

Évaluation des échelles de leadership sous l'angle de leur élaboration et de la psychométrie

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Cette étude vise à élaborer deux échelles de leadership soutenant et à en évaluer les propriétés psychométriques. Il s'agit d'une échelle de soutien dispensé par les infirmières responsables [*Charge Nurse Support Scale*] et d'une échelle de soutien dispensé par les chefs d'unités [*Unit Manager Support Scale*], conçues pour des environnements de soins à long terme. Ces échelles d'auto-vérification contenant six points ont été appliquées auprès de 70 membres du personnel infirmier et la fiabilité de consistance interne, la fiabilité de test-retest, la validité de contenu, la structure factorielle et la validité conceptuelle ont été évaluées. La validité de contenu a été établie avec l'aide d'experts. Les résultats ont démontré que les deux échelles étaient fiables. Conformément à l'hypothèse, l'étude a révélé une relation significative entre le mesurage de l'interaction du personnel infirmier avec les bénéficiaires et le mesurage des comportements soutenant des infirmières responsables ($r = 0,42$, $p = 0,05$). Des méthodes de mesurage fiables et valides du leadership soutenant pourraient être élaborées afin d'évaluer la qualité du soutien offert au personnel œuvrant dans des environnements de soins à long terme.

Mots clés : échelles de leadership soutenant, soins à long terme

Development and Psychometric Evaluation of Supportive Leadership Scales

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The purpose of this study was to develop and evaluate the psychometric properties of 2 supportive leadership scales, the Charge Nurse Support Scale and the Unit Manager Support Scale, designed for long-term-care environments. These 6-item self-report scales were administered to 70 nursing staff and their internal consistency reliability, test-retest reliability, content validity, factor structure, and construct validity investigated. Content validity was established with the assistance of experts. Both scales were deemed reliable. As hypothesized, a significant relationship was found between the measure of how nursing staff related to residents and measures of charge nurses' supportive behaviours ($r = .42, p = .05$). Reliable and valid measures of supportive leadership could be developed for use in identifying the quality of support provided to staff in long-term-care environments.

Keywords: supportive leadership scales, instrument development, supervisors and long-term care

Lack of knowledge about effective management strategies for improving the quality of nursing homes has been identified as a priority concern in long-term care (Binstock & Spector, 1997). Thomas (1994) summarizes the current reality eloquently: "Nursing homes often try to promote warm, nurturing bonds between staff and residents while maintaining a paramilitary command structure" (p. 15). Increasingly, non-registered professionals are being used to provide care and registered staff are being placed in supervisory roles without any training. Despite these demands on the system, there remains a paucity of research on conceptualizing and operationalizing supportive nursing roles in long-term-care environments. The purpose of this research was to develop two instruments to evaluate the supportive behaviours of charge nurses and unit managers, respectively, in these environments. Supportive leadership behaviours were defined as behaviours in which the leader demonstrates empathy and reliability towards staff. This article focuses on the development and testing of the two scales.

Literature Review

Effective support for nursing staff has been subject to little analytical investigation despite the presence of several descriptive reports in the lit-

erature. Before this study was developed, only two studies on the supportive qualities of nurse leaders were found, one conducted in a psychiatric setting and the other in health-care centres in Finland. Firth, McIntee, McKewon, and Britton (1986) attempted to clarify the nature of effective support from a superior as perceived by qualified nursing staff in psychiatric settings. Personal respect, empathy, absence of interpersonal defensiveness, absence of impatience, and concern for feelings were the concepts they used to define support. Firth and colleagues found that empathy and respect on the part of supervisors contributed to reduced burnout amongst nursing staff. Sihvonen and Kekki (1991) identified supportive leaders by their ability to encourage, counsel, and guide their subordinates, communicate information about the subordinates' work, and offer rewards. They found that supportive leaders made staff feel that they were doing a worthwhile job. The scales used in these studies had not been psychometrically tested and were lengthy, atheoretical, and designed for different populations. Previous to the development of the supportive leadership scales by McGilton (2001), Buelow, Winburn, and Hutcherson (1999) developed a supportive scale for supervisors of home-care assistants in a community setting, with the attributes of supportive supervisors being an ability to communicate effectively with staff, show personal concern or caring, and maintain high professional standards. Buelow and colleagues found that supportive leadership practices explained 39% of the variance in intrinsic job satisfaction for the home-care assistants.

The development and testing of the supportive leadership scales in the present study was part of a larger study, *The Effects of a Relationship Enhancing Program of Care on Residents and Nursing Staff*, in which the principal investigator designed a program of care to enhance both the relational care provided by nursing staff and the supportive behaviours of supervisors (McGilton et al., 2003). To enhance the way nursing staff related to residents, Winnicott's (1970) relationship theory was selected, as it not only characterizes the abilities that nursing staff need in order to relate effectively to their residents, but also includes the conditions necessary to enhance their relational abilities. Winnicott advises that continuity in terms of approach and a supportive work environment will enhance the relational abilities of the nursing staff. A supportive work environment is conceptualized as one that includes a supportive leader or supervisor. Many long-term-care environments have two types of leader, the unit manager and the charge nurse. Evidence is beginning to accumulate that, from the perspective of nursing staff, effective long-term-care environments feature supervisors who demonstrate effective relational behaviours (Buelow et al., 1999; Chou, Boldy, & Lee, 2002; Kovach & Krejci, 1998; McAiney, 1998; Sheridan, White, & Fairchild, 1992; Tellis-Nayak & Tellis-

Nayak, 1989). Based on the theoretical model for this intervention study, it was proposed that the supervisor-nursing staff relationship would mirror the relationship between nursing staff and residents. Since a tenet of Winnicott's relationship theory is that nursing staff relate with empathy and reliability towards elders, leaders (unit managers and charge nurses) are expected to show empathy and reliability towards their staff. Supportive leadership is therefore measured by the extent to which the leader demonstrates empathy and reliability towards staff. In the present study, the development of supportive measures was guided by Winnicott's theory to interpret specific empathic and reliable behaviours that serve to support nursing staff. Rafferty (2000) also uses Winnicott's theory to conceptualize the attributes of clinical supervisors in nursing and health visiting. She believes that the application of Winnicott's orientation to clinical supervision involves an empathic concern for the health and welfare of one's colleagues, which leads to a relationship of mutual trust. The supervisors' supportive behaviours were two of the outcome measures for the intervention study (McGilton, 2001).

The purposes of this paper are to (a) describe the development of two supportive leadership scales, one for charge nurses and one for unit managers, specifically designed for long-term-care environments; (b) present the findings regarding the psychometric properties of the measures; and (c) suggest uses for the scales.

Method

The Unit Manager and Charge Nurse Support Scales

The first stage in developing the support scales consisted of delineating the theoretical domains of Winnicott's (1970) theory, generating concepts related to the specific behaviours for each domain, and constructing items to reflect these concepts (Lynn, 1986). The main relational skills were the supervisors' empathy and reliability. Supervisor empathy was conceptualized as the ability to recognize the standards of care among the nursing staff, to recognize and accommodate the nursing staff's expressed needs, such as providing for shift changes, and to understand the nursing staff's point of view when they came forward with concerns. Supervisor reliability was conceptualized as the ability to be available to nursing staff if things were not going well with residents or families, to protect the nursing staff from the unpredictable by keeping them informed of changes in the work environment, and to tolerate feelings of frustration on the part of nursing staff. Thus the six-item Unit Manager Support Scale (UMS scale) and the six-item Charge Nurse Support Scale (CNS scale) were designed to capture the supervisors' characteristics with regard to empathy and reliability.

A five-point adjectival scale was used to measure supervisors' empathy and reliability. The response options were "always," "often," "occasionally," "seldom," and "never." A five-point response scale was selected to allow for a reasonable distribution of responses. To facilitate the interpretation of the measure, the responses to the six items in each scale were summed to obtain a total score. The instruments could yield an overall score ranging from 6 to 30. Nursing staff were asked to complete the six-item supervisory scales with respect to their main charge nurse and their unit manager.

Establishing content validity of the UMS scale. To establish content validity, five local administrative experts were asked to evaluate the UMS scale (Grant & Davis, 1997). All five had master's degrees in nursing, obtained between 1978 and 1993. Two also held doctorates, while the other three were pursuing a doctorate in nursing. On average, they had 20 years of administrative experience. Three had particular knowledge of long-term-care supervisor-staff relationships, and two had expertise related to Winnicott's (1970) theory. Two held faculty positions and had published in the area of administration and leadership, and three held administrative positions at teaching hospitals.

Each reviewer received a detailed package that included a description of the purpose of the UMS scale, a theoretical overview of Winnicott's (1970) work, and instructions for assessing content validity. The panel was asked to indicate on a four-point rating scale whether each item reflected the reliable and empathic concepts and whether it was relevant (i.e., reflective of the underlying theory). The content validity assessment scale was adapted from Lynn's (1986) work. The content validity index is the percentage of total items receiving a score of 3 or 4 and thus deemed content valid. A new instrument should have a minimum content validity index of 80% (Davis, 1992). The content validity index at this phase was 83.5%. The panel was also asked to comment on the comprehensiveness of the total instrument and on the clarity of the items. The main criticism of the initial scale was its failure to contextualize the items. For example, in the case of an item that stated "is dependable," the experts felt it was important to describe the particular situations in which this attribution applied.

The scale was revised based on the panel's recommendations. The panel was then asked to rate the revised scale. At that time, the content validity index was 100%. The experts agreed that the items represented a realistic expectation of a unit manager in a long-term-care facility. All felt that the items covered appropriate context and specificity and therefore that the final scale operationalized three empathy items and three reliability items. The scale was pilot tested for clarity, clinical utility, and

reading level with 30 members of the nursing staff, and no changes were required (see Figure 1).

Establishing content validity of the CNS scale. The CNS scale was developed following pilot testing of the UMS scale. When the investigator was on the unit testing the UMS scale, it became evident that the role of the charge nurse in supporting staff was also important in long-term care. The UMS items were revised to reflect the charge nurses' scope of practice and their responsibilities. Hence, the creation of the CNS scale. Since the UMS had undergone rigorous content validation with the five experts, and since the constructs of the CNS were identical to those of the UMS scale, only two of the experts, both of whom had worked as

Figure 1 Unit Manager Support Scale					
Below are 6 statements that relate to how you feel about your unit manager. Please circle the number that reflects your relationship with your unit manager. Please be as honest as you can. Your answers are confidential and will not be shared with others you work with or with your unit manager.					
	Never	Seldom	Occasionally	Often	Always
My unit manager recognizes the standards of care I try to deliver.	1	2	3	4	5
My unit manager tries to meet my needs in such ways as making shift changes that allow me opportunities to meet family responsibilities or training opportunities.	1	2	3	4	5
My unit manager knows me well enough to know when I have concerns about patient care and tries to understand my point of view.	1	2	3	4	5
I can rely on my unit manager to be there for me when I ask for help, for example, if things are not going well between myself and my co-workers or between myself and residents and/or their families.	1	2	3	4	5
My unit manager keeps me informed of any major changes in the work environment or organization.	1	2	3	4	5
My unit manager tolerates me feeling frustrated or overwhelmed without responding negatively in return.	1	2	3	4	5

administrators in a long-term-care facility, were asked to review the CNS scale. The two experts felt that the items represented what was expected of a charge nurse in a long-term-care facility and that the items covered appropriate context and specificity. Following this process, five charge nurses reviewed the scale for face validity; their comments indicated that they believed the items reflected what was expected of them at work (see Figure 2).

Figure 2 Charge Nurse Support Scale					
Below are 6 statements that relate to how you feel about your charge nurse. Please circle the number that reflects your relationship with your charge nurse. Please be as honest as you can. Your answers are confidential and will not be shared with others you work with or with your charge nurse. If you work with more than one charge nurse, please answer these questions in relation to the charge nurse that you work with most often.					
	Never	Seldom	Occasionally	Often	Always
My charge nurse recognizes the standards of care I try to deliver.	1	2	3	4	5
My charge nurse tries to meet my needs in such ways as informing me of what is expected of me when working with my residents and providing feedback and recognition when I meet these expectations.	1	2	3	4	5
My charge nurse knows me well enough to know when I have concerns about patient care and tries to understand my point of view.	1	2	3	4	5
I can rely on my charge nurse to be there for me when I ask for help. That is, she/he is approachable, for example, if I need assistance with a resident, or if I need someone to talk to if things are not going well between myself and residents and/or their families.	1	2	3	4	5
My charge nurse keeps me informed of any decisions that were made in regards to my residents, for example, information obtained from family meetings or multidisciplinary rounds.	1	2	3	4	5
My charge nurse tolerates me feeling frustrated or overwhelmed without responding negatively in return.	1	2	3	4	5

Setting and Sample

Nursing staff from two mid-sized long-term-care facilities in a large Canadian city participated in the scale development and testing. The data reported in this paper were collected from a correlational study in which the measures were further tested for construct validity (McGilton & Streiner, 2002). Eligibility criteria for participants in the studies were (a) worked longer than 3 months on the unit; and (b) full-time, part-time, or casual status. Ninety members of the nursing staff were approached and 70 (77%) agreed to participate. The majority of the participants were female (84%), ranging in age from 22 to 62 with a mean age of 45 years ($SD = 9.2$); they had worked on the unit for an average of 10.3 years ($SD = 9.9$) and most (70%) were full-time; 25 were health-care aides, 23 were registered practical nurses, and 22 were registered nurses.

Instruments

In addition to the UMS and CNS scales, one other instrument was used to evaluate the construct validity of the scales during the correlational study. The relational care that nursing staff provided to clients was measured using the Relational Behavior Scale (RB scale), a three-item scale that measures the ability of nursing staff to relate to their clients with empathy and reliability. The three items selected for the present study were based on Brown's (1995) and Winnicott's (1970) work and measure effective relational behaviours. The first item was the ability to stay with the resident during the care episode; examples of such behaviours include maintaining close proximity, using various forms of touch that are comforting for the resident, and sitting beside the person. The second item was the ability to alter the pace of care by recognizing the resident's rhythm and adapting to it; examples include hesitating when necessary, being flexible, and pausing, stopping, and trying another approach. The third item was the ability to focus care beyond the task; examples include acknowledging the person's subjective experiences and offering verbal reassurances. Specific nursing-staff actions that demonstrate these behaviours were developed in the pilot phase of the intervention study (McGilton, 2001), and the items and specific behaviours were verified by Maryanne Brown, a clinical nurse specialist, and Francine Wynn, an expert in Winnicott's work. The RB scale is able to capture the unpredictable nature of the interaction between nursing staff and persons with dementia because the constructs focus on adapting care based on the persons' responses. The RB scale is an observational seven-point semantic differential scale with a range of scores from 1 to 7 for each item. The scores for each of the three items were summed. The scores ranged from

6 to 19 (out of a possible range of 3–21). Higher scores indicate more positive behaviours on the part of nursing staff.

Interrater reliability of the RB scale, assessed using Kappa, was .80, .83, and .83 for each domain, and the internal consistency estimate was .89. Construct validity of the RB scale was initially assessed by testing its relationship to negative affect states using the Pittsburgh Agitation Scale, or PAS (Rosen, et al., 1994), and the Philadelphia Center Affect Rating Scale, or ARS (Lawton, 1994). Based on Winnicott's theory and empirical evidence (Brown, 1995; Caris-Verhallen, Kerkstra, & Bensing, 1999; Caris-Verhallen, Kerkstra, Van Der Heijden, & Bensing, 1998; Hallberg, Holst, Nordmark, & Edber, 1995), it was proposed that if residents were relating effectively with the nursing staff they would experience less anxiety, sadness, and agitation during the episodes of care. This hypothesis was supported; the RB scale was negatively correlated with anxiety ($r = -.59, p < .005$), sadness ($r = -.59, p < .005$), and agitation ($r = -.39, p < .05$).

For construct validation of the UMS and CNS scales, it was hypothesized that the RB scale composite score would moderately correlate with those of the UMS and CNS scales. Based on Winnicott's (1970) theory and empirical evidence (Glass, 1992; Kovach & Krejci, 1998; Tellis-Nayak & Tellis-Nayak, 1989), it was proposed that if nursing staff felt supported by their supervisors, they would relate more effectively to their residents.

Analysis

A multiple analytic approach was employed. First, Cronbach's alphas were calculated to evaluate the internal reliability and item homogeneity of the scales. In addition, item analyses were conducted. Construct validity was examined by exploring the relationship between supportive supervisors and related constructs. Finally, dimensionality was assessed using exploratory principal components factor analysis. An orthogonal rotation (varimax) was used to obtain as distinct and maximally interpretable a solution as possible. Items with loadings greater than .50 were used to interpret the content of the factor.

Procedure

The studies were described to the participants following approval by the Ethical Review Board. Care providers were approached to participate and informed consent was obtained. All consenting nursing staff were observed while delivering care and their behaviours were assessed using the RB scale. The residents were informed of the study and consent was obtained from the participants prior to the observation day. A research assistant observed the relational care provided to residents during

morning or evening care. The nursing staff were asked to complete the UMS and CNS scales on the same shift during which they were observed, at a time most convenient for them.

Results

Reliability

Table 1 summarizes the means, standard deviations, and Cronbach's alpha reliability coefficients for the three scales used in this study. Further item analysis revealed that item-total correlations for the CNS and UMS scales were positive and were in the .41 to .70 range. This result is acceptable as the criterion is between .2 and .8 (Nunnally, 1978). For the test-retest correlation, 30 members of the nursing staff were asked to complete the UMS and CNS scales 2 weeks apart. This time frame was chosen so that recall would not be a concern (Waltz, Strickland, & Lenz, 1991). The correlation was .87 for the UMS scale and .85 for the CNS scale, which represented acceptable ranges for stability (Nunnally & Bernstein, 1994). A ceiling effect was noted for 10% of the participants' scores on the UMS scale and 8% of the participants' scores on the CNS scale.

	Mean (SD)	Range	α
Charge Nurse Support Scale	24.2 (9.1)	16–30	0.81
Unit Manager Support Scale	22.6 (7.8)	12–30	0.80
Relational Behavior Scale	5.1 (2.2)	3–21	0.90

Validity

Two methods were used to assess the construct validity of the UMS and CNS scales: factor analysis and correlations based on the theoretical predictions. Data from the correlational study were used because there were enough cases to meet the criterion of more than 10 subjects per variable (Streiner & Norman, 1991). Based on Winnicott's (1970) conceptualization of effective supportive/relational care, a 1-factor solution was predicted. The first factor of the UMS scale explained 51% of the variance. The eigenvalue was 3.0, with factor loadings between .6 and .82 for all six items. The first factor of the CNS scale explained 53% of the variance, with factor loadings between .7 and .8.

The second method used to evaluate construct validity was the extent to which the supportive supervisory scales correlated with predictions based on our theory. It was hypothesized that the UMS and CNS scales would be moderately positively correlated with the RB scale. However, only the hypothesized relationship between the CNS and the RB scales was supported ($r = .42, p = .05$); the hypothesized relationship between the UMS and the RB scales was not supported ($r = .27, p = .23$).

Discussion

The items selected for the UMS and CNS scales were derived from Winnicott's (1970) theory, with contributions from the empirical literature on attributes of supportive supervisors (Buelow et al., 1999; Firth et al., 1986; Rafferty, 2000; Sihvonen & Kekki, 1991). Development of these six-item instruments was guided by content validity assessment and pilot testing. Although the scales are brief, there was no tradeoff in the internal consistency of the measures and the content experts felt that the items reflected the characteristics of a supportive supervisor. Both scales demonstrated good stability. Further, the content experts agreed that they represented adequate sampling of a collection of situations in which supervisors demonstrate reliability and empathy. Ceiling effects were noted for both scales and the means for the scales were skewed. To counteract this bias, the centre will be shifted in future testing so that evaluators have five intervals above average to rate their leader instead of just three (Streiner & Norman, 1991).

Preliminary construct validity of both scales was supported by factor analysis. Because the items had been written to reflect two conceptual domains, reliability and empathy, the 1-factor dimension underlying the scale initially appeared to contradict the conceptual premise of the instrument. However, as Winnicott (1970) states, empathy and reliability are not mutually exclusive attributes. The 1-factor solution was consistent with the Cronbach's alphas of .80 and .81, which provided further evidence that the scales were tapping one domain.

Construct validity of the CNS scale was further supported when relationships predicted on the basis of theory and empirical evidence were tested. As predicted, there was a positive correlation between the CNS and RB scales. This finding provides empirical support for the research hypothesis that when staff members perceive they are valued, they will manifest that perception in the work they do (Gilster, 2002; Kovach & Krejci, 1998). However, no significant relationship emerged between the UMS and RB scales. This finding is not surprising given that supportive behaviours by charge nurses may have a greater impact on nursing staff and the subsequent care of residents because these supervisors interact

more frequently with staff. Furthermore, with the downsizing of nurse-manager positions in all facilities, unit managers have increasing responsibilities that preclude them from being on the unit to support staff. Nonetheless, the significant positive correlation that was found should be viewed with caution, as both the CNS and RB scales were newly developed with limited testing.

Another question worth discussing is whether the behavioural attributions of reliability and empathy should be expected of supervisors. One content expert challenged this expectation as unrealistic in the case of unit managers and suggested that such behaviour falls beyond their scope of practice. Another content expert, in her feedback on the scales, validated this concern. She suggested that implementing empathic and reliable behaviours would require a change in mindset. Although agreeing that reliability is an important aspect of the role of nursing staff, she said she had never thought about its relevance from the perspective of a frontline worker, even after holding management positions for the past 15 years. Having said this, she said she realized that being empathic and reliable was pertinent to the supportive supervisory relationship. Investigators whose findings are consistent with the opinion of this content expert have proposed that the characteristics of an effective long-term-care workplace include a unit manager who makes staff feel they are doing worthwhile work, attempts to meet their personal needs, and makes them feel supported and valued (Firth et al., 1986; Glass, 1992; Gilster, 2002; Kovach & Krejci, 1998; Tellis-Nayak & Tellis-Nayak, 1989).

These supportive leadership scales have potential utility for nursing administration and practice. Clinically, the supportive leadership indicators could be used as outcome measures to identify the quality of supportive care provided to staff in long-term-care environments. The scales also could be used to help supervisors determine the needs of their staff. If supervisors associate low scores with the perception that nursing staff are not being supported, they may be motivated to learn how to provide more support. In contrast, if they take high scores as indicating effective supervisory support, they may recognize and reinforce that support. The scales could thus be used as assessment tools to identify areas of supervisory practice that require more focus or as standards for the hiring of supervisors in long-term-care environments. The utility of adopting these instruments as part of a performance evaluation tool requires further testing.

The UMS and CNS scales could also be used to determine the efficacy of various interventions designed to enhance supportive behaviours among supervisors in long-term-care environments, and therefore used indirectly to guide nursing interventions. Recently the scales were used to measure the effectiveness of a relationship-enhancing program of care.

This was a multidimensional program that included an intervention for supervisors, focusing on their supportive role. In this case, the measures were sensitive to change (McGilton, 2001).

Links have yet to be established between supportive leadership behaviours and improved resident outcomes and nursing-staff outcomes. Ineffective management practices have been found to have a negative impact on employees, such as job dissatisfaction and high turnover (Chou et al., 2002; Clarke et al., 2001). Vance and Larson (2002) note that few studies have demonstrated a link between leadership and client outcomes, but anecdotal evidence suggests that interpersonal relationships with managers may influence the care delivered by nursing staff (McAiney, 1998; Sheridan et al., 1992; Tellis-Nayak & Tellis-Nayak, 1989; Thomas, 1994). Such relationships require empirical validation in long-term-care settings.

Although the present findings support the reliability and validity of the UMS and CNS scales, the instruments must be tested with larger samples and within long-term-care facilities that are not affiliated with a teaching institution. Given the variation in responses found for both scales, further research is needed to determine individual nurse characteristics that may influence nursing-staff perceptions about supervisory support. Use of larger samples may also allow for the testing of differences among staff subgroups. Additional prospective studies using the scales may provide further evidence concerning their validity. In their recent review of leadership research in business and health care, Vance and Larson (2002) conclude that the ability to measure meaningful outcomes is often limited by the lack of precise definitions and sensitive and specific measurement tools. The availability of evaluative instruments that measure supportive leadership would therefore be most helpful.

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