The impact of nurse managers’ leadership styles on ward staff

Usama Saleh, Tom O’Connor, Hattan Al-Subhi, Rana Alkattan, Saad Al-Harbi and Declan Patton

ABSTRACT
Aim: to explore the nature of leadership styles used by the nursing management team, as perceived by nurses working at the bedside. Background: leadership style is related to job satisfaction, staff retention, costs, and quality of care. The leadership styles of managers can be crucial in the healthcare setting, but very few studies have focused on them. Method: the study employed qualitative methodology, involving 35 nurses working in different specialties of a medical city in Saudi Arabia. Data collection consisted of completing demographic and professional information and a semi-structured interview using open-ended questions. Analysis: a phenomenologic-hermeneutic approach was used to identify major themes. Results: the findings showed that participants described four types of leadership styles: relational leadership, preferential leadership, communication chain leadership, and ineffectual leadership. Conclusion: the leadership style employed by nurse managers has a major impact on nurses’ satisfaction, turnover, and the quality of patient care they deliver.

Key words: Leadership styles, Job satisfaction, Nursing turnover, Expatriate nurses, Saudi Arabia

Background
There are numerous definitions of leadership. This may be because the concept of leadership is used in a number of different disciplines. In addition, this variance in definition may be the result of attempts to define an abstract concept that reflects different fundamental values and philosophical issues. In this study, leadership is defined as the process of influencing employees’ behaviours in achieving institutional vision and goals (Furnham, 2005). Leadership became a key subject during the 20th century, initially focusing on the traits and behaviours that differentiated leaders from followers. Later theories of leadership centred around situational factors and leaders’ skills (Northouse, 2015). Today, evidence reveals that four leadership theories—transactional leadership, transformational leadership, situational leadership, and authentic leadership—have been extensively investigated in various professions, including in nursing (Schreuder et al, 2011).

There is increased interest in leadership research in the nursing profession. Studies in the literature view nursing leadership as an integral part of the management role (Sellgren et al, 2006; Azaare and Gross, 2011). Although there are several challenges facing nurse managers as leaders at the present time—new roles, new technology, financial constraints, greater emphasis on participation, cultural diversity and education—it must be emphasised that leadership should not be viewed as an optional role or function for nurse managers (Zydziunaite and Suominen, 2014).

Nursing as a profession has an emphasis on humanism because it is people-centred and this has influenced leadership in this area (Sellgren et al, 2006). Research has shown links between leadership styles in nursing and nurses’ job satisfaction, job retention, quality of care, and hospital costs (Byrne and Martin, 2014; Lin et al, 2015). Laschinger et al (2007) argued that, although nurse managers can be crucial in the healthcare setting, very few research studies have focused on them. There is also little research on the leadership styles of managers in...
Saudi Arabia. The purpose of this study was to further an understanding of the nature of nurse managers’ leadership styles as perceived by ward nurses working at the bedside.

**Method**

**Sample**

A purposive, non-probability sample of ward nurses was recruited for the study. In order to be included, the nurses had to have been employed full time at the institution for a minimum of one year. The demographic and professional characteristics of the sample are set out in Table 1.

**Table 1. Participants’ demographic and professional characteristics (n=35)**

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD) = 30.4 (4.8)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range = 25–47</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>19</td>
<td>45.71%</td>
</tr>
<tr>
<td>Male</td>
<td>16</td>
<td>54.29%</td>
</tr>
<tr>
<td><strong>Nationality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistani</td>
<td>2</td>
<td>5.7%</td>
</tr>
<tr>
<td>Saudi</td>
<td>3</td>
<td>8.6%</td>
</tr>
<tr>
<td>Egyptian</td>
<td>4</td>
<td>11.4%</td>
</tr>
<tr>
<td>Filipino</td>
<td>9</td>
<td>25.7%</td>
</tr>
<tr>
<td>Indian</td>
<td>17</td>
<td>48.6%</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>9</td>
<td>25.71%</td>
</tr>
<tr>
<td>Married</td>
<td>26</td>
<td>74.29%</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma in nursing</td>
<td>2</td>
<td>5.71%</td>
</tr>
<tr>
<td>Bachelor degree in nursing</td>
<td>30</td>
<td>85.71%</td>
</tr>
<tr>
<td>Masters degree</td>
<td>3</td>
<td>8.57%</td>
</tr>
<tr>
<td><strong>Title of present position</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff nurse (SN) 1</td>
<td>10</td>
<td>29.41%</td>
</tr>
<tr>
<td>SN2</td>
<td>15</td>
<td>44.12%</td>
</tr>
<tr>
<td>SN3</td>
<td>9</td>
<td>26.47%</td>
</tr>
<tr>
<td><strong>Nursing unit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical/surgical</td>
<td>8</td>
<td>22.86%</td>
</tr>
<tr>
<td>Cardiac centre</td>
<td>8</td>
<td>22.86%</td>
</tr>
<tr>
<td>Oncology centre</td>
<td>4</td>
<td>11.43%</td>
</tr>
<tr>
<td>Emergency room</td>
<td>5</td>
<td>14.29%</td>
</tr>
<tr>
<td>Intensive care unit</td>
<td>10</td>
<td>28.57%</td>
</tr>
<tr>
<td><strong>Length of employment in months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD) = 46.3 (22.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range = (12-84)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Length of experience in Saudi Arabia in months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD) = 55.4 (31.9)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Range = (12-180)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Length of total nursing experience in months</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean (SD) = 91.0 (43.2)</td>
<td></td>
<td></td>
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<tr>
<td>Range = (5-204)</td>
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</tbody>
</table>

*One participant did not provide this information*

**Data collection**

Following approval by the institutional review board, an email announcement was sent to 40 nurses at the institution, informing them about the study and the expected start date of the interviews. Participants were referred for possible inclusion in the study by professional colleagues. Five out of the 40 practising nurses approached to participate in the study declined. Lack of time due to patient care was the main reason for inability to participate in the study. The 35 remaining participants believed the topic was relevant to their practice and wanted to share their views.

The 35 interviews were conducted on a one-to-one basis in a designated office in the nursing units. Only the participant and the investigator were present during the interview. Each participant completed the following investigator-developed forms before the interview:

- Demographic form. This was used to collect demographic information, including age, gender, marital status, educational status, and nationality
- Professional characteristics form. This was used to collect further work-related demographics, including total number of months of nursing experience, total number of months working in Saudi Arabia, total number of months of employment at the institution, nursing rank, unit of practice, and self-evaluation of Benner’s (1984) stage of nursing development.

After the participant had completed the study forms, he or she was interviewed for 25–30 minutes. Interviews were tape-recorded with the respondent’s permission. Brief notes were made during the interviews. Anonymity and confidentiality were maintained by identifying data forms and tapes only by numbers.

A semi-structured interview guide was designed to elicit data specific to the study, as well as allowing participants to address topics they considered germane to them.

Typical questions included:

- Describe the relationship between you and your manager
- Describe the nature of your manager’s leadership style
- What improvement would you like to see in your manager’s leadership style?

**Data analysis**

The analysis of the data used a phenomenologic-hermeneutic approach inspired by Ricoeur’s philosophy, a five-phase process (Ricoeur, 1976). First, all interviews and the field notes for each participant were transcribed as a text representing the experience of that participant. Second, the transcripts were read to obtain a sense of the whole and to gain ideas for structural analysis, a process described by Ricoeur (2004) as a naïve reading. The third phase of this analysis is what Ricoeur (1976) termed ‘emic’, which refers to the way the participants viewed their experience—their ‘insider’s view’. In this study, participants’ statements describing the nature of leadership were coded and extracted in the most brief form that retained contextual meaning. This third phase was emic in nature because the actual
words of the participants were not altered. In the fourth phase of analysis, these verbatim statements were coded and grouped according to observed similarities. Each group was labelled as a category, and the rules for inclusion in that category were defined. In the final phase of analysis, the categories were grouped into themes based on theoretical similarities or ‘etic’. Relations among themes and strands of meaning that traversed themes were the basis for interpretation of the data as a whole.

The dependability (reliability) of this study was supported in several ways. First, the tapes were reviewed for accuracy of the transcription. Second, an independent nurse researcher coded 10 randomly selected interviews to determine whether the data fell within the boundaries of a specific category. This process established an intercoder reliability of 90%. Finally, an in-depth interpretation of each narrative was written by the first author. These interpretations were validated and supported by the independent nurse researcher.

To ensure the credibility of the study, at the end of each interview the investigator summarised the initial interpretation gained and requested feedback from each participant about the adequacy of the interpretation. The dialogue continued until 100% agreement about the essence of the interview was achieved.

Results

All the nurse participants reported that head nurses were their immediate nurse managers/leaders. The majority (85.7%) of the study participants (n=30) hold a bachelor degree in nursing and about half (48.6%) of the participants were from India (n=17). The participants’ mean length of employment at the institution was 46.3 months (SD = 22.2, range 12-84), while their total nursing experience mean was 91.0 months (SD = 43.2, range = 5-204). The majority (57%) of the nurses (n=20) classified their stage of nursing development as proficient according to Benner (1984) (Table 2). The participants described four major themes relating to the leadership styles they encountered. These were: relational; preferential; communication chain; and ineffectual leadership styles.

Relational leadership style

This theme emerged through the discussion of the nature and quality of nurses’ relationship with their leaders. The study participants viewed the nature of the relationship in different ways. Several viewed the nature of the relationship as ‘professional’, ‘supportive’, ‘cooperative’, ‘understanding’ and ‘problem-solving’, whereas others viewed the nature of the relationship as ‘non-trusting’, ‘dictating’ and ‘ordering’. Most of the participants viewed the relationship as a means to deliver safe and quality patient care. The relationship was viewed as a cooperation between ward nurses and the nursing leadership team to produce the best possible patient outcomes.

This description of the ward nurses’ views of the nature of the relationship with nurse leaders can be observed in the following responses:

‘… It is a fair relationship. It is good … it is very professional … sometimes there are work-related tasks in toxic situations, the head nurse is professional.’

‘… I would say it is a very satisfactory relationship. It is a very accommodating and professional relationship. I feel she is not a boss. Approaching her is not complicated …’

‘In my experience, I’ve been here for 7 years in ICU [intensive care unit], I have a good relationship with my head nurse. He is approachable. We don’t have any problem with him. If there is a problem, he is willing to listen.’

Preferential leadership style

About 90% of the nursing workforce is non-Saudi, from countries including the Philippines, Pakistan, India, Jordan, Egypt, Malaysia and South Africa. Informants’ responses to interview questions suggested head nurses treat nurses who are from the same country of origin more favourably. As one informant stated:

‘The main problem here is the nationalities.’

Several participants were dissatisfied because of the preferential style employed by head nurses and/or charge nurses. They told many stories about how head nurses’ nationalities play a major role in promotion, annual evaluation, vacation planning, patient assignment, and the monthly nursing schedules. One of the participants provided an example of preferential leadership style by stating:

‘If the head nurse of the unit is Indian, all Indian nurses in the unit will have good patient assignments and the charge nurse will be from India.’

Another participant stated:

‘If the charge nurse is an Egyptian, all Egyptian bedside nurses will have a better patient assignment. If the charge nurse is from Pakistan, then all Pakistani bedside nurses will have better patient assignments.’

While participants hoped that issues among ward nurses would be ‘managed fairly, not according to nationalities’, participants noted that head nurses tended to be biased when dealing with problems.
One participant expressed how preferentialism played a role in getting sick leave. The participant reported:

“We go to OPD [outpatient department] clinic when we are very sick; however, other nurses from certain nationalities get 2-3 days sick leave without showing to the clinic.’

Another participant stated:

‘Favouritism always happened, but I don’t pay much attention to it. For others, it is a big deal … it is some kind of a negative trait that I can observe …’

The researchers identified many participants stories that highlighted these preferential leadership styles, which affected nurses’ monthly working schedules (day vs. night shifts, and weekday vs. weekend shifts), patient assignment (depending on patient acuity—the intensity of nursing care required by a patient), nurses’ vacation plans, conflict management, annual evaluations, and promotions.

Communication chain leadership style
All participants in this study were able to identify the chain of communication at the institution, which comprised the charge nurse/head nurse, the nursing director, and the chief nursing officer (CNO). If head nurses are unable to solve a ward nurse’s problem, the ward nurse can approach the nursing director. If they wish to approach the CNO, they may do so by writing a letter that must be approved by the head nurse and the nursing director. Ward nurses are not allowed to go directly to the CNO office to request appointments.

Most of the participants reported that they will go to the charge nurse for patient-related issues. They will go to the head nurses for issues related to scheduling, annual leave, annual evaluation, and/or personal matters.

Many participants wanted an open-door policy with the CNO, or at least to be able to schedule a time to meet with the CNO. One said:

‘There should be [a] two-ways style of communication and [he or she] should come and see and know us.’

Nurses who send letters to the CNO through the head nurse and the nurse director do not receive confirmation. The head nurse will relay a verbal message from the CNO. Study participants questioned the credibility of head nurses, since sometimes they receive conflicting messages relayed by different leaders (head nurse and nursing director).

Several of the participants reported visible conflict among the different levels of the nursing leadership team, as illustrated in the following quotes:

‘Sometimes there is a conflict between the head nurse and the nurse manager, because the head nurse likes a certain protocol to be implemented. Then, the nurse manager objects to that practice protocol.’

‘Charge nurse and head nurse must avoid conflict in front of bedside nurses … they are the role models and must show professionalism.’

Although the chain of communication policy is very well known, the study participants felt that the middle nursing management were blocking the communication between nurses working at the bedside and the CNO. It is the responsibility of the CNO to ensure nurses’ voices are heard. It is also the responsibility of the CNO to ensure that the middle management team are acting professionally and bring any problems to their attention at the appropriate time and place.

Ineffective leadership style
This theme of an ineffectual leadership style emerged through discussion of the improvements ward nurses would like to see in their managers’ leadership styles. A list of participants’ suggestions to address ineffectual leadership practices is given in Table 3.

Typical responses in interviews were as follows:

‘The head nurse must look at her staff’s satisfaction. She must work to support the bedside nurses in all situations … if the bedside nurse is in trouble, she must take care of the staff, not her chair [her own position].’

‘He needs to be fair with us … we present issues, he listens and nothing will happen.’

‘Train the head nurses [in] how to deal with bedside nurses, charge nurse … how to make all equal, because we are all equal on the same unit … how to make us all work as a team for the unit.’

‘Change the head nurse … everyone will say the same.’

‘I wish the head nurse can be proactive … just don’t listen to one particular group of people, but to everyone … I know it’s difficult.’

‘Her attitude … She will need to discuss issues privately when she has a problem with one staff, she could talk calmly … she needs to listen …’

‘The head nurse needs to involve bedside nurses with her unit decision. That is the most important thing.’

Discussion and implications
The results of this study show that the ward nurses’ perceptions of their managers’ leadership styles is complicated and involves different aspects of the nurses’ daily work, such as patterns of communication, relationships, conflict and stress management, equity and equality, change management, and strategic and operational management. The participants identified four major
themes in relation to the leadership styles they encountered: relational, preferential, chain communication, and ineffectual leadership styles.

The ward nurses’ perceptions of their relationships with nurse leaders was very important to their job satisfaction. Ward nurses who describe their relationship with their nurse manager as ‘supportive,’ ‘cooperative,’ or ‘understanding’, reported a high level of job satisfaction. On the other hand, nurses who described their relationship with their nurse managers as a negative relationship, experience job dissatisfaction. This finding indicates that the relationship between ward nurses and their management team is a determinant of job satisfaction, and affects their length of employment, as well as the delivery of quality patient care. This finding validated previously reported findings of the impact of leaders on ward nurses’ satisfaction levels. Nurse leaders play a direct role in controlling the work environment and thus have a big impact on staff satisfaction (Chiu et al, 2005; Kotzer et al, 2006; Roberts–Turner et al, 2014; Byrne and Martin, 2014; Lin et al, 2015).

Initiating and developing good relationships with ward nurses is an essential management competency for nurse leaders. The ward nurses wanted competent leaders who are able to develop and maintain a professional relationship with them. Designing leadership training that focuses on generating collegial and professional relationships with ward nurses can prove to be fruitful for all staff, especially in a multicultural and stressful working environment.

Foreign nurses who come to work in Saudi Arabia are on an annual and renewable working contract and have left behind their family and loved ones. They consider the nursing leadership to be part of their professional and social support, which explains their emphasis on the ‘relationship’ theme as a key indicator of their job satisfaction. Orgambídez-Ramos and de Almeida (2017) reported that job satisfaction was significantly predicted by work engagement and social support from supervisor and co-workers. However, it is a real challenge for the nursing leadership team to develop a culturally congruent relationship while keeping a fine line between the social and professional relationship.

Patient care can benefit from the diversity of the nursing workforce. However, having a highly culturally diverse team presents several working issues, such as the tendency to adopt a preferential leadership style. Although this was not reported by all the study participants, this type of leadership style caused major job dissatisfaction and a feeling of injustice and unfairness among some ward nurses, which may have a negative impact on patient care.

It is understandable that workers from a particular country have stronger social ties because of the commonalities among them, such as language, culture and religion. This finding is supported by the leader-member exchange (LMX) theory, which has its roots in vertical dyads linkage theory (VDL) (Graen and Uhli-Bien, 1995). The basic premise of the VDL theory is that leaders differentiate between subordinates in the way they supervise them (Graen and Uhli-Bien, 1995), such that the leader develops a much closer relationship with some subordinates (the in-group) and gives them more ‘negotiating latitude’ than other subordinates (the out-group) (Cashman et al, 1976; Dansereau et al, 1975). Displaying favouritism towards certain groups of ward nurses can lower the morale of those who are aware that their peers are enjoying extra perks while their own hard work goes unnoticed and unrewarded. As a result, these workers may feel neglected and unmotivated (Fleischman, 2015).

The leadership team must establish a clear policy for patient assignment, nursing schedules, annual evaluation, annual leave and promotion, to avoid any accusations or even any perceptions of favouritism. The preferential leadership style can have a significant impact on nurses’ engagement, motivation, and retention, as well as on job satisfaction. Leaders who practise favouritism in the workplace have no chance to build a culture of trust (Whipple, 2010).

In the midst of the present nursing shortage and competitive nursing market, international or expatriate nurses can easily relocate to different institutions or different countries. This nursing shortage means staff are working in a highly stressful environment. They work with high patient ratios, on long shifts, while meeting the demands of patients and their families, as well as the leadership team’s expectations. Although showing favouritism is part of human nature (Smith, 2013), the nursing leadership should be cognisant of their leadership style in order to be a supportive and retaining force instead of an excluding one. Supportive leaders who are living up to the expectations of their staff are a key factor in organisational success and job satisfaction among nurses (Lewis and Mathews, 1998; Upenieks, 2003).

Participants were dissatisfied with the communication channels within the leadership team, particularly with the CNO’s office. The nurses wanted written communications from the CNO in reply to their letters or emails instead of verbal messages relayed by nursing directors and/or head nurses. Having an official written response to ward issues from the CNO would eliminate doubts and mistrust as well as enhance nurses’ engagement and increase their motivational and satisfaction levels.

The participants desired an open-door policy with the office of the CNO in order to discuss their issues directly. The barriers
Ward nurses want to work for managers who can display effective leadership competencies. The nursing management team should develop a good relationship with ward nurses to earn their trust, increase their job satisfaction, and reduce turnover. The chief nursing officer should have an open and direct line of communication with ward nurses. Members of the nursing management team should be cognisant of their leadership styles created by the chain of leadership were thought to be unhelpful. This finding is consistent with previous research findings in which leadership styles and communication competency were the main elements that affected employees’ job satisfaction in other organisations (Çetin et al., 2012). The authors suggest instituting a monthly meeting between nurses and the CNO, as the literature suggests this would improve retention, engagement, motivation, empowerment and job satisfaction. Remaining highly visible to clinical nurses and responsive to their needs and upholding an open line of communication are crucial in achieving organisational success and improved job satisfaction among nurses (Lewis and Mathews, 1998; Upenieks, 2003). Regular CNO contact with all the nursing workforce is warranted to ensure quality patient care.

Participants suggested that all nurse managers should receive training in key leadership competencies, including effective communication, conflict resolution, and the ability to build good relationships with all staff. All are essential to build trust. Gibson and Petrosko (2014) reported that trust in leaders has a direct effect on workers’ job satisfaction and retention. Ward nurses wanted to see equality and equity and the elimination of preferential leadership style. Ultimately, they wanted qualified and competent leaders who supported and empowered them to deliver safe, efficient, and effective quality patient care.

### Summary and recommendations

This study found that the nature of leadership styles as perceived by ward nurses has a major impact on their satisfaction levels. Nurses’ dissatisfaction can lead to less engagement, poor staff retention and motivation and can consequently affect the quality of patient care. Nursing leadership teams need to be aware of their leadership style and its effect on the nursing workforce. Nurse leaders should establish strategies in initiating, developing, and maintaining collegial and professional relationships with ward nurses, especially those who have left their home countries to work in a different nursing environment while expected to deliver culturally congruent care. Nurses working at the bedside wanted their leaders to listen to them and communicate with them in an effective, professional way.

The study used a moderate sample size of 35 participants. If the study is replicated, the investigators recommend selecting a larger sample representing all nationalities and all units of practice in a hospital. This may increase the transferability of the findings and allow investigators to determine whether demographic and professional factors (such as length of time working in an institution, nursing experience and stage of nursing development) can influence nurses’ perception of the nature of leadership.

This study has added to the research on the nature and effects of leadership styles in nursing. It used a cross-sectional design, limiting the conclusions that can be drawn from the study findings. Further prospective, longitudinal investigations studying the nature of leadership styles and their influence on nurses’ engagement, motivation, and retention may provide a better understanding of the concept of leadership. **BJN**

### Declaration of interest: none


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Furnham A. The psychology of behaviour at work: the individual in the organization. 2nd edn. Hove: Psychology Press; 2005


Ricoeur P. Interpretation theory: discourse and the surplus of meaning.
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