

In this article...

- Different theories and models of leadership
- Evidence around the effectiveness of nurse leadership styles
- Key skills that nurse leaders need to develop

Good leadership in nursing: what is the most effective approach?



Nursing Times
Journal Club

Talking points

1 Good nurse leadership can have a positive impact on both patient experience and outcomes, and nurse satisfaction and retention

2 Transactional leadership – traditionally considered undesirable – has been shown to improve patient satisfaction

3 It is the nature of the relationship between leaders and followers, rather than any specific behaviours of leaders, that produces effective leadership

4 Nurse leaders must create a collective perception of autonomy and empowerment to create positive work environments

5 There is no single best style in nurse leadership and a nuanced blend of approaches should be adopted

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Abstract There is no simple answer to the complex question of what makes good leadership in nursing, despite the existence of evidence showing that it can have a positive impact on both patient experience and outcomes, and nurse satisfaction and retention. This article outlines different leadership theories, describing how they can be applied to nursing and how effective they are. What emerges is that different approaches are needed according to what leaders set out to achieve. One thing is certain: success hinges on good relationships between leaders and teams.

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What is the best approach to nurse leadership – if there is such a thing? What evidence is there on the effectiveness of different leadership styles? Despite overwhelming interest in leadership within the profession, there is surprisingly little evidence about what actually works, and much of the narrative is based on received wisdom or personal experience.

Researching leadership is challenging, as there is no direct link between the actions of leaders and their outcomes. Instead, leadership is one of a number of factors that make up the context in which groups of people work. This complexity means there is no 'one size fits all' answer to what makes good leadership in nursing.

Transactional or transformational?

There has been great interest in the contrast between transactional and transformational leadership following the work of Burns (1978). Transactional leadership is a behavioural model where leaders ensure that work is completed through either reward or sanction, whereas transformational leadership is a motivational model

where leaders seek to trigger motivation in individuals rather than get them to undertake a particular task. Bass and Avolio (1990) describe transformational leadership as the four 'i's:

- Individualised consideration – identifying the needs of individual members of staff;
- Intellectual stimulation – question the status quo and present new ideas;
- Inspirational motivation – present a vision in which people can achieve their personal goals through meeting the organisation's goals;
- Idealised influence – role model the behaviours.

Burns' original work is often presented rather crudely as a stark choice between transactional and transformational leadership, where the former is portrayed as bad and the latter as good. However, in the real world, it is harder to distinguish between the two. Avolio and Bass (1995) found that transformational leadership is more common at senior levels of the hierarchy than at the sharp end of getting the work done. Judge and Piccolo (2004) suggest that even transformational leaders use

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contingent rewards at times. This suggests that the choice of leadership style depends on the task at hand – it could be as dangerous to be a wholly transformational leader as it is to be a wholly transactional leader.

New ways of thinking

What does this mean for nursing? Hutchinson and Jackson (2013) argue that the flaws in how transformational leadership has been researched in nursing mean that “new ways of thinking about nursing leadership within complex dynamic systems are required”. Although these flaws are not described, they might be the use of cross sectional surveys of nurses’ perceptions of the leader’s style and comparing that with nurses’ satisfaction with their jobs.

This is borne out with counterintuitive research findings. Kvist et al (2013) explored the link between transformational leadership and empirical outcomes for patients and nurses. None of the nurse leaders they studied scored highly on the subscales of transformational leadership. However, patient satisfaction was reported to be excellent and patients rated nurses’ professional practice highly. Nurses evaluated their own professional skills as excellent and felt their leaders’ support for professional practice was good.

As Wong (2015) explains, claims have been made that both transformational and resonant leadership (defined later in this article) reduce patient mortality rates but through different mechanisms. Wong also found that transactional leadership can increase patient satisfaction, suggesting that there is no single ‘best’ leadership style.

There is evidence to suggest that nurse leadership has a significant impact in two main areas: patient experience and outcomes, and nurse satisfaction and retention. There is some suggestion that the latter then influences the former. However, determining what makes good nurse leadership is challenging.

In the face of ambiguity and complexity, it seems that good leadership is nuanced and requires careful consideration. Where there are apparently contradictory findings, it is important to go deeper and see what apparently different approaches have in common.

You cannot enforce leadership

Traditionally, leadership studies have focused on the beliefs and actions of leaders, leaving followers with merely a passive role and entirely at the whim of leaders. Recent studies have explored the roles of both leaders and followers, and



Good leadership is nuanced and requires careful consideration

suggest that it is the nature of the relationship between them, rather than any specific behaviours of leaders, that produces effective leadership.

Hersey and Blanchard (1969) observed that the leader’s actions should be determined by the maturity of the team and that the behaviours of good leaders are situational rather than fixed. Leaders in this model assess the needs of the followers and adapt their actions accordingly.

Haslam et al (2011) suggest that leaders must be an integral part of the team, and that their main role is to create a sense of group identity. The leader must articulate what the team values are and why people would want to be part of it, and motivate followers to identify with the group, engendering a sense of loyalty.

Uhl-Bien et al (2014) go further, suggesting that the leadership of a team is co-produced with followers, and that it depends on their behaviours toward the leader and the leader’s behaviours towards them, in a virtuous circle. The idea is that you cannot enforce leadership and that it is a gift from followers. In this model, there is a distinction between people in positions of authority and leaders, and leadership has to be developed rather than assumed.

A plethora of models

In the models described by both Haslam et al (2011) and Uhl-Bien et al (2014), successful leadership is achieved by articulating common goals rather than by leaders presenting their vision. Looking at the attitudes and responses of individuals in isolation is not sufficient – leaders must create a collective motivation that all staff

identify with. This school of thought has led to a plethora of models, including West et al’s (2014) collective leadership, Gronn’s (2002) distributed leadership, Uhl-Bien et al’s (2014) complexity leadership, and Haslam et al’s (2011) social identity leadership – to name but a few.

Avolio, who had worked with Bass on transformational leadership, developed his thinking further into authentic leadership, which emphasises the leader’s ethics and behavioural integrity (Avolio et al, 2004). This is reflected in Haslam’s model, which requires the leader to lead by example, displaying the team’s values and desired behaviours (Haslam et al, 2011). What these theories have in common is a focus on collegiate relationships that leaders form with, and promote between, other members of the team.

In contrast to transformational leadership, which can be criticised for being very leader focused, resonant leadership is described by Goleman et al (2002) as a type of leadership that invests time and effort into creating good relationships rather than into setting an inspiring vision. Depending on the situation, the vision and objectives can be coproduced or team members can operate autonomously, reflecting Hershey and Blanchard’s situational leadership model.

Impact on patient outcomes

There is some evidence that resonant leadership has a positive impact on patient outcomes. Cummings et al (2010) studied nursing leadership in nine acute hospitals in Canada, collecting nurses’ perceptions of their leaders, whose styles ranged from

highly resonant to highly dissonant. They found that the differences in leadership styles explained 5.1% of the variance in 30-day mortality rates between hospitals.

Similarly, Paquet et al (2013) found that good relationships between leaders and staff were associated with decreased medication errors and reduced length of stay. Vogus and Sutcliffe (2007) found that one of the outcomes of resonant leadership – trust – was a factor in the success of a project to reduce the incidence of medication errors. Given the team nature of nursing – nurses rarely act completely on their own – some studies have suggested that good outcomes are seen when nurse leaders focus on facilitating effective teamwork. Anderson et al's (2003) study of US care homes showed that:

- The level of registered nurse participation in clinical decision-making accounted for 15% of the variance in clients' aggressive and/or disruptive behaviour problems;
- The level of transparency accounted for 21% of the variance in use of restraints;
- The degree to which leaders focused on relationships accounted for 11% of the variance in the prevalence of fall-related fractures.

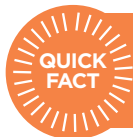
Relational leadership was found to be associated with patient satisfaction by Kroposki and Alexander (2006). In contrast, Havig et al (2011) found a significant positive association between a task-oriented leadership style of nursing home ward managers and the families' satisfaction with resident care. Doran et al (2004) found that a transactional leadership style was related to increased patient satisfaction, proposing that transactional approaches may facilitate patient care by providing the team with direction, defined tasks and clear expectations.

In reality, these findings may be better explained by the fact that the needs of patients are every bit as important as the needs of staff. Sometimes work that does not inspire staff needs to be done for patient safety or cost-efficiency reasons, which may well involve a transactional approach. Furthermore, relational and transactional approaches may not be mutually exclusive. An effective leader should be able to both maintain good relationships with the team and ensure that key tasks are done.

Impact on nurse satisfaction

There is a body of evidence indicating that nurse leadership styles have a strong influence on nurse morale and retention.

Retention is an integral part of safe staffing, and good collegiate relationships between nurses and nurse leaders that increase retention may explain the impact of leadership style on patient outcomes; this could also provide an explanation for Park et al's finding that a high nurse turnover cancelled the effect of increasing the total number of registered nurses on a ward (Park et al, 2012).



5.1% Variance in 30-day mortality between nine hospitals explained by different leadership styles

The evidence around nurse satisfaction and retention draws on the seminal work by Herzberg et al (1959) around the motivation to work. They proposed that the reasons for job satisfaction are intrinsic – that is, based on how the job makes workers feel. However, the reasons for dissatisfaction are extrinsic – for example, dissatisfaction with the material rewards that come with the job. Job satisfaction, they claim, is linked to empowerment and a sense of achieving personal and professional goals, and while low pay can create dissatisfaction, raising it does not create a sense of satisfaction with the job.

This distinction is reflected in the work of Veld and Van de Voorde (2014), who found that the work environment – including leadership – affected nurses' work commitment and their intention to stay. In particular, they found that nurses who felt they had good relationships in their workplace were more committed to the ward than those who felt they were only there to earn a living.

In their Canadian study, Hayward et al (2016) demonstrated how nurses' decisions to leave were influenced by their work environment, poor relationships with physicians and poor leadership, which left them feeling ill-equipped to perform their job. Similar findings were observed in Italy by Galetta et al (2013), who found that the intention to leave was significantly lower where nurses felt they had good relationships with nurse leaders. It was even lower where nurses also felt they had good relationships with medical staff.

Positive work environments

There is some evidence that relationships alone are not sufficient, and attention must also be paid to Herzberg's other intrinsic factors (self-actualisation and personal growth). Nurse leaders must create positive work environments. As

proposed by Laschinger et al (2014), positive work environments are achieved through a shared, collective perception (as opposed to a personal perception) of autonomy and structural empowerment.

This has been a cornerstone of the Magnet Recognition Program created by the American Nurses Credentialing Center (Bit.ly/ANCCMagnet). This is a development of the work conducted in the 1980s by the American Academy of Nursing – according to which, hospitals that were able to recruit and retain highly qualified nurses in a competitive market displayed 14 'forces of magnetism', including quality of nursing leadership and management style (Royal College of Nursing, 2015). The subsequent accreditation scheme requires hospitals to have an explicit professional practice model.

The professional practice model defines each nurse's individual autonomy to practise and therefore their empowerment – one of Laschinger's requirements for a positive practice environment. Hoffart and Woods (1996) have described the five key elements of a professional practice model that an effective nurse leader must ensure are in place (Box 1). Lyons et al (2008) suggest that nurse leaders should develop their own local nursing strategy based on Hoffart and Woods' principles.

While Hoffart and Woods' model is an American model, Papastavavrou et al (2012) have compared survey results of nurses from six European countries and the US using the Revised Professional Practice Environment scale (Erickson et al, 2009). They did find some differences between nurses in Northern Europe, Mediterranean countries and the USA regarding perceptions of control over practice, but none regarding intrinsic work motivation.

Further evidence of the universal application of the concept comes from Joyce and Crookes (2007) who adapted the Nursing Work Index-Revised (NWI-R) for the Australian setting to audit 'magnetism' in Australian hospitals, obtaining acceptable internal consistency scores. Interest in measuring the practice environment in

Box 1. Five key elements of a professional practice model

- Professional values
- Professional relationships
- Patient care delivery system
- Management approach
- Compensation and rewards structure

Source: Hoffart and Woods (1996)

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Australia was also shown by Flint et al (2010), who validated the Brisbane Practice Environment Measure.

The elements of the different professional practice models are not explicitly linked to a single style of leadership and may be used with a number of approaches – and indeed with a mix of the different leadership theories.

“The evidence suggests that nurse leaders should adapt their leadership behaviours”

Conclusion

So what can we conclude about nurse leadership? There is some evidence that good leadership can have a positive impact on patient outcomes through creating the conditions, which allow nurses to reach their full potential and build both personal and organisational resilience in the face of unexpected or increased workload. The evidence suggests that nurse leaders should adapt their leadership behaviours:

- To the task at hand – which may require a transactional approach;
- To the needs of the team – which may require a transformational approach;
- To the pivotal requirement of building and maintaining productive relationships.

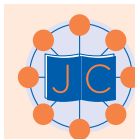
Given the uncertainties that nurse leaders face in their daily work, they can only achieve this by being constantly aware of the changing environment and making sense of it. Box 2 lists four key skills of nurse leaders. Nurse leadership is in truth a pragmatic blend of theory and evidence, adapted to the local circumstances, flexible enough to respond to the reactions of the team, and agile enough to deal with the unexpected. **NT**

Box 2. Four key skills of nurse leaders

- Monitoring and calibrating the team's workload
- Creating a work environment in which all staff feel they can contribute the maximum in a fulfilling way for them
- Creating relationships that build resilience
- Ensuring that the team deliver safe care, good experience (for patients and for staff) and the best use of available resources

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