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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

The importance of inspiring a shared vision

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Abstract

Background: Leadership programmes have been used to support nurse leaders in developing their skills and equipping them as transformative change agents in healthcare organisations around the world. For this purpose, the Royal College of Nursing's Clinical Leadership Programme has been adapted, implemented, and evaluated in Switzerland. Although a shared vision is a key element in leading organisations and in change, the impact of such a vision on clinical practice is rarely described in the literature.

Aims and objectives: To determine qualitatively the benefits of a shared vision as one essential feature of leadership behaviour.

Methods: In the context of a mixed methods research study, individual interviews with nurse leaders, as well as focus group interviews with their respective teams, were recorded and transcribed verbatim prior to qualitative content analysis. In order to integrate all findings, a triangulation protocol was applied after separate analysis.

Findings: Having a vision helped leaders and their teams to become inspired and committed to a shared goal. Moreover, the vision was a strong driving force for ongoing and systematic practice development and thus established a culture that favoured quality and safety improvement in patient care. However, the strategic direction needed to be tempered; the positive impact on teams and their care practices generated a great deal of enthusiasm, which had the potential to overload the organisation through taking on more than could reasonably be accomplished.

Conclusion: The study found that a vision provides orientation and meaning for leaders and their teams. It helps them to focus their energies and engage in the transformation of practice. However, it is very important for leaders to monitor closely the energy level of teams and the organisation, in order to maintain the balance between innovation/transformation and relaxation/recovery.

Implications for practice:

- A vision provides orientation and meaning for leaders and their teams and is a strong driving force for ongoing and systematic practice development
- The enthusiasm at the beginning brought about the danger of starting too many activities, thus overloading the organisation. Therefore, it is important for leaders to maintain the balance between innovation/transformation and relaxation/recovery
- Care should be taken to ensure that a vision and corresponding core values are realistic and achievable. Otherwise, the vision might remain an unattainable illusion, and the individuals who are supposed to turn it into reality may become frustrated and demotivated

Keywords: Leadership programme, nurses, vision, practice development, evaluation, triangulation

Introduction

Effective leadership is an essential attribute for the provision of professional and high quality healthcare, which refers to care that is person centred, evidence based and outcome oriented (Kramer et al., 2004; Manojlovich, 2005a; 2005b; Alleyne and Jumaa, 2007). Effective leadership is also critical for improving the quality and safety of patient care while balancing the increased demands for cost effectiveness (Wong and Cummings, 2007; Watkins, 2010). One key element in effective leadership is inspiring a shared vision, which is a major element of change processes in terms of providing orientation and engaging the whole system towards excellence in healthcare practice (Lukas et al., 2007; McCormack et al., 2007).

However, to achieve effective leadership practices, there needs to be a shift from hierarchical approaches to leadership styles that encourage shared governance and facilitate staff empowerment (Williamson, 2005). With this kind of leadership approach, leaders are better able to convey the need for change, question existing practice, create a vision for the future and develop new models of service provision (Dixon, 1999; Porter-O'Grady, 2003). Transformational leadership is one such approach and has been shown to have a high impact in nursing – on practice changes in care provision and on the development of an organisational culture that is receptive to progression and change (Shaw, 2005; Field and FitzGerald, 2006). The development of transformational leadership skills among nurse leaders is important for healthcare organisations seeking to achieve high quality care (Trofino, 2000; Donaldson, 2001; Cook and Leathard, 2004; Davidson et al., 2006; Watkins, 2010) and an effective workplace culture (Manley et al., 2011). Therefore, a Clinical Leadership Programme for nurse leaders was set up in 1995 by the Royal College of Nursing (RCN) and then delivered internationally (Cunningham and Kitson, 2000).

The need for enhanced leadership skills is also evident in the Swiss healthcare context (De Geest et al., 2003) and in 2006, the RCN's programme was adapted and implemented in the German speaking part of Switzerland for nurse leaders. One of the adaptations was an explicit focus on the development of a unit based vision, since 'to inspire a shared vision' is one of the main competencies of transformational leaders (Kouzes and Posner, 2007; 2010). Previous research asserts that a vision is an extremely powerful tool for driving an organisation toward excellence, and developing a clear vision is the best way to clarify the direction of change (Hoyle, 2007). Moreover, the aim of a vision is to display a picture of a better and more worthwhile future state, which, in healthcare, means an improvement in service delivery. Therefore, participating ward leaders were challenged to develop a shared vision for their unit, as well as corresponding goals and actions, and thus to focus available resources on targeted and evidence based developments in practice. It should be noted that German speaking nurses and nurse leaders seldom use the word 'vision', preferring terms such as 'strategy' and 'strategic direction'.

Although there is a shared understanding in the literature of how important and critical a vision is for outstanding leadership and effective change in organisations (Viens et al., 2005; Felgen, 2007), little is known about the experience of nurse leaders and their teams in developing a vision, or about the impact of a vision on their work and on practice development. Greater knowledge and understanding in this regard may help healthcare leaders to focus energy in this area and secure the resources required to achieve the targeted transformation in practice.

This paper reports on findings from the second, qualitative phase of a mixed methods research study whose overall purpose was to evaluate the impact of the Clinical Leadership Programme in Switzerland. The study was organised in two distinct sequential phases. The first, quantitative phase focused on the evaluation of leadership competencies of programme participants; the second, qualitative phase focused on explanation and validation of the quantitative results obtained in the first phase by exploring participants' views in greater depth.

One particular goal of the qualitative phase was to determine the benefits of a shared vision and corresponding strategies for leaders and their teams, as one essential practice of leadership behaviour

(Kouzes and Posner, 2007). Therefore individual interviews with nurse leaders, as well as focus group interviews with their respective teams, were conducted. In order to integrate the findings of all in-depth interviews, a triangulation protocol was applied. This article reports on the triangulated results from the qualitative follow-up to address the research question:

What was the influence of a vision or strategic direction on practice/practice development?

Theoretical framework

This study was underpinned by two theoretical perspectives. First, the theory of learned leader behaviours of Kouzes and Posner (2007), a transformational leadership theory that postulates that leadership behaviour can be observed and learned. Research within the field has documented a consistent pattern in the characteristics of admired leaders across countries, cultures, organisations, hierarchies, gender, education, and age groups (Kouzes and Posner, 2007). The five fundamental practices of exemplary leadership have been defined as:

1. Modelling the way
2. Inspiring a shared vision
3. Challenging the process
4. Enabling others to act
5. Encouraging the heart

The second theoretical perspective was the conceptual framework of practice development by Garbett and McCormack (2004), who define practice development as a systematic and ongoing process towards effective and person-centred care. Practice development facilitators initiate and support an emancipatory process of change that reflects the perspectives of patients and healthcare providers (Garbett and McCormack, 2002; Sanders et al., 2013). This emancipatory approach aims to empower and enable healthcare teams to transform the culture and context of care in a way that will result in sustainable change (McCormack and Titchen, 2006; Shaw, 2013). Over the past 10 years, various researchers have explored and further developed conceptual, theoretical and methodological elements in the framework to guide practice development activities internationally (McCormack et al., 2007; Manley et al., 2008). Moreover, an international network has been established to facilitate the systematic collaboration and sharing of knowledge in this field. The two perspectives serve as the theoretical framework not only for the study but also for the Swiss Clinical Leadership Programme.

Method

Design

A qualitative research approach within a mixed methods design was used. The overall evaluation study was guided by a sequential explanatory strategy, characterised by collecting and analysing quantitative data in phase one, with a qualitative follow-up in phase two (Creswell and Plano Clark, 2007). In the second phase, the quantitative results obtained in the first phase were further explored by in-depth interviews. The priority in the study was given equally to the qualitative and quantitative approach, because the two phases of the study had shared as well as individual goals. By collecting the quantitative data with Kouzes and Posner's (2003) Leadership Practice Inventory instrument, all five leadership practice behaviours, including 'inspiring a shared vision' were described. However, to be able fully to interpret and to enhance the understanding of these results (Morgan, 1998), the quantitative data were supplemented by qualitative data, gathered through focus group and individual interviews. The integration of methods occurred in different stages of the research process but mainly at final stage by the use of a triangulation protocol (Farmer et al., 2006). Triangulation enhances the validity of research results when multiple methods are employed and produce convergent findings about the same empirical subject (Erzerberger and Prein, 1997). This can lead to a multidimensional understanding of complex phenomena (Farmer et al., 2006), enhanced data richness and greater trustworthiness of findings (Lambert and Loiselle, 2008). Taking a triangulation approach for the study meant that it was possible to gain a more comprehensive understanding about the impact of a vision on clinical practice.

Participants

In mixed methods, sequential, explanatory design, different options exist for case selection in the qualitative part: exploring a few typical cases, or following up with outlier or extreme cases (Ivankova et al., 2006). In this study, nurse leaders and their respective teams were purposefully selected with an extreme case sampling approach for individual in-depth and focus group interviews. The sample population comprised 14 nurse leaders from the first two cohorts of the Clinical Leadership Programme, who were recruited on a voluntary basis after extensive information about the programme's intentions and content. The six interview partners, three women and three men, were selected from this sample population by calculating and selecting the participants with lowest and highest scores of Kouzes and Posner's (2003) Leadership Practice Inventory subscale 'inspiring a shared vision' in the quantitative data. Focus group participants were recruited from teams of interviewed nurse leaders and were identified in a similar way, resulting in four groups, with four to seven participants each. All needed to be registered nurses or midwives with different lengths of job experience. In total, 20 team members participated in the focus group interviews.

Data collection

Data were collected using semi-structured interview guides developed in two independent discussions with members of the research team (two research professors and a senior educator/practice developer), focused on material related to the study's objectives. The phrasing and sequencing of questions followed the recommendations that questions should be conversational and easy to understand, open enough and non-directive to give participants as much latitude as possible for responses. Questions should also be ordered in a logical flow from general to specific (Krueger and Casey, 2001; Helfferich, 2005; Kruse, 2014). All interviews were audio recorded and transcribed verbatim for analysis. The focus group interviews were conducted by the first author as moderator and an experienced qualitative researcher as co-moderator; the latter took additional field notes about the group engagement processes, to provide context. After each interview the co-moderator undertook member checking (Kidd and Parshall, 2000), by summarising key points of the group discussion and asking participants for confirmation, clarification or completion. Directly after the discussion, moderator and co-moderator exchanged their overall impressions and key insights as a first step in the analysis.

Data analysis

The data were analysed using Mayring's (2000; 2003; Mayring and Gläser-Zikuda, 2005) qualitative content analysis, which allows a large quantity of material to be reduced to a manageable size and the most significant content to be obtained. There are two main approaches within these procedures of text interpretation: inductive development of categories and deductive application of categories. In this study, inductive category development was applied by working through the data and developing the categories as close as possible to the material, in a tentative and step-by-step process. For focus group interviews, this step-by-step process was combined with cognitive mapping (Northcott, 1996; Pelz et al., 2004), which is useful for handling a large amount of data material in a structured way. At the same time, it encourages creative and imaginative work (Northcott, 1996; Semple and McCance, 2010). After the inclusion of representative quotes from the transcribed text, a peer review of the categories and themes was carried out by three experienced qualitative researchers, and some participating leaders provided feedback on the findings of the individual interviews to ensure that their own meanings and perspectives had been represented. Thus, different techniques were applied to enhance the rigour of the analysis, such as member checking, peer debriefing, and a comprehensive description of findings, with participant quotations to illustrate the themes and interpretations (Graneheim and Lundman, 2004; Tong et al., 2007).

In order to integrate the research findings from the various sources and gain a more complete picture that would increase the validity of results, a triangulation protocol was applied. The triangulation process consists of a number of steps, which are described in more detail by Farmer and colleagues (Farmer et al., 2006). The findings from each component were first sorted and listed on the same

page in order to decide whether there was agreement, partial agreement, discrepancy/dissonance or silence between them regarding the research question. Silence in this context means that a theme occurs in one dataset only and not in others. This assessment was then displayed in a convergence coding matrix (see page 8). In the last step, the triangulated results were discussed in the research group for review and clarification (Farmer et al., 2006).

Ethical considerations

Participation in the study was voluntary. Informed consent procedures were designed to provide nurse leaders and team members with sufficient information to allow for a considered decision about the potential inconveniences and benefits of participation in the interviews. The study operated according to principles of confidentiality and, as such, all statements by participants made during the qualitative phase of this project have been handled anonymously and appropriately. Leaders and their team members selected a pseudonym from a list of names and these were used in the transcripts to guarantee confidentiality. Consent for the study was obtained from the local ethics committee, the hospital's management, and a university.

Findings

Nurse leaders' characteristics

Half of the six interview participants were women. All leaders were between 41 and 55 years of age. The mean length of work and management experience in healthcare was high at 25.3 years (minimum 19, maximum 30 years) and 11.8 years (minimum one, maximum 21 years), respectively. Only one of the six was a novice leader at the beginning of the programme; all others were experienced clinical leaders with a minimum of eight years in a leading function.

Team members' characteristics

Overall, 15 women and five men took part in the focus groups. All worked in different clinical settings, but only seven people were in full-time employment. They worked on inpatient and outpatient units and the spectrum of fields ranged from geriatric to intensive care. The mean age of participants was 47.15 years (minimum 29, maximum 61 years old) and the mean years of job experience was also rather high at 24.5 years (minimum five, maximum 42 years).

Application of the triangulation protocol, step 1: sorting

The two sets of findings were reviewed separately to identify the key themes related to the guiding research question: *What was the influence of a vision or strategic direction on practice/practice development?* The key themes identified from the individual and focus group interviews were:

- Mediating/providing orientation and meaning
- Steering practice development systematically
- Facilitating motivation, integration and identification
- Promoting quality improvement
- Promoting collaboration and recognition
- Acceleration
- Dilemma
- Incongruence

The selected findings were then sorted and displayed in a unified list of themes for comparison. Table 1 presents an overview of the findings. The left hand column lists the identified themes with the number of mentions in each dataset. In the last column on the right, specific quotes from the interview sets are listed to support or explain the themes.

Table 1: Sorting of key themes regarding the influence of a vision on practice

Theme	Focus group interviews Number of mentions	Individual interviews Number of mentions	Quotes: examples
Mediating/ providing orientation and meaning	12	10	Q1: Mark: <i>'I need to know where I'm going in the longer term... and that's also incredibly helpful in a leadership role too because it enables you to develop a strategy based on the vision, to know what the key milestones are and what we ultimately want to achieve together'</i> (leader) Q2: Juliette: <i>'I think the more you are aware of it (the mission statement), perhaps re-reading it occasionally, the more it becomes internalised. It becomes part of your own beliefs and values. You buy into it or you don't... It gives me a real sense of direction, something to really hold on to'</i> (team)
Steering practice development systematically	0	13	Q3: Alexandra: <i>'I believe that any practice development should be informed by the vision... I do believe that's helpful because it encourages me to stop and think if something makes sense or not – is it right, am I on the right track?'</i> (leader) Q4: Anne: <i>'You need to break the vision down into measurable, bitesized chunks in order to make it real for staff working at the frontline, either through training or project work... otherwise there would be no consistency in the direction of travel. There would just be lots of finished pieces of work but it helps in sorting and prioritising them and establishing the extent to which progress is being made'</i> (leader)
Facilitating motivation, integration and identification	15	16	Q5: Meret: <i>'There is more obligation to engage or to try hard to provide good care. Therefore, it gives you a push... I think one needs something repeatedly that gives you the motivation to work at your best'</i> (team) Q6: Simone: <i>'I raise it. Usually there is a situation involving a patient, or you hear something at a meeting, or something goes wrong – I can seize those opportunities... Using case studies can also be really helpful. One way or another, I need to address it'</i> (leader)
Promoting quality improvement	21	10	Q7: Tobias: <i>'I think there has been a really significant shift over the past few years: we now have some clear standards. We are trying to gather an evidence base so that I can go to my colleagues and say something is outdated and we need to start doing it differently based on the evidence'</i> (team) Q8: Mark: <i>'This means working together with the team in accordance with the vision and strategy. Enabling them to become more autonomous. Improving quality in the context of the vision'</i> (leader)
Promoting collaboration and recognition	18	5	Q9: Robert: <i>'In the meantime, our case study presentations have become so popular that we've had to open them up to staff from other wards... It's like a new way of working'</i> (leader) Q10: Paula: <i>'I think the standing of our ward has improved across the entire hospital... We get calls from other departments about managing confusion... they want our help and that is another indication that we are accepted and respected'</i> (team) Q11: Jasmin: <i>'Patients can tell that the team is clear about its purpose. I think it is great when patients give us feedback which suggests they perceive us working well as a team. They don't talk about having a vision but that we work well as a team and that tells me we are making it tangible'</i> (team)
Acceleration	11	3	Q12: Sarah: <i>'With a mission statement the tendency is to do more and more. But I think sometimes it's important to press the pause button occasionally... to recharge the batteries'</i> (team) Q13: Alexandra: <i>'I really make sure it doesn't place excessive demand on colleagues. I think it has been difficult in the past because sometimes there has been loads of change and every now and again they have said they are fed up with it all'</i> (leader) Q14: Robert: <i>'That was exactly this issue in the team. High levels of motivation and at the same time a kind of weariness because we hadn't really allowed sufficient time for things to bed down, for the team to become confident in the new way. We've made enormous strides and so, too, the team. But this year we've decided to focus on smaller wins, to take things a bit more slowly... and the team has responded really well to this change in pace'</i> (leader)
Dilemma	9	0	Q15: Judith: <i>'It all comes down to what we understand by a mission statement and what would be optimal for us. If we're not able to make it happen then it is frustrating'</i> (team)
Incongruence	10	0	Q16: Jenny: <i>'It's waded in front of us when it suits but when we are short staffed for example and we draw attention to it, then it's always – yes, yes, I'm sorry, there's nothing we can do about it, you just have to make do... Well, then it feels wrong to me because we are not giving the mission statement the importance it deserves'</i> (team)

Mediating/providing orientation and meaning: Leaders and team members experienced that visions had provided clear orientation and a strong purpose in practice. A vision helped nurse leaders to stay on track while working towards the common goal, and accordingly to set priorities in practice development work. Most of the team members participating in this study reported that reflecting on the vision and on core values helped them to become aware of what was requested and to be able to internalise the direction for change. Moreover, it supported their engagement with the same goals in the transformation of practice. As a result, they were able to focus their energies and work in the same direction.

Steering practice development systematically: It was evident from the results that clinical leaders steered practice development more systematically and efficiently if they employed strategic goals, heading towards a higher goal as articulated through a shared vision.

In the sometimes messy reality of day-to-day work, some leaders did find it a challenge to carry out practice development systematically. Despite this, they described how the vision and strategic goals helped them in their decision making processes, as well as in setting priorities and evaluating the progress in practice development. However, no information about this issue was offered by participants in the focus group interviews.

Facilitating motivation, integration, and identification: Identification and hence ownership depends on the integration of teams in the developmental process of a vision. In this study, it was clearly easier for leaders of smaller teams to involve their teams in a bottom up approach, meaning that the team was integrated from the very beginning into the creation of a shared vision. By contrast, leaders of larger teams had a greater challenge regarding the achievement of a shared vision, reflecting the wider span of control. They could only create the vision in a top down approach with a small selection of staff members, so the integration of the entire team remained a huge challenge in the following transfer phase.

Irrespective of the size of team, the most important steps towards integrating teams were undertaken in practice development projects, where team members were part of the project team and knew how the project connected to the overall vision. Focus group participants experienced the strategic direction and the shared values as a strong driving force in their clinical practice. They described how it provided a purpose that facilitated motivation and identification at an individual level.

Promoting quality improvement: A strategic direction with defined values and corresponding practical activities was also seen as promoting quality improvement in the field. Team members experienced a shift from more traditional to evidence based, standardised care in their clinical practice, which helped them to, among other things, speak up and address outdated behaviours that they observed in others. Most importantly for the participants, the vision mediated the need for continuous development in practice – as a result of working with a vision or mission statement, participants realised that change is inherent in today's world. Although quality improvement was not a subtheme in the individual interviews with the leaders, they did talk about it in the context of the vision, but it was less in their focus.

Promoting collaboration and recognition: The vision or strategic direction had an impact on both the individual practitioner and the entire team. In one focus group, participants stated that having the vision had provoked a higher commitment to professional practice, which in turn facilitated their personal growth. This resulted in greater confidence and self-mastery in respect of their practice expertise, as well as a feeling of greater autonomy in practice. This increased confidence in turn gave them greater recognition within the interprofessional team and the broader organisation.

A further positive aspect of a vision which was discussed was that participants experienced the strategic direction as a basic requirement for team and interprofessional collaboration, since it provided a unifying framework and all members of the team could engage in working towards a shared goal. These combined efforts enhanced their likelihood of success, they felt.

Acceleration: The findings discussed above show clearly that there were a number of very positive aspects to using a vision in nursing practice. However, this positive impact on teams and their care practices had a negative counterpart: the acceleration trap. Because many team members felt so enthusiastic at the beginning of the change processes in their units, they sometimes ran the risk of starting up too many activities at the same time and thus overloading the organisation. As a result, the team began to feel overwhelmed by the scale of the changes and stopped feeling so engaged with the transformation of practice.

Dilemma: On a personal level, participants experienced dilemmas when they had not been able to perform according to the defined values and standards. Some described feelings of frustration when confronted with the restraints of the institution, since they knew exactly which kind of care they wanted to perform in order to act professionally but, because of organisational constraints, felt unable to provide that care. This gap between the ideals of the vision and the care that could be provided sometimes provoked feelings of shame and distress.

Incongruence: In their day-to-day practice, some focus group participants experienced that the priorities and activities were not always congruent with the strategic goals and common core values. They acknowledged that it is not always possible to focus on best practice but they were critical that the decision making process of the management was not transparent enough and thus not sufficiently comprehensible for team members.

Application of the triangulation protocol, step 2: convergence coding

In the second step, the two sets of findings were compared regarding the meaning and interpretation of themes, the prominence and coverage of themes, and respective quotes that supported a specific theme. Afterwards, the convergence coding scheme was applied to decide whether the findings agreed (convergence), offered complementary information or contradicted (dissonance) each other (Table 2).

Table 2: Convergence coding matrix				
Theme	Theme meaning, prominence, and coverage			
	Agreement	Partial agreement	Silence	Dissonance
Mediating/providing orientation and meaning				
Steering practice development systematically				
Facilitating motivation, integration and identification				
Promoting quality improvement				
Promoting collaboration and recognition				
Acceleration				
Dilemma				
Incongruence				
TOTALS	2	3	3	0

Application of the triangulation protocol, step 3: convergence assessment

In the comparison of findings, there were two themes in which there was agreement in meaning, prominence and coverage. One of these themes was *providing/mediating orientation and meaning* and the other was *facilitating motivation, integration and identification*. Although the wording of both themes was slightly different in the two sets of data, the meanings behind them were broadly similar. For leaders as well as for team members, a vision or strategic direction provided orientation in practice in a way that transcended the daily workload. This was true for all leaders and all focus groups, and the frequency with which the themes were mentioned by interview participants was comparable. It was also evident throughout both datasets that team members had been integrated in the developmental process of strategic directions to some extent but mainly in the area of clarification of core values and in the subsequent translation of the strategy into practical activities. It can therefore be said that the integration and identification of teams took place mainly in relation to the conjoint transfer of the vision into practice. This theme had agreement on all three components of comparison too.

In contrast to the themes discussed above, the themes *promoting quality improvement, promoting collaboration and recognition, and acceleration* had only partial agreement. Each of these themes originated from the four focus group interviews and was also mentioned by some of the leaders, but only as isolated quotes. However, there was quite a large difference in either the prominence or in the coverage, as only some of the groups or leaders addressed the subjects during the interviews. For example, *acceleration* was mentioned by three out of four focus groups but only by three leaders during the individual interviews. Although the aspect of acceleration was not mentioned in one team, that team's leader (Q14) raised the topic spontaneously in his individual interview, revealing that a year ago they had slowed down the pace of change because he realised that, while his team members were highly motivated, they were also exhausted by the high number of practice development projects. So it can be concluded that acceleration was a problem for all participating teams.

The last three themes, *steering practice development systematically, dilemma and incongruence* were silent from one dataset to the other. In all three subjects this can be explained by the different perspectives of interview participants. Leaders addressed the issue of steering practice development systematically from the point of view of their leading position and responsibility. It would have been very surprising if staff members had addressed practice development in a similar way, unless they had been designated to perform a special role in this context. It was also expected that the other two themes – dilemma and incongruence – would be experienced primarily by staff nurses because they work in practice and can perceive a tension between the ideal of the vision and the reality of their work.

In summary, there was either full or partial agreement between the two datasets on 62.5% of the themes and no instances of dissonance of findings in the convergence assessment.

Application of the triangulation protocol, step 4: completeness comparison

Based on the convergence assessment, it is evident that many core themes are confirmed or partly confirmed by the two qualitative datasets, but with a different emphasis. The two sets provided a different perspective on key themes but the triangulation of findings enabled the views of the leaders and those of the teams to be related to and compared with each other regarding the research question. The triangulation provided a more complete picture and thus enriched the findings of this study on the influence of a vision on practice development. Practice development is a continuous change process that a leader can only initiate and pursue as a goal together with his/her team; it is therefore of value to bring the two perspectives purposefully together.

Discussion

This qualitative study part explored the effect of a shared vision or strategic direction on practice and practice development. It showed that the influence of such a vision is considerable and thus it is

essential to underpin practice development work. A vision provides the direction for change and helps to inspire individuals as well as to focus the energies of all team members. The data also revealed some threats on a personal and organisational level, which need leadership attention.

Leaders and team members experienced that the vision had provided clear orientation and a strong purpose in practice. It helped them to stay on track and to set priorities accordingly. Moreover, it helped them to engage towards the same goals in the transformation of practice. Although most of the focus group participants did not talk about 'a vision' – instead they talked about terms such as 'strategy', 'strategic direction', 'mission statement', and 'portfolio' – the importance of having shared values and defined goals was pointed out. The importance of a vision for practice development has been widely addressed in the literature too (Manley, 2001; Garbett and McCormack, 2004; Hickey and Beck Kritek, 2012). A common vision across stakeholders provides clarity of values and beliefs and is essential to guarantee that there is an agreed focus and targeted outcomes (Boomer et al., 2008; Shaw et al., 2008; Mayer and Carroll, 2011).

A vision can be of help in doing practice development work more systematically, which means that evaluations of all projects need to be planned in order to judge the effects of practice change and not rely solely on anecdotal evidence (Manley and McCormack, 2004; Wilson et al., 2008; Hardy et al., 2013). In this study, the vision and the subsequent annual strategic goals helped the participating leaders to sort, focus, prioritise, and evaluate practice development projects. Moreover, it made them aware of the necessity to evaluate their performance in order to steer change processes purposefully in practice. Practice development research is increasingly calling on practitioners to take a systematic approach to the task of improving patient-centred care (Barrett et al., 2005; Bucknall et al., 2008; Wilson et al., 2008). The main argument used to justify such calls is that systematic work is more likely to result in successful outcomes, enhanced credibility to the health authority and greater cost effectiveness (McCormack and Garbett, 2003; Garbett and McCormack, 2004).

A key purpose of practice development work is to transform the culture of care into that of an effective workplace that adapts and responds to change (Manley, 2004; Bevan, 2010; Manley et al., 2011). Such a culture enables individuals to develop their own potential and their practice (Manley, 2004; Manley et al., 2011). The empowerment of team members is key for this process as individuals need to have a sense of vision and ownership (Shaw et al., 2008). However, this identification and hence ownership also depends on the integration of teams at the ward level in the development of the vision. In this study, it was clearly easier for leaders of smaller teams to involve their teams in the development process because they could use a bottom up approach, meaning that the team was integrated from the beginning into the creation of a shared vision (Martin et al., 2014). By contrast, leaders of larger teams had a greater challenge regarding the achievement of a shared vision, reflecting the wider span of control. They could only create the vision in a top down approach with a small selection of staff members, so the integration of the entire team remained a huge challenge in the following transfer phase. Irrespective of the size of team, though, the most important steps towards integrating teams were undertaken in practice development projects, where team members were part of the project team and knew how the project connected to the overall vision.

The vision or strategic direction had an impact on the individual practitioner and the entire team. In one focus group, participants said having the vision had provoked a higher commitment to professional practice, which they felt had in turn facilitated their personal growth. This resulted in greater confidence and self-mastery as well as in greater autonomy in practice. Empowering practitioners in order to develop their professional competencies as well as their collective service is a key purpose of emancipatory practice development work (Manley and McCormack, 2004; Dewing, 2008).

In this study, a strategic direction with defined values and corresponding practical activities was seen as promoting quality improvement in the field. Focus group participants experienced a shift from more

traditional to evidence based, standardised care in their clinical practice. Most importantly, the vision mediated the need for continuous development in practice – as a result of working with a vision, participants realised that change is inherent in today's healthcare arena. A similar emphasis on quality improvement is also the *raison d'être* of practice development work, in order to achieve better or best care for healthcare users (Manley and McCormack, 2004).

One risk of working with a vision that was identified in this study is the danger of having too many activities, and thus overloading the organisation at the unit level. This risk was identified by focus group members and also some nurse leaders. Although numerous organisations do undergo regular change and therefore experience the acceleration trap – a phenomenon that was for the first time described in the management literature by Bruch and Menges (2010) – a publication addressing a similar phenomenon could not be found in the nursing literature. This is likely to be because this issue of acceleration in change has not been studied in healthcare. However, it would be interesting to do further research with this focus in clinical practice and compare the results with the overall performance of the organisation, since it is very likely that people become exhausted by the accelerated pace of change and that this has an impact on their work.

The two other threats, *dilemma* and *incongruence*, address the gap between the ideals of the vision and the current service provision, experienced on a personal and organisational level. On the personal level, some participants described feelings of frustration and shame when they had not been able to perform according to the defined values and standards. On the organisational level, they described the incongruence between the shared values and the priorities and activities in daily practice. However, there is a positive aspect to these responses, as the primary driver for developing practice is precisely this awareness of a lack of fit between the care provided and the needs of the users. A learning process is then required to identify and analyse problems (Clarke and Wilson, 2008). Moreover, emancipatory practice development can enable practitioners to recognise the power and limitation of their individual influence and to deal with restraints more creatively (Manley and McCormack, 2004). Nevertheless, the experiences of participants in this study emphasise that care should be taken to ensure that a vision and corresponding core values are realistic and achievable. Otherwise, there is a danger that the vision will remain an unattainable illusion, and the individuals who are supposed to turn it into reality will become frustrated and demotivated.

Limitations of the study

This study explored and described the effect of a shared vision or strategic direction on practice and practice development as experienced by nurse leaders and their teams. The average age and leadership experience of the included nurse leaders was high, which might be an advantage in developing and implementing a vision into practice. However, due to the lack of a comparison group with younger/less experienced leaders, and to the small sample size, this study cannot verify that. Moreover, the study was undertaken in only one Swiss hospital and therefore provides only preliminary results that need to be verified through further research. The triangulation of two datasets and the selection of interview participants as extreme cases according to their scores from the quantitative part strengthen the study results. Nevertheless, more studies in this field are needed in order to describe fully the phenomenon in healthcare settings and to see whether similar patterns emerge in other organisations/countries.

Conclusion

Engaging team members in a shared vision is not only a key component of a transformational leadership style but is also essential in practice development activities in order to provide direction and clarity of purpose (Felgen, 2007; McCormack et al., 2007). Thus, inspiring a shared vision is a very strong tool for the successful transformation of practice, as a vision releases four main forces in an organisation: attracting commitment and energising people, creating a meaning for people's work, establishing a standard of excellence, and bridging the present and future (Nanus, 1992).

Implications for practice

This study found that a vision or strategic direction provides orientation and meaning for leaders and their teams and is a strong driving force for ongoing and systematic practice development. It helped participants to focus their energies and engage in the transformation of practice. However, it is very important for leaders to monitor closely the energy level of teams and the organisation, in order to keep the balance between innovation/transformation and relaxation/recovery.

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