Clinical leadership and effective nursing teams

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***Abstract*—Health-related policy and its implementation into everyday practice is complex. The key challenge facing contemporary healthcare is to nurture cultures through effective leadership that continually improve high quality, safe and compassionate care. In the role as guardians of patient safety and quality, clinical nurse leaders are ideally situated to influence the performance of nursing teams through positive leadership qualities, strategies and behaviors. Leaders are effective when they are confident and competent, aware of their own behaviours, strengths, areas for development. Effective leaders can establish positive relationships between individuals helping them to make sense of change, implications for poor performance, successes and the future.**

This present study focuses on clinical leadership and nursing teams and involves a synthesis of findings from qualitative studies to gain further insight into key characteristics of leadership and the reasons why nursing teams are functional or dysfunctional. Using a systematic framework for qualitative data analysis, three distinct themes were revealed. These relate to factors involving individual aspects of leaders, team members and the working environment for clinical teams. The dominant theme was the characteristics of the clinical leader and the impact these have in relation to effectiveness of clinical nursing teams and the culture of the working environment. Clinical leaders demonstrating positive characteristics were described as being 'authentic,' 'inspirational' and 'transforming' leaders for the team. These characteristics were regarded as being the essence of effective leadership. In contrast, others were described as being 'toxic' or 'poor' leaders. 'Toxic' leaders displayed negative personal characteristics, behaviours and conduct which were destructive to the culture and damaging for teams. 'Poor' leaders did not display the required knowledge, ability or characteristics. Findings contributed to current evidence that key characteristics of teams include commitment, coordination, communication, cohesion, decision making, conflict management, social relationships and performance feedback. The effectiveness or ineffectiveness of nusing leadership was strongly associated with the impact it had on individuals and teams, their performance and on the culture of the working environment which could have long-lasting effects.

Keywords- leadership; team working; nursing teams; professional development; motivation; nurse leader; communication; positive cultures; inspirational leader; toxic leader.

I. INTRODUCTION

The healthcare workforce for the 21st century needs to be flexible and responsive to meet the changing health needs and demands of society [1-3]. The provision of healthcare requires to be re-defined by the new ways in perceiving and managing health issues, the introduction of new technologies and the changing societal expectations of health services [4-6]. Global and government health policies inform the direction required to achieve explicit healthcare goals in society. Access to healthcare, the delivery, quality and equity of care provision and resource allocation are key features within such policy guidance [6-9].

In the United Kingdom (UK), there are considerable challenges involved in the provision of healthcare across the National Health Service (NHS), a multifaceted and massive institution which is comprised of large organisations which serve diverse populations [11]. Within this context, repeated restructuring, financial constraints, workforce issues and policy drivers impact on the ability to deliver quality improvements. [12]. The workforce is often in a state of continual change whilst striving to provide a high standard of health care and achieve good, fair and cost effective services for the whole population served [10].

In such a context one of the key challenges is to nurture cultures that provide continuously improving high quality, safe and compassionate care [13-16]. Clinical nurse leaders are the recognized guardians of safety and quality of care [17-18]. This key leadership role has strong potential to influence the nursing workforce through positive leadership behaviors qualities, and strategies [16-17]. The clinical leaders need to be highly skilled, highly knowledgeable, highly motivated and highly recognisable as the leaders of their teams [13, 16-17].

The effectiveness of healthcare teams relates powerfully to how clinical teams work together. Team working is closely associated with performance and impacts on outcomes for patients and their families [19-24]. The key factors impacting on nursing teams and the specific characteristics of clinical leadership have previously been explored and clearly identified through numerous research studies [25-34].

II. BACKGROUND KNOWLEDGE

A. Team working

A considerable amount of available literature puts forward anecdotal and empirical recommendations for creating effective teams. Overall there is a general consensus about the key factors and team characteristics. Components influencing teams need

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to take account of several areas which further complicates this in specific terms and leaves any definition open to criticism. Three areas always need to be taken into consideration when focussing on team work. These include the structure of the organization or environment, the contribution of each individual to team working and the processes in terms of the ability to function as a team. Effective team working relies on the structure of the organisation or environment having stable procedures of control and coordination. The factors related to the organization and environments are presented in Table 1.

TABLE 1. ORGANIZATIONAL FACTORS INFLUENCING TEAMS

Structure of the Organization or Environments
Clear purpose – communicated (engagement with members)
Appropriate culture – shared values. Providing teams with a safe environment to promote communication and cohesion
Specified task that are motivating for members to share responsibility and accountability for achievement
Distinct roles – clarified and understood by all
Decision making
Suitable leadership
Relevant members – appropriate mix and diversity of skills
Adequate resources - financial, support and education

The characteristics of individuals in teams are important pre-requisites for effective team working. These characteristics are presented in Table 2.

The processes involved in teams themselves relate to those integral features of interaction and patterns of organisation within the team that transform input into output. These team processes are usually described in terms of seven characteristics including coordination, communication, cohesion, decision making, conflict management, social relationships and performance feedback [29-31]. These characteristics are influenced by the nature of the culture within the organisation itself and also the everyday working environment at team level.

B. Leadership

The essence of leadership is multifaceted. Leaders are effective when they are confident and competent, aware of their own behaviours, strengths and areas for development [18]. Effective leaders help their teams to make sense of change, implications for poor performance, successes and the future. A critical component of leadership involves establishing and managing relationships between individuals who have a variety of personalities and a range of professional and non-professional experiences [31-33].

TABLE 2. CHARACTERISTICS INFLUENCING TEAMS

Individual Contribution
• Self awareness and self-knowledge: Professional expectations, an understanding of personal knowledge skills and responsibilities and those of colleagues • Self image: Personal and professional self-image, a perception of colleagues' images of the individual • Commitment: Unified team goals and values Self-knowledge and an ability to trust others Involvement in teamwork • Flexibility: Maintains an open attitude, accommodate different personal values and be receptive to ideas of others • Trust: Develops through self-knowledge and competence

III. PRESENT STUDY

This paper aims to revisit clinical teams and leadership with a specific focus to gain further insight into the reasons why nursing teams are functional or dysfunctional. This will involve a synthesis of the findings from four related qualitative studies conducted with workforce teams in both acute hospitals and community based areas. Ethical approval was obtained from the University of the West of Scotland for each of the studies which all related to improving nursing and healthcare. Within each study there was a specific objective to explore those key factors and situations where nursing teams worked effectively or ineffectively within contemporary healthcare.

Qualitative data around clinical leadership and nursing teams were obtained from participants (n=207) using various data collection methods (see Figure 1). This included individual and face-to-face semi-structured interviews, focus group interviews with between 3 and 6 participants and qualitative responses to relevant questions using online surveys. The interviews were digitally recorded with permission. Interviews and focus group discussions were transcribed and qualitative comments were extracted from online questionnaires.

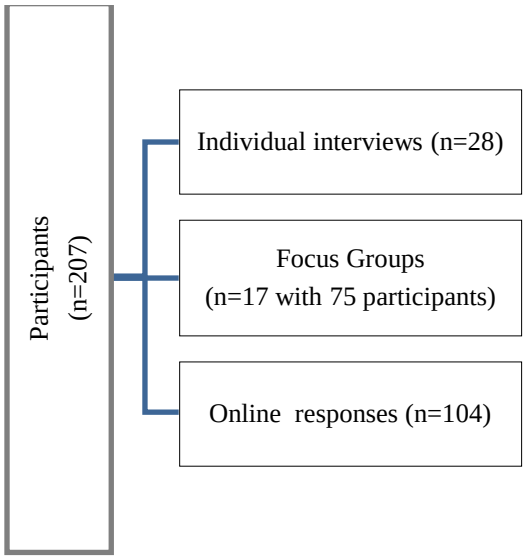

Figure 1. Participants and data collection methods

A systematic framework was used to analyze the qualitative data [34]. Using this structured and systematic approach, the researchers reviewed and searched the large volume of data for recurring patterns of meaningful information. This also supported confirmation of those areas where findings across the studies converged and agreed and any areas where the findings differed.

Three distinct themes were revealed relating to factors involving individual aspects of leaders, team members and the working environment for clinical teams. Within each theme, subthemes emerged and these are summarized in Figure 2.

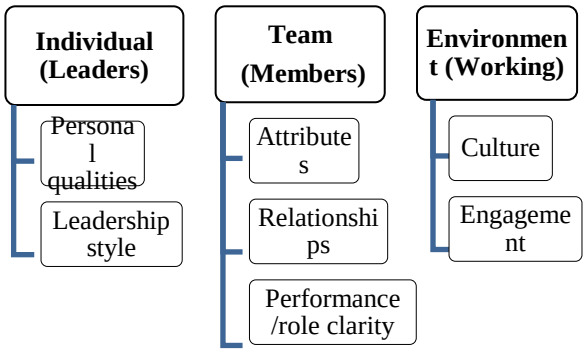

Figure 2. Themes of characteristics and factors influencing teams

Individual characteristics of the clinical leader

The 'characteristics' of the clinical leader was a dominant theme throughout the findings. Perceptions were consistent and reflected how important these factors are perceived to strongly influence the effectiveness of clinical teams. Clinical leaders demonstrating positive characteristics were described as being 'authentic,' 'inspirational' and 'transforming' leaders for the team. The characteristics and attributes were regarded as being the essence of effective leadership. In contrast, others were described as being 'toxic' leaders or 'poor' leaders'. 'Toxic' leaders were those who displayed negative personal characteristics, behaviours and conduct which were destructive to the culture and had a detrimental impact on individual team members and the performance of the team. 'Poor' leaders tended to be ineffective in the role because they did not display the required knowledge, ability or characteristics.

- **Personal qualities**

- Personal and professional self-awareness were essential. There also needed to be clinical credibility with leaders being visible and accessible to the clinical team (extending to patients, service users and family).
- Being confident assertive and professionally accountable at all times was seen to be essential for the leadership role.
- The clinical leader with a positive attitude was closely associated with a positive cultural atmosphere within the clinical environment. This was highly rated to influence a healthier workplace environment for the clinical teams.
- Consistent behaviours and conduct promoting fairness and equity in the teams encouraged trust and cooperation within the team. This also extended to leaders acting professionally at all times.
- Role clarity was essential. Leaders needed to ensure team members were clear about their roles and responsibilities and also the roles of others in the team. They needed to be seen to act promptly to deal with team issues, systems difficulties and coordination problems. These factors together tended to promote coordination, commitment and cooperation within the team.
- Communication and interpersonal skills were essential. The leader's process of sharing information with the team needed to be reliable, appropriate and timely. This included the leader taking time to interpret information and the meaning of events to help team members make sense of these for their roles in everyday practice. Language used also needed to be straightforward and to the point for teams. The ability to promote two-way communication with team members was required. This was seen to be a key factor in promoting staff to engage with the team activities and future directions and plans for the team.
- Ability to nurture commitment and optimism within the teams and to value team contribution. This also related to promoting a sense of team identity and belonging.
- Ability to promote social justice and morality through fairness and honesty with practice issues and challenging situations. This extended to promptly dealing with conflict in the team.
- Ability to provide meaningful and constructive feedback regarding team performance, and to develop and empower members to ensure they have a focus on the continued growth and development of the team.

- Ability to organise and coordinate work efforts in a fair and equitable way.

- **Style of leadership**

It was deemed important that clinical leaders were aware of the different range of styles and leadership and apply these depending on the context of the situations.

The important aspects incorporated in the clinical leadership role related to the following:

- Take a lead role in creating the direction for the team in alignment with strategies and objectives for clinical care. They also need to share these so there is a mutual understanding and agreement about direction and define clear, challenging, measureable objectives for the team.
- The need for the leader to focus on the team itself in relation to encouraging a positive vision for team development and success. This also includes creating a sense of collective identity and a sense of pride in the team.

Leaders need to know their teams in relation to individual team members, relationships, personalities and knowledge and skills. These factors can then be addressed through professional development (education and training) and facilitation through collective learning about system errors, successes and plans to continually improve quality. Individual models such as of clinical supervision, peer support or coaching. This also takes account of monitoring and evaluating quality standards and team performance and providing regular feedback. This type of culture of learning and support was seen to be supportive for team members and provided them with a sense of safety and security in the workplace.

When these positive characteristics and factors were not displayed then this had a detrimental effect on the team to the point that the teams become dysfunctional. This included the clinical leader not having the essential characteristics, behaviors, conduct and ability to lead the teams appropriately. Often this was related to a lack of communication or information poorly communicated through the use of 'corporate speak' and abbreviations which made no sense to the teams working at patient level. Other key factors identified related to inconsistent behaviors and poor conduct of the clinical leader, lack of ability or self-awareness, lack of fairness and equality across all team members (mainly in relation to workload allocation and professional development opportunities), lack of a coherent direction for team members or a direction which changed 'according to how the leader felt on that day'. This was described as *'poor leadership'* or *'toxic leadership'*. This was strongly associated with teams being unproductive and team members becoming demotivated and lacking enthusiasm, commitment and cooperation within the team.

- **Team members**

There was evidence demonstrated that the clinical leader had a powerful influential role in how the teams performed. It was clear when the clinical leader had all the pre-requisite characteristics, behaviors and ability to be effective and positively influential within the team. This created a positive culture for clinical teams and resulted in effective team work. Teams were more empowered and productive with individual members feeling more included and engaged within the teams.

Other contributing factors included:

- Sharing of information – this provided opportunity for team members to engage with the teams.
- More positive working and social relationships.
- Clarity around roles and responsibilities reduced confusion and misunderstanding and improved working relationships and team efficiency.
- This involved commitment, co-operation through supporting each other and valuing each other's contribution to build cohesion and trust within the team.
- Conflicts were resolved more efficiently.

This all contributed to building a strong sense of identity and community and helped team members to act cooperatively and be supportive of their other team members.

- **Environment**

A positive culture was seen to be crucial in facilitating positive working relationships and improving staff morale and productivity. This needs to be evident in every environment and at every level of the organization. The nature of the culture was seen to have long-lasting effects. It was emphasized that role models were required to consistently adopt this approach within the context of a positive and healthier working environment.

Other related factors included:

- Fair and equitable systems were required to be in place for professional development opportunities and succession planning.
- Effective communication processes sharing meaningful and easily understood messages were needed for staff to be confident that all information shared with them is open and transparent. Hidden agendas and limiting or not sharing relevant information was reported to have a negative effect on team morale and motivation. These negative characteristics were associated with staff being distrustful and disengagement from relevant processes.
- Necessary resources are available to facilitate the teams with professional development, education, and training. This is related to facilitating the teams to provide safe and effective patient care and to achieve the targets set.

The study findings were controversial in relation to the different aspects and roles relating to clinical leadership and management. Whilst many participants viewed management as being a part of the clinical leadership role, there was an opposing viewpoint suggesting that these were two separate and distinct roles. Managers were seen by some participants to require both managerial and leadership skills. Other

participants believed that clinical leaders needed only leadership and not management skills. There was a polarised and unresolved argument around whether this joint role of manager and leader actually caused a conflict of interest for the clinical leader. This dichotomy stimulated debate and warrants further more in-depth investigation specifically focussing on this area.

IV. DISCUSSION

Clinical leaders have an influential role in developing a culture that promotes positive working relationships, strengthens team working and also advances the status of the nursing profession. There is also clear evidence that clinical leadership impacts on teams, on performance and the effectiveness of teams and patient outcomes. It is important in clinical practice to ensure both optimal outcomes for patients and service users and succession planning for future generations of motivated and enthusiastic clinicians. The crucial role is currently supported in the UK through strategic initiatives to provide a professional voice to advance nursing and recognise clinical leaders as the guardians of clinical quality and patient safety [17,22,34].

This study has confirmed the range of findings already acknowledged in the literature as being characteristics of effective leadership. This is in relation to the three key areas including characteristics of the individual leader, the team members and the organization or environment [20-34]. The nature of culture in which teams worked was also seen to be crucial and an important influencing factor which could act as either a facilitator or barrier to the essence of effective team working. This tended to be dependent on the availability of resources for teams, support from management, and opportunities made available for professional development to meet the needs of the team.

Clinical leaders who demonstrated positive characteristics were described as being as being 'authentic,' 'inspirational' and 'transforming' leaders for the nursing team and profession. In these circumstances, some of the individual attributes or characteristics described included promoting a positive culture for stimulating positive relationships, role clarity, effective coordination, a positive attitude and the art of communicating and sharing information in a way that was meaningful for teams. Consistent behaviours and professional conduct promoting fairness and equity in the teams also encouraged trust and cooperation within the team. These factors all contributed to team members being more trusting and confident in the leader. Effective clinical leadership promoted more commitment, cooperation and engagement of teams. This in turn was perceived to improve team working, through motivated teams, more efficient team working an increased likelihood of commitment to excellence, and improved patient care and outcome.

In contrast to this viewpoint, clinical leaders who demonstrated negative characteristics, behaviours and conduct had a negative impact on teams and their performance. These leaders were described as being '*poo*r', '*ineffective*' or '*toxic*' which were strongly associated with teams being 'dysfunctional'. This meant that teams were not cohesive or performing well with individual members often being de-motivated, with a lack of commitment, lack of the spirit of cooperation and disengagement from the team vision and objectives. These findings are concerning as this negatively reflects on the aspirations and future direction of the nursing profession.

Clinical leadership is clearly an important but challenging role that influences the provision of high quality, safe and compassionate care to meet the future health needs of the population. The role is multifaceted and needs leaders with those personal characteristics and behaviors that promote positive working relationships and culture to influence team performance. This role also demands skills to ensure expertise, responsibility and accountability to improve positive clinical outcomes and promote the nursing profession. They need to work towards providing evidence-based practice, strategies to develop the mechanisms that empower clinicians to ensure participation in clinical decision-making.

In conclusion, effective leadership is fundamental to nursing practice and creates positive and productive teams. Leadership training and development needs to remain a high priority for nursing teams including managers and senior staff within organisations. Current leadership research is broad ranging covering behaviour and conduct of leaders, team members and the environment where leadership takes place. It is evident that these factors clearly influence and impact on leadership, culture and the performance of nursing teams. Therefore any research conducted in this area needs to take these factors into account to gain a full understanding and insight into the complexity of nursing leadership.

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REFERENCES

[1] World Health Organization. The health workforce: Shaping the future, 2003. Geneva: WHO.

[2] World Health Organization. Preparing a workforce for the 21st century: the challenges of chronic conditions, 2005. Geneva: WHO.

[3] World Health Organization. The health workforce: Current Challenges, 2004. Geneva: WHO.

[4] World Health Organization. Global strategy on human resources for health: Workforce 2030 (draft for 69th World Health Assembly 2016), 2015. Geneva: WHO.

[5] World Health Organization. Changing history report, 2004. Geneva: WHO.

[6] World Health Organization. Health workers: Just what the doctor ordered for economic growth and health security, 2016. Geneva: WHO.

[7] Public Health England. Global Health Strategy 2014 to 2019, 2014. London: Public Health England, www.gov.uk/phe

[8] Scottish Government. A National Clinical Strategy for Scotland, 2016. Edinburgh: Scottish Government.

[9] National health policies, strategies and plans. http://www.who.int/nationalpolicies/about/en/ (accessed 12 May 2016).

[10] Harvard School of Public Health, Department of Health Policy and Management About Health Care Policy, http://www.hsph.harvard.edu/health-policy-and-management/(accessed 12 May 2016).

[11] National Health Sevice (NHS) history and challenges, www.nhshistory.net/shorthistory.htm. (accessed 05-2016).

[12] Dixon-Woods M, McNicol S, Martin G. Ten challenges in improving quality in healthcare: lessons from the Health Foundation's programme evaluations and relevant literature. BMJ quality & safety, 2012, qualitysafety.bmj.com.

[13] NHS Scotland, Everyone Matters: 2020 Workforce vision, 2013. Edinburgh: Scottish Government.

[14] NHS Scotland, The healthcare quality strategy for NHSScotland, 2010. Edinburgh: Scottish Government.

[15] Healthcare Improvement Scotland, 2013, http://www.healthcareimprovementscotland.org/.

[16] NHS Quality Improvement Scotland. The Impact of Nursing on Patient Clinical Outcomes. Edinburgh:NHSQIS.

[17] Leading Better Care Framework.

http://www.leadingbettercare.scot.nhs.uk/ (accessed 07-2016).

[18] Department of Health. Front Line Care: the future of nursing and midwifery in England. Report of the Prime Minister's Commission on the Future of Nursing and Midwifery in England 2010, 2010. London: DoH.

[19] West, M.A. Creating a culture of high-quality care in health services. Global Economics and Management Review, 2013, 18 (2), 40-44.

[20] West M. Leading Cultures that Deliver High Quality Care *University Hospitals of Morecambe Bay NHS FT, 2015*. The King's Fund, http://eprints.lancs.ac.uk/74379/1/2015_04_30_MBHT.pdf

[21] Leadership and Leadership Development in Health Care: The Evidence Base http://www.kingsfund.org.uk/

[22] Wong CA., Cummings GG, Ducharme L. The relationship between nursing leadership and patient outcomes: a systematic review update. Journal of Nursing Management, 2013, 21 (5), 709–24.

[23] Perra B.M. Leadership: the key to quality outcomes. Nursing Administration Quarterly, 2000, 24 (2), 56–61.

[24] Health Foundation What's leadership got to do with it? Exploring links between quality improvement and leadership in the NHS, 2011. London: Health Foundation.

[25] Gilmartin, M. J., & D'Aunno, T. A. (2007). Leadership Research in Healthcare: A Review and Roadmap. The Academy of Management Annals, 1 (1), 387-438.

[26] Davidson PM, Elliott D, Daly J, Clinical leadership in contemporary clinical practice: implications for nursing in Australia, 2006. DOI: 10.1111/j.1365-2934.2006.00555.x

[27] West, MA, Borrill, C, Dawson JF, et al. Leadership clarity and team innovation in healthcare. Leadership Quarterly, 2003, 14 (4-5), 393-410.

[28] Wong CA, Laschinger HKS. Authentic leadership, performance, and job satisfaction: the mediating role of empowerment. Journal of Advanced Nursing, 2013, 69 (4), 947–59.

[29] Mickan S, Rodger S. Characteristics of effective teams:a literature review, Australian Health Review, 2000, 23(3), 201-8.

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