in demotivation. It is important to enable occasional "timeouts" for critical assessments of the situation. We experienced a lot of bumps in the way: too much is going on at the same time, implementation failed, physicians did not understand our approach and thought it was nonsense – "we should just take care of the patients", it was difficult keeping up, we lacked staff, we did not feel informed enough, we did not understand the meaning of instructions and so on. However, the employees manage to focus on the dream of section M and the core mission: to organise and structure nursing of patients with haematological cancer diseases for it to make sense to patients, their relatives and themselves as health professionals.

EPILOGUE

Developing a competence bridge and keeping it going requires a great deal of courage and leadership. Courage to letting the voice of the nursing group be heard and letting employees guide/lead you. It is a very thrilling and unique feeling to see employees grow, both personally and professionally, see them take responsibility and lead themselves, each other and me, see them smile, come to work happy and go home happy.

As a leader, it is also a great feeling not to be alone. I do not want to oversee everything and make all the decisions; I want to create the best environment possible, lead the way/set the course and coordinate to create opportunities and open doors, making the employees commit to doing their best and making them want to participate in the development of nursing.

It was good that the management decided to use an actor-based approach, but it has presented challenges, and it continues to do so. We work within a scientific organisation, where everything must be evidence-

based and 100% measured and weighed. When a research or development project is launched within nursing, it is done qualitatively and with an actor-based approach using all experiences. Such a project does not end up with results that can be measured and weighed, which contrasts with the positivistic approach of physicians. The various sides and health professionals do not appreciate the actor-based approach, meaning that the research and development projects within nursing face difficulties in being acknowledged and respected by “scientific persons”. However, many also find the actor-based approach interesting, educational and meaningful, providing me and the staff with the inclination and courage to continue working with this approach.

Afterword July 2024

What has happened since I wrote the book chapter "Leadership – Let Employees Speak and Be Heard"?

By letting my employees speak and be heard, I also hear and see myself as a leader. More than ever before, I can feel myself. I am not afraid to admit that I can be wrong or that I do not know everything. I have the courage to ask for help. I am not embarrassed if one of my employees needs to explain or show me something new. In fact, I am only proud to feel and see that they have the courage to also lead upwards.

I reflect a lot, take many walks in the forest, by the beach, at the harbour, and write a lot in my reflexive notes. I have many conversations with myself: why, why, why. This has led to me becoming much braver, more open, and more confident in who I am as a leader and as a person, and what my values and norms are. I rest in leading according to my ethical values.

As a leader, I have also become more resilient to people who disagree with the way I lead and develop nursing. When I am on shaky ground, I quickly find my footing again. I listen curiously and with wonder to what the person says, and hope that together we can become wiser. If the person is not interested in understanding why I do what I do, that is completely okay. I stand firm in the service of the cause and expect to be respected and recognized for the leader and person that I am.

I have succeeded in building a person-centred culture where everybody is seen, heard, and can speak freely and courageously. I can feel it when we look each other in the eyes in the hallway, say good morning, see each other at lunch, ask each other for help, and help each other without being asked. Even in hectic periods, such as a summer vacation, employees come and say thank you for a good week... What made it a good week? It has been pleasant, there has been a strong work community, cohesion, a nice atmosphere, and no absenteeism. Two years ago, the absenteeism rate for June was 6.99%, one year ago it was 4.84%, and now in 2024, it is 1.17%.

I am constantly getting wiser and wiser about myself, and I am proud to be who I am. I am also not blind to the fact that there will still and always be challenges where we cannot break down the wall, encounter a lack of understanding, recognition, respect, and curiosity about why we do what we do. But I/we stand firm, as having a person-centred approach makes an indescribably positive difference for both me as a leader, for the staff I lead, and for patients and relatives.

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A DEVELOPMENT CULTURE SUPPORTED BY LEADERS THROUGH REFLECTIVE DIALOGUES WITH NEW NURSING EMPLOYEES

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I have since 2012 worked as head nurse in the Department of Neurology at Zealand University Hospital.

I became a nurse in 1989 and have subsequently worked 10 years within intensive care, before being employed in the Department of Neurology in 2000. Initially, I worked as assisting ward manager before becoming responsible for education and working as a clinical development nurse.

The Department of Neurology has about 230 employees within 10 different specialist fields in two in-patient wards, an outpatient clinic with a neurophysiologic centre, a centre for functional disorders, a regional knowledge centre for dementia, an administration and a research unit.

My postgraduate education includes a Master of Adult Education in 2002. I am currently finalising my Master of Public Governance.

Let it be said: My primary tasks as a head nurse include employment, development of skills and retaining nurses. The shortage of nurses requires vigorous attention by leaders in the healthcare system, including in the Department of Neurology. This chapter is therefore a description of how I, both as a clinical development nurse and as a leader, have worked with the development culture of the department through reflective dialogues with new nursing employees to develop their skills and retain them. In this context, reflective means “mirroring” and development culture means a positive change and professional development for individuals,

but also for the department as a whole and finally for the benefit of the patients. The chapter incorporates my theoretical inspiration, which I use to support my claim that reflective dialogues still make sense. Reflective dialogues may also meet the requirements of our ever-changing healthcare system that come with being a nurse in a hospital. It will not always be possible to implement the things that some nurses have learnt during their education and reflection may here be a useful tool. A somewhat insecure employee doubting his or her abilities and experienced employees will with feedback hopefully be able to take on new tasks without feeling alone or inadequate.

I will therefore in the following try to illustrate two things: 1. how reflective dialogues are used as a leadership tool to mirror the clinical reality, in which the new employee is to act to acquire skills. 2. How I as a leader become aware of possible improvements.

ADAPTIVE LEADERSHIP IN A THEORETICAL SETTING

The role as head nurse is easily filled with administrative tasks, but I personally find it appropriate to combine these tasks with nursing tasks.

For one thing, all hands are needed during busy times. I have a leading position, but I am also a nurse and able to help on busy days. Unfortunately, I often do not get the chance to do so when it is required. Further, I make appointments with outpatients a few times a month to relieve the pressure on other nurses in the outpatient clinic. Combining the administrative and the nursing tasks enables me to use my professional knowledge when meeting patients and maintaining my clinical skills, and I further get to gain insights and uphold a form of acknowledgement at department meetings, when staff members discuss professional problems and questions, since they know that I also “encounter” these problems. Ultimately, I want the staff to know that we all have the same goal, regardless of education and position: We are here for the patients and

that is only possible, if we work together and help each other with all the tasks related to patient care.

From my perspective, public hospital service is under pressure from the complexity and variability of the surrounding world in terms of requirements for optimal operation with limited resources, entailing the intense need for innovation. I have therefore been inspired by the following experts in my job as a leader: First, Mary Uhl-Bien (Uhl-Bien & Russ, 2009), a professor of leadership, who discusses the difference in complex and complicated issues as well as the use of adaptive leadership. Secondly, Ronald Heifetz, (American university lecturer in public leadership), who in his theory on adaptive leadership approach describes different ways of challenging your personal leadership style when under pressure by the surrounding world with requirements for optimal operation with limited resources (Heifetz et al., 2009).

Mary Uhl-Bien distinguishes between complicated (technical) problems and complex (innovative) problems (The Q community, 2019). Uhl-Bien thinks that a leader should be able to combine the complicated and the complex by means of adaptive leadership; by ensuring sufficient room for differences and that they can be combined. You should support a style that challenges the experiences, dilemmas and conflicts of employees. Uhl-Bien points out that some leaders try to solve complex problems with "orders" and directives to create systematics and restore order. According to Uhl-Bien, many people find it hard to solve vocational challenges with new methods. Adjusting to a new and unknown reality is demanding and should be expected when starting a new job. Some people prefer being in control and want to return to that feeling and try to avoid too many new challenges/problems.

An adaptive leadership approach means making it possible to create a collective learning space, in which employees can move outside their comfort zone, take risks and improvise. As a leader, you can try to handle

challenges by asking questions and reflect on your skills as well as limitations. In The Practice of Adaptive Leadership (Heifetz et al., 2009), Ronald Heifetz describes, how you can act as a leader in an institution, which constantly has to adapt to new challenges, for instance like in the healthcare system. According to Heifetz, you can use an adaptive leadership approach by asking questions and reflecting, by testing immediate solution models and again reflect on the result and possibly try a new strategy. The employees may further require that the organisation restore order and predictability, even if you as a leader would like to "do some more exploring". According to Heifetz, a swift restoration of order and predictability does not leave much room for innovation. As a leader, but also as an employee in the healthcare system, it is important to be challenged in terms of dilemmas, experiences and issues of conflict. This space enables victories – and space for development as professionals. This space is created, when I conduct reflective dialogues with a new employee. In this space, we discover a new angle to our department or something, which the employee must work on together with the department, for instance being able to work within the settings offered by a healthcare system under pressure.

In a university hospital, focus is concentrated on education and training of staff as well as the need for change and innovation. Being innovative is all about finding new ways of solving problems at the same time as meeting constant requirements in terms of operation and results. Innovation and operation often end up being opposites, but both are important. The field of tension between innovation and operation is by Uhl-Bien described as "the adaptive space". The tension between the two sides makes it difficult to implement new measures. However, this field of tension generates new ideas and measures for adaption and implementation in the structures and daily operation of a hospital department.

When the opposites are successfully combined, Uhl-Bien refers to it as a "connection". When we connect, we succeed in incorporating new ideas

and structures in our professionalism and daily operations (Uhl-Bien & Russ, 2009).

Creating this form of connection is one of my goals as a leader, so I prioritise my participation in patient care as well as creating a space for reflection with new employees.

A WRITTEN REFLECTION ASSIGNMENT FOR NEW EMPLOYEES

It is my experience that you as a newly graduated nurse often need to be in control without having to face too many challenges at the same time. This is in line with what Patricia Benner describes in her book "From Novice to Expert" (Benner, 1984), on how the newly graduated nurse depends on procedures and rules, and that storytelling and reflections are key to clinical development of skills.

All new employees with nursing tasks are after starting the job informed that they must write a reflection assignment after three to six months of employment based on their experiences as newly employed, and they are to send this reflection to me. They are handed a written discussion paper containing a model, which I have developed based on problem-based learning – see figure 1. Problem-based learning (PBL) refers to a learning perspective, especially focusing on two aspects: Problems are the basis of learning, and the participants of lessons (students) independently must find the solutions to these problems, meaning that PBL combines problem orientation and participant control. Problem-based learning has its origin in the US and Canada (Andersen & Larsen, 2004). In Scandinavia, PBL has been used especially in occupational education as well as within health and social studies (Pettersen, 2001).

The model is easy to understand and follow, and contains relevant questions to the problem statement, meaning that anyone can write "something". The assignment is ideal for the space, in which the concepts of operation and in-novation/development meet.

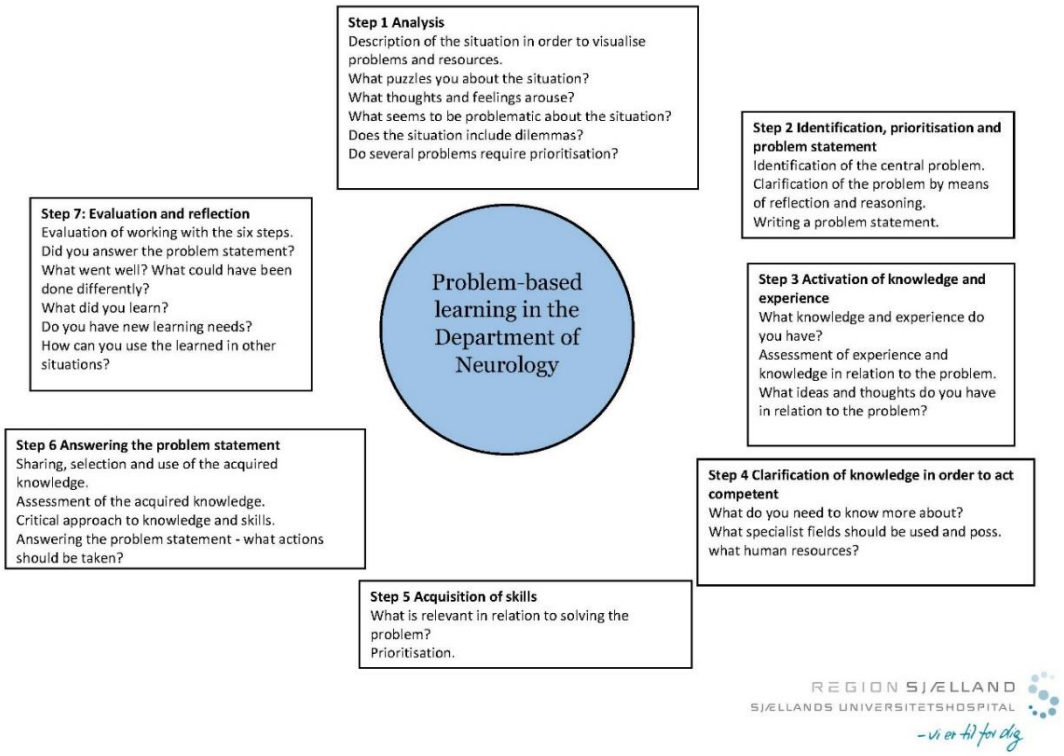

Figure 1 Problem-based learning in the Department of Neurology, freely interpreted accordingly to Roar C. Pettersen's model (Pettersen, 1999)

The assignment should maximum be one or two pages long. The new employees are told that the reflection is most important for the dialogue, not the layout. The assignment can relate to a practical patient task or relate to communication and cooperation with patients, relatives or colleagues. The assignment serves as a discussion paper for discussions between the employee and me, concerning what is of importance for the individual employee daily. I mainly focus on three areas: 1) The theory of problem-based learning used as basis for the assignment; 2) The reflections of the new employee in terms of complex and complicated work tasks, and 3) The trust, which numerous nurses and social and health care assistants have shown me over the years by sharing their reflections on being a new employee in the Department of Neurology.

The written assignment and the dialogue take place in a confidential space, and whether the assignment or subsequent reflections are shared with others, remains the decision of the individual employee.

Over the years, I have encountered reflections on problems, which cannot be solved in the confidential space and here, it is agreed how to handle it collectively. The dialogue does not focus on a specific solution, since the solution depends on what the new employee has learned from both the written reflections and how they are used during the dialogue. Together, we discover how the reflections from writing the assignment and the dialogue can be useful in the future - for the individual employee and maybe for the department.

The dialogue is for me the ideal way to meet new employees in person and a great opportunity to hear about the introduction period, what the employee experiences as being positive in the department and what do not work and should be improved. The employee often has specific suggestions and ideas, which I urge to test, preferably in cooperation with others. These ideas may just work and if they do not, new ideas can arise and will require testing.

Personally, I find it interesting to test new solutions without knowing, whether they work in practice or not. To me, that is the essence of adaptive leadership - getting the opportunity to “walk” on the edge of the tension field between order and predictability with a new employee and maybe change or add something new to one of the in-patient wards, which would never have been possible without the reflections of a new employee.

I always ask the employee how it has been to work on the reflection assignment. Often, I receive answers like: “At first, it was a bit hard to write an assignment again, but then I found out that it was a great way to think through the problem” and “it was great working through the experience

in the writing process. It makes it easier the next time I experience a similar situation".

Through the years, 166 reflection assignments have been written in the Department of Neurology. For this chapter, I have categorised the assignments in six overall themes:

1. Communication for the benefit of patients
2. Good nurses require good training
3. Professional development despite of mistakes, negligence and conflicts
4. Development of care together with other groups
5. Focus on the joy of working
6. Moral and ethical dilemmas in everyday life

Box 1 contains an example of an assignment from category 1, but it could also refer to categories 2 and 6. Other assignments concern problems related to colleagues handling nursing tasks or ideas for new methods of organising care or something as tangible as the physical settings. Some assignments are very suitable for discussion at staff meetings or with the individual ward manager; most employees have a subsequent dialogue with their ward manager, pointing out a subject for the next staff meeting based on the reflection assignment.

Box 1 Example of an assignment

A nurse describes a shift, during which she passes a patient's room and can hear a patient cry hard from the hallway. She walks into the room, but communication is complicated, since the patient suffers from a neurological disease and has difficulties communicating. The nurse tries using a word board, which the patient ends up pushing aside and writes on a piece of paper: "You - hold hand - time?"

In her assignment, the nurse describes her personal feeling of inadequacy. Even though she has only been in the department for a short time, she feels in need of knowledge and time to acquire new and necessary knowledge. Fortunately, she has already discussed with colleagues that we as nurses may tend to think of solving problems and forget that the solution could be just being present. Being present requires time not always at hand.

During the dialogue, we talk about her experience of the situation, and she describes the shift in general, her actions in the situation and her thoughts afterwards. It is crucial to conclude, what she is going to do the next time, when she faces a similar situation that makes her feel powerless. I ask her, whether she knows the resource persons in the department, who could be relevant to approach. We talk about acknowledging her action in the situation and the importance of writing about it and sharing it with me, but also with her colleagues in the department. Sharing the experience with me and her colleagues, and succeeding in reflecting on it, to know what to do in a similar situation, is of importance to how much the incident comes to mean and will hopefully remove the feeling of being inadequate. Finally, we focus on whether the department can do anything different. This will probably include involvement of the direct superior, ward manager and deputy manager (when a specific example is used, you can describe what and when you as a head nurse used this conversation for leading department development).

ACCUMULATED REFLECTIONS AND IMPLICATIONS FOR PRACTICE

Today, I work as a head nurse in the same department as when I started working as a clinical development nurse. Despite the change, I decided to conduct reflective dialogues with newly employed nursing staff, since these dialogues provide me - being a leader - with the opportunity to stay updated on the development within the department, and I can further support the new employees. It gives me a clear sense of "connectivity".

During my work on writing this chapter, I was asked about the possible dilemma in being a head nurse and continuing to conduct reflective dialogues with new employees. I therefore asked the ward manager, and they answered without hesitation that they did not consider it to be a dilemma at all. One added that it was a good detail in the already planned introduction process, and that it adds good energy to the department, since the new employees talk to each other about tasks and topics and gladly share reflections with colleagues and the ward manager. The other ward manager added that it was natural for her, since she was used to me conducting these dialogues, even before she became a ward manager. The clinical development nurse is part of the onboarding group of the department (onboarding group refers to the department group in charge of planning how new colleagues are welcomed and introduced to their work), meaning that she participates in planning the schedule for newly employed nurses and supports them during their first days of work. Thus, the development nurse finds it natural and even necessary for ward managers, deputy managers and me to be part of the introduction process to make the group of leaders visible.

The adaptive leadership perspective contributes to my role as a leader within the healthcare system. By being an adaptive leader, it becomes possible in line with theory, to establish a collective learning space between individuals. In practice, this means that I through nursing tasks establish a community in terms of nursing, in which we collectively can discuss experiences and solutions based on our experience and various professional values.

The adaptive perspective is created, when nurses show courage and start discussing alternative and new solutions than those, which they may have heard about at nursing school or have tested in clinical practice. This require that I as a leader contribute to creating a safe environment for dialogues with my employees for them to have the settings to “tread” new paths in relation to their nursing practice.

I have learned that adaptive leadership is not easy at all. As a leader, you must try to handle challenges by asking questions and reflecting on skills, but also on limitations. It requires time and courage to accept a bit of chaos, when new employees are to find their way as well as a pedagogical and kind approach. I prioritise that time, since I believe that results are best, when you are allowed to reflect your way to a solution, test it and maybe adjust it - just like the quality models in healthcare service require.

The reflective dialogues with newly employed nursing staff are an example of the fact that leadership is about more than just assigning tasks and making decisions. Reflective dialogues complement the introduction process, and the interviews and evaluations conducted in cooperation with the ward manager. I believe that the basis for good and patient safe operation is achieved by focusing on the introduction of new employees and development of skills for all nurses.

Everyday life in the nursing group does not offer much time for reflection on nursing tasks, either individually or with colleagues. This means that individuals too often stand alone with their reflections on nursing practice. When you are newly graduated and newly employed, it is my experience that individuals are eager to show that they are skilled and worthy. However, my experience has also taught me that you often end up doubting yourself, when you are alone. I focus on creating a confidential space based on recognition of individuals and with room for dialogue and reflection. Of course, the power balance is unequal, when one is the leader of the other. Therefore, I know that I may not be informed about everything, but I address it and ask the new employee to reflect with others on thoughts and what affects the self-esteem negatively, if the person does not find me suitable for sharing - this for it to be minimised to something that can be processed. In general, I address the importance of reflection and discussion with others to maintain your professional energy and enthusiasm. If you have doubts about yourself, it is important that you go

to your leader, because she can help you avert the thoughts of inadequacy or ensure that individuals receive professional feedback during clinical tasks, for instance from the clinical development nurse. If it is more about professional astonishment, I often find it ideal to share these thoughts with other, more experienced colleagues - different professional observations come to light, which the individuals can then compare with personal knowledge and learning.

If we in hospital service need nurses and time to provide ideal nursing within complex and complicated patient care, these reflective dialogues remain a modest contribution for sparring with the new employees and especially for helping individuals to develop own nursing practice through reflections. In this way, you can become more knowledgeable about your own practice. The ward manager and sometimes I are further reminded of what is important when you are new employee. I hope that the stories and reflections can be one of the keys to development of skills in a complex and sometimes complicated life, resulting in staff staying longer in the Department of Neurology.

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CHAPTER 10

PLANTING A SEED REGARDING RESEARCH AND DEVELOPMENT IN A BUSY, PERFORMANCE-ORIENTED DEPARTMENT – AND ENSURING THAT IT SPROUTS!

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I am the head nurse of the Department of Cardiology. I have moved up through the various levels of management within nursing, I started as a registered nurse and then slowly supplemented my education to the management level that I am at now. From registered nurse to special training as an ICU nurse, nurse with clinical responsibility and a role as assisting ward manager at the ICU, Diploma of Health, Clinical Training and Health Education. Ward manager, consultant at the Department of Quality, and now, head nurse. I have a professional master degree in Public Governance, which I completed in

January 2020. I have now been employed in my current position for 2 years.

BACKGROUND AND PURPOSE OF THIS CHAPTER

I have had a long career that has helped shape me as a person, but it has also shaped me into the leader that I am today. That I now have a position as head nurse has been a rather natural development of being a ward manager and wanting to develop my management style, but also of working with quality and obviously my Master of Public Governance. After this, I wanted to develop my management skills at my current level. Perhaps primarily because I have always enjoyed being at the forefront and making a difference. Professional development has always been of interest to me, and this has followed me throughout all my years as a nurse. Often, I have been a part of development projects myself, and particularly as a leader, this has been an important beacon for me, as it not only helps

create development in nursing, but also in the people working on development.

In 2015, I started at Copenhagen Business School to take my Master of Public Governance, which I completed in January 2020. A somewhat long process, but due to several job changes, this was simply the time required.

The focal point of my master's thesis was my curiosity regarding promoting research and development in a busy, performance-oriented department – and specifically my own role in this (Hykkelbjerg Bruhn, 2020). When I was asked whether I would write a chapter for this book, I thought it would be an obvious opportunity to write down my reflections and share them with others.

My vision regarding research and development is that I want us to move towards being the professional beacon of cardiology in Region Zealand. This is to help us ensure recruitment and retention of employees, but primarily, it is to be instrumental in ensuring the best possible treatment and care for our patients. This should be our constant focal point as well as our guiding light regarding which direction to move. We can only do this by continuously becoming better at including them in their own care and treatment and planning their course of treatment based on our professional knowledge but also based on a view of humanity that entails that every person in unique and should have a say in which treatment and care they want.

In my function as head nurse, it is important that I constantly focus on education, research and development, recruitment and retention of skilled employees, because otherwise, we cannot maintain the high standard of service that we want for the benefit of our patients. Nonetheless, I often find that this ambition is challenged by day-to-day operations, including a tough prioritisation of how staff resources should be allocated. Should they be used for care-related tasks with the individual

patient, or for a colleague to spend their time on administrative tasks for the benefit of research and development? I lack no inspiration regarding which direction to move. However, largely, the framework and external conditions for research and development are poor, and I must fight to improve those conditions.

Department of Cardiology

The Department of Cardiology has been an independent department since 2009. We currently have two wards with 24 patients in each, a cardiology lab with 5 operating rooms and an appurtenant observation unit with 12 beds. We have a large outpatient clinic. In addition to this, we have the management responsibility for the Department of Vascular Surgery as an out-patient clinic and ward. Last, but not least, we have a clinical research unit (CRU) and a project department. The CRU includes 4-5 medical PhD students and six project nurses. In total, we have 300 employees, of which approximately 170 are registered nurses.

From 2009 to 2018, the focus of the Department of Cardiology was to develop and expand in size, for example by taking over regional functions within a large part of the cardiological area of specialisation. It was a time without much pressure. Recruitment of staff was not a problem, neither was the retention of competent employees.

The department is looking quite different in the year 2021. We went through some cost-cutting measures in 2018, where we were asked to close a unit, which has resulted in significant busyness as well as an everyday life where there is often overcrowding. There has been a significant change in management, resulting in new department management as well as new ward managers in all units. Add to this that in the last few years we have also had difficulties recruiting employees, similarly to many other departments. However, we are lucky that we have continued to be good at retaining competent employees, which means that we do not experience major turnover in the staff group. This is an important

point, as it means that there is a high professional standard, on which the nurses do not wish to compromise – but which can also be a stress factor, as it might not always be possible to achieve the desired quality because of busyness.

Organisation of research and development at the Department of Cardiology

The culture in the department is characterised by a great desire for research and development. This applies to all levels of nurses. It is very important to allocate time for this task, because if that does not happen, day-to-day operations take over and become the controlling element. For example, this is evident from CAPAN Survey ll (Forskningsstøtteenheden, 2019), a survey of attitudes and knowledge regarding research and development[1]. The following quotes can support a desire for research and development:

> *"Research is important in order to develop practice. However, it is important to have visible management of research".*

> *"Research helps maintain focus on the development of nursing"*

> *"It is quite the task to ensure that the strategy for research and development does not drown in day-to-day operations, particularly when the clinic is very busy, and we are short-staffed. However, there should be a culture for spending time on strategy and development regardless of if we are busy!"*

In the research and development field, we are in the process of pushing our department in the right direction. We are leaning on the overall strategies and visions for this field at a regional level (Region Sjælland, 2019), as well at a hospital level in the shape of the Strategy for the Academic

[1] Read more about the CAPAN survey in chapter 1.

Council and the Strategic Management Forum 2020-2024, and the Strategy for the nursing/Allied Health (AH) area at Zealand University Hospital (ZUH) (Sjællands Universitetshospital, 2020).

The vision, goals and strategies for nursing have been expressed as a desire for excellent quality – first class nursing, and:

> *"That nursing at Zealand University Hospital is based on the best documented and available knowledge from research, development, and clinical experience as well as from patients and relatives. The care should be person-centred and adapted to the local context, making this knowledge relevant and application-oriented"*
> *(Sjællands Universitetshospital, 2020, p. 2)*

In 2016, the department created a strategy for nursing at the Department of Cardiology (Kardiologisk Afdeling, 2018). The strategy leans on the overall strategies for the nurses/AH area at ZUH and is renewed every four years. We use this strategy as a goal for nursing, but similarly to many other strategies and visions, there is a tendency that it does not come to life in the organisation. In the department, everyone at mid-level management level knows the strategy – or they certainly know that it exists. However, none of the current ward managers was employed when the strategy was developed. When working on my master's thesis, it became clear to me that my current ward managers do not feel a sense of ownership of the strategy, as they have not participated in creating it. When introducing new nurses to the department, I always tell them about the strategy and the expectation to work strategically, and the significant focus on professional development and preferably research. However, the CAPAN II survey showed that many among the clinical staff are not aware of any nursing strategy. Those of the nurses who are aware that we have a strategy describe this in CAPAN in the following way:

”The strategy helps render visible what we would like to work towards regarding general topics such as management, research, development and education”.

”That we have an overall goal and ideas about where we would like to go with our nursing, what we would like to develop and move towards with focus on professional as well as practical development of the profession”.

I sense that the nurses are quickly engulfed in everyday life, and they do not spend time getting familiar with the strategy and thus do not use it as intended. The seeds I attempt to plant at the introduction do not take root, and we need to do something about that.

I would like all nurses to know that the department has a nursing strategy. However, most importantly, that there is constant focus on professional development and research in the department. It is an important part of our work to combine day-to-day operations with professional competence, and the strategy can be used for that. My hypothesis is clear: it helps us recruit and retain staff. It gives us job satisfaction and urges us to provide our patients with the most outstanding treatment and care.

Therefore, in the spring of 2021 we have started revising our strategy. Everyone with leadership, education and development tasks in all units take part in the process, a group of 20 people led primarily by our clinical development nurse and me. A process where we have turned the old strategy upside down and set new future goals going towards 2025. It is very important that this group take ownership of what they will be involved in implementing in their own units. At the end of 2021, the nursing strategy has been written, and we have planned a strategy day with the same people involved, where we will discuss implementation and the further process. In 2022, we will have a half project day for registered nurses and auxiliary nurses, where the main theme will be how to incorporate the strategy at all units. Most importantly, it needs to come to life out in

the units. This will be a long and continuous process, but I am certain that it will also contribute to everyone becoming informed and knowledgeable about the direction we should take regarding goals for nursing. In this way, it becomes visible what needs to be prioritised at our department, and as so many have been involved in the process, I hope that we will succeed in this task.

This also means that we need to allocate time for research and development, which cannot be deprioritised. It is the task of the mid-level managers to allocate time for this. My task as head nurse is to maintain constant focus on primarily recruitment and retention of employees, making time for day-to-day operations as well as research and development. My task is to be specific regarding how to allocate financial resources for the task, as we from my perspective use many words on describing how important it is to ensure research and development in nursing but lack a clear strategy for how to find money for the task. It is my clear intention that if we want to increase our research and development, and this is also desired at hospital management level and regional level, my task is to maintain focus on promoting this part as well. I.e. to be specific about the fact that it is not possible to create major projects from nothing, but it needs to be prioritised by everyone regarding time as well as finances. Therefore, we still have unfinished business – the fact that we talk about increasing research, but the finances are not prioritised in the same way. This is very problematic and often has a hand in stopping innovation and innovative thinking.

EMPLOYEES

I see an increasing tendency that new nurses at the department have completed entire - or parts of - master degree or Master of Science (MSc). For example, within the last six months, we have hired two nurses with MSc, where this is not required for the positions, they have applied for, but they are employees with potential that it may be possible to develop by offering them to be included in various new research and development

initiatives. I cannot handle this task alone. Therefore, I have a great need for and benefit from my qualified employees.

To support nursing profession development in the department, we have hired a clinical development nurse in the cardiology staff with the overall responsibility for development and quality work at all units. She plays a very important part in keeping processes going on in the units, and she is involved in everything from documentation on The Electronic Healthcare Platform, to new development projects where guidance of clinical staff is required as well as anything regarding strategic work.

Furthermore, she takes part in network meetings with the clinical specialists in the units. There are currently clinical specialists in three of five units. The plan is to have clinical specialists in all units and for them to have an education corresponding to either a master degree or MSc level. For now, there is one nurse with an MSc; another has started in a 4-year professional master, and the third nurse would like to start a master, which will probably start 2022. In the other two units, there are nurses in specialist functions, and here, we are starting a process for how to have clinical specialists similarly to the other units. At all units, there is close cooperation between clinical specialists, the ward manager and the assisting ward manager – and with the general clinical development nurse on the side-line. Furthermore, we have hired a nurse with a PhD, who is an experienced cardiology nurse. She is working on her project and expected to finish in the middle of 2022.

To support nursing profession research, we are currently hiring an associate professor/head of research for nursing profession. This person's task will primarily be to bring focus to research in the department. We are still novices regarding research, and the mid-level managers have expressed clearly that if we are to meet a goal of being active in research in nursing, there is a great need for a person who can guide us in the right direction. As a leader, it is important that the head of research and I work

to create space and include knowledge and competences in the department as a launch pad for further research.

As the heads of department, we have a great desire for research to be a prioritised task across professions. In 2021, we formed the Cardiology Research Council (KFR), which is cross disciplinary and includes us as the heads of department as well as our medical specialist professor as permanent members. In addition to this, the specialist nursing PhD, a nursing profession associate professor (in the long term), two research-active physicians as well as a secretary participate. The council meets once a month, where we focus on the ongoing research as well as future projects, but also focus on strategically looking ahead – what we should aim for in the coming years. It is also important that we make the council's work transparent by telling everyone in the department what is going on in the research and development field. In relation to this task, a physician is responsible for sending out newsletters to the department. It is important to make it visible what is going on, as this can contribute to other and new projects and shows the clinical staff that research is not impossible. It has been a major wish on my part to form this council, primarily to bring focus to research in general, but also to give nursing a voice similarly to medical professional competence. In that I as a head nurse am part of the council, it can help ensure that nursing is included in the projects we would like to get started.

Transparency in activities all over the department is another important factor. We have not been good enough at that at all, and this became obvious to me when I carried out focus group interviews for my master's thesis: Primarily clinical frontline staff was quite unaware of what research activity that took place in the department, but also of what takes place in the units. It is very important to make sure that everyone gets a sense of what we are doing in the department. Therefore, we will send out these newsletters, which are intended to describe research and development across disciplines, but also in the specific units. In the autumn

of 2021, we have had a project day for the benefit of research and development in all units. Here, the individual units presented input on what is going on, and this included anything from major medical studies to small local projects for the benefit of our patients, but we also focused on job satisfaction of the employees. A research weekend in the spring of 2022 is in the pipeline, which will be offered to all employees, but where the focus will be on getting an impression of what is going on regarding research in the Department of Cardiology, and the plan is for this to be a recurring event.

Learning environment

I consider our learning environment in this department to be good in general. All units have scheduled teaching séances on a weekly basis, which includes nursing conferences as well as actual vocational lessons, five professional minutes and time for reflection. These séances are preferably not cancelled. We persistently try to make sure that the teaching that takes place is also available to persons on evening or night duty to make sure that everyone is brought up to date on new knowledge or information, either through e-mail or notices, or in the long term through video footage as well. In the entire department, we have a scheduled morning conference for all professions, where we start with singing as a social activity – which is my initiative. I always select songs that I know that most people are familiar with, and I have teamed up with three nurses that are great singers and used to singing in a choir! I am convinced that the relational aspect of singing together also influences getting involved in professional development. The professional contribution alternates between professions, and the only criterion for the presentation is to consider things in a wide sense to make sure that everyone gets something out of it.

Regarding training for nurses, we have basic education in cardiology, continuing cardiology education as well as continuing education for experienced nurses. It is my job as a leader to challenge employees who want

courses/educations by asking them how they think this will help develop not just individuals, but also the entire department. My ward managers are also familiar with this expectation, and they are good at providing the framework for new knowledge to be shared and discussed.

We have an overall strategy that entails that all employees coming back from education, regardless of if it is diploma modules or professional conferences, are expected to share new knowledge. The purpose of this is to share the experience with everyone; particularly the ones who choose to stay home and take care of the department while a colleague is out learning new things. I constantly challenge employees who want courses/education by asking them how this can help develop the department to make sure that they know that it is not for personal gain. Rather that they are part of something bigger that must be shared with everyone. My ward managers are familiar with this and are good at guiding in the right direction.

INVOLVEMENT OF PATIENTS AND RELATIVES

I feel that we still need to involve patients much more than we are currently doing regarding research and development. We obviously always have them in mind when dealing with research and development but going into details about how to include the patient to a seat at the table, we still have a way to go. We involve patients and relatives through focus group interviews as well as telephone calls in relation to small quality projects, and that is a good start. However, my vision is that we need to become much better at asking patients and involving them in their own treatment and care. In addition, how we can become better at developing from their point of view. The Hospital management has a strategy at ZUH level where I am for example part of a task force group that is focused significantly on precisely how to become better at involving patients and relatives in treatment and care. We have already started this work, and it will affect all future strategy work, which will be a very interesting pro-

cess. Furthermore, it is worth mentioning that the strategy in the nursing/AH area at ZUH (Sjællands Universitetshospital, 2020) is a person-centred vision. This means that it is based on an approach to practice that is established through care and treatment relations between all health care professionals, patients and relatives, and it is focused on patients and relatives as well as the health care professionals. Preferably, this should be reflected in our own strategy at the Department of Cardiology.

DISCUSSION

I feel that we are moving in the right direction in my department regarding development. However, I feel that the organisation in general – at hospital level – is still characterised by us being novices in the research field. As head nurses, we are quite alone in the tasks and perhaps particularly the ideas regarding how to create a structured plan and strategy for how to push our own organisation forwards to live up to the general goals for research and development. However, we are moving in the right direction. Primarily because at ZUH, we at hospital level have a head of research and professor and a nursing deputy director, who are major driving forces regarding guiding us in the right direction. Their role as a source of feedback for each department means a lot regarding being strategic and visionary in relation to the tasks. Many of us are also part of various networks, and these initiatives are important to create cooperation across departments, but also as a kind of idea bank, where we get great ideas about how to develop our own department. However, I think we need to become much better at considering inter-disciplinary aspects. It would be obvious to seek inspiration from physicians regarding research, as they have many years of experience in how to structure this. If we want a strong research culture, we as a profession need to think along the same lines. This is also one of the underlying philosophies in our own department, with our new research council, and a deliberate act for the members of the council to be equally distributed among professions as well.

However, there is still a lot to be desired regarding achieving the regional goals as well as the goals at hospital level at ZUH. For example, there is a clear plan for how many professors that are needed at ZUH by 2025. However, when we go into specifics and enquire into how this will be financed, there is a definite need for realistic plans of action. I believe that the region has a significant responsibility in allocating finances for the task, as it is not possible to take the funds from our wage budgets. Thus, research becomes diffuse, if there is a desire for department managements to prioritise this, but it is not clear where the money should come from. For example, when I am asked whether we can finance wage for a nurse for six months, there is no lack of desire to do this, but the funds must come from somewhere in our own budget and that is problematic.

Therefore, the leadership challenges are greatest at a higher level, and I as a head nurse and us as heads of department are responsible for acting regarding this matter.

In my own department, there are many good intentions and ideas, and I am confident that we are achieving development. It is a leadership challenge for me to ensure that there is visible leadership regarding where to go as a department. It has certainly become obvious to me through my master degree work that if mid-level managers and employees do not have a sense and knowledge of where to go in the research and development field, they will pull in opposite directions. Thus, clear and visible leadership is very important, as well as transparency regarding what is taking place in the entire department. It becomes much too diffuse, if we do not spend time, explaining what takes place in the department. This can also inspire others to evolve budding ideas among the employees. It is important to spend time and resources on educating employees and on hiring relevant research-intensive employees with qualifications that can help initiate and promote development. Research will not appear in the department overnight, it must be created from scratch and develop

slowly over time, and in this way, we will surely become the professional beacon that we have an ambition to become.

Afterword July 2024

Planting seeds of development and research in a busy, operations-oriented department – and ensuring growth

With the publication of a second edition of this book, an opportunity has arisen to take stock of how far we have come in the Cardiology Department at Roskilde since the chapter was originally written – almost three years ago.

At that time, my vision was to be the cardiological beacon of expertise in Region Zealand. To ensure continued recruitment and retainment to the department – with a focus on education, development, and research. I believe we have achieved that vision and the associated strategies – or at least we are well on our way. At that time, my goal was to start developing a new and revised version of our nursing strategy.

We have fully achieved that goal. Today, we work purposefully with our nursing strategy. It describes three focus areas: Clinical Nursing, Education, and Leadership. Within each focus area, goals and actions have been developed, which we continuously work on in all units.

Having the strategy means that we worked with a continuous focus. The nursing strategy has evolved from being a dusty document in the chief nurse's drawer to becoming a living and dynamic resource actively used by both midlevel managers and staff to promote development, education, quality, and research in the department.

One of the goals is to ensure professional development and that we work evidence based. For this task, it is necessary to have employees with high competencies who can participate in clinical work and at the same time have experience in project work. The department participates in SUH's pilot program TECS (Team Professional Master in Clinical Nursing), which is a partnership with University of Southern Denmark, and the professional master program helps meet the employees' wishes for professional development.

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The goal is that by 2029 we will have 2 clinical specialists in each section, which means more than 10 master's degree nurses in the department. The clinical specialists, together with our clinical development nurse, will be the cornerstone for planting the seeds for growth! Already now, we can feel a difference in the department, where the nurses who began at TECS a year ago take on tasks and drive them in the sections. It creates professional pride that colleagues greatly appreciate that there are those who seize the ideas that, despite great busyness, constantly pop up. These ideas are like seeds that sprout. But there is a big difference in whether the seeds get nourishment to grow.

They do now, as a curiosity about something is brought up and discussed. Thus, what could previously have been a curiosity, often turning into frustration, now becomes a curiosity and a change over time. It is interesting, especially when viewed from the sidelines, that although it requires resources to offer employees education, it surprisingly takes a short time before one can see the results of this hard prioritization.

However, it is very important that there is leadership behind it – and the midlevel managers are invaluable in the process!

Since 2021, the department has employed a nursing lecturer who has brought a focus on nursing research to the department. This focus has resulted in us having 1.5 PhD students in the department today, as well as a very active postdoc nurse. Their focus is constantly on cardiological nursing, ensuring that the care and treatment of cardiological patients are evidence-based.

Planting seeds has metaphorically become a mantra in the department, where the constant changes are often followed by questions from the nurses. Questions that could be ideas for development and research.

It shows that our focus in the department is a strong desire to use changes, both good and perhaps not so good, as a springboard to create learning for everyone. This also helps us continue to recruit and retain our employees in the department.

Therefore, we have also developed a career path for nurses in the department (and soon also for the auxiliary nurses). I believe that today we need to make ourselves 'attractive' – to brand ourselves – and show that if you apply as a nurse/auxiliary nurse in the cardiology department, there are different paths to take. It's also about planting seeds right from the start of employment!

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CHAPTER 11

FROM REFLECTION TO IMPLEMENTATION
THE CAMINO – THE ROAD TO RESEARCH

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When I was asked to write a chapter about the process in our department as to employment of a PhD nurse as well as describing my reflections as to the reasons for employment, I instantly knew what to answer - I answered yes with all my heart, joy and pride of finally being able to start the process.

I work as head nurse in the Department of Plastic and Breast Surgery and hold diplomas in Nursing and Management as well as a Master of Hospital Management from SDU. I have worked at Zealand University Hospital (ZUH) since 1997, where I initially was employed as ward manager in the operating ward at ZUH, Køge. Here, I worked until December 2008 and started working in my current position in January 2009.

Throughout my education, I have focused on leadership. I gained research experience while working on my master's thesis with focus on management across two department locations with a merging of different cultures, integration of a new field of speciality, implementation of new leadership, optimisation of workflows and processes as well as minor development projects within the department.

The department did not have a veritable research environment, and primary research within the department mainly consisted of medical studies, publications and reports. In nursing, we worked with minor projects with the objective of optimising patient care and workflows.

As a department, we are obliged to have a clinical research unit, and for a long time, it existed in name only. My hope was that we, in a mono-professional and inter-professional forum, could participate in strengthening this role, extend it and make it come alive.

Context of the process

The Department of Plastic and Breast Surgery at Zealand University Hospital (ZUH), Roskilde, providing the background for this chapter, is a complex organisation. Plastic and Breast Surgery has existed for a long time as two independent departments at different locations in the region, but merged in 2015. The Department of Breast Surgery was located at Ringsted Hospital and the Department of Plastic Surgery at ZUH, Roskilde - two different department locations with individual histories and cultures. Both departments focused on working with cancer patients. The Department of Plastic Surgery holds a regional role in terms of patients with melanoma and other forms of skin cancer. The Department of Breast Surgery primarily focused on women with breast cancer.

In September 2020, we finally merged physically and now share the same address in Roskilde. The physical merger became a very important context for the employment process as well as the initial employment of a new clinical nursing specialist. Upon the merger, the surgical process for breast surgery patients was passed to the outpatient Department of Surgery within the Department of Anaesthesiology, meaning that patients now visit the outpatient clinic for their surgery and leave the same day. Patients unfit for same-day surgery, are admitted to the plastic surgery ward.

The department was at the time of merger employing a clinical development nurse with a Master of Science (MSc) degree and broad experience within plastic surgery for handling quality and development.

The nursing staff within the department primarily includes registered nurses, but also auxiliary nurses.

In the long term, the chief physician and I wanted to participate in the research strategy for ZUH, describing the objective of employing at least

one person with a research education plus being a nurse/AH in all departments (Sjællands Universitetshospital, 2020). Our clinical development nurse was not at a place in her career, where working on a PhD was realistic, so when she for the sake of her own work-life balance left the department, it was time to take the next step in making the vision come true.

The Department of Breast Surgery was throughout the process of merging, in close contact with the Patient Safety Authority due to the "Ringsted Incident" discussed in the media, concerning the inadequate examination of women with possible breast cancer. A 360-degree assessment of all breast cancer cases at ZUH was initialised, having a positive effect, since the improvement requirements led to the employment of our clinical nursing specialist.

Finally, part of the department's context is that we have made six beds available to the gynaecological department, since the nursing staff was reduced due to cutbacks in 2018. Thus, the plastic surgery staff has taken over an assisting role, which we refer to as a working community, in terms of gynaecological patients physically in the same ward as plastic and breast surgery.

The wish of Region Zealand to optimise medical patient care has also had an effect on the department, since we have made three beds available for women diagnosed with "urinary tract infection" hospitalised via the emergency unit at ZUH, Køge. These patients are hospitalised under gynaecological responsibility, but receive care from the plastic surgery department - a division of responsibilities and a patient category that may present pragmatic challenges, and often led to the question of how much the care from the department of plastic and breast surgery actually accounted for.

In 2019, the Department of Plastic and Breast Surgery employed a new chief physician, who is very enthusiastic about research and development. The chief physician fully shared the wish of strengthening nursing research as the most important factor in the employment process of the department's clinical nursing specialist. We wanted to employ a nurse with research skills, and we were specifically going for a candidate holding a PhD. Another important process facilitator was that the chief physician had knowledge of patient-reported outcome measures (PROM) (Krogsgaard et al., 2021), including the tool BREAST-Q (Pusic et al., 2017) and advocated for implementation of this in the department.

BREAST-Q is a specific breast surgery PROM tool, which is able to support and monitor patient experiences and x½assessments of the surgical result as well as patient perceptions of life quality, before and after being a breast surgery patient.

INITIATING REFLECTIONS

Finally being able to employ a PhD nurse should not only base on my personal reflections, but also on the reflections of the staff, since I believe that research should live, develop and make an impact in this context. However, as mentioned above, it was very important that the department management agreed on the employment. Alongside the initiating reflections, it was a process of reflection, doubt, the need for counselling and guidance, conviction and finally being able to take the plunge - just like when you decide to walk the Camino.

STAFF REFLECTIONS

In 2019, the CAPAN Survey II[1] was published; a survey of knowledge and opinions about development, research and conditions for person-centred practice among nurses in the Region Zealand (Forskningsstøtteenheden,

[1] Read more about the CAPAN survey in chapter 1

2019). I believe that the following quotes from nursing staff in the department supported the wish for a road ahead based on research:

"That we continue to have a quality nurse/development nurse/clinical nursing specialist in the department, who with a post graduate can provide the nursing staff with easy access to and help for work flow improvements. "

"The development nurses in the department are quitting, but we all want to start working with research and development on a higher level, and I am not sure that we have the required skills to do so."

"The need for someone in the department with a research background in order to raise the level of improvement work, which we have started."

PERSONAL REFLECTIONS

In order to become more distinct in terms of my personal reflections, I was in close dialogue with both central figures in my department and professor Bibi Hølge-Hazelton, and I participated in meetings with my Action Learning Set group (ALS)[2] managed by our professor and consisting of five colleagues focusing on management of research and development in the respective departments. These meetings were and are very inspiring, since we can share our excitement, dreams and ideas as well as our frustrations and receive the required feedback for our work with researchers and research. Further, I looked for inspiration in the book " Research- and development culture - researchers in clinical practice" (Hølge-Hazelton & Thomsen, 2018).

SHOULD THE RESEARCHER HAVE CLINICAL EXPERIENCE WITHIN THE DEPARTMENT'S FIELD OF SPECIALITY?

No, the nurse should primarily have research skills. Preparing the researcher for the speciality of the department is in my opinion a leadership

[2] Read more about ALS in chapter 2

task, which is conducted in close cooperation with the ward manager and chief physician. We implemented an introduction programme with study days in outpatient clinics and wards. You can gain clinical experience from many things, and one of our approaches is experience through research. When research dictates knowledge about clinical experience, we need to acquire it - through participation in daily practice, dialogue with the nursing staff, literature - you can acquire it anywhere. The fact that we already had the BREAST-Q research project based on our breast surgery patients was to me an absolute strength in acquiring clinical insight and understanding. However, this entailed a pitfall, since focus could become too one-sided on the breast surgery part of the department; however, as we were aware of it, we did not expect it to become a problem.

We consciously decided to place our researcher in office with our quality and care coordinator in order to enable dialogue and professional feedback, resulting in insight into the department specialities from other perspectives. The office is located at the end of our ward, signalling that research and development should be closely connected to daily practice.

As described above, the ongoing 360-degree assessment and the wish for implementation of BREAST-Q are two important parameters for introducing the researcher into the department specialities.

It was therefore natural for the researcher to be part of the group responsible for the 360-degree assessment, since it included a thorough review of for instance workflows and instructions, which contributed to insight in the department "DNA."

SHOULD THE RESEARCHER BE VISIBLE DURING DAILY PRACTICE?

Yes, but this requires consensus on the term "visible". I have decided to emphasize that the position is about 100% research; of course upon agreement with our ward manager and chief physician as well as the researcher, but some research will by nature require participation in daily

practice; the researcher employed has the skills to stay on top of this. Finally, there will be force majeure events that require participation in clinical practice - for instance in the case of COVID-19.

The researcher should be visible in terms of mediation of the theoretical and practical foundation for development of our nursing and clinical practice, by participating in the provision of new knowledge and implement competence development, by initiating and driving research, independently as well as with incorporation of the staff working in daily practice. However, also by supporting and working actively on development projects and education in the department. Finally, the researcher should be visible by means of focus on interdisciplinary research.

WHAT ROLE SHOULD THE LEADER PLAY IN TERMS OF THE CONDUCTED RESEARCH?

To me, the researcher plays an integral role in the department - our researcher should be part of our daily routines and be visible. We would for instance quickly include our researcher in employment interviews with nursing staff, in order to draw attention to the fact that we have a researcher and that we consider research important in the department; the whole staff should feel familiar with this field. However, the researcher also gains an impression of the future employee and his or her experience with - or passion for - research and development. It provides knowledge about the department's resources.

The leader should participate in creating the appropriate settings for research, in terms of finances, mediation of ongoing and future research projects and support - when research is "uncomplicated" and when the process is difficult. Finally, participation in staff meetings is of high priority.

Being a messenger of current research, not just internally within the department, but also in terms of the remaining organisation, is also an important task - the ability to convey, support and explain. The role as provider of dialogue and feedback, and strategic and financial mediator is also important. Many of my personal skills are within these areas and I regard them as a supplement to the skills of our researcher.

Mutual matching expectations between the researcher and leader is vital for the abovementioned, and expectations should be matched continuously. Our roles, experiences and skills change over time and expectations may therefore change accordingly.

Should the researcher be responsible for initiation, facilitation and management of practical research and development?

The researcher should largely be responsible for the above, but not alone. Research should be an integral part of the department, both mono-professionally and inter-professionally, and all management levels are required to participate as a supporting, initiating and guiding entity. In order to ensure this, we established a small group in the department, consisting of the ward manager, quality and care coordinator, researcher, our nurse research assistant as well as the head nurse. In the group, we discuss subjects like ongoing and future research projects, quality development, staff conditions and possible research barriers. The idea is for us to be able to strengthen our roles and ensure integration between roles and work areas by means of knowledge sharing and feedback. The group is intentionally mono-professional and relates to the subjects that concern our nursing staff. The cooperation between the researcher and ward manager is in my opinion vital, since the ward manager is the immediate link to the nursing staff, and implementation of research should be anchored here.

Visions, objectives and strategies for the nursing/AH area towards 2025 describe the road, which ZUH wishes to go in terms of supporting research, development, education as well as retaining and recruiting employees (Sjællands Universitetshospital, 2020). This requires determination, for instance by employing PhD nurses. As a nursing leader, I wanted to support and implement this within my own department, and the reflections of the staff as well as my personal reflections confirmed that the initiated process was right.

Learning environment

The learning environment in the department was characterised by plenty of good intentions, but it lacked practical implementation as the following quote from the CAPAN II survey shows on the subject of wishes and needs in the department:

> *"I would like a weekly nursing meeting for discussion of nursing issues, in order to improve the knowledge of nurses and nursing as a whole. We could discuss issues like new knowledge relevant to the patient groups of the department, professional discussions on nursing problems, difficult patient care situations etc. Younger staff members learn more from experienced colleagues. I sometimes experience that new knowledge is available, but not conveyed to the staff and it therefore remains unused/non-implemented."*
>
> *(Forskningsstøtteenheden, 2019, p. 23).*

The department has, with the best of intentions, written down rules for course participation and the obligation of conveying newly acquired knowledge and experience, but the quote above shows the lack of practical implementation. Implementation of new knowledge does not come by itself and should not be the responsibility of individual employees. The nursing management is hugely responsible for creating the appropriate space for this form of mediation and implementation.

Development of skills through acquisition of new knowledge, existing experiences and daily clinical practice is very important to the department, both mono-professionally and inter-professionally, and it is a clear premise that the wish for education should relate to the core purpose of the department, meaning the professional nursing tasks required for patient care.

The learning culture of the staff is in general characterised by a strong desire to acquire new knowledge and skills, which is an asset for the department and supported whenever possible. Examples: one of our nurses is currently undergoing special education in care of cancer patients, and one of our other nurses has just finished the education as grief counsellor. Co-worker training was part of both processes, and a strategy for implementation of new initiatives has been created. We further have two nurses, who started their master degree programme in quality and management at SDU in August 2021.

Part of the nursing learning environment has been characterised by restructuring related to the abovementioned obligations concerning the gynaecological working community as well as departmental obligations for women with urinary tract infections. In order to meet the need for professional skills related to care and treatment of gynaecological patients, mono-professional and inter-professional training was within the department planned, as well as peer-to-peer training in order to upgrade staff skills. However, patients hospitalised with urinary tract infections, turned out to be more complex in terms of nursing care needs. The nursing management has been in close contact with the nursing staff in order to identify the need for skills, and I have been in contact with the head nurse of the medical department in order to plan acquisition of skills, for example by means of “skills stations” based on the areas identified by the nursing staff.

Incorporation of the patient perspective/patient experiences was characterised by sporadic projects, which have contributed with knowledge for improved understanding of our clinical practice, and the partial implementation has resulted in patients being increasingly involved in their own care. Specifically, this means that we in some cases have worked with nursing contact via telephone before and after surgical treatment in the department.

The obvious improvement potential in relation to the above is a vital part of the working field of the clinical nursing specialist. The initial approach has been a common review of CAPAN II in order to implement wishes and intentions through dialogue and mediation of the result to the nursing group, and create a common strategy for improving knowledge sharing and implementation of new knowledge.

PERSPECTIVATION

After the first 13 months with a clinical nursing specialist in the department, new perspectives for research appear - both mono-professionally and inter-professionally - for learning, increased competences and focus on nursing. I am convinced that the reflections and the decision to employ a clinical nursing specialist were right.

The department has:

- Employed a clinical nursing specialist with a PhD, who has started postdoc employment between the department and the university.

- Established a research strategy for nursing, meaning that the clinical nursing specialist alongside me commits to a practical research and development approach with evidence-based nursing. As part of implementation of the above, we have initiated an educational process that conveys and spreads the research strategy, and is associated to our context. The objective of the strategy is to make the

nursing staff contribute to innovation and thereby create positive changes for patients and their relatives.

- Initiated the first research projects.
- Created a structure for nursing education and knowledge sharing.
- Strengthened the inter-professional research unit.
- Strengthened already existing development projects in the department.
- Employed a nursing research assistant.
- Strengthened our focus on patient involvement and a person-centred approach.
- Initiated the work on integration of the CAPAN II results in the common dialogue about research and development.

I have:

- Gained a partner, mentor and teacher.
- Strengthened my personal awareness in terms of nursing and research.
- Gained a colleague able to strengthen my management skills and deepen my insight.
- Gained a significantly more stringent perspective and a clearer insight into my role.

Research and professional development are now considered equal focus areas for the department, since the synergy between research, development and practice has become the foundation of building a research culture and learning environment in the department, where we were not used to working with research in evidence-based nursing. The common understanding of evidence-based nursing is that knowledge comes from research, clinical experience, patients and relatives as well as the department's local context (Sackett et al., 1996; Sackett & Rosenberg, 1995). We are, as described by Annesofie Lunde Jensen "(*…) required to apply a wide range of knowledge in order to provide evidence-based nursing*." (Handberg & Jensen, 2021, p. 80). Our new approach is therefore that research and development projects arise from the department's practice for development and improvement of practice, based on systematic, scientifically recognised research methods for examination of practice. We will in practice conduct research with users (patients/relatives, nursing staff and physicians) in order to support learning and development individually, collectively and organisationally.

Finally, we were fortunate in our department. Not only have we employed a researcher able to connect with the department; we also had the wish to implement BREAST-Q, which turned out to be an important parameter. It was not just in line with the core area of our researcher - it became a strong focus point of our nursing staff and therefore an indispensable tool in terms of introducing our researcher and her specialist research area. Inter-collective knowledge is beginning to grow and make sense. Other minor development projects quickly became part of our research area, gained new life and new perspectives, and thereby constitute a link between research and clinical practice/development.

Our clinical research unit has grown and become stronger. Research across departments is incorporated in both existing and new projects,

and fortunately, we were able to employ a research assistant with nursing experience.

Our clinical nursing specialist has written the following in a column: “Being employed as a new clinical nursing specialist results in a close partnership, almost like in a twosome.” The column ends: “Status of the twosome is that we have found the rhythm and we are building a research and development culture” (Thestrup Hansen, 2021).

I hope that the coming CAPAN survey will show that all the reflections within the department, manifested in the employment of a postgraduate will prove to be right.

Did I walk the Camino? Yes - not physically, but I made it through all the aspects of a pilgrimage.

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DO WE HAVE (PART OF) THE SOLUTION TO CREATING THE SUSTAINABLE HEALTHCARE SYSTEM OF THE FUTURE?

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It is interesting - but not surprising - that this anthology has gained international attention. The entire world is transforming their healthcare systems and the way they create value for patients. There are several reasons for this. In Denmark, we are currently particularly talking about the "double demographic challenge": that there are more elderly people (especially those aged 80+), and at the same time, the workforce is stagnating. The challenges of the future healthcare system will therefore NOT be solved by doing more of the same. It is simply not possible to hire more healthcare professionals. They do not exist in society.

This problem has been internationally recognised for many years. For example, in the UK, it has been discussed for at least 20 years (Morgan, 2022). During this period, there has also been extensive writing about the solution: more innovation and development of the healthcare system. Preferably research-based development and innovation, as it is preferred that healthcare treatments are evidence-based if possible. The preferred

international solution to this is often called "Academic Health Science Centres" (AHSC). These are collaborative structures where universities with strong medical faculties form close strategic alliances with one or more hospitals (or hospital groups). Well-known universities and hospitals such as The Mayo Clinic, Johns Hopkins University, and Karolinska are examples of AHSCs. In Denmark, this type of structure has also been used to establish Greater Copenhagen Health Science Partners (The Capital Region of Denmark, Region Zealand, University of Copenhagen, and Technical University of Denmark) and Human First (Central Region Denmark, Aarhus University, Denmark, VIA, and the municipalities in Central Region Denmark). The idea is that these collaborative structures can strengthen the research conducted in the healthcare system and thereby create a solid foundation for the innovation of the healthcare system.

There are now 15-20 years of international experience with this way of creating innovation and development in the healthcare system. Experiences were shared, for example, in Aarhus in June 2024 at the conference "The future of health care systems - supporting clinical-academic integration for health system sustainability." Participants from the UK, the Netherlands, Singapore, Sweden, Norway, and Denmark gathered to evaluate the experiences of working with AHSCs. There were strengths to these structures, but there were also several challenges - and it is three of these challenges that I will now highlight.

Firstly, AHSC structures are best suited for gradual innovation, where the existing way of doing things is improved. How can the professional quality of existing treatments be made even better? It is not as easy to create more radical or disruptive innovation, where, based on the citizen's/patient's needs (which are being worked on to understand even better), completely new ways of treatment can be developed. To put it bluntly, one could say that AHSCs are best at innovating based on the professional's (typically a doctor's) understanding of the situation – and not so much

on the citizen's/patient's or the system's understanding of the situation and innovation needs.

Secondly, it is not easy to make innovation happen in AHSCs. Innovation is when something new and useful is utilized. There is no doubt that the research in AHSC structures will ensure that there is plenty of new and useful knowledge. But the same research has difficulty ensuring that the research is put into play – utilized – in the clinic. Without clear leadership and organizational work, AHSCs become better at conducting research than at creating innovation. The focus easily becomes on financing and realizing exciting new research projects – and not so much on how the generated knowledge is subsequently put into play. And innovation is not only about developing new and useful knowledge. It is also about maturing this knowledge so that it can be put into play in operations. It is not enough that the new useful knowledge is there; it must also be usable in large operational organizations, such as hospitals. Organizations with production requirements and budgets that must be adhered to. Organizations that will face even greater problems in the future with recruiting enough staff.

Thirdly, it is a clear problem that AHSCs build research and innovation capacity where there is already research capacity. In the sociology of science, it is said that the significant focus on excellence in research creates a "Matthew effect" – that those who already have should be given even more. Thus, capacity is built close to university environments and in clinical environments where there is already a lot of research and staff who, through joint positions, frequently attends the university. Not much research and innovation capacity are built in the regular operational clinical departments. It is precisely this lack that makes it difficult to mature and spread the new and useful knowledge. The organization's "absorptive capacity" – that is, its ability to find new knowledge, assimilate and apply it – is not increased through AHSC structures. Perhaps it has (uncon-

sciously) even been diminished, because people, competencies, and resources that could be used to build absorptive capacity are instead used to conduct even more and better research.

Now we come to this anthology and why it is receiving international attention. The anthology shows a clear alternative path. Instead of creating large and strong research environments in a few places, efforts have been made over several years to create research and innovation capacity in several of the regular clinical environments. Clinical department leaders have been trained to create a research and innovation culture, where the ability to wonder, research, and innovate is slowly and surely built during the clinical everyday life. Also, with professional skills that focus on the patient's needs and overall life situation. In this way, innovation capacity has been built from the bottom up.

Central to the development at Zealand University Hospital (ZUH) is also building the will, courage, and competence among department heads to work on this – and to share experiences with each other. For it is neither simple nor easy to transform the operation in a clinical hospital department. Transformational leadership is both managing daily operations and developing them over months. As Erik Jylling, Chief Medical Officer in the Capital Region, says: It is like cycling and patching tires at the same time. It requires finesse and courage.

The figure below describes at least four tasks that transformational leadership must focus on if the operation is to be innovated. First, future needs for operational development must be determined. Here, it is important to consider the future societal situation – not least the double demographic development. Secondly, one must scope the development: what development project do we need? How much research do we need? How expensive can it be? Who should be involved in the project (which professional groups)? Here, it is crucial to focus on ensuring that the project meets the operational needs. So that researchers' engagement in

specific issues does not steer the project in another direction. Thirdly, knowledge must not only be developed but also matured and prepared for an operational situation. There must be resources to train clinicians in the new knowledge. It is not enough to have new knowledge. It must be conceptualized and packaged, ready to be delivered into a busy operational everyday life. Lastly, the new – the delivery – must be integrated into operations. This requires a well-functioning operation that can manage being disrupted by the new for a period – before the new becomes daily practice. As we saw with the integration of the Health Platform, this is neither simple nor without problems.

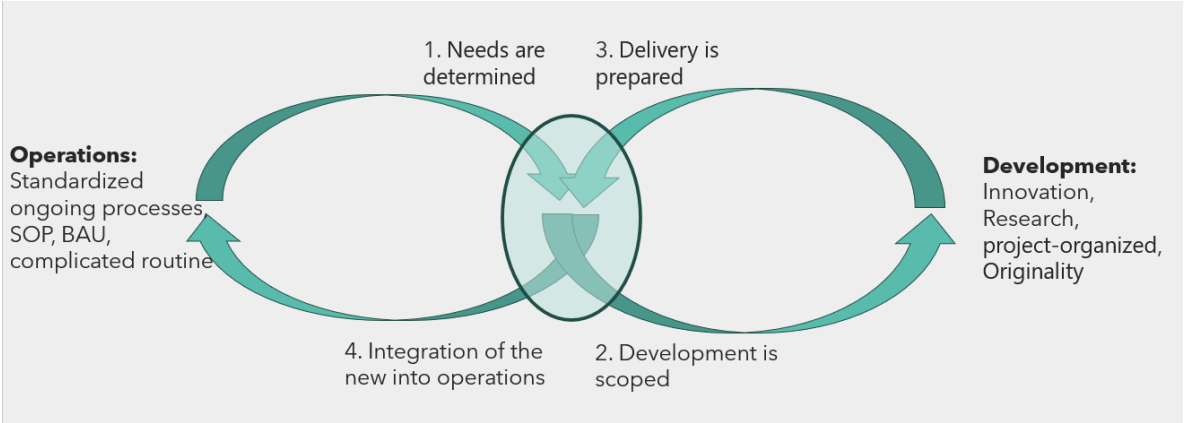

Figure 1 The Transformation Model: the link between operations and development - the central focus of transformational leadership.

With all four types of tasks, it is important that transformational leadership does not leave this to the researchers alone. Many functions and roles must be represented and involved when the four tasks are to be conducted: different professions from operations, researchers with various expertise, lecturers, nursing specialists, etc. For example, it is not enough for clinical lecturers to be involved only when the delivery is being prepared. They must also be involved at a minimum when the project is scoped, so that the development project from the start considers that the new knowledge will eventually lead to new competencies through some form of education.

Thus, transformational leadership is not easy. It is an extremely demanding leadership task that requires a lot of learning along the way. One must understand the research but also understand how the research becomes innovation by building capacity in the clinical operational environment. The anthology from ZUH shows how a learning community can be built, where leaders help each other get started with the transformation task that the healthcare system of the future so strongly needs. The anthology from ZUH also shows how AHSC structures can be further developed in the future, so that all the good and useful research is utilized to an even greater extent. Therefore, it is such an important anthology. It is good that it is receiving international attention.

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ORIGINAL ARTICLE

WILEY

Cultivating a culture of research in nursing through a journal club for leaders: A pilot study

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Aim: To describe whether an action learning-inspired journal club for nurse leaders can develop the leaders' self-perceived competences to support a research culture in clinical nursing practice.

Background: Development of clinical research capacity and nurse leaders with the requisite competences are key factors in evidence-based health care practice. This study describes how nurse leaders at a large regional hospital took part in a journal club for nurse leaders, with a view to developing their competences to support a nursing research culture in their departments.

Methods: A pilot study using a multimethod approach to evaluate the journal club for nurse leaders. Four nurse leaders participated in the journal club for nurse leaders. Content analysis on the data was performed.

Results: Data revealed that participation in journal club for nurse leaders gave the leaders a feeling of increased competences to support nursing research culture in their departments. They stated that the action learning approach and the competences of the facilitator were key factors in this outcome.

Conclusions: An action learning-inspired journal club for nurse leaders can be useful and meaningful to nurse leaders in developing leadership competences.

Implications for nursing management: As an approach in journal club for nurse leaders, action learning can develop nurse leaders' competence to support a research culture, and thus ensure evidence-based nursing is practised.

KEYWORDS
action learning, capacity building, facilitation, Journal clubs, nurse leaders

1 | INTRODUCTION

> *'Nurse leaders are essential for establishing evidence-based practice and a research culture, thus enhancing nurses' scientific attitudes and capacity'*
> *(Lode, Sørensen, Salmela, Holm, & Severinsson, 2015).*

The development of clinical research capacity is regarded as an important factor in the success of an evidence-based health care practice. Success factors include the attraction of highly qualified staff (Severinsson, 2014). Internationally, the concept of Magnet hospitals is one example of how formal recognition of nursing excellence, research and innovation can play a vital role in enhancing the reputation of organisations and opportunities for research action (Stimpfel, Rosen, & McHugh, 2014). However, in Denmark, it is only in the most recent decades that utilisation of nursing research and integrating academically educated nurses in clinical practice settings has taken place, both resulting in opportunities as well as barriers (Hølge-Hazelton, Kjerholt, Berthelsen, & Thomsen, 2015). According to Berthelsen (2015), a group mentality among nurses could lead to a suppression of individual nurses' opinions and motivation

for research and development. Hølge-Hazelton et al. (2015) highlight that nurse leaders might not always consider that their level of competence is sufficient to support a nursing research culture.

This article describes a leadership intervention initiative whose aim was to develop nurse leaders' competence to support research in clinical practice. The intervention took place in the Zealand region of Denmark, where the development of research among nurses and other allied health care professionals is in its early stages. The region covers 7,273 km^2, has 820,000 inhabitants, 17 municipalities and five hospitals.

As in most countries (Corchon, Portillo, Watson, & Saracíbar, 2011; Segrott, McIvor, & Green, 2006; Wilkes, Cummings, & McKay, 2013), the health care system in the region of Zealand is driven by a general call for research capacity building, including evidence-based nursing (Thomsen & Hølge-Hazelton, 2014). At both the regional political and executive hospital management levels, there is a clear signal that nurses and other allied health care professionals must build and strengthen the research culture (Region Sjælland 2015).

At the forefront of this development is a group of nurse leaders from one of the five regional hospitals who discuss and share experiences about the development of a nursing research culture at their monthly joint meetings.

The intervention was initiated at one of these meetings, where the issue of formal and informal qualifications of the leaders themselves was debated. None of the leaders had any formal research training; rather, they were primarily trained as managers at master's level. The debate led to the identification of a shared need for guidance and qualification in relation to leading and supporting a research culture in clinical practice. It also led to the agreement that this training should be exclusive to nurse leaders at this level, a sort of 'protected learning space'. The leaders then suggested that a journal club for nurse leaders (JCNL) should be set up as a first step.

The director for nursing research (second author) was asked to initiate the process and help appoint a competent JCNL facilitator (first author). Because the initiative came from the leaders themselves, a participatory approach – action learning – was chosen as the pedagogical method (McCormack, Henderson, Boomer, Collin, & Robinson, 2008; Wilson, McCormack, & Ives, 2008).

Within the framework of a nursing journal club, the aim of the intervention was to empower and support nurse leaders, who had little or no academic research background, to feel more competent with research capacity building including supporting a nursing research culture. Because no articles or studies were found that linked journal clubs for nurse leaders with action learning, it was decided that the intervention should be regarded as a pilot research project, and that it should include appropriate evaluation and documentation.

2 | KEY CONCEPTS

2.1 | Journal club

The journal club in this study is viewed as 'a mechanism by which health care professionals can update their knowledge, promote critical thinking and research, assess the validity and applicability of the literature, improve competences in critical appraisal, increase the use of literature in clinical practice, and influence changes in care practices' (Honey & Baker, 2011). Nursing journal clubs have been proven to represent an effective teaching and learning strategy (Lachance, 2014). Furthermore, Duffy, Thompson, Hobbs, Niemeyer-Hackett, and Elpers (2011) found that a nursing leadership journal club was valuable in increasing awareness of nursing leadership research, promoting leadership development and improving competence in the performance of research appraisals.

2.2 | Competence

According to Roach (1987), nursing competence can be defined as the state of having the knowledge, judgement, skills, energy, experience and motivation required to respond adequately to the demands of one's professional responsibilities. This definition comprises both personal and professional skills, which is consistent with the aim of JCNL.

2.3 | Research capacity building

This is viewed as 'enhancing the ability of individuals within a discipline or professional group to undertake high-quality research and enabling such activities' (Lode et al., 2015). Research capacity building is an important element in strengthening a contextually sensitive nursing research culture.

2.4 | Nursing research culture

Despite the fact that it is often stated that the development of a research culture is essential to enhance the evidence-based knowledge in nursing care in clinical practice (Back-Pettersson, Hermansson, Sernert, & Bjorkelund, 2008; Segrott et al., 2006), the concept of a nursing research culture has not been studied to a great extent. This article draws on Berthelsen and Hølge-Hazelton's (2017) analysis of the concept of a nursing research culture. They state that a nursing research culture must be characterised by an approach that fosters and encourages inquiry and critical thinking. Critical questions from patients, students and from both new and experienced nursing staff are to be welcomed and seen as a means for development. Nursing leaders should not feel threatened by research in nursing or by staff who are well educated in research (Berthelsen & Hølge-Hazelton, 2017).

2.5 | Action learning

Action learning is well known in clinical nursing where, for instance, it is used as an approach in the development of practice (Olsen & Hølge-Hazelton, 2016) and competences (Young et al., 2010). Action learning is a collective term for practical approaches and methods to create learning in clinical practice contexts, where it is based on the professionals' practice. Action learning is characterised by: learning together by way of enquiring studies and reflections in relation to the participants' work, such as their actions and their practices, and by learning groups with specific parameters and voluntary participation

(Wilson et al., 2008). For the last 50 years, organisations and individuals internationally have reported success in their use of action learning programmes to solve problems and develop leaders. The evidence for the effectiveness of action learning, elicited from a review, supports the suggestion that action learning develops broad executive and managerial leadership competences (Leonard & Marquardt, 2010).

The role of the facilitator in action learning processes is to create an environment in which it is not only safe to reflect on practice, but where reflections among the participants do, in fact, occur (Wilson et al., 2008). The facilitator is also expected to ensure an appreciative approach, where mutual respect and recognition of other(s') perspectives is fundamental (Wilson et al., 2008).

3 | AIM

The overall aim of the study was to describe whether participation in an action learning-inspired JCNL could lead to an improvement in a group of nurse leaders' competences to support a research culture in clinical nursing practice. The research questions were (1) How did the nurse leaders experience participation in JCNL?, and (2) Did participation in a JCNL result in the nurse leaders feeling more competent to support a nursing research culture in their departments?

4 | DESIGN, METHODS AND MATERIALS

A pilot study was conducted. Pilot studies can be viewed as a mini-version of a full-scale study (Kim, 2010; van Teijlingen & Hundley, 2002), and can be used to investigate whether methods or ideas can work in practice (Kim, 2010).

A multimethod approach (Brewer & Hunter, 2006) to data collection was chosen, including field observations and field notes of the participants' verbal and non-verbal communication and interactions during and between the JCNL meetings, logs written continuously by the facilitator during the project period, an evaluative group interview with the JCNL participants, written documents – such as email correspondence from the participants to the facilitator during the project period – and minutes from the four JCNL meetings. Each data source was selected based on the assumption that it could triangulate the data (Brewer & Hunter, 2006).

4.1 | Analysis

Manifest and latent content analyses were performed (Catanzaro, 1988) because they are suitable for analysing data that are relatively focused. Manifest analysis constitutes the descriptive part of the analysis, in which what is directly said and written is revealed and described. Latent analysis is the interpretive part of the analysis, in which meaning structures in the text come to light.

All data were transcribed into text. First, the data were read several times in their entirety. Subsequently, the text underwent coding, whereby units of meaning emerged. Next, latent analysis was performed, starting with a reading of the meaning units across all the data material and a search for inherent themes. During a dialectical process of moving back and forth between the parts and the entire text, in a search for the underlying meaning, themes emerged and were interpreted.

To optimise the credibility of the analysis process, two researchers (the authors) analysed the data. First, they analysed each data source individually, and then undertook a joint analysis. During this process, the themes were discussed and decided upon.

Communicative validity was sought by inviting the participants to read and comment on the Results section, in particular, and on the article as a whole.

4.2 | Ethical considerations

The participants were informed about the study before and at the first meeting of the JCNL, and that they had a right to withdraw from the study at any time without adverse consequences. Because the participants had asked for a meeting forum that would engender a feeling of trust, the facilitator pointed out at the first meeting that what was talked about at the meetings was confidential and that the approach at the meetings should be appreciative.

The participants were told that their contributions would be anonymised in a forthcoming article. Furthermore, they were assured that they could read and comment on the article before publication, which they have done.

According to Danish law, the study did not need to be registered at the Danish Data Protection Agency.

4.3 | The intervention

The JCNL facilitator was a nurse and research leader and had extensive experience of action learning processes. In line with action learning principles, it was set out that the facilitator should base her role on the inclusion and involvement of the participants in the learning process, and that she should ensure a safe and trusting atmosphere at the meetings, so that participants would feel comfortable 'exhibiting' their own ignorance and vulnerability, both to themselves and in front of other participants (Wilson et al., 2008). In addition, the facilitator should ensure that the participants felt that JCNL was adapted to their wishes and needs, so that the process and their attendance were meaningful to them.

The JCNL met on four occasions of 3.5 hrs' duration, between April and June 2015. The participants were four nurse leaders from different departments and with varying levels of qualification and leadership experience. Three of the participants had master's degrees.

The form and content of the meetings was a combination of analysis and joint discussions of selected texts (scientific texts, professional articles and book chapters) and teaching on a range of themes that arose for the participants from the texts and about which they wanted to hear more, such as research methods and barriers to implementation.

TABLE 1 Overview of included literature

JC meeting number	Reference	Brief characterisation (research/professional article, book chapter)
1	Malterud (2001)	Research article (in English) Describes qualitative research methods as complementary to quantitative research strategies
1	Wilson et al. (2008)	Research article (in English) Describes action learning as a strategy for reflective enquiry
1	Deenadayalan, Grimmer-Somers, Prior, and Kumar (2008)	Research article (in English) Describes the core processes of a successful health journal club
2	Johansen (2014)	Book chapter (in Danish) Describes managerial perspectives on developing a research culture in a department
2	Kjerholt and Sørensen (2013)	Professional article (in Danish) Describes how the use of a participatory approach to research and leadership in a department can lead to the development of an innovative practice culture
2	Byrne and Keefe (2002)	Research article (in English) Describes how mentoring can be used to build research competence in nursing
3	Rycroft-Malone et al. (2004)	Research article (in English) Describes the multiple factors that can influence the implementation of evidence-based practice
3	Kajermo et al. (2008)	Research article (in English) Describes nurses' self-reported barriers to using research findings in clinical practice
4	Faebo Larsen and Hølge-Hazelton (2014)	Book chapter (in Danish) Discusses the potentials and barriers of establishing a course in facilitating journal clubs among non-medical health professionals[1]
4	Fagerström (2009)	Research article (in English) Describes how use of a theoretical framework (RAFAELA) can be used to facilitate evidence-based human resource management in accordance with patients' care needs

The book chapter is a short version of an article available in English (Faebo et al., 2015).

The texts were selected in advance and during the course on the basis of both literature searches and the group's own knowledge of relevant articles that addressed relevant themes. Themes included journal clubs, health care leadership, management of research and researchers in health care and the creation and development of a research culture. The texts were in both English and Danish, and of a research and professional academic nature (see Table 1).

4.4 | Overview of included literature

4.4.1 | Before the first meeting

On signing up for the JCNL, participants received an information letter from the facilitator containing course background, purpose and a description of the action-based approach. Because an important aspect of action learning is the participants' own reflections, they were asked to write down their reflections before, during and after each JCNL meeting, and submit them either in the form of an email or logbook. Participants were also asked to describe their own personal objectives and goals of participation and these descriptions formed the basis of a joint discussion at the first meeting.

4.4.2 | First meeting

The first meeting began with a presentation round and introduction to the background, purpose and goals of JCNL and the action-based approach. This formed the basis of a discussion among participants about proposed changes to the planned processes, including choice of articles, which would be responsible for analysis, and meeting dates. All the participants had a clear expectation that the content and form of JCNL would reflect their individual learning needs and give them the opportunity to 'spar' with peers, and that this could mean that the formal objectives would not be met.

At the first meeting it was also decided that the facilitator should write a report after each meeting to document participants' reflections and discussions.

4.4.3 | Second and third meetings

Each meeting opened with a follow-up from the previous meeting, based on the minutes, and ended with an evaluation of what participants gained from the meeting, both individually and collectively, and any need to adjust the process for the following meeting.

[1]The book chapter is a short version of an article available in English FAEBO LARSEN, R., MOESGAARD RAVNHOLT, M. & HØLGE-HAZELTON, B. 2015. Establishing a course in how to facilitate journal clubs: opportunities and barriers. *Nordic Journal of Nursing Research*, 35, 29-37.

4.4.4 | Final meeting

The evaluation meeting began with a short repetition of the background, purpose and goals of JCNL. The facilitator then held a group interview with the participants to evaluate the benefits gained from participation, both in terms of the relevance/usefulness of the articles discussed, choice of the action-based approach to learning and their thoughts about the extent to which they had increased their knowledge of leading – and competences to lead – researchers and research in clinical practice.

5 | RESULTS

This section is presented according to the two research questions and quotes from the themes are provided.

5.1 | How did the nurse leaders experience participation in JCNL?

In general, the data revealed that the participant evaluations from each meeting and the final evaluation were very positive, both in relation to the content (the selected texts) and format (action learning and facilitation processes).

As early as the first meeting, the participants pointed out that they did not want the meetings to focus on methodological aspects in their discussions of articles, but on the relevance and transferability of their content to their clinical leadership practice. The participants expressed it like this: 'I should get something out of the texts – 'What's in it for me as a leader, in reading this text?' (meeting 1). They also stated at the first meeting that the key point for all of them was that there should be: 'Openness within the group, but not outside the group. What is said in JCNL remains in JCNL' (meeting 1).

It was the opinion of the participants that the selected texts were relevant and, at times, almost directly transferable to their own practice. 'The articles we've had are really good in relation to research, research leadership and researchers' (meeting 4). 'Some of the texts are almost recipes about how one establishes a research culture in one's own department, and I really got something out of that' (meeting 4).

The texts opened up discussions, not only directly related to the focus of the content, but also about other leadership-related challenges, not directly addressed in the texts. 'JCNL has been a catalyst for reflections and discussions about all possible aspects of leadership.' 'The professional aspects that we've discussed at the meetings are worth their weight in gold' (meeting 4).

Despite agreement from the start regarding the significance of written reflections about JCNL, none of the participants wrote logbooks. The participants stated that immediate leadership challenges and tasks had occupied their consciousness more between the meetings than had reflections about the JCNL itself. 'When I go out of this door, I'm done with JCNL and I'm already thinking about the other things I have to solve … so, it can happen that thoughts (about JCNL) crop up along the way, but I push them to the back of my head until our next meeting'. 'Yes, I think the same – but they get stored anyway' (meeting 4).

As regards the formal purpose of JCNL versus the participants' own individual goals of participation, the participants expressed that they had fulfilled their own goals: 'I think that the individual approach means much more to me than whether I fulfil the formal objective of JCNL' (meeting 4).

The participants also emphasised the significance of being in a group where they felt safe enough to dare show their own vulnerability and lack of competence: 'For me, it's also meant an awful lot to be in a small group with my peers, where I don't have to keep up a facade because I'm a leader – if it hadn't been like that, I'd not have chosen to participate' (meeting 4).

5.2 | Did participation in a JCNL result in the nurse leaders feeling more competent to support a nursing research culture in their departments?

The participants emphasised that the action-based approach was well chosen in relation to the purpose and objectives of JCNL, and in that, as leaders, they were used to reflecting on their practice, making decisions and taking responsibility. They stated that they had discovered several blind spots in their own practice, thanks to the dialogical processes, and thereby had achieved both individual and collective learning in the group, and opened up the possibility of organisational learning: 'The questions you [facilitator] asked, they were spot on, and you could always connect the literature to everyday practice' (meeting 3).

> *'What's so good about this JCNL and this group is that you get to reflect together on a theme – I mean, the space for reflection in the JCNL, it's like a kind of free period, and we leaders need that' (meeting 3).*

They expressed that the JCNL had made them more aware of their competences and responsibility to develop and support a nursing research culture in their departments: 'I think that I've become more aware of an awful lot of things in relation to nursing and research' (meeting 4).

Both the participatory learning approach and the selected texts were considered meaningful and relevant in relation to the development of leadership competences: 'Both in form and content, JCNL has really helped me a lot to develop myself and in developing a strategy for development and research in the department, and I'm already in full swing with that' (meeting 4).

The selected texts were, as mentioned above, found to be relevant and useful on many different levels – including direct applicability to the development of a research culture.

Several of the participants expressed that they found it difficult to put forward an argument about the significance of nurses leading research, but had found the texts and dialogues with other participants helpful in this: 'I can take away from here something in relation to engaging in dialogue with the doctors about, for example, the resources that nursing has to give to doctors' research at the expense of our own

research – I definitely think that our ability to relate critically to this has improved' (meeting 4).

Despite the participants' agreement that JCNL had made them more aware of how they could support a nursing research culture in their departments, all of them also expressed that they wanted to continue with this JCNL: 'I think that this journal club is only the very beginning, and I would very much like it to continue, so that we can become even sharper at leading research and researchers' (meeting 4).

In relation to the theme 'Facilitator's role and skills', the participants expressed: 'I think that the leader of a journal club should be a facilitator, precisely because it should be action-based – there should be some interaction, some activity, and if it were to be led in a different way, for example, formal lecturing, it would give it a different direction'. 'Yes, the facilitator role is a good idea – I've heard that, in other journal clubs, there is a teacher who stands and says what you are going to do and not going to do, and, as a leader, that's not something I need' (meeting 4).

The results presented in this section clearly demonstrate that participation in an action learning-inspired JCNL, lead to an improvement in their self-perceived competences to support a research culture in clinical nursing practice.

6 | DISCUSSION

The findings show that, in addition to being a learning network, JCNL also served as a leadership forum, supervision forum and sparring network for participants, in terms of the challenges faced in leading research and development in their respective departments. Action learning as a pedagogical method was found to support this.

Participants indicated that one of the most beneficial outcomes of participating in JCNL was that it provided an opportunity to discuss their current practices and their problems/challenges with peers. This could be interpreted that it is not enough that leaders just read and discuss selected texts, but that they need input from other leaders and a facilitator to gain from other(s') perspectives on a specific issue or problem area and, thus, uncover blind spots and unknown areas (Bondas, 2010). The findings could also indicate that the most important aspect for the leaders, in terms of increasing their knowledge and awareness concerning the management and support of research in clinical practice, is the opportunity to participate in a safe and appreciative learning environment with peers, where they are challenged and dispel their preconceptions. This is supported by other studies (Wilson et al., 2008).

Regarding the facilitator role the participants indicated that it supports the desired process, as opposed to traditional and authoritative teacher role competences, where the teacher teaches the participants in relation to predefined themes. The participants indicated that they needed a dialogue partner who had expertise in both management and research in addition to competences as a facilitator.

Participants generally did not reflect between meetings on the discussions held at JCNL, although they said they were both relevant and significant. They stated that they solved one task at a time and reflected in relation to this task, either just before or during the meeting. The reason for this is, presumably, the fact that they have to undertake multiple tasks in which they have to deal with just about everything that takes place in the organisation, and often carry out ad hoc tasks (Kanste, Kyngäs, & Nikkilä, 2007). In a learning translation perspective (Faebo, Moesgaard, & Hølge-Hazelton, 2015; Holton, Bates, & Ruona, 2000; Merriam & Leahy, 2005), it is problematic that the workplace learning transfer climate and culture does not seem to include space for reflection in between meetings. It may therefore be necessary to address and take account of managers' workloads and practices in planning and implementing journal clubs for leaders (Lachance, 2014).

This JCNL had a different purpose to other, traditional journal clubs. The participants had chosen to build up a journal club as a framework in which they could develop their competences in relation to supporting a research culture. The pilot project showed that participation took the form of that known in clinical supervision, which is characterised by being 'a house for complex feelings and thoughts' (Bondas, 2010). Both in clinical supervision and action learning, the facilitator's competences are the crucial factor in successful outcomes for participants.

7 | STRENGTHS AND LIMITATIONS

This article reports on a pilot study and provides valuable insights into establishing action learning-based journal clubs for nurse leaders. The pilot study only involved four participants, which can be seen as a limitation. Therefore, this pilot study can be viewed as a basis for carrying out a full-scale study according to JCNL.

Communicative validity was sought by inviting the participants to read and comment on the article, which they did and they all agreed upon the content.

Each item of data agreed with all the others – hence there was no conflict in the data.

8 | CONCLUSION AND PERSPECTIVES FOR PRACTICE

An action learning-inspired JCNL can be useful and meaningful to nurse leaders. In this case, participation in the JCNL made the leaders more confident with their competences of supporting a nursing research culture in their departments. In particular, the appreciative interaction and dialogues among the participants and the competences of the facilitator were highlighted as key factors in relation to developing the participants' leadership competences, because the dialogues revealed the participants' blind spots and unknown areas.

This pilot study has revealed important aspects to take into account when an organisation wants to establish and implement JCNL. Similarly, the study linked JCNL and action learning, which proved to result in synergies and positive outcomes in relation to the development of the nurse leaders' personal and professional competences.

Furthermore, the study revealed the desire and need of the participants to continue JCNL to ensure the continuous professional development of peers regarding managerial challenges, which is an important perspective to take into account, from a management and organisational perspective.

It would therefore be appropriate to examine, by an evaluation focus group interview with the participants, whether and how the impact and outcomes of this learning intervention are sustained after 1 year.

The study has already formed the basis for the creation of new JCNLs in Region Zealand. It has also created valuable insights into aspects to include or exclude in a larger, forthcoming study.

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Research and Development Culture

- Leaders with Determination and Courage

is a book in which leaders at Zealand University Hospital – from ward managers to executive level – share how they have worked to establish and develop a research and development culture.

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Brendan McCormack, Professor of Nursing.

"I take my hat off to the ZUH leadership team. To the work they have done, the work they continue to do and the sharing of their narratives in this book"

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Zealand University Hospital has over several years worked determined to develop evidence-based practice. This has resulted, among other things, in the employment of several researchers with a nurse/allied health professional background as well as in the building and development of local nursing research environments. This development places new demands and adds further complexity to the leadership role.

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The book is the fourth in a series about the work with research and development culture in Region Zealand and it fits into the current discussion about how to build capacity, develop a profession culture and get research and development to fill in a busy everyday life.

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