Scientific Paper Presentation during Concurrent Interest Session

Clinical Leadership Issues and Qualities among Selected Clinical Nurse Leaders in Medical Wards of Christian Medical College, Vellore

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Nurses in every position and in all settings are expected to demonstrate leadership competencies. In supervisory or managerial relationship nurses have an opportunity to strongly influence the subordinate nurses, succeed in developing the leadership skills they need for professional practice and potential advancement into formal leadership roles. A qualitative study by David (2006) showed that clinical leaders appeared to be present at all nursing levels and in considerable numbers, but they were often not the most senior nurses and their approach to clinical leadership was based upon a foundation of care that was fundamental to their values and belief or in view of nursing and care.

Objectives

The study sought to explore clinical leadership issues and the qualities of clinical leaders among selected nurse leaders in the medical wards of CMC and to appreciate the leadership qualities identified among clinical nurse leaders.

Review of Literature

Lee studied the importance of allowing time for formal courses or programmes, time for nurses to be involved in activities where they can practice developing leadership skills, time for reflection, and refinement of skills. Nurse leaders in healthy, supportive practice environments encourage professional growth and development and allocate time required for various learning activities.

Qualitative studies by Griffin et al showed organisational issues as barriers to managers' abilities to affect research use. Four studies, one of which was experimental, included an intervention to support managers, but all had insufficient information about leadership development.

Another systematic review by Greta et al found that leadership focused on task completion alone is not sufficient to achieve optimum outcomes for the nursing workforce. Efforts by organisations and individuals to encourage and develop transformational and relational leadership are needed to enhance nurse satisfaction, recruitment, retention, and healthy work environments, particularly in the current nursing shortages.

In a qualitative study, David Stanley showed that clinical leaders at all levels and in considerable number, though were often not the most senior nurses and their approach to clinical leadership was based upon a foundation of care that was fundamental to their values and beliefs or view of nursing and care. The type of clinical area had an influence on who might be seen as clinical leader. The attributes of clinical leaders appeared to be clinical competence, clinical knowledge, approachability, motivation, empowerment, decision-making, effective communication, being a role model and visibility.

Methodology

A qualitative research design was used. The population consisted of all charge nurse and acting charge nurses in the medical wards. Nine samples were selected based on the inclusion criteria using total enumeration sampling technique. The tool, prepared by the investigator, consisted of three parts. Part I, Demographic data, Part II self-administered questionnaires and Part III questions for interview. After getting a written consent Part I and Part II were given to the samples on individual basis and an interview was done using the questionnaire as a guide. The second investigator monitored and recorded the interview. The data were analysed.

Results

The major roles as a leader in the clinical area were patient care provider, staff educator, medical manager, supervisor, problem solver and good delegator. Majority (55%) of them practiced democratic style of leadership and none of them followed autocratic style of leadership. The reasons for practicing democratic styles were better cooperation, involving everyone in decision making, free communication and exploring ideas from the subordinates. Majority (33.3%) of them felt that managing class four workers was the major problem encountered as a leader and 11.1 percent of them felt that they had role confusion, poor interpersonal relationship, bed management and staff management; 55.5 percent of them felt that there was a need for introducing changes in their leadership styles. Some of the changes they had introduced as a middle level leaders for patient care were taking complete authority for decision making for internal bed management, making checklist for documentation online, maintaining safe environment for both patient as well as staff, improving team spirit, motivating staff towards personal and professional development,

Table 1: Major roles as a leader in the clinical area (n=9)

S no	Roles	Number	Percentage
1	Patient care provider	8	88.9
2	Ward manager	1	11.1
3	Staff educator	4	44.4
4	Material manager	2	22.2
5	Supervision	2	22.2
6	Problem solver	2	22.2
7	Good delegator of work	2	22.2
8	Evaluator	1	11.1
9	Coordinator	1	11.1
10	Time manager	1	11.1

Table 2: Type of leadership styles practiced as a leader (n=9)

S No	Types	Number	Percentage
1	Autocratic	Nil	0
2	Democratic	5	55.5
3	Lai ssefaire	1	11.1
4	Democratic & autocratic	3	33.3

improving soft skills, high tech high touch approach and staff awareness regarding patient care were also highlighted by them.

The characteristics and qualities expected from a good leader were being non-judgmental, approachable, sensitive to patient care needs, good decision maker, and counsellor. She also needs to have sound knowledge, accountable, sincere and punctual. The suggestions for better leadership were effective time management, God fearing, authority with responsibilities. They also expressed that a leader should be a role model with good education and skills as a crisis manager and mentor (Table 1).

Experiences as a leader: Majority (44%) of them expressed it as challenging (Table 2). It had helped them to learn about leadership qualities, communication skills, problem solving techniques, ward management and mentoring junior staff nurses. It also helped them to be more familiar with the hospital policies, protocols and procedures.

Moments of happiness/appreciation as a leader: 33.3 percent of them expressed that they were appreciated for their excellent patient care by the medical fraternity, 22.2 percent were appreciated for their bed management in acute crisis. Few were recognized for their input in HICC projects, and special nursing skills like difficult NG tube insertion, starting IV line, and identifying deviation in patient progress for timely life saving interventions. They were also appreciated for their professional communication especially in solving the problem.

Moments of unhappiness as a leader: 22.2 percent of them expressed dissatisfaction of staff nurses towards their duty schedule, IPR among themselves, managing IV class workers in emergency or corrected by the superiors in front of the others. They also expressed their unhappiness when the inadequate care provided by their staff and no improvement in spite of their guidance and support to their subordinates.

Table 1 reveals that majority (88.9%) of the study subjects are patient care providers mentioned whereas 11.1 percent of the study subjects are ward manager. Table 2 shows that majority (55.5%) of the study subjects follow democratic leadership styles whereas 11.1 percent of them follow laisse faire leadership style. Table 3 shows that all (100%) of them mentioned the reason for practicing democratic leadership that it involves everyone in decision-making; 33.3 percent of them mentioned that managing IV class workers as major problem they encountered whereas some of them felt that role identification (11.1%) staff management, bed management are the problems (Table 4); 55.5 percent said that no changes needed for leadership styles whereas 44.4 percent wanted changes in leadership styles (Table5).

Table 6 shows that some of the changes they introduced as middle level leader for the patient care are: Making checklist for online documentation; Complete authority for decision making; Safe environment for patient care; Increase team spirit; Motivating every staff towards personnel and professional development; High tech high touch approach.

Table 7 shows that majority of them (44.4%) mentioned that non judgemental is the best quality expected from a good leader whereas 11.1 percent felt that innovator, good organizer, good evaluator, accountable and responsible are good qualities.

Table 3: Reasons for practicing the democratic styles (n=9)

S No	Reasons	Number	Percentage
1	Better cooperation	5	100
2	Involves everyone in decision-making	5	100
3	Free communication	2	40
4	Exploring ideas from the subordinates	2	40
5	Respects the staff views	1	20
6	Appreciation & awards from the higher authorities	1	20
7	Results in quality patient care	1	20

Table 4: Problems encountered as a leader

S No	Reasons	Number	Percentage
1	Role identification not clear	1	11.1
2	Staff management	1	11.1
3	Bed management	1	11.1
4	Poor IPR	1	11.1
5	Managing IV class workers	3	33.3
6	Has problems but doesn't want to express the problems	2	22.2
7	No problems encountered	2	22.2

Discussion

In this study the major roles as leaders in the clinical area were patient care provider, staff educator, material manager, supervisor, problem solver and good delegator. Majority (55.5%) of them practiced democratic style of leadership and none followed autocratic style of leadership. Whereas Feltner (2008) described the roles of nurse leaders are effective communication skills, fairness and knowledge about staff member's job, passion

Table 5: Need for introducing changes as a leader for patient care

S No	Changes needed	Number	Percentage
1	Yes	4	44.4
2	No	5	55.5

Table 6: Changes introduced as a leader for patient care

S No	Changes	Number	%
1	Complete authority for decision making for internal bed management	1	11.1
2	Checklist for documentation- online	1	11.1
3	Safe environment for patient and staff (theft, harm from unknown person)	1	11.1
4	Increase team spirit	1	11.1
5	Motivate every staff towards personnel and professional development	1	11.1
6	Improve soft skills	1	11.1
7	High tech high touch approach	1	11.1
8	Staff awareness regarding patient care	1	11.1

for nutrsing, optimism, the ability to form personal connections with their staff, excellent role modelling and mentorship; and the ability to manage crisis while guided by a set of moral principles. Although certain roles are differently identified by nurses, these are important roles of manager. This differences may be due to the cultural variations.

Better cooperation involving everyone in decision making, free communication and exploring ideas from the subordinates were the reason for practicing democratic styles.

Table 7: characteristics and qualities expected from a good leader

S No	Characteristics	Number	%
1	Sincere	3	33.3
2	Maintains professional relationship	2	22.2
3	Good listener	1	11.1
4	Flexible	2	22.2
5	Approachable	3	33.3
6	Non-judgmental	4	44.4
7	Counselor	2	22.2
8	Motivator	3	33.3
9	Mentor/ guide	2	22.2
10	Innovator	1	11.1
11	Good organizer	1	11.1
12	Good evaluator	1	11.1
13	Good decision maker	2	22.2
14	Expert teacher	2	22.2
15	Punctual	3	33.3
16	Knowledgeable	2	22.2
17	Kind	1	11.1
18	Courageable	1	11.1
19	Efficient manager	1	11.1
20	Sensitive to patient care	2	22.2
21	Be practical	1	11.1
22	Accountable and responsible	1	11.1
23	Material manager	1	11.1

In this study, majority (33.3%) of them felt that managing class IV workers was the major problem encountered as a leader since these workers are managed by different group of people all over the world. This study suggests that class four workers need to be managed similarly as this time can be used for improving patient care.

The characteristics and qualities expected from a good leader were being identified as non-judgmental, approachable, sensitive to patient care needs, good decision makers and counsellor. The study identified sound knowledge, accountability, sincere and punctuality as major qualities. These are also mentioned in the study by Anonson (2013).

The moments of unhappiness expressed by the charge nurse included dissatisfaction of staff nurses towards duty schedule. IPR among themselves, correction in front of the others had lot of psychological stress. There is a similar findings stated by SU SF (2012) that autocratic leadership and lowest and powerless nurse subordinates result in deterioration of nurses work environment.

There are no effective study to support some of the findings like the experience as a leader, or moments of happiness as a leader as expressed in this study.

Recommendations

Nurse leaders need to explore their leadership styles and explore their qualities to improve supervision. Nurses will continue to be devalued if there is no professional identity to support their roles. Good role models and mentors are needed to improve the nurses' role as a patient care provider which remains the base for the nursing profession.

Similar studies can be done in all the areas of the hospital and other tertiary hospitals to identify the present role changes and the influence of needs and demands faced by the hospitals to retain the staff nurses and also to improve the staff satisfaction.

Periodic workshops on leadership issues and qualities should be conducted for the nurse leaders to gain more insight towards new strategies towards leadership.

This study can be replicated in a larger setup to identify the leadership qualities. Periodic awareness among the supervisors about their leadership qualities will ensure and enable them to adapt to qualities which will improve the staff performance and patient care.

This study illuminated the importance of leadership, qualities and issues required for clinical nurse leaders. It also highlighted individuals to encourage transformational and relational leadership to enhance satisfaction and retention, healthy work environment and quality patient care. ■