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EDITORIAL

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Is the PhD well for nursing faculty running dry?

1 | IS THE PHD WELL FOR NURSING FACULTY RUNNING DRY?

In many of the countries to which we travel for professional purposes, it is inconceivable that anyone in any university nursing department could join the academic staff without a research doctorate. That includes the United States, Australia, China, South-East Asia and some parts of Europe.

We specify 'research doctorate'. In the United States, for example, other degrees with the title 'doctorate' such as the Doctorate in Nursing Practice—the DPN—are not recognized by some universities as qualifying the holder for an academic position (Birks & Watson, 2017). Not so in the United Kingdom (UK) where, despite our pre-eminent position in the history of nursing education, we seem continually to be on the back foot when it comes to setting academic standards. We were the first country in Europe to introduce graduate education for nurses, yet we were one of the last countries in the world to introduce all graduate entry to our profession. And this continues to be controversial (Watson, 2016). We are also a country where, coming late *en masse* to the university sector, we continue to lag in terms of the level of academic qualification of our academic staff.

Put simply, we continue to employ large numbers of staff who do not hold PhDs. Some of these colleagues are remnants of the move of nursing education from further to higher education and who had no choice in that move, approximately 20 years ago. There followed a period of transition when, to fulfil our teaching obligations, we continued to employ colleagues with minimal academic qualifications, very few of whom had PhDs but gave assurances that they would pursue one; very few did. In addition, many UK universities promote nursing academics up to and including professorships and honorary professorships without them holding a PhD—something rarely seen in most other academic disciplines (Thompson et al., 2019; Watson and Thompson, 2010). This is often done in collusion with human resources, allowing 'or equivalent' to sit alongside the requirements for academic promotion candidates to have a PhD. Our view on this is clear—there is nothing that is equivalent to a PhD. Twenty years on we continue to be in a transition period and continue to employ colleagues without PhDs and some are employed without even master-level qualifications.

To address this, we continue to expect academic nursing staff to pursue PhDs and we continue to offer PhD programmes. However, the success rate for colleagues completing PhDs is low and many who do manage to complete research-based doctoral training do not go on to do any further research work. There is also—again almost unique to the United Kingdom—a reluctance in clinical practice to value nursing staff holding PhDs and to cooperate with academia to produce PhD-trained staff who could make a valuable contribution to service and, eventually, become academic staff. Clinical staff undertaking doctorates almost always do this at their own expense and on a part-time basis. If time off is negotiated with employers to undertake a PhD, it is frequently not honoured at times of health care crises. It is understandable that the needs of service are considered important, but such short-term thinking demonstrates a lack of appreciation of the potential long-term benefits of doctorally prepared staff. There is some promise through the National Institute for Health Research (NIHR) in England that offers a clinical academic PhD scholarship route for clinical nurses—but these are highly competitive and limited in number. Furthermore, many of those on our nursing PhD programmes are international students who will return to their own countries. Ironically, most of these are undertaking a PhD to enable them to become academic staff as, in many parts of the world, this is considered the entry-level qualification. Does this matter? We think it does.

2 | WHY IT MATTERS

It matters because we are situated in the university sector where we have responsibilities that extend beyond our primary obligation to teach students. Being an academic nurse means more than teaching—teaching is an important aspect of the role but equally important are other aspects including knowledge generation through research and application of high-quality evidence. Research is the one thing that sets university academics apart from all other educators. These activities are essential if we are to continue to develop nursing knowledge and practice, to meet community needs better. Furthermore, as academic nurses, we are also role models for what is expected in nursing. We can talk about the importance of research, research literacy and higher-level studies to students, highlighting their importance. However, if we then continue to have large numbers of academic staff who are under-qualified for their roles as academics, what message is being sent to students?

And there is no contradiction between having doctorally qualified staff and delivering good teaching to nursing students. The idea that doctorally qualified nurses are somehow out of touch with 'real world' nursing practice (and, therefore, suspect as teachers) is an academic version of the 'too posh to wash' argument

reflecting a form of anti-intellectualism that does not serve nursing well. Other professions located in universities such as engineers and chemists would find this concept inconceivable. If we are to earn and maintain our place in the university sector, then we must recognize our obligation to produce scholarly work, based on research evidence, that adds to knowledge, and not only in our own field. We must contribute to developments in our profession and know how to use evidence to make arguments. Research literacy is also essential if we are to teach in ways that are contemporary, and evidence informed.

If we do not address the apparent shortage of doctorally prepared nurses, especially in clinical practice, then this will have an adverse effect on the pipeline into academia. Consequently, this will have an adverse effect on our ability to teach future generations of nursing students and it will also threaten our place in universities. Nursing students deserve to be taught in universities by academics who have the necessary clinical backgrounds and expertise who can also contextualize their teaching within the latest research-based evidence and help nursing students to evaluate that evidence. Without doctorally prepared nurses, our ability to conduct research and publish that research will be severely curtailed and nursing is in danger of being returned to the further education sector. We may even lose all graduate entry to the profession. This will be a loss with direct implications for patient care, given the demonstrable success of graduate education (Aiken et al., 2014).

As nurses, we are at the frontline of public health and other major issues of public concern and so we also have a responsibility to contribute to public debate on major public health issues and to speak out on key health issues, and to demonstrate to the public why it is worth situating nursing education in universities. Doctoral training confers many essential skills. Through doctoral training graduates have demonstrated the ability to identify a research problem or question, set about identifying and synthesizing the extant evidence, identify gaps in evidence then develop and implement a systematic plan to address that gap in knowledge, then finally, communicating it in ways that are defensible and able to be understood by others. We argue these are essential entry-level skills for nurse academics and the very minimum that our students deserve.

CONFLICT OF INTEREST

The author declare no conflict of interest.

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REVIEW ARTICLE

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An integrative review on interventions for strengthening professional governance in nursing

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Abstract

Aim: To identify the interventions for strengthening professional nursing governance and describe their outcomes.

Background: The ever-changing health care environment requires empowering governance structures and shared decision-making. The costly nature of reshaping governance makes the identification of effective interventions vital.

Evaluation: An integrative review was carried out between January 2007 and May 2020 in the CINAHL, PubMed, Scopus, PsycINFO, Business source, Cochrane and Medic databases. The quality of the 12 included studies was evaluated with the Joanna Briggs Institute critical appraisal tools.

Key issues: Eight studies reported that the implemented interventions had positively influenced organisation regarding creating positive work environments, building new leadership competencies and increasing personnel's ability to take part in decision-making. The overall quality of the evidence was judged to be moderate.

Conclusion: Comprehensive decision-making structures, efficient teamwork and transformational leadership competencies among nurse leaders enable personnel to participate in decision-making. Further research is needed to identify the most effective interventions for improving professional governance.

Implications for Nursing Management: Nurse leaders have to ensure that personnel have adequate opportunities to congregate and decide over matters concerning their work. Positive organisational climate and relational leadership style, along with highly functioning teams, are important prerequisites to nursing councils producing the desired outcomes.

KEYWORDS

evaluation, integrative review, intervention, nursing, professional nursing governance

1 | INTRODUCTION

Health organisations have a history of hierarchical governance characterized by strict lines of command. For this reason, stakeholders in the field of health care have attempted to implement shared governance for over 35 years to engage nursing personnel in organisational decision-making relevant to their professional tasks (Hess, 2011; Porter-O'Grady, 2019). Shared governance, now professional governance (PG), is defined as a 'multidimensional organizational characteristic that encompasses the structure and processes by which professionals direct, control, and regulate goal-oriented efforts' (Hess, 2017, p. 1). PG has become a critical component of the nursing discipline, with the Magnet® and Pathway to Excellence® programmes recognizing its importance by requiring health care organisations to adopt empowering governance structures and shared decision-making (ANCC, 2016, 2019).

Each health care organisation is different and has a unique PG structure. This committee/council structure affords nursing personnel an avenue for addressing clinical and administrative challenges, exercising their professional autonomy and participating in clinical decision-making (Hess, 2017). As such, councils are key to employee engagement and at the heart of PG (Hess et al. 2020; Olender et al., 2020).

It should, however, be noted that the mere existence of a council structure does not guarantee successful PG. The PG structure is but one piece in the whole organisation and its work culture. Councils need resources and support to be effective, and personnel need to be encouraged to participate in PG work. The work of the CNO and other nurse leaders is vital to ensuring that councils produce the desired outcomes. Management support facilitates professional development and involvement of personnel, while access to work empowerment structures builds trust in the management (Brull, 2015; Moore & Wells, 2010). Nursing personnel, on the other hand, need to create a collegial, supportive and fair culture to guarantee equal participation and effective communication (Latham et al., 2011; Moore & Wells, 2010).

When needed, the PG council structure can be renewed or strengthened through different kinds of interventions. A search of the literature revealed a scarcity of reviews covering interventions for strengthening PG. There are, nevertheless, reviews closely connected to our subject. The review by Twigg and McCullough (2014), with 39 papers, covered different strategies related to how enhancing the practice environment and clinical setting helps retain nurses. These strategies included an empowering work environment, shared governance structure, autonomy, professional development, leadership support, adequate numbers and skills, and collegial relationships within the health care team.

Various styles of nursing leadership, along with their outcomes for both the nursing workforce and clinical work environment, have also been recently studied. For example, three reviews synthesized the results from a total of 186 original papers (Bianchi et al. 2018; Cummings et al. 2018; Wei et al. 2020). These reviews demonstrated that it is important for nurse leaders to have relational skills and the ability to work collaboratively in a supportive environment. Furthermore, employee engagement is effective at reducing nurse burnout, while a healthy work environment is essential to promoting nurses' development and health, and vital for the implementation of evidence-based practice (Bianchi et al. 2018; Cummings et al. 2018; Wei et al. 2020). Other research has evaluated interventions that aim to promote teamwork, with the results revealing that effective interventions, including simulation and education, build and maintain highly functioning teams (Richmond Campbell et al., 2020).

All of these reviews stressed the importance of healthy work environment in health care settings, but none suggested the best practices for creating or strengthening PG. Hence, this integrative review aimed to identify empirical evidence of interventions linked to PG and to describe their outcomes. The research was guided by the following questions: (1) What kinds of interventions have been used to strengthen professional nursing governance? And (2) what have been the outcomes—in relation to professional nursing governance—of these interventions?

2 | METHODS

2.1 | Design

This review adopted Whittemore and Knafl's (2005) five-stage integrative review method to allow the inclusion of diverse study designs. The search strategy and the reporting of results followed the PRISMA approach (Liberati et al., 2009). In the first stage of the review process, that is problem identification, a broad range of research articles that had applied various methods to study PG were gathered. The keywords in these articles were collected to identify appropriate search terms and specify the problem that the review addresses.

2.2 | Literature search

The second stage, that is the systematic literature search (Whittemore & Knafl, 2005), involved seven databases: CINAHL; PsycINFO; Business source; Cochrane; PubMed; Scopus; and Medic. The search terms for the English databases were as follows: ("shared leader*" OR "shared manage*" OR "shared governance" OR "participatory management" OR "shared decision making" OR "collaborative governance") AND (chang* OR improv* OR develop* OR enhanc* OR strenghten* OR reshap* OR challeng*) AND nurs*. The search terms used for the Finnish database Medic were ("osallistav* joht*" OR "neuvosto*" OR "asiantuntija ryhm*") AND (kehitt* OR vahvist*) AND hoitot*. An experienced librarian was consulted when the relevant databases were being identified, and the test searches were conducted to determine sensitivity and specificity.

The search was limited to peer-reviewed studies published in English and Finnish between January 2007 and May 2020 that had an abstract available.

The initial search revealed 3,305 studies. The search results were exported to RefWorks, after which duplicates were removed. When the title and abstract met the inclusion criteria, two team members independently assessed the full-text article (n = 112) for eligibility. In the case that the two reviewers disagreed, discussion with a third reviewer was used to reach consensus. This process, which is presented as a flow chart in Figure 1, yielded 12 articles that met the inclusion criteria.

2.2.1 | Inclusion and exclusion criteria

Original studies that presented the outcomes of interventions aiming to strengthen PG were eligible for inclusion in this review. We included developmental projects or programmes that aimed to improve the governance style of an organisation towards a shared or participative approach if the outcomes had been evaluated scientifically. We included studies that involved only nurses, or nurses and other health care professionals, such as managers and assistants, in different health care settings. The initial screening applied a liberal approach to ensure that we did not overlook potentially relevant interventions. We excluded reviews and interventions that targeted strengthening patient participation.

2.3 | Quality evaluation

In the third stage, that is data evaluation (Whittemore & Knafl, 2005), the appropriate Joanna Briggs Institute (JBI) critical appraisal tool was used for each study design (the Joanna Briggs Institute, 2017a, 2017b). The scores were used as an additional criterion for inclusion/exclusion. Two members of the research team appraised the studies independently. JBI has not described a certain cut-off point for the inclusion of studies, and the reviewers were determined in advance to exclude a study if the score was <50%. A total of nine studies were excluded after quality assessment (Figure 1).

2.4 | Data analysis and synthesis

The goal of the fourth stage, that is data analysis (Whittemore & Knafl, 2005), was to extract data from the identified studies into a matrix to synthesize the reported results. The following data were extracted from each of the included studies: author(s), year of publication, country, quality, theory, goals, intervention, setting, participants, tools, analysis and outcomes (Table 1). Each study was read through carefully to identify meaningful sentences related to the studied phenomenon, which were coded with descriptive labels. Extracted data were then converted into systematic categories that describe the common components of PG. To address our first and second research questions, the interventions were categorized into two core categories according to their goals and content. The

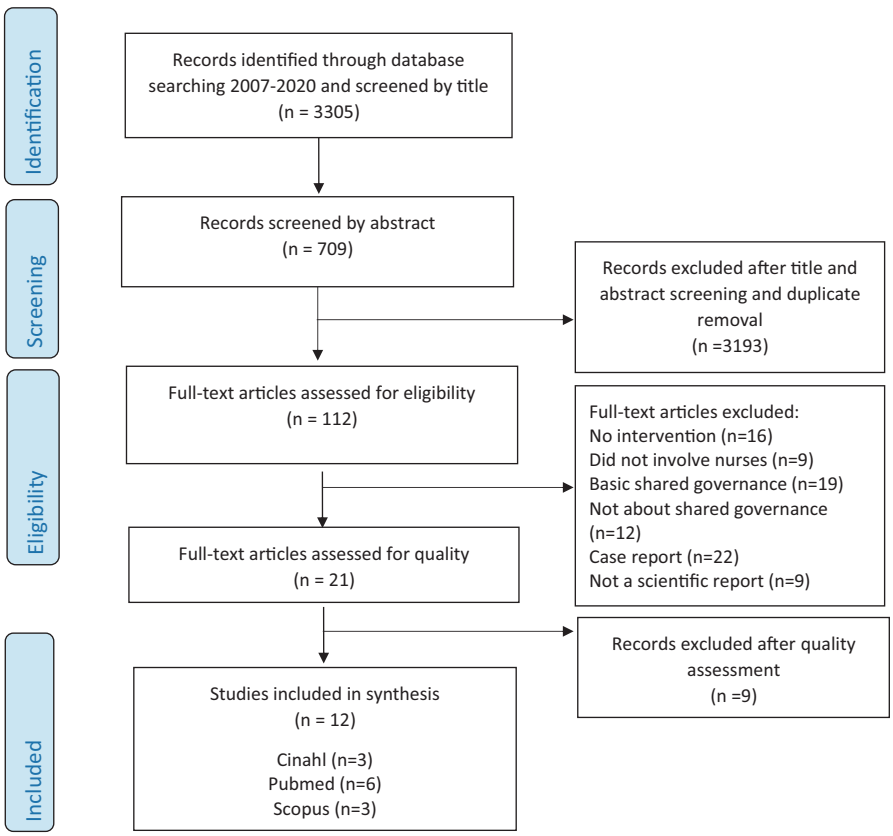

FIGURE 1 PRISMA 2009 Flow Diagram

TABLE 1 Summary of the studies included in the review

Author, year, country, quality appraisal	Theory and goals	Content of the intervention	Setting and participants	Measurement tools and analysis	Outcomes
Pretest–post-test, quasi-experimental and control group design					
Shiao et al., 2019, Taiwan, 8/9[a]	No theory base reported To enhance understanding of cross-profession language and capacity	Implementation of scenario/video-created workshops for training interprofessional collaboration team efficiency skills of nursing trainees	36 nursing trainees, medical students and other profession	Selected items in assessment of Interprofessional Team Collaboration Scale, Attitudes Toward Interprofessional Health Care Teams Scale Data were expressed as mean, the changes in scores were calculated and compared among groups	Statistically significant rise (p <.05) in team performance in the 'partnership', 'cooperation' and 'shared decision-making' domains and the self-assessed 'quality of care delivery'
Moore & Wells, 2010, USA, 7/9[a]	Kanter's theory of structural empowerment To improve the representation and focus of the traditional nursing staff council	Restructuring the systemwide staff nurse councils to four councils. Further upgrades included staff nurses serving as co-chairs and nursing executives partnering in planning meeting agendas ahead and in problem-solving issues during the council meetings	Academic medical centre. 204 nurses.	Conditions for Work Effectiveness Questionnaire, Job Activities Scale Organizational Relationship Scale, Organizational Commitment Questionnaire Inferential statistics using Pearson's r correlations, analysis of variance and regression analysis were completed	No confirmation that participation in councils enhances the nurses' perceptions of empowerment
Pretest–post-test, quasi-experimental and no control group design					
Adams et al., 2019, USA, 6/9[a]	A literature review to identify solutions for nursing burnout and turnover To improve the perception of the clinical practice environment by increasing meaningful recognition, shared decision-making, and leadership support and involvement	Adding a department-specific gratitude board, a thank-you card programme, a practice-based suggestion box, daily leadership rounding and a staff feedback portion added to daily nurse huddles	Emergency department at a community hospital. 30 ED nurses	The Anticipated Turnover Scale, The Oldenburg Burnout Inventory The mean rate of anticipated turnover, exhaustion and disengagement was compared between pre- and post-intervention. An overall total burnout level was determined, and the differences were evaluated with the paired Student's t test	A statistically significant reduction in the self-reported rates of nursing exhaustion and disengagement (p =.004)

Author, year, country, quality appraisal	Theory and goals	Content of the intervention	Setting and participants	Measurement tools and analysis	Outcomes
Brull, 2015, USA, 6/9[a]	No theory base reported To increase PG subscale scores and to test whether implementation of shared governance could be done more efficiently and effectively using a comprehensive and robust education plan	Strengthening shared governance in an organisation with several new councils	Mercy Medical Center, 260 nurses	The Index of Professional Nursing Governance Pre- and post-measurements, a *t* test	A rise in self-reported sense of structural empowerment by 6,5%. A significant increase in access to information, control over practice and ability to set goals (p = <0.04–0.05)
Dechairo-Marino et al., 2018, USA, 7/9[a]	A literature search of nursing shared governance To shift governance towards the centre of the governance continuum by allocating more control and influence on the staff	Enhancing PG structures and processes with 3 new, unit-based councils, having interprofessional strategic planning retreats every year, celebrating SG achievements annually, increasing access to library, equipment and paid SG time, expanding RN staff involvement in department budgeting decisions and educating councils on effective meetings, goals and progress reports.	Catholic community medical centre. 240 + 220 nurses.	The Index of Professional Nursing Governance Descriptive statistics Inferential *t* tests Tukey post hoc testing	A significant increase in overall structural empowerment and all subscales (p =.001)
Latham et al., 2011, USA, 7/9[a]	No theory base reported To institute and evaluate mentoring support for front-line RNs to determine changes in nurse perceptions of their workplace, professional skills and unit governance involvement	Instituting and evaluating mentoring support and a formalized mentor–management workforce environment governance board for front-line RNs.	Two acute care hospitals. 198 front-line nurses and new nurse graduates	Occupational Stress Inventory, the Memletics Questionnaire, the Jung Typology Test, the Professional Practice Environment Scale, the Nursing Services Questionnaire and the Decisional Involvement Scale pre- and post-measurement, *t* test	A statistically improved ability to work in teams (p =.001) and an enhanced ability to handle disagreement and conflict (p =.030).
Martin et al., 2012, Switzerland, 6/9[a]	Kouzes and Posner's theory of learned leader behaviours To promote transformational leadership among nurse leaders to encourage decentralized decision-making and availability of information and support structures to facilitate staff empowerment	Initiation of the Clinical Leadership Programme to develop transformational leadership competencies of nurse leaders at the unit level	The University Hospital Basel. 14 nurse leaders	Leadership Practices Inventory The data were summarized using descriptive statistical methods. For the specific analyses, multivariate analyses of variance were conducted.	Ward leaders significantly (p =.011–0.004) improved the scores in two subscales of their leadership practices—inspiring a shared vision and challenging the process.
Meyers & Costanzo, 2015, USA, 6/9[a]	Kanter's empowerment theory To facilitate implementation of a PG structure in an ambulatory care clinic system	Formation of a stakeholders group, implementation of stakeholder and staff education, development of a specific PG model for the clinic system and evaluation of the implementation process	A clinic system. 57 + 35 registered nurses	The Index of Professional Nursing Governance The independent *t* test A paired *t* test	No significant change was present in structural empowerment

Author, year, country, quality appraisal	Theory and goals	Content of the intervention	Setting and participants	Measurement tools and analysis	Outcomes
Moreno & Girard, 2019, USA, 7/9[a]	Kouzes and Posner's theory of learned leader behaviours To strengthen the internal promotion of nurses to manager or educator positions	Integrating a succession planning framework into the existing shared leadership council structure	An academic medical centre. 150 nurses	A balanced scorecard A feedback survey *t* test	Results indicate a significant (p <.05) increase in council members' perception of structural empowerment. Leadership competencies as practitioners showed a statistically significant difference (p <.05)
Olender et al., 2020, USA, 5/9[a]	Watson's theory of human caring To strengthen staff's self-report of caring, work engagement and workplace empowerment	Implementation of several unit councils and a caring professional practice model.	A 300-bed tertiary teaching facility. Over 800 respondents.	Caring Factor Survey, Utrecht Work Engagement Scale, the Conditions of Work Effectiveness Questionnaire II Descriptive statistics and frequency distributions Factor analysis and reliability testing Pearson's correlation Hierarchal regressions	Work empowerment scores among staff increased progressively and significantly (11%) over time.
Post-test, quasi-experimental and no control group design					
Di Fiore et al., 2018, USA, 5/9[a]	No theory base reported To evaluate the current perceptions of clinical nurses and to guide possibilities to implement interventions to further improve IPNG scores	Evaluation of the existing shared governance and comparing results with base-level measurement	Community-based medical centre. 303 nurses	The Index of Professional Nursing Governance Descriptive statistics and frequency distributions, Pearson's #2 tests and 2-sample *t* tests	There was no difference in the overall sense of structural empowerment
Interview study design					
Lavoie-Tremblay et al. 2014, Canada, 8/10[b]	Rogers' theory of innovation To encourage personnel to identify, implement and test changes that could improve their work practices and environments	Development of change capacities with the TCAB programme	University-affiliated health care organisation. 19 nurses	Three focus groups and three individual interviews The data were analysed using the NVivo	The intervention expanded the participants' vision and taught transformational leadership skills. The work culture of the teams evolved by reinforced sense of group cohesiveness and belonging, as well as awareness of others

[a]JBI Critical Appraisal Checklist for Quasi-Experimental Studies, max 9 p.

[b]JBI Critical Appraisal Checklist for Qualitative Research, max 10 p.

core categories were divided into four main categories, which also included five subcategories: goals and theory; content of the intervention; setting and participants; measurement tools and analysis; and outcomes.

3 | RESULTS

3.1 | Descriptive results

A total of 12 studies were selected for this review. The studies were carried out in the USA (n = 9), Canada (n = 1), Taiwan (n = 1) and Switzerland (n = 1). The publication period ranged from 2010 to 2020. Most of the studies were quasi-experimental, uncontrolled and before-and-after studies (n = 8). A further two quasi-experimental studies included a control group, and another included only post-test measurements. The review also included one qualitative study that applied interviews to collect data (Table 1).

The sample size in the included studies varied from 14 to 460 participants, with seven studies including more than 100 participants. Most of the studies (n = 9) included a large proportion of female registered nurses with a bachelor's degree (mean age: 49,5 years). Some of the studies failed to report the demographics of the study participants. The Index of Professional Nursing Governance was employed in four studies to measure the outcomes, while the remaining studies applied several validated and non-validated tools, along with interviews. Most of the studies used descriptive statistics to describe the participants' demographic variables. Several studies employed the Pearson correlation coefficient and/or t test to examine the relationships between study variables (Table 1).

3.2 | Quality of studies

The quality assessment revealed that most of the included studies were of medium quality (median score: 6,4; range: 5–8). Discrepancies in quality assessment were mainly related to limited information about adjustment for confounders and differences between groups in the follow-up stage. Most of the quasi-experimental studies had no control group, and two studies only achieved a 55% quality score as the employed methods could not determine causality (Di Fiore et al., 2018; Olender et al., 2020). The only qualitative study included in this review (Kyytsönen et al. (2020), Lavoie-Tremblay et al. 2014) failed to position the researcher culturally or theoretically and did not specify how the researcher may have influenced results (Table 1).

3.3 | Interventions to strengthen professional nursing governance

The interventions described in the studies included in this review employed different strategies to reach their goals and were divided into two main categories: interventions to enhance structural empowerment (n = 6); and interventions to reinforce leadership and teamwork (n = 6) (Figure 2).

3.3.1 | Interventions to enhance structural empowerment

Interventions aiming to enhance structural empowerment were divided into two subcategories according to content: creating new structure(s) (n = 5); and evaluating existing structure(s) (n = 1) (Figure 2).

3.3.2 | Creating new structure(s)

The goal of five of the interventions described in the identified studies was to enhance staff involvement and empowerment, as well as the work of existing nursing councils, by establishing new decision-making structures. Three interventions were based on Kanter's empowerment theory (Meyers & Costanzo, 2015; Moore & Wells, 2010) and Watson's theory of human caring (Olender et al., 2020). The study by Dechairo-Marino et al. (2018) was based on a literature review on nursing shared governance, while Brull (2015) did not report a clear theoretical foundation (Table 1).

The described interventions aimed to create one council for one division (Meyers & Costanzo, 2015), three new councils at the unit level (Dechairo-Marino et al., 2018) or hospital level (Moore & Wells, 2010), or several new councils at different levels of the organisation (Brull, 2015; Olender et al., 2020). Various types of education or orientation were offered to either the whole staff or different stakeholders to make the intervention more efficient (Table 1).

In addition, interventions included increased library access, paid council time, expanding staff involvement in department budgeting decisions (Dechairo-Marino et al., 2018), staff nurses serving as co-chairs and nursing executives partnering with the council co-chairs for planning and problem-solving (Moore & Wells, 2010). Videoconferencing between clinics was also offered to ensure that nurses could attend the meetings (Meyers & Costanzo, 2015), and unit managers were afforded leadership empowerment programmes so that they could support council work (Olender et al., 2020; Table 1).

The participants in these studies were nurses working in different health care organisations in the USA. The tools applied in these studies to measure the impact of the intervention were validated and have been previously used on the international level (e.g. Caring Factor Survey, Utrecht Work Engagement Scale, the Conditions of Work Effectiveness Questionnaire II and the Index of Professional Nursing Governance). The results were analysed through appropriate statistical methods, such as the t test (Table 1).

The interventions presented in three studies yielded significant outcomes in the strengthening of structural empowerment

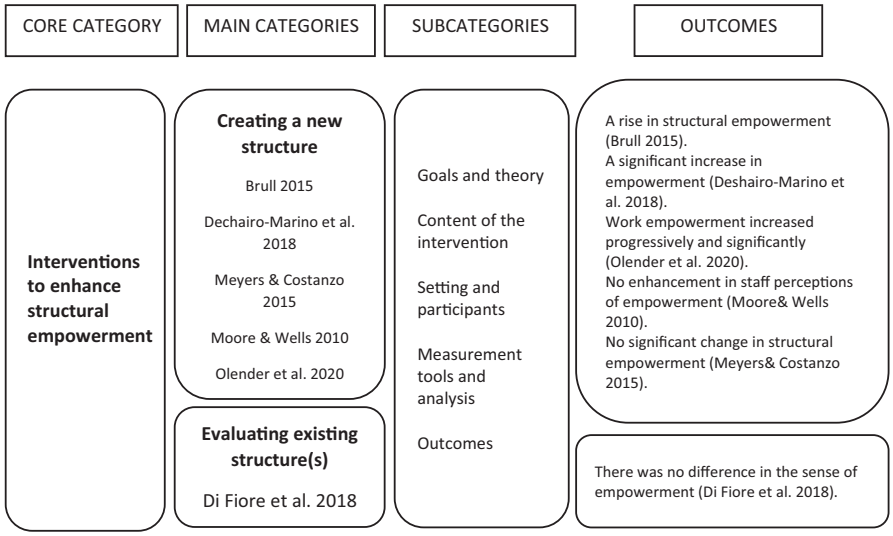

FIGURE 2 Interventions to enhance structural empowerment and their outcomes

(Brull, 2015; Dechairo-Marino et al., 2018; Olender et al., 2020). Notably, the interventions increased employees' ability to participate in decision-making and thus created a more empowering work environment. Dechairo-Marino et al. (2018) also reported a significant post-intervention rise in employees' sense of having control over practice. Two of the studies (Meyers & Costanzo, 2015; Moore & Wells, 2010) did not report statistically significant differences as the pre- and post-implementation outcomes indicated traditional governance (Table 1).

Evidence of how these interventions can facilitate the creation of new governance structures remains limited, and it was not possible to conclude whether future interventions would result in similar outcomes. All of the studies were quasi-experimental and mostly uncontrolled. The findings are difficult to interpret due to the lack of a comparison group. One of the identified studies was controlled (Moore & Wells, 2010) yet did not include randomization. Hence, it is difficult to determine whether the described outcome is a result of the intervention. The studies employed over 1,200 participants, but—as they were single-centre studies—the quality of the evidence must be ranked as low.

3.3.3 | Evaluating existing structure(s)

Di Fiore et al. (2018) described a case from an organisation that had evaluated nurses' perceptions of current shared decision-making three years after PG had been implemented. No clear theoretical foundation was reported. The intervention included an evaluation of the existing shared governance and a comparison of the results with baseline measurements. The intervention was conducted in a single hospital with over 300 nurses and only implemented post-intervention measurements. The data were collected with a validated tool and then analysed with appropriate statistical methods. The intervention did not cause any significant changes at the hospital as the post-implementation outcomes indicated that traditional governance still existed. The presented evidence was of low quality (Table 1).

3.4 | Interventions to reinforce leadership and teamwork

interventions with a focus on reinforcing leadership and teamwork were divided into two subcategories according to the content of the intervention: enhancing teamwork ($n = 3$); and enhancing leadership skills ($n = 3$) (Figure 3).

3.4.1 | Enhancing teamwork

A total of three studies (Latham et al., 2011; Adams et al., 2019; and Shiao et al., 2019) described interventions aimed at reinforcing shared decision-making, enhancing multiprofessional teamwork and battling disengagement by using locally developed programmes. Adams et al. (2019) utilized a review on nursing burnout and turnover as a theoretical base, while the other two studies lacked a theoretical foundation (Latham et al., 2011; Shiao et al., 2019).

Adams et al. (2019) designed their intervention around practical tools, such as a department-specific gratitude board, a thank-you card programme, a practice-based suggestion box, daily leadership rounding and staff feedback during daily nurse huddles. Latham et al. (2011) created a mentoring support programme for professional RNs and new graduates and a formal mentor–management workforce environment governance board. Shiao et al. (2019) created scenario/video workshops to enhance interprofessional collaboration and the team efficiency skills of nursing trainees (Table 1).

These three studies involved a total of 264 nurses, new graduates and trainees, with two studies set in a health care setting. Shiao et al. (2019) failed to report the setting of the study. The studies applied a total of ten validated tools (e.g. Interprofessional Team Collaboration Scale, the Anticipated Turnover Scale and the Decisional Involvement Scale, among others) and relevant statistical methods to measure outcomes. All of these studies reported significant outcomes; more specifically, both exhaustion and disengagement decreased and employees' abilities to work in teams and handle conflicts improved. Furthermore,

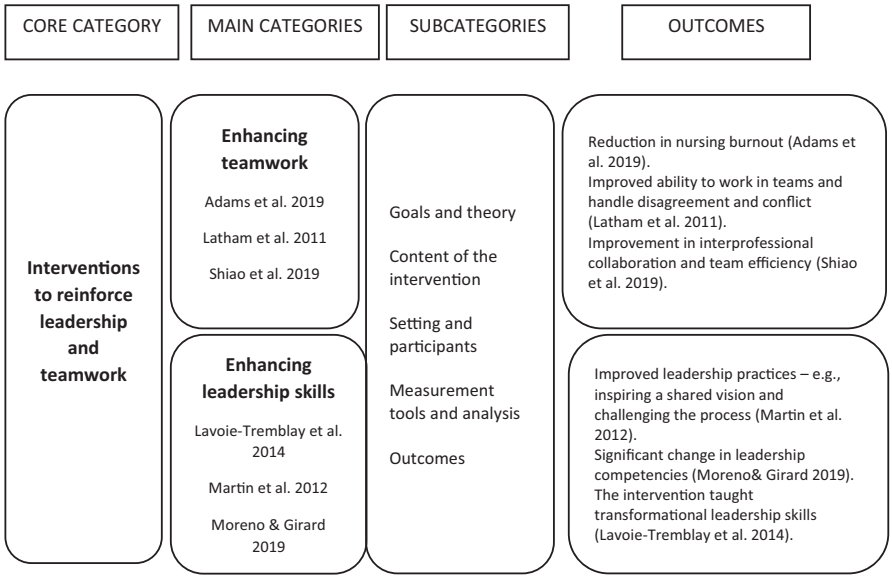

FIGURE 3 Interventions to reinforce leadership and teamwork, and their outcomes

team culture improved in terms of group cohesiveness, belonging and awareness of others (Table 1).

All three of these studies used quasi-experimental methods, with one including a control group (Shiao et al., 2019). As such, the evidence was assessed to be of moderate quality. The outcomes are based on a single population, which makes the robustness and generalizability of the evidence questionable. Furthermore, all of the interventions were utilized for the first time. Thus, further research from different health care settings and larger populations is needed to evaluate the effectiveness, appropriateness and feasibility of the described interventions.

3.4.2 | Enhancing leadership skills

Interventions to reinforce leadership skills sought to empower staff by promoting transformational leadership among nurse leaders. All of these interventions had a theoretical base, for example Kouzes' and Posner's theory of learned leader behaviours (Martin et al., 2012; Moreno & Girard, 2019) and Rogers' theory of innovation (Lavoie-Tremblay et al. 2014) (Table 1).

Moreno and Girard (2019) used locally developed programmes, whereas the two other interventions were internationally utilized. Moreno and Girard (2019) integrated a succession planning framework into the existing shared leadership council structure. Lavoie-Tremblay et al. (2014) used modules of the TCAB programme to teach nurses how to use teamwork to identify, implement and test changes that will likely lead to improvements. Martin et al. (2012) utilized the Clinical Leadership Programme to educate ward leaders on transformational leadership competencies. All of these interventions offered an extensive package of learning modules, such as lectures, coaching, individualized development plans, action learning and simulation workshops. A total of 183 nurses and nurse leaders working in health care organisations in Switzerland, Canada and the USA participated in these studies (Table 1).

Only Martin et al. (2012) used a validated measurement tool, the Leadership Practices Inventory and appropriate statistical methods. Moreno and Girard (2019) utilized scorecards and surveys, while Lavoie-Tremblay et al. (2014) employed focus groups and individual interviews. Martin et al. (2012) and Moreno and Girard (2019) reported significant increases in the participants' leadership skills, for example inspiring a shared vision and working as council chairpersons. Lavoie-Tremblay et al. (2014) reported that the intervention expanded the participants' outlooks and taught transformational leadership skills (Table 1).

The studies involved single-centre populations, which makes the robustness and generalizability of the evidence questionable. Of these three studies, two applied quasi-experimental methods, while one was an example of qualitative research. Due to the use of non-validated measurement tools and content analysis, the evidence was assessed to be of low quality.

4 | DISCUSSION

Health care organisations are reforming nurses' work environments to be more empowering and professional. As a result, hundreds of development projects aimed at aligning the work of an organisation with Magnet requirements have been published over the years. As interventions consume both resources and time, an organisation must carefully consider which approach will be the most effective (Hess, 2011). The studies included in this review reported various multicomponent interventions, which were divided into two main categories based on how they targeted PG: interventions to enhance structural empowerment; and interventions to reinforce leadership and teamwork.

Using PG structures to create a more empowering work environment enhances staff involvement in decision-making, which—in turn—improves professionality among nurses and the overall standard of care (Hess, 2017; Twigg & McCullough, 2014). Three accounts

of interventions belonging to the first main category created several new councils on both organisation and unit levels, as well as amplified the effects through extensive education. They reported significantly positive outcomes in increased employees' ability to participate in decision-making and a sense of control over practice. The evidence was judged to be of low to moderate quality (Evans, 2003). Earlier reviews have strongly linked decentralized organisational structure, along with cooperation between nurse managers and nurses, to nurse's ability to express their concerns and contribute to shared ownership (Bianchi et al., 2018; Twigg & McCullough, 2014).

It is important to state that the existence of a decentralized decision-making structure does not alone guarantee the empowerment of nursing personnel. A positive organisational climate and transformational leadership are essential contextual factors for successful PG. Some of the research included in this review reported that implementing different kinds of education and a succession planning framework promoted transformational leadership and improved employees' leadership skills. Although the evidence in the presented studies was of low quality, relational leadership styles, such as transformational leadership, have been shown to significantly empower staff and foster a healthy work environment (Cummings et al., 2018; Wei et al., 2020).

Even though interventions can be an effective method for improving leadership among nurses, it should be noted that leadership practices are heavily influenced by the complex structures within an organisation and cannot solely rely on the abilities of single nurse leaders (Cummings et al., 2021). For this reason, employees from all levels of the organisation must collaborate to create a healthy and productive work environment in which the leaders can succeed. Distinct interventions to enhance teamwork were reported in three of the included studies. These interventions, which utilized mentoring, simulation workshops and practical tools (e.g. a gratitude board), all produced significant outcomes. The interventions were characterized by a high degree of heterogeneity, which made it difficult to generalize which features made them successful. Nevertheless, the results demonstrate that various types of teamwork interventions, such as simulation, can positively impact health care processes and outcomes (Richmond Campbell et al., 2020).

To the best of our knowledge, this is the first integrative review that has identified and categorized various interventions for strengthening PG. The interventions covered in this review were heterogeneous, and therefore, the outcomes will not necessarily be reproducible. Hence, further research is a prerequisite to any reliable recommendations. Also, the results of this review emphasize that more robust research methods are warranted to strengthen the current knowledge base, while the context of each intervention should be clearly described to enhance the replicability of the results.

4.1 | Strengths and limitations

The validity of this review was enhanced by two researchers independently conducting the systematic literature search, and that the literature search was completed with the help of a science library information technician. We were stringent in following the methodological approach of Whittemore and Knafl (2005), which has been extensively applied to literature reviews on nursing. The research team commented on the whole review process and quality assessment.

The overall methodological quality of the included studies was judged as moderate. Many of the studies included limited sample sizes and used non-validated tools. The studies were also limited to three geographical areas (the USA, Canada and Switzerland), were solely reported in the English language and were conducted in various health care settings.

5 | CONCLUSION

This review was conducted to identify previously reported interventions for strengthening PG and describe their outcomes. According to the reported outcomes, eight interventions achieved positive results in relation to the strengthening of PG. However, it is important to state that the evidence base included in this review was judged to be of low quality; as such, no strong recommendations can be given at this time, and further research is needed to reliably state which interventions are most effective at improving PG.

Comprehensive and efficient PG structures increase the ability of personnel to participate in decision-making. The functioning of councils within PG structures can be improved by ensuring transformational leadership competencies among nurse leaders. This will also enhance teamwork, resulting in increased staff empowerment and a higher overall standard of care.

Future research must include robust research designs and clear descriptions of the context to reliably evaluate the effectiveness of various PG interventions. Researchers can provide high-quality empirical evidence by applying relevant theories, previously validated tools and the appropriate statistical methods.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

The findings of this review highlight how influential nurse leaders can be in creating a healthy work environment that will retain and develop nursing personnel. Professional governance has been found to result in empowerment and professionalism, both of which enhance care quality. As such, it is the responsibility of the CNO and other nurse leaders to ensure that personnel have adequate opportunities to congregate and decide over matters concerning their work. Relational leadership style, along with highly functioning teams, are important prerequisites to nursing councils producing the desired outcomes.

Nurse leaders can utilize interventions such as those introduced in this review to implement and strengthen evidence-based measures for empowering nursing personnel. Choosing an effective intervention is not easy, as results achieved in one setting may not be replicable to another context. For this reason, leaders should be

aware that contextual factors can largely affect PG, leadership practices and teamwork within an organisation. Educated nurse leaders, a positive work culture and support throughout the organisation are necessary for successful PG.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

Ethical approval

An ethical approval is not needed in a literature review.

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REVIEW ARTICLE

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Nurse managers' competencies: A scoping review

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Abstract

Aim: To describe and synthesize scientific literature on nurse managers' competencies.

Background: The key strategy for the success of health organisations currently resides in the capacity of the nurse manager to develop advanced competencies in management. However, there is a lack of systematic reviews that synthesize knowledge about nurse managers' competencies.

Evaluation: A scoping review was conducted using electronic databases including Web of Science, Scopus, PubMed and Cumulative Index to Nursing and Allied Health Literature.

Key issues: After the first analysis, 392 competencies were observed from 76 studies. Finally, 53 competencies were grouped according to their characteristics. The two most-cited competencies were communication and finance.

Conclusions: Knowing the competencies required by nurse managers can help organisations create strategies to develop competent managers. In addition, from the results we can infer what might be the core competencies, since 22 main competencies from the total number were identified.

Implications for Nursing Management: The competencies identified constitute the body of knowledge necessary for nurse managers. In addition, it is possible to generate a pathway for learning and professional development for nurses before they work at the microlevel of management. The starting point for this pathway could be the 22 core competencies.

KEYWORDS

competencies, nurse executive, nurse manager, scoping review

1 | BACKGROUND

A nurse manager is responsible for translating the culture and strategy of an organisation at the operational level, as well as managing resources, coordinating nursing care, planning and contributing to the evaluation services provided, together with supporting and encouraging teamwork in the relevant units and implementing innovative practices (Carney, 2006; Engle et al., 2017; Holden & Roberts, 2004; Lalleman et al., 2015; Scoble & Russell, 2003). Therefore, nurse managers play a key role, since they not only

carry out clinical leadership and management, but are also responsible for translating the strategic vision and the values and objectives of the organisation's care actions (Chase, 2010; Ofei et al., 2020). Due to increasing responsibilities of nurse executives, extensive training—including adaptation to complex environments and competencies—is often required, for which a doctoral degree is preferable (Clark,2012).

Upon conception of this research, direct contact was made with the American Organization of Nurse Executives (AONE), in order to define the different terms related to nurse managers. Thus, with the help of MTM, a member of AONE, the table in Appendix S1 was developed.

Although there is no standard definition of competency, in 1973 McClelland defined it as an underlying characteristic of an individual, which is causally related to effective or superior performance in a job, role or situation (McClelland, 1973). New (1996) defined competencies as those in which nurses are able to collaborate with other people, while Hudak et al. (2000) defined them as the skills, knowledge and capacity necessary to achieve quality health care. Therefore, competency can be defined as the appropriate combination and application of nurse executives' knowledge, attitudes and skills in specific management functions that are observed and measured as behaviours (Gunawan et al., 2020). In order to identify, orient and train the nurse managers, competencies are an essential resource (Meadows & Dwyer, 2015). Thus, competency training in management must go beyond the ambit of nursing and include, for example, business management, artificial intelligence and technology (Baxter & Warshawsky, 2014; Chase, 2010; DeOnna, 2006).

The relationship between economic and sustainability policies with respect to offering quality care in health systems is the starting point to justify the development of managerial competencies; these competencies are necessary for a higher degree of performance and results (Groves, 2011; Kerfoot & Luquire, 2012; MacMillan-Finlayson, 2010). Yoder-Wise et al. (2013) states that the development of an advanced level of managerial competencies is fundamental in achieving the objectives of the organisation. Warshawsky et al. (2020) highlights the capacity of the nurse manager to develop advanced competencies in management as one of the key strategies for the success of health organisations. This development is achieved through postgraduate studies (Institute of Medicine of the National Academies, 2010). Management competencies are an essential resource to identify, guide and train nurse executives (Meadows & Dwyer, 2015).

A review of literature indicates that it is necessary to improve the knowledge about nurse managers' competencies (Meadows, 2016; Scoble & Russell, 2003; Vance, 2009), since their necessary competencies are usually not clearly defined, which could explain the lack of conceptualization of their roles. Previous systematic reviews have only discussed factors and characteristics that could be seen as essential components of the nurse manager role (Gunawan & Aungsuroch, 2017; Gunawan et al., 2020). Thus far, to the best of our knowledge, no reviews have been conducted to describe the competencies required for nurse managers. Therefore, there is a need to synthesize available evidence about competencies for nurse managers which was the purpose of this study.

In addition, for this research, we refer to the term nurse manager in a generic way. Thus, the nurse manager is defined as a nurse who performs the role of nurse executive, middle management role or nurse manager role.

2 | REVIEWED METHODS

2.1 | Aim

This scoping review aimed to describe and synthesize scientific literature on nurse managers' competencies.

2.2 | Design

A scoping review was utilized, incorporating summaries, explanations and interpretations from available quantitative and qualitative studies to address review questions. This method allows a review to extract different data and develop them in a way that is meaningful, transparent and systematic (Grant & Booth, 2009). Reporting followed the PRISMA checklist in the manner indicated by Moher et al. (2009).

2.3 | Search methods

The scoping review was conducted as suggested by Arksey and O'Malley (2005).

- Examining the extent, range and nature of research activity.
- Determining the value for undertaking a full systematic review.
- Summarizing and disseminating research findings.
- Identifying research gaps in the existing literature.

For this review, three research questions were asked:

- What are the competencies of the nurse manager?
- What are the most frequently cited competencies of nurse managers?
- What tools are available for measuring, developing, and evaluating competencies of nurse managers?

Before identifying relevant journal articles, the authors determined keywords based on the research questions and contacted a panel of experts by mail to obtain their opinions on these keywords used in the scoping review process. These experts were DG, LKC and JM.

The electronic databases Web of Science, Scopus, Cumulative Index to Nursing and Allied Health Literature and PubMed were searched for relevant articles published between 2010 and 2020.

Search terms included terms used to refer to nurse managers and competencies (Appendix S2).

The inclusion criteria for papers in this scoping review were as follows: (a) articles published between 1 January 2010 and 31 December 2020. Articles from the last 10 years were included to guarantee the synthesis of updated knowledge, considering that the role of nurse managers has evolved in recent years; (b) articles written in English or Spanish, providing information about competencies of nurse managers; and (c) quantitative and qualitative articles, theses and dissertations, and review articles. The reason for including these sources was to ensure that the research captured all existing knowledge about nurse manager competencies. Exclusion criteria were papers that did not report information about competencies of nurse managers.

2.4 | Search outcome

The selection process is shown in Figure 1. A total of 565 titles were identified by searching through databases and other sources. After screening the titles and abstracts, 170 studies remained for full-text review. Finally, 76 studies were included in this scoping review (Appendix S2). Three research team members (AGG, SPG and APC) screened the titles and abstracts and then full texts of the remaining articles according to the inclusion and exclusion criteria. Any disagreements were resolved by consensus and consultation with the fourth reviewer (PMG) when required.

Each of the 76 selected full-text papers was read thoroughly, several times by the three authors to capture all relevant information and to ensure that nothing important was missed. The dataset for the paper was constructed by extracting findings that were relevant to the research questions.

2.5 | Quality appraisal

An assessment of literature quality was conducted. Since developed and validated tools for assessing the different methodologies of the included publications are lacking, development of a specific tool to serve this purpose was necessary. To this end, parts of the method presented by Hölbl et al. (2018) were used and modified as appropriate. No papers were excluded in the quality assessment process. The papers received a score based on the criteria presented in Table 1. The score was given as follows: No or Scarcely = 0; Moderately, the

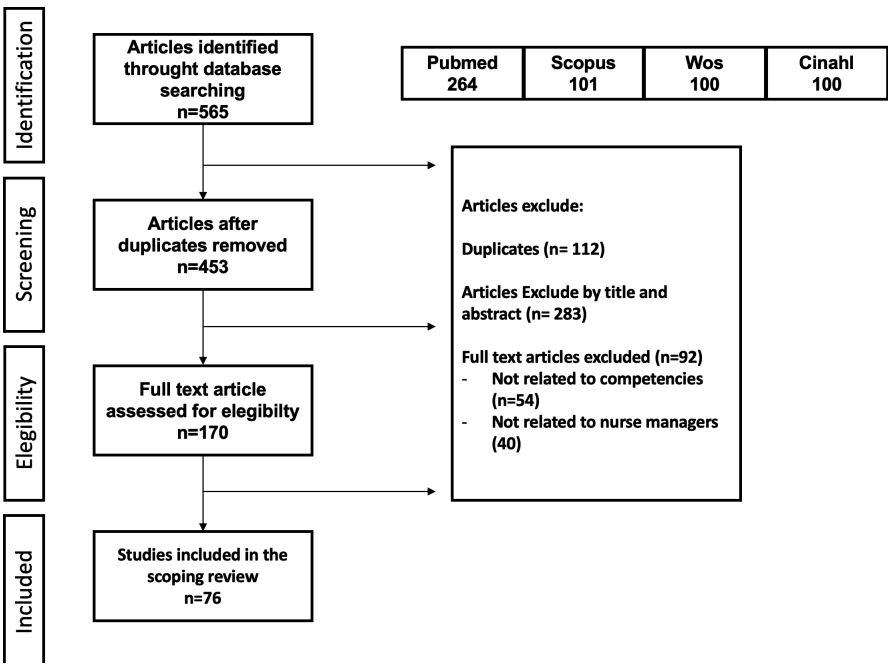

FIGURE 1 Flow chart of study selection process

TABLE 1 Quality assessment tool adapted from Hölbl et al. (2018)

Domain	Indicator (0–2)
Q1—Is the nurse manager competency described?	No-Moderately-Yes
Q2—Are the research objectives clearly outlined?	No-Moderately-Yes
Q3—Are the main contributions well described to the nurse management?	No-Moderately-Yes
Q4—How appropriate is the problem solution fit?	No-Moderately-Yes
Q5—Are the proposed solutions feasible (scalable, economical, implementable)?	No-Moderately-Yes

criterion could be interpreted = 1; Yes or Adequately = 2. The process of quality assessment was carried out by reviewer 1 (AGG) and later independently reviewed by reviewers 2–4 (APC, SPG and PMS).

2.6 | Data extraction

Data were extracted by three reviewers (AGG, SPC and APC) using the prespecified data extraction forms. Extracted information included studies, sample size, participant characteristics, countries, competencies, model of competencies and instruments. Data analysis was completed in Microsoft Excel.

Articles and competencies were coded using the following process to correctly identify them:

- Articles: These were encoded with the letter 'A' followed by three digits, beginning with 'A001' as the code to identify the first article.
- Competencies: These were encoded with the letter 'C' followed by three digits, beginning with code 'C001'.

Therefore, for example, the competency encoded as 'C589 A021' can be identified as: competency 589 belonging to article 21.

With this system, we first listed the competencies described in the articles, giving each a code. Second, the competencies were analysed, grouped if identical and counted for frequency of repetition. Finally, we grouped the competences according to common characteristics.

Any disagreement was resolved by consensus or the fourth reviewer (PMS). The expert panel were contacted when required, for example, in cases of lack of understanding of the context, no understanding of the functional role of nurse manager or lack of understanding of the term that referred to a certain competency.

For this review, the terms competency model and domain were defined as:

> A competency model provides a conceptual framework defined by the process for achieving outcomes, the critical path to achievement, the related tasks and best practices that people consistently perform to achieve objectives.

A domain is a group of terms with shared defining characteristics.

3 | RESULTS

3.1 | Bibliographic overview

Seventy-six papers were reviewed in the current scoping review (Appendix S3), conducted in 15 countries: United States, Oman, South Africa, Australia, Switzerland, Finland, China, Slovenia, South Korea, Taiwan, Brazil, Iran, Indonesia, Ghana, Spain and Canada.

A total of 680 competencies were identified from 76 studies, 288 were duplicated, so their frequency of repetition was analysed and duplicates were eliminated. After the first analysis, 392 competencies were observed (Table 2). Next, the meaning of each competency was analysed and those that referred to the same competency, described in different ways, were grouped together. Finally, 53 competencies were grouped according to their characteristics (Table 2), for example, decision-making, financial competencies, result orientation, leadership, change management and ethical principles. It was especially relevant that competencies required by nurse managers emerged from the literature belonging to the area of personality, such as emotional intelligence, integrity, diversity and compassion, and those regarding personal and professional balance. The list describes the competencies for the nurse manager in the different functional roles. The competencies come from very diverse health care systems, which makes it convenient to determine their validity in a specific health care system and the nurse manager's role in it. These competencies of nurse managers were grouped into six dimensions based on their defining characteristics (Table 3).

3.2 | Quality assessment

Appendix S4 presents the results of the quality assessment. The maximum number of total points was 10, and the minimum was zero. The total mean score was 6.77 and the average score for each of the sections was Q1 = 1.32 ± 0.57, Q2 = 1.54 ± 0.55 and Q3 = 1.05 ± 0.43 which were lower than Q4 = 1.62 ± 0.59 and Q5 = 1.24 ± 0.54. The quality of the included publications varied with a standard deviation of 1.23 for the total mean score and a range of 4–9.

3.3 | Most-cited competencies and competency aggrupation

The selection criterion that was followed for the most-cited competencies was a relative frequency equal to or greater than five, and through this, 22 most frequently cited competencies were identified (Table 4). The two most-cited competencies were communication and finance.

TABLE 2 Analysis of competencies and domains

Domain	First analysis	Final grouped
Management	76	10
Communication and Technology	43	6
Leadership and Teamwork	122	15
Knowledge of the health system	61	7
Nursing knowledge	48	8
Personality	42	7

TABLE 3 Competencies for nurse managers

I. Management	IV. Knowledge of the health system
Analytical thinking	Care management systems
Decision-making	User care skills
Innovation	Health policy
Strategic management	Identification and responsibility with the organisation
Human resources management	Knowledge of the health environment
Legal aspects	Quality and safety
Organisational management	Quality and improvement processes
Result orientation	
Marketing	
Finance	
II. Communication and technology	V. Nursing knowledge
Communication	Clinical skills
Feedback	Standard nursing practice
Evaluation of information and its sources	Nurse research
Listening	Nursing theories
Information systems and computers	Care planning
Technology	Nursing training planning
	Professionalism
	Infection control practices
III. Leadership and team work	VI. Personality
Relationship management	Serve as a model
Leadership	Awareness of personal strengths and weaknesses
Career planning	Strategic vision
Influence	Personal and professional balance
Change management	Compassionate
Delegate	Diversity
Conflict management	Emotional intelligence
Ethical principles	Integrity
Power and empowerment	
Critical thinking	
Collaboration and team management skills	
Interpersonal relations	
Multi-professional management	
Team-building strategies	
Talent management	

In addition, competencies such as change management, conflict management and decision-making also emerged from the literature. Competencies that refer to aspects such as ethics or integrity were also relevant among the articles that make up this review.

The competencies were grouped into six domains. Consequently, in order to name each domain, the most representative terms were selected for all the competencies included in each domain. The results are shown in Table 3.

3.4 | Model of competencies

A competency model provides a conceptual framework defined by the process for achieving outcomes, the related tasks and best practices that people consistently perform to achieve objectives.

After reviewing the literature, nine models of competencies were identified (Table 5). Eleven articles (22%) of those reviewed include the AONE model of competencies.

The following are highlighted for their presence in the literature reviewed: the competency model based on the standards of management practice established by the American Nursing Association (ANA); Nurse Executive Competencies focused on senior nurse managers; Nurse Executive Competencies: Chief Nurse Executive (CNE) System focused on top nurse managerial representation; nurse manager competencies oriented to logistical and operational management; Lead, achieve, system transformation, engage, develop coalitions Capabilities Framework based on the Canadian College of Health Leaders competency repository; The Managerial Competencies of the Head Nurses originating from the assessment of nurse managers in Taiwan; and The Magnet Model taking into consideration the standards of magnet hospitals.

3.5 | Instruments for measuring competencies

From the reviewed papers, the available instruments for measuring, developing and evaluating competencies were identified. The instruments are (Appendix S5):

- Nurse Executive Assessment Tool (AONE, 2015).
- Nurse Leader Competency Assessment Tool (AONL, 2021).

TABLE 4 Most-cited competencies

Competency	Relative frequency	Absolute frequency (%)
Communication	22	5.60
Finance	18	4.58
Change management	14	3.56
Conflict management	12	3.05
Motivation	12	3.05
Leadership	9	2.29
Negotiation and conflict resolution	9	2.29
Clinical skills	8	2.04
Relationship management	8	2.04
Decision-making	7	1.78
Strategic thinking	7	1.78
Team-building strategies	7	1.78
Time management	6	1.53
Strategic vision	6	1.53
Human resource management	5	1.27
Information systems and computers	5	1.27
Integrity	5	1.27
Legal issues	5	1.27
Power and empowerment	5	1.27
Professionalism	5	1.27
Research and evidence-based practice	5	1.27
Technology	5	1.27

- The Chase Nurse Manager Competency Instrument (Chase, 2010).
- Nurse Managers Leadership and Management Competencies Scale (Kantanen et al. 2015)
- Competency Assessment Scale for Head Nurses (CASHN) (Tongmuangtunyatep, 2015).
- The Human Capital Competencies Inventory (HCCI) (Donaher et al., 2007).
- Nurse Manager Competency Inventory (NMCI) (DeOnna, 2006).

The Nurse Executive Assessment Tool was developed by the AONE as a tool for the evaluation and self-assessment of senior nurse managers and for identifying areas for improvement. Nurse Leader Competency Assessment Inventory Tool was also developed by the AONE and focuses on the assessment of nurse manager competencies at the executive, logistical and operational levels. The Chase Nurse Manager Competency Instrument is oriented to the assessment of competencies required to perform nurse manager functions. Nurse Managers Leadership and Management Competencies Scale aims at detecting the competencies of nurse managers during the performance of their duties. Competency Assessment Scale for Head Nurses focuses on the evaluation of nurse manager performance. The Human Capital Competencies Inventory focuses on the measurement of the nurse manager's human capital competencies. Finally, the Nurse Manager Competency Inventory focuses on the measurement and evaluation of nurse manager competencies at the operational level.

TABLE 5 Model of competencies

Competency model	Author/Year	Focused on	Core of competencies
The Magnet Model	Martin (2009)	Nurse manager	Transformational leadership, structural empowerment, exemplary professional practice, new knowledge, innovations, and improvements, empirical quality outcomes force
The Managerial Competencies of the Head Nurses	Hu (2010)	Nurse manager	Administrative competence, leadership competence, recognition, managerial ability training
LEADS capabilities framework	Canadian College of Health Leaders (2011)	Nurse manager	Leads self, engages others, achieves results, develops coalitions, system transformation
Competency Model	ANA Leadership Institute (2013)	Nurse manager	Leading yourself, leading others, leading the organisation
Nurse Manager Competencies	American Organization of Nurse Executives (2015b)	Nurse manager	Managing the business, the leader within, leading the people
Nurse Executive Competencies: System CNE	AONE Nurse Executive Competencies (2015)	Nurse executive	Knowledge of the health care environment, communication and relationship building, professionalism, leadership skills, business skills
Nurse Executive Competencies	American Organization of Nurse Executives (2015a)	Nurse executive	Communication and relationship building, a knowledge of the health care environment, leadership, professionalism, business skills
Managerial competencies of head nurses	Moghaddam et al. (2019)	Nurse manager	Planning, organising, leadership, control, managerial roles
Model of competencies for nurse managers	González-García et al. (2019)	Nurse manager/ middle nurse manager/nurse executive	Relationship management, communication, listening, leadership, conflict management, ethical principles and team management skills

4 | DISCUSSION

This scoping review demonstrates the competencies required for nurse managers identified in scientific literature. This is the first scoping review to describe the competencies of nurse managers at the international level. The strength of this research is its stringent inclusion criteria, the quality assessment approach and the use of a panel of experts to guide the approach to the subject.

We found 392 competencies that are required by nurse managers, although the number was reduced to 53 after individually analysing each competency and grouping them according to their defining characteristics. The Healthcare Leadership Alliance (HLA), since 2005, was created and developed a directory of competencies required for managing health care organisations (Healthcare Leadership Alliance, 2010). It has been updated in the last few years, and we can observe a significant growth in the number of competencies, a trend that can be attributed to the ever-increasing need to be in possession of competencies from disciplines other than health-based ones. In this regard, Deyo et al. (2016) argues that there is a need to develop a suitable set of competencies, as well as a set of risks for the health system if nursing managers do not follow this path of skills development. Following the procedure used by Kirk (2013), we asked ourselves what the basic competencies that a nurse manager must possess are. Generally speaking, nurse managers are focused on clinical and technical aspects, a situation that is not valid for the current needs of patients or health care organisations because of the complexity of data and information management, networking as a standard practice and so forth (American Nurses Association, 2015).

Nurse managers must have solid experience based on the tasks undertaken by nursing professionals, but it is also necessary for them to develop advanced management competencies to address current and future challenges (Kirk, 2013). Our findings align with what the AONE suggests, since this group of competencies also appears within its model of competencies (AONE Nurse Executive Competencies, 2015; American Organization of Nurse Executives, 2015b). As a result, changes in the development of clinical skills in favour of other types of competencies intended for organisations more focused on efficient resource management and quality of service have made it necessary to develop competencies that cut across other fields of knowledge, with a consequent reduction in the weight placed on clinical skills. Thus, clinical skills fall within a broader scope of knowledge required for health care and assistance provided by nurses (Healthcare Leadership Alliance, 2010).

With regard to the classification of competencies in different domains, once the competencies had been identified, they were grouped according to their characteristics via the establishment of six domains: management, communication and technology, leadership and teamwork, knowledge of the health system, nursing knowledge and personality. As a result, similarities can be found between these domains and AONE's model of competencies (which is the most-cited model) such as, communication and relationship building, knowledge of the health care environment, leadership, professionalism and business skills (AONE Nurse Executive Competencies, 2015; American Organization of Nurse Executives, 2015b). The main difference therefore consists of the interpretation given in this work in relation to the development of leadership. In contrast to the AONE model, we differentiate the development of teams and personality components.

Based on information obtained from the articles, nine models of competencies were identified, although three of them, namely those developed by AONE, are subspecialties of the main framework. In this regard, we find two orientations in the development of the models. On the one hand, there are the models developed by AONE and by Hu (2010), which make the need for the development of financial management competencies very clear, and on the other hand, there are the models developed by the ANA, the Canadian College of Health Leaders, Martin (2009) and González García 2019, in which the emphasis is on leadership, the development of people and personality, and in which there is a confluence around leadership, communication, administration, resource management and organisational knowledge. It is worth mentioning that the model produced by Martin (the magnet model) is fundamental to what the ANA has produced (American Organization of Nurse Executives, 2015a; ANA Leadership Institute, 2013; Canadian College of Health Leaders, 2011; González-García et al., 2019; Hu, 2010; Martin, 2009).

This review also noted the development of seven instruments for measuring, developing and evaluating competencies. Although all articles have used to measure and assess competencies, not one of them mentions used for the process of selecting nurse managers (Lehtonen et al., 2018; Tongmuangtunyatep et al., 2015). For example, the Nurse Leader Competency Assessment Tool was used to perform a self-assessment of competencies, and although the Nurse Managers Leadership and Management Competencies Scale has been developed, its use is not evident from the literature, as is the case for the Competency Assessment Scale for Head Nurses (CASHN). The Human Capital Competencies Inventory (HCCI) indicates its usefulness for selection processes, but no evidence of its use for this purpose has been found.

5 | CONCLUSIONS

Knowing the competencies required from nurse managers can help organisations create strategies to develop competent managers in health care organisations. We identified 392 competencies, which were synthesized into 53 competencies and grouped into six dimensions. In addition, from the results, the most frequently cited competencies emerged, which could be the core competencies for the nurse manager. A total of 22 competencies were identified as being the most cited in the literature included in the review (communication, finance, change management, conflict management, motivation, leadership, negotiation and conflict resolution, clinical skills, relationship management, decision-making, strategic

thinking, skill systematic, team-building strategies, time management, strategic vision, human resource management, information systems and computers, integrity, legal issues, power and empowerment, professionalism, research and evidence-based practice, technology). The two most-cited competencies were communication and finance.

The findings of this scoping review demonstrate nine models of competencies, among which the most referenced competency model was the AONE's Nurse Executive Competency Model. We can also state that the most referenced instrument for evaluating, measuring and developing management skills was the Nurse Executive Assessment Tool, which was also developed by the AONE.

Another important finding of this study is the fact that the literature suggests the use of instruments to develop, measure and assess competencies, although we cannot explicitly state that any of the models has been used for the selection of nurse managers. This implies that these competency models could be included in the process of selecting nurse managers, since a posteriori development can mean inefficiencies for the organisation and therefore for the management of patient care.

The insight of the knowledge gained through this review will add to the body of nursing knowledge in the area of the role of the nurse manager.

6 | IMPLICATIONS FOR THE NURSE MANAGER

This research brings together a series of competencies that could be kept in mind in relation to both the training and selection of nurse managers. The competencies identified undoubtedly constitute the body of knowledge necessary for the work of a nurse manager. Given the large number of competencies, as well as the difficulties in developing all of them, the core competencies identified represents the minimum qualifications that a nurse manager must possess. In addition, it is possible to generate a pathway for learning and professional development for nurses before they work at the microlevel of management, and the starting point for this pathway could be the 22 core competencies. Nurses can then subsequently opt to develop meso-management and senior management functions by developing more advanced competencies or competencies that entail a higher degree of responsibility.

Our findings can also have implications for the selection of nurse managers. There is a need to change the current selection processes of nurse managers that is based on merit and not on skills. It is possible to use the evidence generated in this review to formulate selection processes founded on the above-mentioned competencies. Accordingly, using the most-cited competencies as a starting point, the selection of nurse managers may be carried out according to these competencies and their degree of development. Doing so will ensure that the most appropriate individuals are appointed to management positions.

CONFLICTS OF INTEREST

There are no conflicts of interest.

AUTHOR CONTRIBUTIONS

Data were extracted by Alberto González, Silvia Pérez and Arrate Pinto. Any disagreement was resolved by Pilar Marqués. Alberto González and Arrate Pinto did the statistical analysis. Alberto González, Pilar Marqués, Arrate Pinto and Silvia Pérez prepared the manuscript draft. All authors contributed to the revisions in depth for the manuscript and approved the final manuscript.

ETHICAL APPROVAL

A scoping review not involves human subjects, human material, human tissues or human data. Therefore, the approval of an ethics committee was not necessary.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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REVIEW ARTICLE

WILEY

A systematic review exploring the impact of focal leader behaviours on health care team performance

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Abstract

Aim: The aim of this study is to understand how the behaviour of focal leaders impacts health care team performance and effectiveness.

Background: Despite recent shifts towards more collectivistic leadership approaches, hierarchical structures that emphasize the role of an individual focal leader (i.e., the formal appointed leader) are still the norm in health care. Our understanding of the effect of focal leader behaviours on health care team performance remains unclear.

Evaluation: A systematic review was conducted. Five electronic databases were searched using key terms. One thousand forty-seven records were retrieved. Data extraction, quality appraisal and narrative synthesis were conducted in line with Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines.

Key issues: Fifty papers met the criteria for inclusion, were reviewed and synthesized under the following categories: *task-focused leadership*, *directive leadership*, *empowering leadership* and relational *focused leadership*.

Conclusions: Categories are discussed in relation to team performance outcomes, safety specific outcomes, individual-level outcomes and outcomes related to interpersonal dynamics. Emerging themes are explored to examine and reflect on how leadership is enacted in health care, to catalogue best practices and to cascade these leadership practices broadly.

Implications for Nursing Management: Empowering and relational leadership styles were associated with positive outcomes for nursing team performance. This underscores the importance of training and encouraging nursing leaders to engage in more collaborative leadership behaviours.

KEYWORDS
focal leader, health care teams, team performance

1 | BACKGROUND

Leadership has been cited as 'the most influential factor' in shaping organizational culture (West et al., 2015). Yet there remains a lack of definitional clarity in how to conceptualize leadership. For example, Zaleznik (1992) defines leadership as 'using power to influence the thoughts and actions of other people' (p. 67), while Bolden (2004) characterizes leadership as 'a *process* of influence, whereby people are inspired to work towards group goals, not through coercion, but through personal motivation' (p. 5). This diversity reflects a movement from conventional to post-industrial perspectives of leadership (Komives & Dugan, 2010), comprising varied definitions and conceptualizations of what leadership is and the behaviours that are indicative of this interpretation of leadership. In this review, we investigate the influence of focal leaders, which we define as one or more individuals within a team who occupy a formal role of leadership, management or coordination.

Dominant leadership paradigms have shifted over time, with resulting impacts on leadership training and on research on the impact of leadership. Early 20th century perspectives conceptualized leadership in terms of specific personality traits (e.g., intelligence, masculinity and dominance) (Stogdill, 1974). This single, focal leader understanding supports a one-way approach to leadership that is characterized by hierarchical relationships, linear decision-making and productivity (Komives & Dugan, 2010). Leadership styles adopting this conventional perspective focus on compliance, control and leading through power. Within health care, leadership styles that emphasize hierarchy can inhibit a positive safety climate due to fear of blame and repercussions for reporting safety-related problems (Hartmann et al., 2009). Post-industrial perspectives characterize leadership as a relational and reciprocal process, in which followers are active collaborators rather than passive dependents (Komives & Dugan, 2010). This paradigm shift to critical inquiry captures the complexities of leadership and accounts for the dynamism of the rapidly changing and emergent nature of organizations in which these individuals work (Burns, 1978). Recent studies have highlighted how transformational leadership can have a positive impact on health care team outcomes (including increased quality of care, patient satisfaction, team learning and team performance) and can cultivate empowering working environments within nursing teams (Anselmann & Mulder, 2020; Boamah et al., 2018; Lega et al., 2017). Focal leaders who adopt more inclusive practices recognize the need for leadership that goes beyond linear problem-solving and hierarchical decision-making towards an approach that focuses on mobilizing employee intelligence (Heifetz & Heifetz, 1994; Komives & Dugan, 2010). Within the nursing workforce, relational leadership styles are more commonly linked to positive outcomes than task-focused or laissez-faire leadership styles (Cummings et al., 2018; Sammut et al., 2021).

The paradigm shift towards more collectivistic approaches to leadership also aligns with the evolution of health systems from care by one 'all-knowing' physician to current practice where patients can be cared for by an average of fifteen health care professionals (Gawande, 2011). Literature suggests that organizations such as health care have turned to more team-based, collectivistic structures to contend with the growing complexity of their environments (Oates, 2012; Salas et al., 2008) and to facilitate the coordination of safe, efficient, interdisciplinary patient care (Baker et al., 2006; Government of Ireland, 2019). Aligned with this evolution, the role of leaders has expanded from enhancing individual and organizational performance to promoting, developing and maintaining team effectiveness (Burke et al., 2006; Jønsson et al., 2021). However, Pearce and Conger (2002) draw attention to the risks associated with ignoring the focal leader due to the reliance of organizations on traditional hierarchical structures. Similarly, Hernandez et al. (2011) assert that even within shared leadership, the leader remains a critical component in the leadership process and that traits of a focal leader can be applied to more shared leadership approaches. Therefore, it is important to understand the role and influence of focal leaders (Begley, 2002; Crowe et al., 2017). Despite this growing body of work, our understanding of the effect of focal leader behaviours on health care team performance remains unclear. We address this identified gap by asking: *How does the behaviour or leadership style of the focal team leader impact health care team performance?*

2 | METHODS

A systematic review was conducted to explore this research question. The Cochrane and Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Higgins et al., 2019; Liberati et al., 2009; Moher et al., 2009) have been followed.

The protocol for this review has been published on Prospero (registration number: CRD42020207533).

2.1 | Inclusion and exclusion criteria

Studies eligible for inclusion were peer-reviewed articles, from any country, published between the 1 January 2000 and 1 July 2020. Empirical, experimental and observational research studies, along with case studies, were eligible for inclusion if they explored the impact of focal leaders' behaviours on team performance or team effectiveness (objective or subjective outcomes). Included studies also had to focus on staff (clinical, management or administrative) working in a health care setting.

Studies were excluded if they were not available in English or if they reported on interventions conducted outside health care settings.

2.2 | Search strategy

The search strategy used key words identified through a scoping review of the literature. They were grouped together using the AND/OR Boolean terms. As the grey literature databases searched were less sensitive, a modified search strategy was used. The final search strategies are presented in Table 1.

TABLE 1 Final search strategies

Academic databases				
Team* OR group*	AND	Collaborative leadership OR participatory leadership OR participative leadership OR inclusive leadership OR backstage leadership OR transformational leadership OR transactional leadership OR compassionate leadership OR ethical leadership OR spiritual leadership OR authentic leadership OR focal leader behavio* OR leader integrity OR leader espoused values OR leader enacted values OR leader value adherence OR leader behavio* reliability OR leader behavio* adherence OR leader behavio* integrity OR word-deed congruence OR charismatic leadership OR psychological contracts OR word-deed misalignment OR word-deed alignment OR word-deed consistency OR word-deed inconsistency OR word-action congruence OR word-action misalignment OR word-action consistency OR word-action inconsistency OR word deed congruence OR word deed misalignment OR word deed alignment OR word deed consistency OR word deed inconsistency OR word action congruence OR word action misalignment OR word action consistency OR word action inconsistency OR leader-member relationship* OR leader-follower relationship* OR leader-member exchange OR values-based leadership OR leader organizational value* OR leader organizational value* OR inconsistent behavio* OR consistent behavio* OR leader* behavio* inconsistency OR leader* behavio* consistency OR leadership psychological contract	AND	Health OR health care OR health care OR medical OR clinical OR nursing OR hospital OR community care OR primary care OR public health OR secondary care OR clinic
Grey literature database				
Team*	And	Leader*	And	Health care

2.3 | Information sources

The five electronic databases searched were PsycINFO, ABI/Inform, PubMed, Cochrane and CINAL.

A grey literature search was conducted using the OpenGrey electronic database, which had a broad scope and the ability to conduct specific searches (Godin et al., 2015; Oliver & Swain, 2006). The authors also hand-searched the reference lists of included studies.

2.4 | Study screening

Covidence, an online specialized systematic review tool, was used to screen records. Two reviewers independently screened titles and abstracts based on the eligibility criteria. When the eligible papers were identified, two reviewers then independently reviewed each full text. The reviewers met to discuss and resolve any conflicts or disagreements. If an agreement was not reached, there was an option to involve a third reviewer; however, ultimately, this was unnecessary, as reviewers reached agreement following discussion.

2.5 | Data extraction process

- A standardized data extraction template was developed to capture the relevant information from included studies. Cochrane guidelines (Cochrane, 2014; Higgins et al., 2019) and recommendations from Hoffmann et al. (2014) informed the development of the data extraction tool. Information was collected on the aims, design, theoretical underpinnings, details of the intervention, participant information and outcomes. The final template can be seen in Table S1.

2.6 | Quality assessment and study synthesis

Two reviewers assessed the quality of included studies using the Mixed Methods Appraisal Tool (Pluye et al., 2011). Because the included articles used a variety of methodologies, the Mixed Methods Appraisal Tool was used to facilitate consistency in the quality criteria assessed in each article.

Given the heterogeneity of the studies included in this review, a narrative synthesis of the findings was deemed the most appropriate (Popay et al., 2006). Based on guidelines from Popay et al. (2006), the

narrative synthesis followed three iterative steps: (1) organizing studies into logical categories by becoming familiar with them; (2) comparing them to one another and synthesizing their findings; and (3) analysing the findings within each category by exploring relationships within and between the studies and synthesizing data under the relevant themes.

3 | RESULTS

3.1 | Search results

Fifty-five studies met the inclusion criteria and were included in the review. A summary of these included studies can be found in Table 2. Figure 1 shows the PRISMA flow chart which summarizes the screening process of this review.

3.2 | Quality assessment

No study was excluded from the review based on quality assessment (see Table S2 for results of quality appraisal). All studies met at least 50% of the quality criteria.

3.3 | Narrative synthesis of findings

Given the heterogeneity of included studies (Table 2) and to enable meaningful synthesis, papers were divided according to the focal leadership style and behaviours identified and are described in the following narrative synthesis. The 13 focal leadership styles identified in this review are grouped into four overarching categories. Table 3 presents each of these focal leadership styles, along with their definitions and associated behaviours. First, ***task-focused leadership*** includes transactional leadership, situational/flexible/adaptive leadership and continuous quality improvement (CQI). ***Directive leadership*** incorporates directive/autocratic leadership and abusive/overcontrolling leadership. ***Empowering leadership*** includes transformational leadership, distributed leadership, servant leadership, inclusive or participative leadership, authentic leadership and laissez-faire/passive/passive-avoidant leadership. Lastly, ***relational focused leadership*** includes leader member exchange (LMX) and leader behavioural integrity.

3.3.1 | Task-focused leadership

Transactional leadership

Five studies explored the impact of transactional leadership styles. Transactional leaders rely on reward and punishment to motivate the team to comply with their requests and organizational rules (Aarons et al., 2016; Dierckx de Casterlé et al., 2008; Mulenga et al., 2018).

Transactional leadership was marginally associated with the sustainment of evidence-based practice (EBP) interventions. However, transactional leadership can also result in dissatisfaction among subordinates and negative responses to new initiatives such as EBP implementation (Aarons et al., 2016). Active management by example (MBE) leadership (leaders anticipate mistakes before they occur through continuous monitoring and intervene as required) helped in clarifying expectations, enabling continuous monitoring, anticipating mistakes and promptly taking corrective action. This improved team performance during a crisis. However, focal leaders also display passive MBE during crisis situations (Sommer, 2008). The passive MBE leadership style was positively associated with negative affect (in followers) in both crisis and non-crisis situations. Another study found a positive correlation between transactional leadership, job satisfaction and teamwork. However, staff had a negative impression of leaders who exhibited a management by exception leadership style. This study did not state whether this result was in relation to active management by exception (a leader who only provides assistance in exchange for their efforts and focuses attention on irregularities) or passive management by exception (similar to laissez-faire leadership, the leader focuses on fighting fires) (Musinguzi et al., 2018). Health care providers did not favour transactional leadership as it did not provide encouragement to the team (Mulenga et al., 2018).

Situational, flexible or adaptive leadership

Two studies discussed situational/flexible/adaptive leadership style. Focal leaders who engage in this style are socially intelligent and perceptive. They can anticipate the requirements of the situation and respond appropriately (Klein et al., 2006).

This leadership style involves dynamic delegation, which has been found to increase reliable performance and individual learning. However, it is unlikely to stimulate team shared learning and team creativity (Klein et al., 2006). One study found that a situational leadership style among senior leaders may be more beneficial than an authentic leadership style. This is because, at critical points in the work process, focal leader directiveness and role modeling are more important than characteristics associated with authentic leadership, such as being engaging (Stevens et al., 2014).

CQI leadership

Only one study focused on CQI leadership (Rathert & Fleming, 2008). CQI leadership, characterized by focal leaders who focus on encouraging CQI, was associated with improved psychological safety among lower status team members, interpersonal trust, respect and increased participation in quality improvement efforts (Rathert & Fleming, 2008).

3.3.2 | Directive leadership

Directive/autocratic leadership

Four studies examined the impact of directive or autocratic focal leaders. Directive/autocratic leaders provide team members with a framework for decision making and action, which is aligned with the

TABLE 2 Summary of included papers

Paper reference	Methodology	Population	Setting	Leadership styles identified	Team outcomes
Tomlinson (2012)	Qualitative case study	20 staff nurses	Acute surgical wards in Glasgow hospitals	Transformational leadership Distributed leadership	Team engagement
Aarons et al. (2017)	Quantitative descriptive	Clinicians or case-managers providing direct services to clients (providers) and program managers or team leaders that directly supervised providers (supervisors)	Mental health clinics in San Diego County, California	Transformational leadership	Defensive culture including consensus culture, conformity culture, subservience culture and overall defensive culture
Aarons et al. (2016)	Mixed methods	45 administrators 212 service providers	Eleven system-wide implementations of the same EBI across two US states and 87 counties	Transformational leadership Transactional leadership	Sustainment of evidence-based practice intervention (EBPI)
Aarons and Sommerfeld (2012)	Randomized control trial	140 service providers working in 30 teams	Teams providing comprehensive home-based services to families involved with the child-welfare system in Oklahoma Children's services	Transformational leadership Leader member exchange	Innovation climate Attitudes to evidence-based practice implementation
Barling et al. (2018)	Mixed methods	Surgeons, anesthesiologists, nurses and residents working in an operating room	Departments of surgery, obstetrics and gynecology and urology in a Canadian tertiary care teaching hospital	Abusive leadership Overcontrolling leadership Transformational leadership Passive leadership	Psychological safety Collective efficacy
Bellé (2014)	Randomized control experiment	138 nurses	A group of public hospitals belonging to the same local health authority (LHA) in Italy.	Transformational leadership	Team performance
Cheng et al. (2016)	Quantitative cross-sectional study	Registered nurses	Large metropolitan public health service in Victoria, Australia	Transformational leadership	Team climate, perceptions of quality of care, burnout, turnover intention, social identification
Sommer (2008)	Field quasi-experimental design	406 team members in 71 teams and their team leaders	Two large hospitals and 17 smaller sites in Canada	Transformational leadership	Team resilience and performance Affect
Rosengren et al. (2007)	Qualitative	10 ICU staff members who represented variation in professions, work experience, years in their own profession and gender	ICU in Sweden with 10 beds and 84 employees	Transformational leadership	Professional development High quality of care

(Continues)

TABLE 2 (Continued)

Paper reference	Methodology	Population	Setting	Leadership styles identified	Team outcomes
Henderson et al. (2013)	Mixed methods	Registered nurses (RNs) with five endorsed enrolled nurses, who are licensed nurses who must practise under RN supervision	Nursing unit- full details not stated	Transformational leadership	Increase in help-seeking behaviour and response to help-seeking. Open communication. Increased engagement in decision making. Statistically significant improvement in reported acknowledgement and teamwork. Improvements in communication, preparation, affiliation and accomplishment were not statistically significant.
Raes et al. (2013)	Cross-sectional study	498 health care workers from 28 nursery teams	A university hospital in Flanders	Transformational leadership Laissez-faire leadership	Team learning
Cohen et al. (2012)	Quantitative descriptive	A variety of occupations (nurses, social workers, physiotherapists, laboratory employees, administrative staff, etc.) working in 31 medical units.	Two public health care organizations in the Centre of Israel.	Transformational leadership	Organizational citizenship behaviour In-role performance Group cohesiveness
Corrigan et al. (2000)	Quantitative descriptive	68 teams—200 leaders and 600 subordinates	State hospitals and community mental health programs, providing psychopharmacological and psychosocial treatments for adults with serious and persistent mental illness.	Transformational leadership Passive/laissez-faire leadership	Consumer satisfaction and quality of life
Craven (2017)	Quantitative	110 participants were DCMs and dental employees	Own practices, solo practices, group practices, corporate dental practices	Transformational leadership Servant leadership Passive leadership Inclusive leadership	Team psychological empowerment Employee engagement Emotional intelligence
Dierckx de Casterlé et al. (2008)	Qualitative	17 professionals in the study unit participated: 9 nurses, 3 physiotherapists, 1 psychologist, 1 occupational therapist, the ward physician, the head nurse and the nursing manager	A large academic hospital that had participated in clinical leadership development project (CLP). Selected unit had a bed capacity of 30 that housed chronic care (rehabilitation) patients.	Transformational leadership	Improved continuity of care, patient centred communication, interdisciplinary collaboration, team- and self-management and relationships with the organization

(Continues)

TABLE 2 (Continued)

Paper reference	Methodology	Population	Setting	Leadership styles identified	Team outcomes
Frumenti and Kurtz (2014)	Quantitative nonrandomized	178 registered nurses 7 licensed practical nurse managers 46 nursing aides	Large metropolitan hospital Centre 7 medical/surgical nursing units	Transformational leadership	Pressure ulcer-performance Approach to addressing operational failures.
Hauck et al. (2013)	Quantitative (prospective, descriptive comparative)	475 registered nurses and nurse leaders	429-bed non-teaching, faith-based hospital was located in a moderate sized city in the Midwest United States.	Transformational leadership	Beliefs/perceptions of evidence-based practice and organizational readiness.
Olvera et al. (2017)	Cross sectional	388 workers grouped in 54 work teams and the 54 supervisors of these teams	Four health care centres (three hospitals and one primary attention center)	Transformational leadership	Team performance: Intro-role performance and extra-role performance
Nielsen et al. (2009)	Cross sectional	274 elderly care employees	Two elderly care centres in large Danish local government.	Transformational leadership	Self-efficacy and team efficacy
Musinguzi et al. (2018)	Cross sectional	564 health workers	228 health facilities across 3 geographic regions of Uganda.	Transformational, transactional and laissez-faire leadership	Motivation, job satisfaction and teamwork
Mullen and Kelloway (2009)	Pre-test, post-test and control group design	The pre-test sample consisted of 60 nurses from 21 long-term health care organizations. 56 participants completed the post-survey.	21 long-term health care organizations	Transformational leadership	Safety attitudes, intent to promote safety and self-efficacy and safety climate outcomes
Mullen (2005)	Experimental	32 leaders and 114 health care workers (subordinates)	21 long-term health care organizations and their leaders	Safety-specific and transformational leadership	Improved leaders' safety attitudes and self-efficacy to promote safety. Improved subordinately rating of leaders and their perceptions of safety climate
Mulenga et al. (2018)	Cross-sectional qualitative	12 leaders and 30 health care providers	6 hospitals in Lusaka Province-Zambia	Transactional, transformational and laissez-fare leadership	Health care delivery services outcomes confidence, motivation, quality of care and performance
Mitchell et al. (2014)	Cross sectional	Members of 75 interprofessional teams. Included: Nurse, dietician, physiotherapist, social worker, medical practitioner, pharmacist, occupational therapist and psychologist.	Acute health care	Transformational leadership	Motivation, diversity, team effectiveness, affective tone
Malik et al. (2012)	Cross sectional	100 students from Punjab University Gujranwala campus and 25 from civil hospital	Punjab University Gujranwala campus and civil hospital	Participative, transformational and autocratic leadership.	Team collaboration, team cohesiveness, goal clarity

(Continues)

TABLE 2 (Continued)

Paper reference	Methodology	Population	Setting	Leadership styles identified	Team outcomes
Liu et al. (2020)	Cross sectional	193 doctors and 180 nurses.	Hospitals in China—All general public hospitals, providing a full range of medical and surgical services.	Transformational leadership	Quality of patient care
Stetler et al. (2014)	Mixed methods explanatory case study	Staff nurses from three embedded units. Formal (managers) and informal (individuals potentially key to EBP, such as various specialists and designated staff nurses) leaders	Two departments of nursing within a hospital were purposely selected to provide 'contrasting results for predictable reasons'	Strategic leadership behaviours, functional leadership behaviours, cross-cutting leadership behaviours	Evidence-based practice culture
Huis et al. (2013)	Cluster randomized trial (mixed methods)	All inpatient nursing wards ($n = 67$) and all affiliated nurses participated in the study	Three hospitals in the Netherlands: Two general hospitals and one university medical Centre.	Leaders who motivate, encourage and hold team members accountable	Hand hygiene compliance
Macphee et al. (2010)	Cross-case qualitative	4 sites of nursing teams and nurse leaders		Empowering leaders Fostering participation	Trusting relationships shared decision making, communications, conflict management, team-building and change management
Grady (2016)	Qualitative	Type 1: Authors, academics and advisors in health care. Type 2: Physicians and non-physicians employed by, or associated with, health-care organizations at the senior and mid-management level. Type 3: Physicians and non-physician members of the Ontario hospital Association's provincial physician leadership council	Health-care organizations in Ontario	Supportive, collaborative leadership	Team development and patient safety
Mitchell and Boyle (2019)	Cross sectional	60 teams including 60 leaders and 280 members.	UK-based teams	Inspirational leadership	Positive mood, professional salience and innovation.
Luu et al. (2019)	Longitudinal and cross sectional	Teams were clinical departments in the hospitals. Each team comprised a team manager (a physician in all cases), physicians and nurses.	Twenty-four public hospitals in Ho Chi Minh City, Vietnam, were invited to participate.	Charismatic leadership	Team creativity, team job crafting and collective public service motivation
Castelao et al. (2015)	Randomized, controlled and simulator-based study	Fifth-year medical students	Georg-August University medical School in Göttingen (Germany)	Leader CRM training Leader distributed/delegates tasks	Cardiopulmonary resuscitation performance

(Continues)

TABLE 2 (Continued)

Paper reference	Methodology	Population	Setting	Leadership styles identified	Team outcomes
Thylefors and Persson (2014)	Quantitative descriptive. a cross-sectional study	380 members from 47 teams. Subsequently, 38 of those teams took part in an observation event.	Western part of Sweden. Occupational health service, psychiatric care, rehabilitation and school health care.	Directive leadership Participative leadership (vertical leadership)	Team climate, teamwork organization-, self- and manager-assessed effectiveness and case quality
Klein et al. (2006)	Qualitative	Phase 1: 10 members of the trauma resuscitation unit (TRU): Two attending surgeons, three attending anaesthesiologists, two residents and three nurses. Phase 2: 23 TRU members: Six attending surgeons, seven fellows and 10 residents.	City trauma center is an urban level-1 shock trauma Centre located in the mid-Atlantic region of the United States	Shared leadership	Learning and reliability
Hinski (2017)	Mixed methods	Employees part of a code blue pilot program. Included physicians, nurses, respiratory therapists and pharmacists. Ten participants not part of the hospital's code team recruited by an attending physician. Code team leaders. Four additional non-leader code team members. Included two ICU nurses, one respiratory therapist and one simulation nurse educator	The Mayo clinical hospital	Key leadership behaviour identified: Good communication skills, the ability to distribute tasks, gather information and maintain an overview without getting involved in practical code tasks.	Code team performance
Stevens et al. (2014)	Mixed methods	30 medical staff and 23 dental staff from two clinics in two tertiary level hospital	One community and one hospital-based dental clinic in two Australian states	Authentic leadership	Hand hygiene compliance and safety culture
Wong (2008)	Cohort study (secondary analysis)	335 employees spit into clinical group (registered nurses, pharmacists, physicians and other health care professionals) and the nonclinical group (administrative, research and support staff)	17 cancer treatment facilities in a western-Canadian agency	Authentic leadership	Trust in management, voice behaviour (speaking up), self-rated job performance and burnout
Wong et al. (2010)	Non-experimental, predictive survey	280 registered nurses	Acute care hospitals in Ontario	Authentic leadership	Trust in their manager, work engagement, voice behaviour and perceived unit care quality.

(Continues)

TABLE 2 (Continued)

Paper reference	Methodology	Population	Setting	Leadership styles identified	Team outcomes
Nembhard and Edmondson (2006)	Mixed methods	Interviews: 23 staff members (5–7 members per team). Survey: 1440 health care professionals (46% of team members contacted) from 23 neonatal intensive care units (NICUs)	NICUs in the United States and Canada	Inclusive leadership	Psychological safety
Hirak et al. (2012)	Cross sectional	277 unit members from 67 work units were surveyed—Including medical doctors and nurses	Large hospital in Israel	Inclusive leadership	Psychological safety Unit performance
van Zijl et al. (2020)	Cross sectional	143 primary care teams, including 1105 professionals and 97 supervisors. Teams were included in the final sample if their supervisor and at least 30% of the team members had completed the survey.	Dutch primary care teams in 13 municipalities, including the four Dutch municipalities with the largest number of inhabitants.	Participative leadership Directive leadership	Functional heterogeneity and information elaboration
Bortoluzzi et al. (2014)	Quantitative cross-sectional descriptive	238 nurses- 175 were returned fully completed by nurses, giving a response rate of 73.5%.	3 public hospitals in northern Italy	Participative leadership	Mobbing
Somech (2006)	Cross sectional	Data were collected from the 1292 members of the 140 primary care teams and their corresponding 140 practice managers. These teams consisted of 290 physicians, 692 nurses, 100 social workers, 138 occupational therapists and 72 dieticians. Team size ranged from 5 to 20 members.	The largest health maintenance organization in Israel.	Participative leadership Directive leadership	Team reflection Team innovation
Nayback-Beebe et al. (2013)	Mixed methods	Intermediate care unit staff members	Intermediate care unit	Authentic leadership	Staff absenteeism patient compliments open communication, patient falls, patient safety reports and monthly performance metrics

(Continues)

TABLE 2 (Continued)

Paper reference	Methodology	Population	Setting	Leadership styles identified	Team outcomes
Rathert and Fleming (2008)	Qualitative	Clinical staff. Most respondents were nurses (79%), but several other clinical professions responded as well: Health care support (8%), allied health (7%) and other (1%). Five per cent of respondents did not indicate their job type.	A large acute care hospital on the west coast. The facility includes over 500 beds for speciality and tertiary services.	Continuous quality improvement (CQI) leadership	Psychological safety, trust, respect, participation in quality improvement efforts, teamwork, ethical climate
Anderson et al. (2019)	Cross sectional	746 registered nurses employed in 36 hospital units	One hospital system that covers 29 counties in the South-Eastern United States	Leader member exchange	Patient safety culture
Donohue-Porter et al. (2019)	Cross-sectional descriptive correlational predictive study	206 nurses (including staff nurses, nurse managers and nurse administrators)	600-bed hospital that was a non-academic medical Centre	Leader member exchange	Job satisfaction Organizational commitment Organizational citizenship behaviours
Galletta et al. (2013)	Cross sectional	1343 nurses working on medical, surgical and intensive care units	Medical, surgical and intensive care units in medium and large-scale public hospitals in Italy	Leader member exchange	Turnover intention Organizational commitment (specifically affective commitment)
Leroy et al. (2012)	Longitudinal and cross sectional	Teams within 54 nursing departments	4 Belgian hospitals	Leader behavioural integrity	Team priority of safety Team psychological safety Error reporting
Portoghese et al. (2015)	Cross sectional	935 nurses nested within 74 teams	4 public Italian hospitals	Leader member exchange	Turnover intention Job satisfaction
Turner (2018)	Mixed methods	123 physicians, 148 nurse leaders and 263 hospital employees (secondary survey data). The interviewed participants consisted of senior leaders; the chief executive officer (CEO), chief nurse executive (CNE), chief operations officer (COO), chief medical officer (CMO) and chief nursing officer (CNO).	Midwestern health care organization- inpatient capacity of 600 beds or more.	Leader member exchange	Communication Coordination Teamwork Trust Patient safety Job satisfaction
Tordera and González-Romá (2013)	Longitudinal field study	536 subjects belonging to 33 work teams completed the questionnaire. Team members included health care professionals and administrative staff.	A regional health care service	Leader–member exchange	Innovation climate

(Continues)

TABLE 2 (Continued)

Paper reference	Methodology	Population	Setting	Leadership styles identified	Team outcomes
Squires et al. (2010)	Cross sectional	267 registered nurses	Registered nurses working in medical, surgical or critical care in an acute care hospital in Ontario	Leader–nurse relationship: Resonant leadership style (i.e., listening and empathizing) and Just practices (i.e., open and respectful dialogue)	Improved quality work environment, positive safety climate, improved nurse and patient outcomes (medication errors, nurse emotional exhaustion and Intentions to leave)
Yun et al. (2005)	Confounded factorial design	91 staff members actively involved in trauma resuscitation: Including attending surgeons, attending anesthesiologists, residents, certified registered nursing anesthetists, nurses and trauma resuscitation unit technicians.	Level I trauma Centre (TC) of a major Mid-Atlantic medical Centre in the United States.	Empowering leadership Directive leadership	Team effectiveness and learning opportunities

leaders' vision (Hinski, 2017; Malik et al., 2012; Somech, 2006; van Zijl et al., 2020).

There were mixed results for the impact of this focal leadership style. According to Malik et al. (2012), autocratic leadership negatively impacted team building. Directive leadership positively moderated the negative relationship between functional heterogeneity[1] and information elaboration[2] (van Zijl et al., 2020). In addition, directive leadership negatively impacted the indirect negative effect (through information elaboration) of functional heterogeneity on team performance (van Zijl et al., 2020). Somech (2006) found that directive leadership promoted team reflection when there was low functional heterogeneity, and it mediated the relationship between team functional heterogeneity and team in-role performance. Although Thylefors and Persson (2014) found that directive leadership improved team climate, teamwork organization and self- and manager-assessed effectiveness, it had a negative impact on case quality.[3] Yun et al. (2005) found that directive leadership was most effective within trauma resuscitation teams when trauma severity was high or when an inexperienced team treated a severely injured patient.

Abusive leadership/overcontrolling leadership

One study examined the impact of abusive/overcontrolling leadership (Barling et al., 2018). They found that surgeons' abusive supervision, characterized by hostile verbal and nonverbal behaviours, had a negative impact on subordinates creativity, performance, psychological safety and collective efficacy (Barling et al., 2018).

3.3.3 | Empowering leadership styles

Yun et al. (2005) assigned the term 'empowering leaders' to a focal leader who delegated responsibility and encouraged team members to express their opinions, actively participate in decision making and task management. This leadership facilitated learning and was most effective within teams when trauma severity was low and within experienced teams. In this section, we include studies relating to transformational, distributed, servant, laissez-faire and authentic focal leadership styles as broadly indicative of an empowering approach to leadership.

Transformational leadership

Thirty studies examined the impact of transformational leadership in health care teams. Many of these studies focus on nursing staff or multi-disciplinary teams where nurses are in the majority.

Studies identified a relationship between transformational leadership and various aspects of team performance and innovation (Bellé, 2014; Macphee et al., 2010). Tomlinson (2012) illustrated that transformational leaders provided team members with a clear understanding of their goals and supported teams in operationalizing and achieving these goals. In absence of a transformational leader, team members lacked clear guidance and felt that their achievements were not recognized. Cohen et al. (2012) found that transformational leadership was related to organizational citizenship behaviour (OCB).[4]

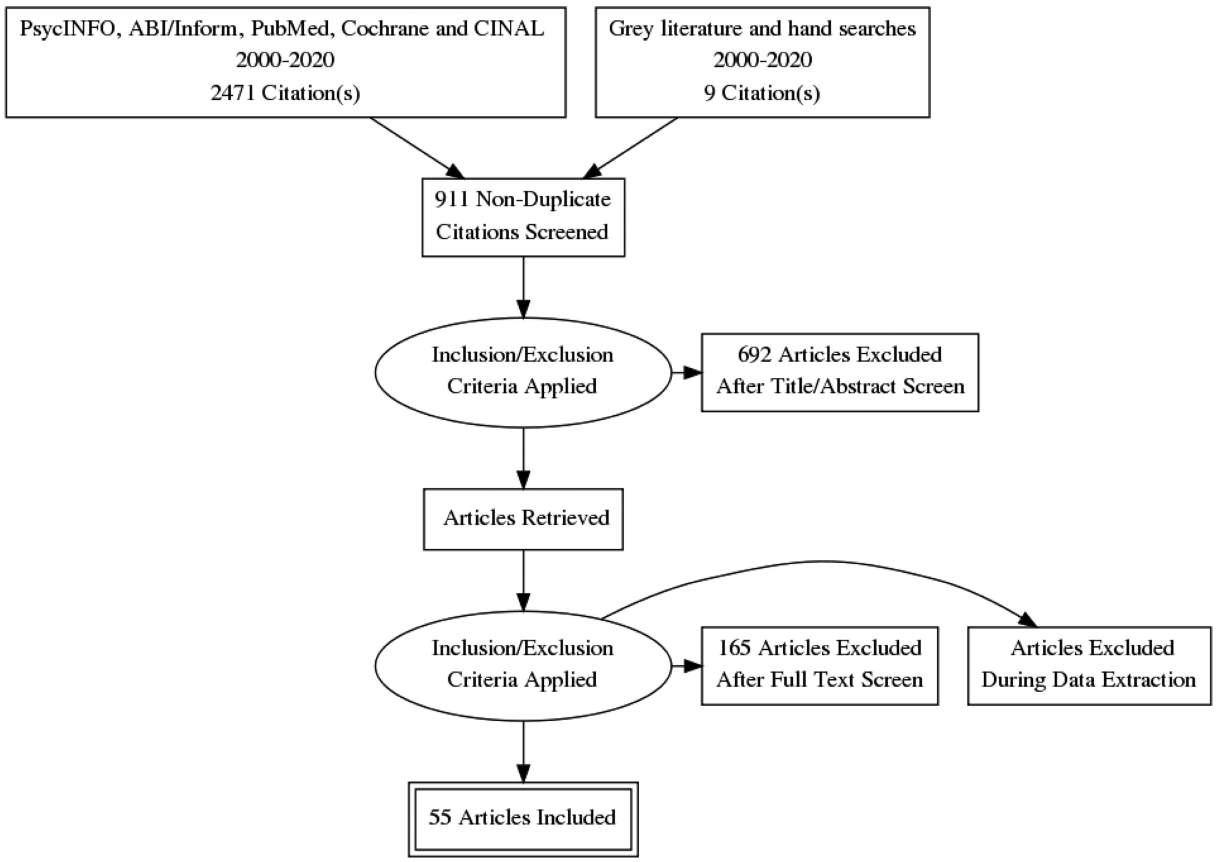

FIGURE 1 Preferred reporting items for systematic reviews and meta-analyses (PRISMA) diagram

This relationship was moderated by group cohesiveness. Transformational leaders facilitated team building (Malik et al., 2012) and developed collaborative and supportive relationships with team members (Grady, 2016). Transformational leadership also contributed to team creativity, psychological safety and, as a result, team learning (Raes et al., 2013). For this narrative synthesis, we have grouped charismatic and inspirational leadership as components of transformational leadership as they are included as key behaviours of transformational leadership. Although charismatic leadership fosters team creativity (Luu et al., 2019), inspirational leadership promote a positive mood within the team and, as a result, team innovation (Mitchell & Boyle, 2019).

Transformational leadership supports the implementation and sustainment of improvement efforts and can create and sustain an EBP culture (Aarons et al., 2016; Aarons & Sommerfeld, 2012; Stetler et al., 2014). Enhancing transformational leadership has the potential to facilitate the implementation of EBP (Aarons et al., 2016; Aarons & Sommerfeld, 2012) and drive organizational change by improving group and organizational readiness for innovation (Hauck et al., 2013). Aarons et al. (2017) found discrepancies between supervisor and mental health service providers' reports of transformational leadership. They also found an association between negative organizational culture and supervisors who rated themselves more positively than the mental health service providers. The authors concluded that this discrepancy should be considered when implementing and sustaining EBP initiatives.

Enhancing transformational leadership qualities can facilitate improvements in the continuity of care, patient-centred communication and interdisciplinary collaboration (Dierckx de Casterlé et al., 2008). Nursing leaders who enacted transformational leadership behaviours facilitated professional development and high quality of care (Cheng et al., 2016; Rosengren et al., 2007) improved team climate and reduced burnout and turnover intention by strengthening social identification (Cheng et al., 2016). Transformational leadership improved patient safety metrics, including nurses' hand hygiene compliance (Huis et al., 2013), quality of patient care ratings (Liu et al., 2020), pressure ulcer performance and approaches to addressing operational failures (Frumenti & Kurtz, 2014). Results from a leadership training intervention illustrated that when compared to general transformational leadership, safety-specific transformational leadership had significant effects on managers ratings of safety attitudes, intent to promote safety and self-efficacy and on employee perceptions of safety climate outcomes (Mullen, 2005; Mullen & Kelloway, 2009).

Transformational leadership can improve team efficacy and in turn increase health care professionals' job satisfaction, motivation and psychological well-being (Mulenga et al., 2018; Musinguzi et al., 2018; Nielsen et al., 2009). Mitchell et al. (2014) found that

TABLE 3 Definitions and behaviours associated with each leadership style

Leadership style	Definition	Key behaviours
Task-focused leadership		
Transactional	Transactional leaders rely on reward and punishment to motivate the team to comply with leader requests and organizational rules (Aarons et al., 2016; Dierckx de Casterlé et al., 2008; Mulenga et al., 2018). They continuously monitor adherence to quality standards (Aarons et al., 2016; Musinguzi et al., 2018; Sommer, 2008). Based on the relationship intensity and nature of interaction with the team, transactional leadership can be categorized as contingent reward, active management by example and passive management by example (MBE) (Sommer, 2008).	Focused on compliance, control and leading through power which can lead to dictatorial governance, selfishness, disrespect and the team being overworked (Mulenga et al., 2018). Transactional leaders may ask for employee opinion on issues but typically have made their decisions beforehand and employee opinion does not impact the decision (Mulenga et al., 2018). In contingent reward leadership, leaders establish clear objectives and performance standards and provide rewards when these goals are met (Sommer, 2008). Active MBE leaders anticipate mistakes beforehand through continuous monitoring and intervene as required while passive MBE leaders intervene only after a problem has arisen (Sommer, 2008).
Situational/flexible/adaptive leadership	Leaders are socially intelligent and perceptive individuals who anticipate requirements of the situation and tailor their responses accordingly (Klein et al., 2006).	Can adapt their leadership styles to correspond to the issue at hand and to the different phases of the team's development (Stevens et al., 2014). Engages in dynamic delegation of authority which can occur upwards or downwards in the hierarchy depending on whether the senior leader assumes an active or a passive role (Klein et al., 2006).
Continuous quality improvement (CQI) leadership	Leaders who focus on and encourages CQI (Rathert & Fleming, 2008)	Listens to the ideas of the frontline staff, actively seeks staff input in decision making and facilitates collaboration and teamwork across traditional professional boundaries (Rathert & Fleming, 2008).
Directive leadership		
Directive/autocratic leadership	Directive or Autocratic leaders provide team members with a framework for decision making and action which is aligned with the leaders' vision (Hinski, 2017; Malik et al., 2012; Somech, 2006; van Zijl et al., 2020).	Providing clear direction to the team; communicating decision-making framework; regularly posing questions; tapping into the needs for a shared language and purpose among the various professionals (Hinski, 2017; Malik et al., 2012; Somech, 2006; van Zijl et al., 2020).
Abusive leadership/overcontrolling leadership	Abusive or overcontrolling leaders restrict followers' decision-making and require them to "follow orders" (Barling et al., 2018).	Focus on performance mistakes or failures and their behaviours may include hostile verbal and nonverbal behaviours (e.g., rude, demeaning and demoralizing behaviours) that are sustained but intermittent (Barling et al., 2018)
Servant	Servant leaders serve those who are led by focusing on variables that help organizations and individual employees and fostering relationships of respect and admiration.	Key behaviours exhibited by servant leaders include service, stewardship and demonstrating belief in individuals (Craven, 2017).

(Continues)

TABLE 3 (Continued)

Leadership style	Definition	Key behaviours
Empowering leadership		
Transformational	Transformational leaders inspire, motivate and empower other team members to help them grow personally and professionally (Aarons et al., 2017; Avolio et al., 2004; Corrigan et al., 2000). They focus on motivating others to achieve a shared team goal and engage staff to promote a climate for innovation and change (Aarons et al., 2016; Aarons & Sommerfeld, 2012; Cheng et al., 2016; Sommer, 2008). Transformational leaders are trusted, admired and respected by other team members (Bellé, 2014; Musinguzi et al., 2018; Tomlinson, 2012).	There are four key behaviours associated with transformational leadership: idealized influence/charisma, inspirational motivation, individualized consideration and intellectual stimulation (Aarons et al., 2017; Cohen et al., 2012; Fletcher et al., 2019; Nielsen et al., 2009). Idealized influence requires leaders to act as role models for their teams by engaging in the behaviours they expect of other team members. Leaders can engage in inspirational motivation by providing support and encouragement to motivate team members to achieve team goals. They provide individual consideration when they capitalize on individual differences and tailor motivational styles to improve team efficacy. Lastly, intellectual stimulation involves leaders encouraging followers to be innovative and seek solutions to challenging problems.
Distributed	Distributed leadership involves a redistribution of power and realignment of authority (Tomlinson, 2012). It empowers team members, blurs the roles of followers and leaders and can be carried out by single individuals or as a collaborative process. Neither possible nor reasonable.	Distributed leadership behaviours include giving others autonomy, encouraging them to take opportunities, recognizing contributions made by other and delegating work (Castelao et al., 2015; Klein et al., 2006; Thylefors & Persson, 2014; Tomlinson, 2012).
Inclusive/participative	Inclusive or participative leaders indicate an invitation and appreciation for others' contributions to team discussions and decisions (Nembhard & Edmondson, 2006).	Inclusive leadership behaviours include words and deeds exhibited by leaders that invite and appreciate others' contributions; modeling openness; listening to suggestions from the group engaging in shared decision making (Bortoluzzi et al., 2014; Grady, 2016; Hirak et al., 2012; Macphee et al., 2010; Malik et al., 2012; Nembhard & Edmondson, 2006; Somech, 2006; van Zijl et al., 2020).
Laissez-faire/passive/passive-avoidant leadership	Laissez-faire leadership is characterized by an abdication of responsibility, decision making and response from the leader (Musinguzi et al., 2018; Raes et al., 2013). Such a leader is described in the literature as being detached from the team and uninterested in daily activities (Corrigan et al., 2000).	Leader's failure to use reward and punishment when required and often predicts workplace accidents, bullying and poor information sharing and team performance (Barling et al., 2018). Leader does not actively engage with the team (Aarons et al., 2016), avoids influence, believes that staff know best how to complete their jobs and gives them autonomy (Craven, 2017). Employees are forced to problem solve on their own because the leader is absent in crises (Mulenga et al., 2018). It grants employees autonomy and freedom, to independently establish goals, make decisions and solve problems (Raes et al., 2013).

(Continues)

TABLE 3 (Continued)

Leadership style	Definition	Key behaviours
Authentic leadership	Authentic leaders have strong values, and their actions are consistent with these. They have a high level of awareness of their own strengths and weaknesses and the impact they have on other team members (Nayback-Beebe et al., 2013; Stevens et al., 2014). Leader behavioural integrity reflects the extent to which leaders 'walk the talk' or 'practice what they preach' concerning safety (Simons, 2008).	Listening and allowing followers to have ownership in the problem-solving process; admitting mistakes; seeking the views of others before considering them carefully and using these to modify, when appropriate, their own views (Nayback-Beebe et al., 2013; Stevens et al., 2014). Leaders words and deeds align (Leroy et al., 2012)
Relational focused leadership		
LMX	Focuses on the interpersonal interactions (Galletta et al., 2013) and bi-directional relationship (Aarons & Sommerfeld, 2012; Donohue-Porter et al., 2019; Turner, 2018) between a leader and a staff member.	Mutual trust, respect and obligation (Anderson et al., 2019; Donohue-Porter et al., 2019; Galletta et al., 2013; Turner, 2018).

transformational leadership impacted openness to diversity and interprofessional motivation. Although Craven (2017) found that transformational leadership predicted team psychological empowerment, this leadership style did not contribute to employee engagement and emotional intelligence. Henderson et al. (2013) found that, following training in transformational leadership behaviours, registered nurses began to communicate more openly were proactively engaged in decision-making and felt more recognized for their work.

Four studies found no relationship or mixed results for the impact of transformational leadership on team performance. Each of these studies examined leadership in multi-disciplinary teams. Barling et al. (2018) found that transformational leadership was not linked to collective efficacy and did not influence team performance. Although Sommer (2008) found no significant relationship between leadership styles and performance, transformational leadership helped team members regulate their negative affect during crisis situations. Corrigan et al. (2000) found that transformational leadership resulted in benefits for consumers (persons being treated by the mental health teams participating in the study); however, it was unclear whether transformational leadership leads to consumers' satisfaction and better quality of life. Another study found that perceived horizontal trust mediated the relationship between perceived transformational leadership and the supervisors perceived team performance (Olvera et al., 2017). However, the team's intra-role performance did not correlate significantly with the vision, communication or intellectual stimulation dimensions of transformational leadership. Additionally, there was no significant correlation between the extra-role performance and intellectual stimulation dimensions of transformational leadership.

Distributed leadership

Six studies examined the influence of distributed leadership. In these papers, distributed leadership was evident when the focal leader delegated responsibilities, roles or tasks to other team members.

There was a positive relationship between distributed leadership behaviours and team performance (Hinski, 2017). Team members had a positive attitude towards distributed leadership (Tomlinson, 2012). Successful teams had focal leaders who engaged in distributed leadership behaviours such as fostering participation in decision-making and providing freedom and autonomy from bureaucratic constraints (Macphee et al., 2010). Klein et al. (2006) found that delegating the active leadership role between three team members working within a Trauma Resuscitation Unit fostered learning and reliability. According to Castelao et al. (2015), distributed leadership can improve patient safety outcomes by allowing the team leader to focus on coordinating team processes by delegating hands-on tasks to others. Some mixed results were also found. According to Thylefors and Persson (2014), effective team leadership requires sensitivity to the task or issue in question as some tasks will benefit from relatively centralized leadership and others from a distributed leadership approach.

Servant leadership

Craven (2017) was the only identified study to examine the impact of servant leadership. This study found that a servant leadership style (e.g., behaviours including service, stewardship and demonstrating belief in individuals) significantly and positively predicted team psychological empowerment and employee engagement within dental teams.

Inclusive or participative leadership

Eight studies explored the impact of participative or inclusive focal leaders. Participative leadership influenced various aspects of team performance, including team building and teamwork (Malik et al., 2012). Macphee et al. (2010) found that successful teams had leaders who fostered participation in decision-making. Participative focal leaders can reduce the negative relationship between functional heterogeneity and information elaboration (van Zijl et al., 2020).

In addition, the indirect relationship between functional heterogeneity and team performance, through information elaboration, improves as levels of participative leadership increase. Similarly, in teams with high functional heterogeneity, participative leadership was positively associated with team reflection, which fostered team innovation (Somech, 2006).

Participative leadership is also associated with improved interpersonal dynamics. Inclusive leadership fostered psychological safety (Hirak et al., 2012; Nembhard & Edmondson, 2006) and this mediated the relationship between leader inclusiveness and engagement in quality improvement (Nembhard & Edmondson, 2006). Unit performance was improved by encouraging team members to learn from failure (Hirak et al., 2012). Bortoluzzi et al. (2014) examined the impact of participative leadership on the risk of 'mobbing', which is a process of harassing, offending or socially excluding someone or negatively affecting someone's work tasks repeatedly, over time (Bortoluzzi et al., 2014). Nurses 'at risk' of mobbing perceived a significantly lower level of participative leadership compared with those nurses 'not at risk', suggesting an important role of participative leadership in reducing the risk of mobbing (Bortoluzzi et al., 2014).

Other studies found a negative impact of participative leadership on performance. Somech (2006) reported that in high functional heterogeneous teams, participative leadership has a negative influence on team in-role performance, which was defined as the extent to which the team accomplishes its purpose and produces the intended, expected or desired result. No impact was found within low functional heterogeneity teams. This finding suggests that the relationship between participative leadership and team outputs vary depending on the selected team output (Somech, 2006). Although Thylefors and Persson (2014) found that participative leadership was positively related to team climate, teamwork organization and effectiveness, it was negatively associated with case quality.[5]

Laissez-faire/passive/passive-avoidant leadership

Although laissez-faire leadership may not be experienced as empowering by all employees, we have taken the view that through not taking on the responsibility of leadership, laissez-faire focal leaders are at least allowing for the possibility of followers to empower themselves to take on the leadership responsibility. Six identified studies examined laissez-faire/passive/passive-avoidant leadership styles.

Passive-avoidant leadership, characterized as an abdication of responsibility, decision making and response from the leader (Musinguzi et al., 2018; Raes et al., 2013), was associated with the non-sustainment of evidence-based interventions (Aarons et al., 2016). One study evaluating the satisfaction of persons being treated by mental health teams reported lower satisfaction and diminished quality of life when the programme was led by a leader who practised a laissez-faire leadership style (Corrigan et al., 2000). Laissez-faire leadership did not significantly contribute to the prediction of team psychological empowerment in dental teams (Craven, 2017). Additionally, laissez-faire leadership was negatively correlated with motivation, job satisfaction and teamwork; however, this association was not statistically significant (Musinguzi et al., 2018). Another study discovered that there is no significant association between passive leadership and psychological safety or collective efficacy (Barling et al., 2018). However, a significant positive relationship was found between team learning behaviours and laissez-faire leadership. This predicted team psychological safety and social cohesion (Raes et al., 2013).

Authentic leadership

The role of authentic leadership in health care teams was examined in five studies. Authentic focal leaders have strong values, and their actions are consistent with these. They have a high level of awareness of their own strengths and weaknesses and the impact they have on other team members (Nayback-Beebe et al., 2013; Stevens et al., 2014).

When examining the influence of authentic leadership on the work outcomes of nurses and other health care providers, Wong (2008) found that authentic leader behaviour had a direct effect on voice among clinical employees and an indirect effect for non-clinical staff members. Among clinical staff, authentic leadership also had a direct effect on self-rated individual performance. Among non-clinical staff members, leader supportiveness and ethical behaviour impacted self-rated performance and prevented or reduced burnout. Similarly, Wong et al. (2010) reported that authentic leadership increased registered nurses trust in the leader, their engagement in work and, therefore, increased voice behaviour and perceived unit care quality.

Mixed results were found for the impact of authentic leadership on team performance, interpersonal dynamics and safety metrics. Nayback-Beebe et al. (2013) found that an authentic leadership initiative decreased staff absenteeism, resulted in positive feedback from both staff members and patients on the quality of care being provided and improved performance metrics over a 3-month period. However, the authors also identified a lack of trust in senior leaders' ability to continue implementing the changes needed to create a healthier work environment. This suggests the need for more time to repair and build trust in team leaders. Stevens et al. (2014) found a modest negative relationship between perceptions of an 'authentic' leadership style and rates of hand hygiene compliance. They conclude that an authentic leadership style may be less important than a 'situational' leadership style (being able to adapt leadership style to suit different issues or different phases of the team's development). Therefore, improvement in hand hygiene compliance may be better suited to a directive style of leadership compared to having a fixed leadership style, even if it is open, approachable and engaging.

3.3.4 | Relational focused leadership

Leader member exchange

Seven studies focused on LMX (Aarons & Sommerfeld, 2012; Anderson et al., 2019; Donohue-Porter et al., 2019; Galletta et al., 2013; Portoghese et al., 2015; Tordera & González-Romá, 2013;

Turner, 2018). Donohue-Porter et al. (2019) underscored the utility of this relational approach to leadership in health care settings where collaborative multidisciplinary team work is needed in order to provide optimum patient care. Galletta et al. (2013) also posit gratitude as an additional characteristic of this reciprocal leadership style. The studies included in this review examined the influence of LMX relationships on a diverse range of outcomes: innovation climate, staff attitudes to EBP implementation (Aarons & Sommerfeld, 2012), patient safety (Turner, 2018), job satisfaction (Donohue-Porter et al., 2019; Portoghese et al., 2015; Turner, 2018), organizational commitment (Donohue-Porter et al., 2019; Galletta et al., 2013) and organizational citizen behaviour (Donohue-Porter et al., 2019).

Aarons and Sommerfeld (2012) found that LMX was significantly associated with innovation climate in the service as usual group (teams not assigned to implement the intervention). This highlights that the quality of the leader–provider relationship is important in supporting a positive innovation climate during more stable periods of service provision. Active implementation appears to require alternative leadership approaches (such as transformational leadership), which was associated with more positive attitudes towards EBP adoption (Aarons & Sommerfeld, 2012). Similarly, Tordera and González-Romá (2013) found that when the teams' average LMX quality was high, they had a better innovation climate.

Turner (2018) and Anderson et al. (2019) evaluated the influence of LMX on patient safety. Anderson et al. (2019) focused on patient safety culture, while Turner (2018) examined four quality safety indicators of patient safety (catheter-associated urinary tract infections, central line associated bloodstream infections, *clostridium difficile* and the prevention measure of hand hygiene). Both studies highlight a positive association between LMX and patient safety outcomes. Turner (2018) demonstrated that all four quality safety indicators significantly improved after the implementation of a LMX approach and the creation of dyadic relationships. Anderson et al. (2019) found that high-quality relationships within a team contribute significantly to most patient safety dimensions. However, the quality of the relationship between a leader and staff member and the number of events reported was not statistically significant. This suggests that something other than the relationship with the leader impacts staff members willingness to report an error. Both studies also examined mediating factors. Anderson et al. (2019) found that frequent contact between the leader and staff member improved both leader–member relationships and patient safety culture. Turner (2018) found that LMX strengthened care coordination, communication, teamwork and trust which in turn positively impacted patient safety indicators. According to registered nurses (Squires et al., 2010), leaders who listened and empathized with them and engaged in open and respectful dialogue enhanced the quality of nurse leader–nurse relationships, which in turn lead to improved nurse and patient outcomes, including reduced medical errors.

Squires et al. (2010) also found that high-quality leader–nurse relationships resulted in lower levels of nurse's reported emotional exhaustion and intentions to leave. The remaining four studies evaluated the influence of a LMX leadership approach on job satisfaction (Donohue-Porter et al., 2019; Portoghese et al., 2015; Turner, 2018) and organizational commitment (Donohue-Porter et al., 2019; Galletta et al., 2013) and OCB (Donohue-Porter et al., 2019). Strong relationships between leaders and staff members were significantly correlated with higher reported job satisfaction (Donohue-Porter et al., 2019; Portoghese et al., 2015; Turner, 2018). Turner (2018) suggests that the reciprocal exchange of ideas promoted through LMX empowers leaders and staff to challenge each other in a respectful manner without fear of retaliation, which facilitates a positive work environment and job satisfaction. Staff members positive perceptions of their relationship with a leader were a significant predictor of higher self-reported organizational commitment (Donohue-Porter et al., 2019; Galletta et al., 2013). Galletta et al. (2013) posit that LMX quality may act as an 'affective force' that connects workers to the workplace, reducing the probability of turnover intentions by motivating employees and maintaining their commitment to the leader's directives'. Donohue-Porter et al. (2019) also investigated the association between LMX and OCB. They found that self-reported OCBs were not significantly correlated with nursing staff's perception of their relationship with their supervisor. The researchers conclude that this finding may relate to how nurses are socialized within the profession where OCB may be ingrained within routine nursing duties.

Leader behavioural integrity

Leroy et al. (2012) was the only paper to examine leader behavioural integrity, that is, the extent to which leader's words and actions align. Leader behavioural integrity for safety was positively related to the teams' priority for safety and team psychological safety (Leroy et al., 2012). These findings imply that when leaders are perceived to stay true to the safety values they promote, they emphasize that followers should also place a high priority on safety. Additionally, when leader's words and actions align, this informs followers that their concern for safety is genuine and that it is safe to report treatment errors. The results also suggest that both team priority of safety and psychological safety mediate the relationship between leader behavioural integrity for safety and reported treatment errors. These findings signify that when leader's words and actions align in relation to safety values, leaders foster a safer working environment because they clearly communicate that safety should be prioritized while also fostering a trusting environment, supportive of reporting treatment errors.

4 | DISCUSSION

This review explored the ways in which focal leader behaviours impact health care team performance. Identified studies were grouped into four main categories: task-focused leadership, directive leadership, empowering leadership and relational focused leadership. Consistent with the structure of the results section, an overview of our findings in the context of the extant literature along with a discussion of emerging themes and areas for future research are discussed below.

4.1 | Impact of focal leadership style or behaviour on team performance

Our review identified ***directive leadership*** and ***task-focused leadership*** styles, which reflect the early 20th-century leader-centric perspectives, which focus on the focal leader as a positional authority (Komives & Dugan, 2010). These leadership styles and associated behaviours had a negative impact on health care teams' psychological safety, collective efficacy, subordinate creativity, job satisfaction and overall performance (Barling et al., 2018; Malik et al., 2012; Musinguzi et al., 2018; Thylefors & Persson, 2014). However, there were also studies that showed improved team climate, teamwork and effectiveness (Somech, 2006; Thylefors & Persson, 2014; Yun et al., 2005). It is likely that some of this variance was due to context; for example, directive leadership was reported to be more appropriate in emergency situations (Yun et al., 2005). Thus, directive styles may be more appropriate in situations where rapid decisions and action are required. This emphasizes the necessity to explore context conditions in research on leadership on team effectiveness. Context has long been underappreciated as a key influence in the study of leadership (Gronn & Ribbins, 1996; Liden & Antonakis, 2009), and thus, greater consideration of the role of context in leadership and team performance is advocated in future research. An enhanced understanding of the contextual conditions (e.g., task characteristics and team membership) in which directive styles may be more appropriate and promote more effective outcomes is crucial to appropriate deployment and leveraging of these leadership behaviours.

4.1.1 | Shift towards person-centred leadership styles

The majority of papers described leadership styles related to ***empowering leadership,*** reflecting the theme of focal leaders redistributing power, which is common within contemporary leadership theories. These approaches to leadership differentiate between authority and influence by highlighting the influence that both individuals and the collective may have. Our results highlight some of the positive team performance outcomes associated with this redistribution of power. These outcomes include improved team performance, creativity and learning (Bellé, 2014; Craven, 2017; Henderson et al., 2013; Hinski, 2017; Klein et al., 2006; Luu et al., 2019; Macphee et al., 2010; Mitchell et al., 2014; Raes et al., 2013), higher job satisfaction, psychological well-being and engagement (Craven, 2017; Mulenga et al., 2018; Musinguzi et al., 2018; Nielsen et al., 2009) and improved quality of care, safety attitudes and patient safety metrics (Castelao et al., 2015; Frumenti & Kurtz, 2014; Huis et al., 2013; Mullen, 2005; Mullen & Kelloway, 2009; Nayback-Beebe et al., 2013). These findings are in line with past research that highlighted that person-focused, empowering focal leader behaviours are related to perceived team effectiveness, team productivity and team learning (Burke et al., 2006). They highlight the beneficial team performance outcomes of focal leaders engaging in ***empowering leadership*** by redistributing power and influence across teams and effectively leveraging and deploying the expertise that exists in teams.

Similar positive results for innovation climate, patient safety outcomes and employee engagement, were found within the category of ***relational leadership*** (Aarons & Sommerfeld, 2012; Anderson et al., 2019; Donohue-Porter et al., 2019; Galletta et al., 2013; Leroy et al., 2012; Tordera & González-Romá, 2013; Turner, 2018). Relational-focused leadership approaches emphasize the reciprocal nature of the relationship between the leader and team members, along with the importance of trust and integrity within these relationships (Komives & Dugan, 2010). This corresponds with the emerging ideas highlighting that high-quality reciprocal relationships with team leaders enable employees to develop positive psychological experiences, such as psychological safety, which in turn fuel their learning and development (Binyamin et al., 2018). This is similar to other contemporary leadership theories that have reframed leadership as a dynamic, collaborative and reciprocal process between people pursuing a common goal and where followers are encouraged and supported to act as leaders themselves (Komives & Dugan, 2010). In addition, it supports Burns (1978) critical distinction between leader (reflecting position or responsibility) and leadership (reflecting a collaborative process).

4.1.2 | Mixed results

The majority of leadership styles examined were associated with mixed results for health care team performance outcomes. There were some notable exceptions: only positive outcomes were reported for servant leadership ($n = 1$), leader behavioural integrity ($n = 1$), CQI leadership ($n = 1$) and situational leadership ($n = 3$) and only negative outcomes were associated with abusive leadership/overcontrolling leadership ($n = 1$). However, these uni-directional results may be due to the lower numbers of studies reporting on these leadership styles and/or some degree of publication bias.

Although ***empowering leadership*** styles were associated with improved team performance, there were also examples of empowering focal leaders having negative effects (Barling et al., 2018; Nayback-Beebe et al., 2013; Olvera et al., 2017;Somech, 2006; Thylefors & Persson, 2014). Laissez-faire leadership did not significantly contribute to team psychological empowerment (Craven, 2017) and participative leadership had a negative impact on in-role performance and case quality (Somech, 2006; Thylefors & Persson, 2014). Passive-avoidant leadership was associated with the non-sustainment of interventions, lower satisfaction and diminished quality of life among patients (Aarons et al., 2016; Corrigan et al., 2000).

4.1.3 | Leadership in complex health care systems

The complex and diverse nature of health care services and teams means that it may be necessary to adapt leadership approaches, depending on the nature of individual health care settings or

situations (i.e., crisis or routine care). Although mixed results were also found for situational/adaptive leadership, other studies argued that leadership styles should be adapted depending on the situation and the goal that a leader pursues (Yun et al., 2005). DeRue posits for an approach to leadership that enables groups to develop and adapt in dynamic contexts (DeRue, 2011). In line with this argument, Thylefors and Persson (2014) found that some tasks benefit from relatively centralized leadership and others from a distributed leadership approach. Likewise, directive leadership was more appropriate in emergency situations (Yun et al., 2005). Past research has recommended that leaders be trained in both task and person-focused leadership behaviours, as they both play important roles in team performance (Burke et al., 2006).

Many existing theories fail to capture the context in which leadership is occurring (DeRue, 2011). Leadership theories and approaches that prove successful in the corporate world may not meet the same level of success in health care organizations. The complex and continuously evolving nature of health care delivery, coupled with the interdependencies within and across teams and organizations, creates unique leadership challenges. An additional layer of complexity is evident in the different results we see for certain leadership styles, depending on whether the task focuses on emergency or routine care. Due to the variation in context and samples evident in included studies, it is difficult to determine whether the effectiveness of leadership styles varies within different disciplines. However, some disciplines have a more hierarchical structure than others (Gergerich et al., 2019; Liberatore & Nydick, 2008) and may react differently to certain leadership approaches when compared to other disciplines or multidisciplinary teams. Future research should focus on examining the context in which leadership takes place. This approach will clarify some of the mixed results found in the current health care literature and will support in exploring the effectiveness of different leadership approaches within single disciplines and in multidisciplinary teams. Given that multidisciplinary teams are the principal vehicle for care delivery, we contend that this will be the most fruitful avenue of future research and will have greatest relevance to practice. Understanding and accounting for contextual issues is particularly important to implement meaningful and sustained improvements within complex systems such as health care (Braithwaite, 2018; Burton et al., 2018; Rogers et al., 2020).

Another significant gap in the literature is longitudinal studies that explore consistency and change in leadership styles over time (Tretiakov et al., 2017). The acceptance of a directive style of leadership in a crisis situation may be greater if that leader's usual style is more empowering, as compared to a leader whose dominant style is directive. Following leaders over time and observing individual's leadership approaches in different contexts and situations may help explain some of the mixed results on the impact of directive styles of leadership (Tortorella et al., 2019). Longitudinal research would also contribute to our understanding of leadership integrity. In this review, we identified only one study (Leroy et al., 2012) that explored the alignment between leaders' words and actions. The finding that leaders who act with integrity promote a trusting environment which in turn impacts on safety culture seems an important one and requires further exploration.

Complexity leadership considers the context in which leadership occurs, reflects the complex interactions between individuals and systems and focuses on cultivating system-level outcomes such as innovation, learning and creativity (Uhl-Bien et al., 2007). This approach to leadership shifts our focus from an individual as the leader to recognizing that leadership is a system-level phenomenon (Lichtenstein et al., 2006; Uhl-Bien et al., 2007). Within a complexity leadership approach, all members are encouraged to be leaders, and, as a result, leadership can occur within any interaction. This expands the potential for creativity, influence and positive change in an organization (Lichtenstein et al., 2006). Similarly, early research by Hosking (1988) called for a focus on understanding leadership as a process rooted in the dynamics of an organizational system rather than in 'leadership roles'. The findings from this review underscore a focus on context and shifting trends in leadership, which are particularly important to consider and understand during the current Covid-19 pandemic. In dealing with the Covid-19 pandemic, some researchers report softer hierarchies and greater staff autonomy within health care teams (Bailey & West, 2020; Slater, 2020), while others note that as the emergency nature of the crisis wanes, care decisions are reportedly shifting back towards a hierarchical model of leadership due to restrictions on face-to-face team interactions (Wensing et al., 2020). The Covid-19 pandemic provides an important opportunity to examine and reflect on how to lead health care during a crisis, to catalogue best practices and to embed this learning in the leadership of current and future health systems and organizations (Stoller, 2020).

Finally, it is important to acknowledge that whilst leadership style is crucial in consideration of impact on team performance, the need for leader clarity and lack of conflict regarding leadership have been advocated (West et al., 2003). Beyond any specific set of leader behaviours, team clarity regarding leadership is associated with clear team objectives, higher levels of engagement to promote excellence and greater innovation. This emphasises the crucial role of the focal leader, and the necessity for leadership theory that incorporates clarity of leadership and not just style of leadership (West et al., 2003).

4.2 | Strengths and limitations

To minimize the risk of publication bias, searches were conducted on academic and grey literature databases. In addition, the eligibility of the included papers was independently screened by at least two reviewers at each phase of screening and quality appraisal results are reported for transparency.

A limitation inherent in much of the published literature regarding leadership and its impact on team performance outcomes is the weak study designs employed, the lack of consideration of context and the few longitudinal studies available (West et al., 2015). This limits our ability to draw strong conclusions based on the extant evidence.

5 | CONCLUSIONS

In this review, we explore the impact of ***task-focused leadership***, ***directive leadership***, ***empowering leadership*** and ***relational focused leadership*** behaviour on health care team performance/effectiveness. Although mixed results were found, our findings indicate a shift towards empowering and relational leadership styles that can support teams in operationalizing and achieving their goals, foster team creativity and improve decisions making. We call on future research to emphasize the context in which leadership takes place in order to clarify some of the mixed results found to date and to understand the impact of different leadership approaches within single disciplines as well as in multidisciplinary teams.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

The studies identified in this review identified positive outcomes associated with empowering and relationship leadership styles among nursing leaders. Many of the studies examining transformational leadership involved nursing staff. When nursing leaders engaged in transformational leadership, it resulted in a variety of positive outcomes including increased quality of care (Cheng et al., 2016; Rosengren et al., 2007), improved team climate (Cheng et al., 2016), more open communication (Henderson et al., 2013) and improvements in nurses' hand hygiene compliance (Huis et al., 2013). Authentic leadership, inclusive leadership and high-quality leader–nurse relationships were also associated with positive outcomes for nursing staff (Bortoluzzi et al., 2014; Hirak et al., 2012; Nembhard & Edmondson, 2006; Squires et al., 2010; Wong, 2008; Wong et al., 2010). These findings highlight the importance of training and encouraging nursing focal leaders to engage in empowering and relational leadership behaviours.

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CONFLICT OF INTEREST

None.

ETHICAL APPROVAL

Not applicable.

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ENDNOTES

[1]The diversity of organizational roles within the team.

[2]Includes the discussion and amalgamation of different perspectives and information within the team.

[3]Measured by expert evaluations of teams' hypothesis and recommendations following simulated consultation conference.

[4]Extra-role behaviours or actions not normally expected in a prescribed employee role and in-role performance.

[5]Measured by expert evaluations of teams' hypothesis and recommendations following simulated consultation conference.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of this article.

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ORIGINAL ARTICLE

WILEY

Workplace violence from the perspective of hospital ward managers in Sweden: A qualitative study

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Abstract

Aim: The aims of the study are to explore workplace violence perpetrated by patients or visitors from the perspective of hospital ward managers and to describe how ward managers perceive their leadership role and manage related incidents.

Background: Few studies focus on workplace violence from the perspective of ward managers even though they are the closest managers to the operational staff.

Method: Fifteen semistructured interviews were analysed using qualitative content analysis.

Results: Four categories emerged: the face of workplace violence, a two-fold assignment, strive towards readiness to act, and managing incidents.

Conclusion: While the most common acts of workplace violence are considered less serious and related to patients' medical conditions or dissatisfied visitors, hospital organizations focus on serious but rarely occurring incidents. Consequently, ward managers have limited opportunities to ensure a safe work environment on an everyday basis.

Implications for nursing management: To support ward managers' occupational safety and health management, workplace violence prevention and management should be acknowledged as an important responsibility for senior management in hospitals. It is important to identify incidents that most likely will occur at the wards and to create strategies related to those incidents. Strategies could include risk assessments, prevention, evaluation, education and reflection combined with, for example, scenario training.

KEYWORDS
content analysis, interviews, nurse manager, qualitative methods, workplace violence

1 | BACKGROUND

Workplace violence perpetrated by patients or visitors against health-care professionals is regarded as a global problem (ILO/ICN/WHO/PSI, 2002) and research repeatedly testifies to consequences in terms of reduced well-being, negative impact on family and social life, and on efficiency and skills at work (Ashton et al., 2018; Hassankhani et al., 2018; Nyberg et al., 2021). The management's significance in relation to workplace violence has been underlined before, and ward managers have an important role in ensuring occupational safety (Havaei et al., 2019). Still, few studies have focused on workplace violence from the perspective of ward managers.

Nursing shortages and heavy workloads can contribute to high levels of tension in both nurses and patients resulting in threats and violence (Najafi et al., 2018). Health-care professionals' experience is that preventive strategies at an organizational level are more or less absent or inadequate (Jakobsson et al., 2020) and that a typical managerial attitude is that workplace violence should be accepted as an inherent part of nursing (Ashton et al., 2018; Jakobsson et al., 2020). In contrast, ward managers have described workplace violence as part of nursing, though unacceptable, draining on resources and disrupting care delivery (Heckemann et al., 2017; Morphet et al., 2019). Ward managers' situation has been described as complicated and their leadership role as a loyalty battle between being a part of the management system and advocating for the nurses and assistant nurses at the ward (Ericsson & Augustinsson, 2015). In situations of workplace violence, the battle has been described as an ethical conflict since the responsibility of a ward manager involved the rights of both patients and staff and simultaneously the hospital's standards (Sato et al., 2016).

Even though ward managers are part of the management system, they have described themselves as excluded from important decision making and without support from higher management (Ericsson & Augustinsson, 2015; Hedsköld et al., 2021). It has also been explained that available policies and guidance are difficult to apply in various situations and contexts (Morphet et al., 2019). As an example, official policies on how to prevent and manage delirium in patients have been insufficiently implemented and unknown among physicians, resulting in incidents (Heckemann et al., 2017). Considering their own leadership role in relation to workplace violence, ward managers have identified a need to be able to increase the staffing, especially during night shifts, as well as to educate health-care professionals in managing incidents (Morphet et al., 2019). However, it may be difficult to justify initiatives to higher management if this will result in financial costs (Heckemann et al., 2017).

A high frequency of workplace violence has been reported by health-care professionals internationally (Babiarczyk et al., 2019; Spector et al., 2014) and in Sweden, a recent report made by the Swedish Association of Health Professionals show that nurses experience a higher risk to be exposed now compared with 3–4 years ago. Acknowledging workplace violence should therefore be an important issue for ward managers. The aim of this study was to explore workplace violence perpetrated by patients or visitors from the perspective of hospital ward managers and to describe how ward managers perceive their leadership role and manage related incidents.

2 | METHOD

2.1 | Participants

A purposeful recruitment was made with the intention of including ward managers in public hospitals located in different parts across Sweden. Ward managers in surgical wards were included in this specific study because it has been described that patients admitted to surgical wards can be threatening or violent when they are cognitively affected due to age, disease, trauma, surgery or opioid analgesics (Jakobsson et al., 2020).

In total, 42 ward managers from 15 hospitals were contacted by an e-mail containing written information about the study and a request for an answer by replying the e-mail in case of an interest in participating. Those who answered were contacted either by telephone or by e-mail to decide the time and locations for the interviews.

2.2 | Data collection

Data were collected between March 2020 and January 2021 using semistructured interviews based on an interview guide (see Appendix). The applicability of the interview guide was discussed after the three first interviews, but no major changes were needed. Four interviews were made face-to-face in a secluded room at the university or at the ward managers' offices and the remaining ($n = 11$) by telephone or videotelephony software programme. The mean duration of interviews was 49 min, ranging from 28 to 67 min. All interviews were audio-recorded and transcribed verbatim.

2.3 | Data analysis

Data was analysed using manifest, content analysis (Elo & Kyngäs, 2008). Accordingly, all transcripts were initially read to obtain a sense of the whole. Thereafter, transcripts were re-read, during which open coding was carried out by each author individually. After three transcripts, all authors met to discuss conformity of coding. Subsequently, coding was continued by all authors individually until nine transcripts had been completed. At this stage, a distinct pattern had emerged from the data, and therefore, the codes were transferred and grouped into preliminary categories. To verify the preliminary categorization, the first and last authors continued coding the rest of the transcripts, but no changes were made and the abstraction process continued. This process was led by the first and last authors with frequent reconciliations with all the authors jointly to maintain consensus.

2.4 | Ethical considerations

The study was approved by the Regional Ethics Review Board and followed ethical standards expressed in the Declaration of Helsinki. Participants were informed verbally and in writing about the study, voluntary participation and the right to withdraw without explanation. Written consent was collected prior to the interviews.

3 | FINDINGS

Fifteen ward managers from 11 different hospitals participated in the study (Table 1). Four categories emerged from the analysis: *the face of workplace violence*, *a two-fold assignment*, *strive towards readiness to act* and *managing incidents*.

3.1 | The face of workplace violence

Workplace violence was a rare phenomenon according to some of the ward managers while others experienced it as recurring. Incidents were regarded as commonly related to crisis reactions and to patients' medical conditions in connection with trauma, substance abuse, cognitive disorders and particularly in patients with dementia. Workplace violence typically occurred when patients were unprepared for care activities.

> After all, it is not gang members who are threatening and violent, mostly, but rather elderly persons who are confused and fight to defend themselves (7).

TABLE 1 Participants' characteristics ($n = 15$)

Age (years)	
Mean	46
Min–max	27–60
Gender (*n*)	
Male	2
Female	13
Basic profession (*n*)	
Registered nurse	14
Assistant nurse	1
Education in leadership (*n*)	
Yes	6
No	9
Experience as ward manager (years)	
Mean	7
Min–max	1 month–35 years
Type of hospital (*n*)	
University hospital	7
County hospital	7
Smaller county hospital	1

Note: n = number.

Threatening and violent situations also happened as an expression of dissatisfaction among patients or relatives regarding provided care or limited visiting hours. These situations gave rise to verbal threats directed against the health-care professionals regarding their competence, their privacy or that their professional license would be revoked.

Some ward managers argued that registered nurses and nurse assistants were more exposed to workplace violence because they performed nursing care close to the patients. Others stated that all professional categories were at risk of being exposed, but more likely those who were less confident in their professional role. It was also perceived that situations sometimes arose due to the health-care professionals' approach towards the patient or to personal chemistry. In addition, some ward managers explained that females or health-care professionals with minority ethnical backgrounds were especially exposed, but this was not acknowledged by all.

> Many of our colleagues who come from other countries are mocked and harassed because of the colour of their skin and their headscarves, there is lot of that stuff, verbal violence (12).

3.2 | A two-fold assignment

Ward managers' role and responsibility was perceived as a two-fold assignment, requiring them to ensure both high-quality care and occupational safety. On the one hand, they were responsible for the care of patients, and their leadership included ensuring that patients were cared for in the best possible way. A basic attitude was that patients are entitled to equal care regardless of their personal background or behaviour.

> … everyone is entitled to the same healthcare. We work according to that principle and you can think what you like but it must never affect the patients (3).

On the other hand, they were responsible for the safety of employees. Workplace violence was considered somewhat inevitable in a human care profession, but the goal was to avoid it as far as possible. Ward managers aimed to build structures to prevent and deal with incidents and the managerial assignment was perceived to run 24/7. Most ward managers accepted to be contacted during their free time if necessary. However, workplace violence was described as challenging the ward managers' leadership role and responsibility. A low tolerance for unacceptable behaviour among patients or patients' visitors was expressed, but despite this, there were situations when it was necessary to care for a potentially threatening or violent patient. In such cases, it could be difficult to balance the provision of high-quality care against maintaining workplace safety.

> You cannot decide not to take care of a threatening patient, the patient has to be cared for somehow, in

> these cases it can be challenging to be responsible for both patient security and the work environment… (14).

Regarding threatening or violent patients who did not have any cognitive disorder or patients' visitors, it can be hard to set a limit for what should be tolerated. The ward managers felt responsible for the ward, but with limited decision-making authority. For example, they might confront patients or patients' visitors to indicate that their behaviour was unacceptable, but it was not in their mandate to refuse provision of care or visits. In situations where it became necessary to set an ultimatum for patients or visitors, this had to be in consultation with a chief physician or the senior manager.

Registered nurses were regarded as responsible for and coordinating the immediate patient care and also to signal to the ward manager if something was perceived as problematic. However, it was sometimes a challenge to get information about minor incidents because the employees handled it themselves. In wards where workplace violence occurred regularly, ward managers reflected that registered nurses and assistant nurses might become used to it and therefore not pay so much attention to it. All this could jeopardize the ward managers' ability to maintain their two-fold assignment as the patients received good care but potentially at the expense of work environment.

> A lot might be happening that I do not even know about or have any possibility of knowing. So this is a challenge, that the employees have to tell me about it or I might intercept it up if I am there (1).

By contrast, in wards where threatening or violent incidents were rare, it was a challenge for everyone to know how to act in a situation. Here, it was described as even more important to regularly discuss workplace violence, and to educate.

Lack of resources was another problem that was described as a challenge for both quality in care and workplace safety. A high staff-turnover led to frequent staff shortages and inexperience among many of the employees, due to both youth and little work experience. Therefore, they needed more support in different situations. At times when a threatening or violent patient was cared for, ward managers tried to increase the staffing level; however, this was solved internally in the wards, which could lead to a risk that the employees became worn out.

> It's difficult to strike a balance between what is beneficial or what… in the long run. It's hard to be at work, but if I cannot rest then I am not going to feel well in the longer term. This is a difficult balance (4).

3.3 | Strive towards readiness to act

Considering that workplace violence could not be completely avoided, most ward managers strived for a general readiness to act. This involved preparing the employees with education and reflection. Many of the ward managers stated that the health-care organization provided on-line training about how threatening and violent situations should be prevented and tackled. Some ward managers expected their employees to take part in this training and repeat it yearly, others stated that they were not aware of any training addressing this topic. However, training or lectures offered by the health-care organization were rarely mentioned by the ward managers as mandatory or offered on a regular basis. Many ward managers arranged lectures themselves held by experts in, for example, geriatric or psychiatric care to learn how to prevent or handle different states of confusion.

> Training is very important, because the more knowledge you have the more you can do to prevent that they [threatening and violent situations] arise (12).

With knowledge and clinical experience, it was perceived that it was possible to identify patients with a risk of aggressive behaviour due to cognitive disorders. Patients with substance-induced delirium, for example, could receive medication at an early stage to relieve their abstinence and consequently prevent aggression. For patients with dementia, care could be adapted to approach the patients according to their conditions. Furthermore, communication was highlighted as an important factor in the prevention of workplace violence. Much irritation and misunderstanding could be avoided, and ward managers aimed to coordinate the interprofessional team and to promote good communication.

3.4 | Managing incidents

Ward managers' actions in a threatening or violent situation differed depending on the incident's severity and also on whether or not the patient was considered of sound mind. From the interviews, it could be understood that the hospital organizations had the same approach, which mainly focused on serious incidents. Many ward managers trusted their employees' competence to handle less serious incidents themselves, for instance threats and violence perpetrated by patients with cognitive disorders or crisis reactions. Still, they felt that they had to be responsive and talk with the employees if needed.

> I would assume that they talk with each other and get that support from a colleague rather than from me. In case they do not do so, and they do not feel well, then this will become visible quite quickly and then it is necessary to be attentive and notice this (1).

A few hospitals had general 'house rules' that were available to the public and such documents were regarded as helpful in situations when the ward manager had to, for example, confront bad-mannered patients or visitors. General guidelines formulated by the hospital organization were mentioned by most of the ward managers and contained information and routines about how to act in more serious

situations. In such cases, security guards could be called in for protection, to create a feeling of security and if necessary or to evict visitors. For an employee who had been exposed to a more serious incident, it was possible to put the person off duty and to offer paid sick leave. If needed, occupational health care could be contacted to provide support with processing the experience. There was also the human resources department, although some ward managers were satisfied with their support while others expressed dissatisfaction.

In the ward managers' safety work, general hospital guidelines had to be adapted to fit the specific ward, and routines concerning less serious incidents seemed to depend on the ward managers' own interest and was generally not automatically encouraged or facilitated by the hospital organizations. In the absence of organizational support, other ward managers or operational managers, to whom they could turn for advice, were a source of support that was highlighted as particularly valuable.

> We cooperate a lot and support each other a great deal. And our operational manager, if there is an issue, then he is there for us, he really is. And then there is occupational healthcare and things like that who are available to support if there is a need, or external guidance or anything. So there is support, but mostly we support each other, us managers (11).

When a more serious incident had taken place, it was regarded as important that everyone reflect on the incident. This was achieved in different ways, by a debriefing together with the interprofessional team, by writing reports to start an event analysis or by discussing it with the security department. Although workplace violence was considered somewhat inevitable, learning from experience was considered a significant part of the safety work.

> As long as we reflect on what we do and kind of deposit it in our knowledge bank for the future, then perhaps sometimes we have to accept that this is the way it is (5).

4 | DISCUSSION

This study aimed to explore workplace violence from the perspective of hospital ward managers and to describe how they perceived their leadership role and managed related incidents. According to the ward managers, serious incidents were rare. Serious incidents have been described in earlier research as physical attacks by confused or delirious patients, including breaking things in acts of aggression or confusion. It could also take the form of personally directed, verbal threats (Jakobsson et al., 2020). In the current study however, workplace violence was described as consisting mostly of less serious incidents, that is, incidents that occurred due to the patients' health status, crisis reactions or to lack of communication. It was also expressed that incidents commonly took place in connection with caring for patients with cognitive disorders. Such incidents have been described in hospital ward contexts earlier and involve patients throwing items such as shoes or medicine cups at the professionals, hitting them with a fist or cane, pushing or biting (Ferri et al., 2016; Hahn et al., 2008; Jakobsson et al., 2020).

One challenge in ward managers' leadership role was to combine the responsibility for ensuring high-quality care while caring for a threatening or violent patient. This challenge was also described in the study by Sato et al. (2016) where ward managers struggled with an internal ethical conflict between keeping staff safe, advocating for the patient and maintaining organizational functioning. Ward managers in this current study had many years of managerial experience. Even though less than half had any leadership training, they seemed confident in their leadership roles. Their leadership style can be described as both task-oriented, dealing with practical matters, and relation-oriented, communicating and reflecting with the employees as a means to prevent and manage workplace violence. Challenges were described as mostly of practical nature and concerning allocation of resources. However, it has been shown that task-focused leadership styles are not associated with any positive outcomes in relation to work environment but rather with significant lower job satisfaction among nurses (Cummings et al., 2018). Practical matters, such as the need to increase staffing, or to lead and coordinate professionals when dealing with workplace violence have been highlighted also in other studies (Heckemann et al., 2017, 2019; Morphet et al., 2019) indicating that a task-focused leadership is predominant for hospital ward managers.

Although other studies have described ward managers as excluded from important decision making and lacking support (Ericsson & Augustinsson, 2015; Hedsköld et al., 2021), ward managers in the current study appeared independent and relatively unconcerned about support provided from the hospital organization. When needed, security guards could be called in and occupational services could support victimized professionals. Less serious incidents were managed with joint efforts in the wards, and for ward managers, support was found in colleagues rather than the hospital organization. This might be yet another example of the distance between ward management and the senior hospital management as seen in previous research (Ericsson & Augustinsson, 2015; Heckemann et al., 2017, 2019; Hedsköld et al., 2021; Morphet et al., 2019). Importantly, there were occasions when the voice of the hospital organization strengthened the authority of the ward manager, for instance when printed 'house rules' were used in a confrontation with threatening or violent patients or visitors.

In the current study, it became apparent that there was an organizational discrepancy in the management of workplace violence depending on the severity of incidents. For serious incidents, the hospital organization could provide support measures. Less serious incidents were solved ad hoc by the staff involved and consequently, responsibility rested on the ward managers. Whereas occupational safety and health management concerning those commonly occurring events more or less depended on the ward managers' own interest, many ward managers trusted the nurses and assistant nurses to

handle the situation. This approach was also reported by Heckemann et al. (2019) where health-care professionals coped with situations themselves without managerial involvement. Corresponding results were described in this current study as ward managers found it challenging to be informed of minor incidents. The findings point towards an acceptance within health-care in general that threats and violence by persons who are not fully of sound mind is unintentional and therefore excused. Such mitigating circumstances have been described by nurses in studies before (Hahn et al., 2008; Hogarth et al., 2016; Luck et al., 2008; Pich et al., 2011) and might also explain the absence of guidelines addressing this sort of workplace violence—simply put, no one asks for it. However, earlier research has shown that physical violence is commonly performed by patients affected by psychiatric disease, cognitive disorder or under the influence by drugs (Ferri et al., 2016). It could therefore be argued that even if threatening or violent actions are unintentional, they can be harmful. Furthermore, it is likely that patients in hospitals with cognitive disorders will become more common due to an ageing population in several parts of the world, leading to an increased risk of incidents.

4.1 | Study limitations

This study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) to enhance rigour (Tong et al., 2007). Although, some limitations should be considered. We approached 42 ward managers, but only 15 responded and agreed to participate. According to Malterud et al. (2016), sample size in qualitative research is guided by information power. Sufficient information power can be obtained with fewer participants if the aim of the research is narrow, including a specific target group, supported by established theory, conducted by experienced researchers and, including in-depth exploration of narratives. Hence, 15 participants could be considered as a sufficient sample size.

Due to the Covid-19 pandemic, the majority of interviews were conducted by telephone. By tradition, qualitative interviews are made face-to-face in order to capture nonverbal aspects, which are assumed to provide richer data. However, it has been argued that face-to face interviews have some disadvantages (Burnard, 1994). For example, nonverbal communication can be difficult to interpret. Further, the 'exposure' during interview can inhibit sharing of experiences regarding sensitive topics. Telephone interviews are easier to arrange, allowing researchers to collect data effectively and with more comfort for participants. Research has shown that people are comfortable using the telephone in daily life and therefore perceive telephone interviews as convenient (Ward et al., 2015). Thus, telephone interviews can be regarded as an adequate data collection method.

5 | CONCLUSION

In relation to workplace violence, occupational safety and health management by ward managers and hospital organizations seem to focus on incidents that are dramatic, out of control and require the intervention of security guards. However, such events are rare. Instead, the majority of incidents are caused by patients with impaired cognitive function or persons with crisis reactions. The findings from this study indicate signs of unreflected and misdirected efforts for occupational safety within hospital organizations. Efforts related to workplace violence need to focus on commonly occurring incidents to support ward managers in balancing the responsibilities for high-quality care and for occupational safety.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

This study provides insights that can inspire a more reflective and relational leadership among ward managers as well as hospital organizations internationally. It is important that ward managers and hospital organizations not only focus on serious incidents but on all forms of workplace violence as those most likely will increase. Hence, it is time for everyone to stop seeing workplace violence as part of the job. The occupational safety and health management at hospital wards should focus on risk assessments, prevention, evaluation, education and reflection combined with, for example, scenario training. It is necessary to identify incidents that are likely to occur and to create strategies for those incidents. This can help avoid escalation of some events that otherwise would require greater resources with the presence of guards and in worst case result in injured professionals. However, this work should not depend on ward managers' own interest but needs to be mandatory and included in a systematic, hospital-wide occupational safety and health management initiated and directed by the hospital organizations. Otherwise, there is a risk that these important issues will be forgotten and deprioritised because of the ward managers' other work.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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The Regional Ethics Review Board in Lund, Sweden (no 2018/800).

DATA AVAILABILITY STATEMENT

Data available on request due to privacy/ethical restrictions (Appendix S1).

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of this article.

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ORIGINAL ARTICLE

WILEY

Distributed leadership as a predictor of employee engagement, job satisfaction and turnover intention in UK nursing staff*

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Abstract

Aim: To investigate how distributed leadership via the Shared Governance programme influences employee engagement, empowerment, job satisfaction and turnover intentions among direct care nursing staff in a large UK hospital.

Background: Increasing turnover rates and shortages of health care staff in the UK has called for interventions to improve employee engagement and job satisfaction.

Methods: 116 direct care nursing staff were sampled in a mixed-methods explanatory sequential design. A maximum variance sample of 15 participants were subsequently interviewed to gain a deeper understanding of the motivations and attitudes that influenced employee outcomes through distributed leadership.

Results: Higher levels of distributed leadership predicted increased employee engagement and job satisfaction, and lower turnover intentions. Staff also felt more empowered and committed to the organisation despite some challenges experienced in implementing the Shared Governance programme.

Conclusion: Distributed leadership was found to be beneficial in promoting employee engagement and empowerment, increasing job satisfaction and organisational commitment and reducing turnover intention in the UK health care setting.

Implications for Nursing Management: By encouraging the practice of distributed leadership at work, health care staff can become more engaged and empowered, leading to higher rates of job retention, job satisfaction and organisational commitment.

KEYWORDS

distributed leadership, employee engagement, job satisfaction, nursing, shared governance

1 | BACKGROUND

Research shows that low job satisfaction and poor employee engagement are among the most frequently reported causes of high turnover in the UK health care context (Alarcon & Edwards, 2011; Collini et al., 2015; Fasbender et al., 2019). With a predicted shortage of 100,000 nursing staff in the UK by 2028/29 (The King's Fund, 2020), it is critical to retain staff by increasing their engagement and job satisfaction to ensure continual delivery of high-quality patient care (West, Bailey, & Williams, 2020). One promising solution that strives to address this is the implementation of distributed leadership through the Shared Governance (SG) framework in the UK health care context.

**This study has received ethical approval from an institutional review board.

Although researchers have yet to agree on the constituents of distributed leadership, this paper adopts Tashi's (2015) definition of distribution leadership as a shared decision-making framework or practice applied by various staff members across multiple organisational levels. This differs from other types of leadership where it emphasizes leadership as a practice that focuses on influence and agency through interpersonal interactions rather than formal roles, responsibilities and actions (Harris & DeFlaminis, 2016). Within the UK health care context, distributed leadership is demonstrated through SG, which is a form of structural empowerment where nurses are given greater autonomy and control in their practice to facilitate organisational change and improve patient outcomes (French-Bravo & Crow, 2015).

Through a formalized support structure, SG facilitates an inclusive, collaborative and shared decision-making process with the aim of driving innovative quality and service improvements that benefit staff and patients (NHS, 2021). Staff are voluntarily appointed to a council to make decisions that improve long-term professional, organisational and patient outcomes (Hess, 2020). Through SG, opportunities are given to staff to meet with the Chief Nurse to present pertinent issues and learnings concerning new ways of working clinically and operationally, and to advance nursing as a profession (NHS, 2021).

Although there is emerging evidence on the impact of SG, this evidence is primarily studied in the American private health care system. While researchers have attempted to examine how distributed leadership is implemented in a UK hospital (Geoghegan & Farrington, 1995; Jackson, 2000), there is still a paucity of research to understand how distributed leadership influences outcomes such as employee engagement, job satisfaction and turnover intentions in the UK. In this study, job satisfaction is defined as the positive affect and attitude one feels towards their job, which influences personal fulfilment, sense of achievement and opportunities for recognition and promotion (Armstrong, 2006; Kaliski, 2007). Employee engagement is the cognitive, emotional and behavioural aspects of an individual who are directed towards desirable organisational outcomes (Shuck & Wollard, 2010). Turnover intention is defined as an employee's intentions to stay or leave the organisation in which they are employed (Bothma & Roodt, 2013).

To better understand how distributed leadership affects these employee outcomes, this paper reports findings from a study conducted in a large UK teaching hospital that implemented a SG programme that has applied distributed leadership since 2012. Specifically, this study explores how distributed leadership through the SG programme has influenced employee engagement, job satisfaction and turnover intention among staff in the UK health care system.

2 | METHODS

2.1 | Design and procedures

A mixed-methods explanatory sequential design (Creswell & Plano Clark, 2017) comprising a survey and semi-structured interviews was used to address the research question. A sequential approach of quantitative followed by qualitative methods (Morse, 1991, 2003) was used due to the deductive nature of the research question. This allowed the a priori hypotheses of the effect of distributed leadership to be tested first through quantitative survey data and then complemented by qualitative interviews to deepen insights and explain the influence of distributed leadership on employee outcomes (Creswell & Plano Clark, 2017; Gutterman et al., 2015).

Participants were registered and non-registered direct care nursing staff[1] (DCNS) from an NHS Teaching Hospital Trust who demonstrated distributed leadership agency either formally via the SG programme or informally in their current roles. They were recruited via email, which contained a link to an online questionnaire, which took 30 to 45 min to complete. At the end of the questionnaire, participants who were currently involved in the SG programme were invited on a voluntary basis to participate in a follow-up face-to-face interview. Purposive sampling was used to select participants for the interview to achieve a maximum variance across demographics, roles and experience within SG. Prior to the interviews, an interview guide was designed to explore themes relating to the impact distributed leadership had on participants via SG while allowing other relevant themes to emerge during the interview. The length of the interviews ranged between 20 and 40 min, and they were conducted on hospital premises during working hours. All interviews were audio-recorded and transcribed verbatim.

2.2 | Participants

Due to the limited time to complete the study, a convenience sample of 116 DCNS completed the questionnaire. To achieve maximum variance based on the sample's gender, age, ethnicity, highest education level, job designation and length of time participating in the SG programme, 15 participants were recruited for the interview. Recruitment was stopped when data saturation was reached. Participants who were interviewed were involved in the SG programme between 1 and 84 months ($M = 19.60$; $SD = 21.71$).

2.3 | Measures

The Distributed Leadership Agency (DLA) is a 7-item scale assessing involvement in leadership tasks (Jønsson et al., 2016; Unterrainer et al., 2017) comprising three dimensions related to change, tasks and relations (Yukl et al., 2002). Responses are measured on a 5-point scale ranging from *1 = not at all* to *5 = very much*. The DLA was validated in a hospital setting and was shown to have high reliability, with Cronbach's α ranging from 0.91 to 0.93 (Unterrainer et al., 2017).

[1]Direct care nursing staff are registered nurses who are responsible for assessing, planning, implementing and evaluating care of patients (e.g. treatments, patient education and administration of medicines). This also includes non-registered nursing auxiliaries that work alongside registered nurses to deliver patient care.

The Utrecht Work Engagement Scale (UWES) is a 17-item scale assessing levels of engagement at work (Schaufeli & Bakker, 2004) and comprising three subscales: vigour, dedication and absorption. Responses were scored on a 7-point scale ranging from *0 = never* to *6 = always*. The UWES was shown to have adequate reliability and good internal consistency of Cronbach's α between 0.80 and 0.90 (Schaufeli & Bakker, 2004).

The Minnesota Satisfaction Questionnaire-Short Form (MSQ-SF) is a 20-item scale measuring job satisfaction (Weiss et al., 1967) and comprising three subscales: intrinsic satisfaction, extrinsic satisfaction and general satisfaction. Responses were recorded on a 5-point scale ranging from *1 = very dissatisfied* to *5 = very satisfied*. The MSQ-SF was shown to have good reliability and discriminant validity between intrinsic and extrinsic job satisfaction in relation to other relevant variables in the MSQ (Hirschfeld, 2000).

The Turnover Intention Scale (TIS-6) is a 6-item scale assessing behavioural intention to leave the organisation (Bothma & Roodt, 2013; Roodt, 2004). Responses were measured on a 5-point Likert scale with higher scores reflecting a greater intention to leave. The TIS-6 was shown to have good criterion-predictive validity, differential validity and reliability of Cronbach's α = 0.80 (Bothma & Roodt, 2013).

2.4 | Analysis

Hierarchical multiple regression was used to test whether the addition of DLA (Step 2) obtained from a submaximal test improved the prediction of employee engagement, job satisfaction and turnover intentions over and above demographic variables (i.e. sex, age, ethnicity and highest education level) while controlling the effects of covariates (i.e. supervisory role, length of time working in health care and length of time involved in the SG programme) (Step 1).

Thematic analysis was used to analyse qualitative interview data. Braun and Clarke (2006)'s 6-phase approach was followed, comprising: (1) familiarization with data; (2) generation of initial codes; (3) search for themes; (4) review of themes; (5) defining and naming of themes; and (6) producing the report. Both deductive and inductive approaches were used during coding and analysis of data to ensure identified themes matched existing literature while allowing the emergence of new themes. Data collection stopped when data saturation was reached.

3 | RESULTS

3.1 | Quantitative results

Table 1 summarizes the demographics of the participants surveyed.

3.1.1 | Distributed leadership and employee engagement

As indicated in Table 2, in Step 1, the combined covariates did not predict employee engagement, although time in the SG

TABLE 1 Demographics of survey participants (*N* = 116)

	n	Percentage
Sex		
Female	108	93.1%
Male	8	6.9%
Age		
20–29 years	34	29.3%
30–39 years	26	22.4%
40–49 years	27	23.3%
50–59 years	22	18.9%
60–69 years	7	6.1%
Highest education level		
Secondary school	8	6.9%
College	10	8.6%
Further education college or sixth form	15	12.9%
Diploma	8	6.9%
Undergraduate degree	48	41.4%
Postgraduate degree and above	26	22.4%
Professional development certification	1	0.9%
Job band		
2	17	14.7%
3	13	11.2%
4	2	1.7%
5	41	35.3%
6	32	27.6%
7	9	7.7%
8a	1	0.9%
8b	1	0.9%
Supervisory role		
Yes	43	37.1%
No	73	62.9%
Length of time working in health care		
1–5 years	38	32.8%
6–10 years	24	20.7%
11–15 years	18	15.5%
16–20 years	8	6.9%
21–25 years	7	6.0%
26–30 years	11	9.5%
31–35 years	5	4.3%
36–40 years	2	1.7%
41–45 years	3	2.6%
Length of time involved in the SG programme		
0 months	20	17.2%
1–12 months	54	46.6%
13–24 months	23	19.8%

(Continues)

TABLE 1 (Continued)

	n	Percentage
25–36 months	7	6.0%
37–48 months	5	4.3%
49–60 months	2	1.7%
61–72 months	1	0.9%
73–84 months	3	2.6%
85–96 months	1	0.9%

programme showed a significant positive relationship (B = 0.11, $p < .05$). The full model predicting employee engagement (Step 2) was statistically significant ($R^2 = 0.232$, $F(10,105) = 3.166$, $p = .001$; adjusted $R^2 = 0.158$), showing that the addition of DLA led to a statistically significant increase in R^2 of 0.107, $F(1,105) = 14.670$, $p < .0001$.

3.1.2 | Distributed leadership and job satisfaction

As indicated in Table 2, in Step 1, the combined covariates did not predict job satisfaction, although time in the SG programme showed a significant positive relationship (B = 1.70, $p < .05$). The full model predicting job satisfaction (Step 2) was statistically significant ($R^2 = 0.324$, $F(10,105) = 5.041$, $p < .0001$; adjusted $R^2 = 0.260$), and the addition of DLA led to a statistically significant increase in R^2 of 0.126 ($F(1,105) = 19.659$, $p < .0001$).

3.1.3 | Distributed leadership and turnover intention

As indicated in Table 2, in Step 1, the combined covariates did not predict turnover intention. The full model predicting turnover intention (Step 2) was statistically significant ($R^2 = 0.231$, $F(10,105) = 3.149$, $p = .001$; adjusted $R^2 = 0.157$), and the addition of DLA led to a statistically significant increase in R^2 of 0.081 ($F(1,105) = 11.077$, $p = .001$).

3.2 | Qualitative results

Table 3 summarizes the demographics of participants interviewed. The themes identified in the data are described below and illustrated by original quotations.

3.2.1 | Engagement at work and in the profession

Participants reported that distributed leadership enhanced their engagement at work as it gave them opportunities to represent and share their peers' and teams' perspectives to influence departmental and organisational issues.

> *'We've got a voice…we can share our ideas'*. (P8)

Because their ideas were positively received and taken seriously despite their job bands, participants felt validated and valued that they could actively contribute to changes that benefitted patients, staff and their communities.

> *'You feel like you've been listened to…[which] makes people more involved, included and valued'*. (P12)

This engagement and validation were also found to extend beyond their formal job roles, increasing their interest and passion for nursing as a profession.

> *'Because I became more engaged, I have been more interested [and]a lot more engaged in the profession'. (P10).*

3.2.2 | Empowerment and confidence to make positive changes

Through the structural empowerment that SG provided, participants felt empowered to make positive changes that influenced patients and organisational outcomes. This empowerment was visibly demonstrated through direct contact with the SG leadership council and the Chief Nurse during monthly council meetings to present their ideas. Relevant support and resources were also provided to facilitate collaboration and teamwork in planning and executing these ideas to improve patient care and staff well-being.

> *'You feel more empowered to change things for patients and staff'*. (P14)

This empowerment seemed to shape their beliefs that they could make a difference beyond their current job roles and band. Participants also verbalized a greater sense of confidence in their work as they witnessed how their contributions made an impact on outcomes they valued.

> *'I've actually done more than what I thought I could. It has been confidence building and has enabled me to think, I can achieve what I want to achieve'*. (P10)

3.2.3 | Empowerment and positive appraisal of work contributed to job satisfaction

Through their involvement in SG, participants appeared to appraise work positively, knowing that their contributions made a difference. This contributed to them feeling happier and more satisfied at work.

> *'I ended up looking at the work I did differently and actually was much happier doing the work anyway'*. (P10)

TABLE 2 Hierarchical multiple regression predicting employee engagement, job satisfaction and turnover intention from demographics and DLA

	Employee engagement				Job satisfaction				Turnover intention			
	Step 1		Step 2		Step 1		Step 2		Step 1		Step 2	
Variable	B	β	B	β	B	β	B	β	B	β	B	β
Sex	−0.051	−0.014	0.110	0.031	4.368	0.093	6.673	0.143	−1.107	−0.051	−1.962	−0.091
Age	0.088	0.237	0.097	0.261	0.889	0.182	1.018	0.209	−0.776*	−0.344	−0.824*	−0.365
Ethnicity	0.185	0.123	0.197	0.131	−2.111	−0.107	−1.947	−0.098	−0.001	0.000	−0.062	−0.007
Education level	−0.107	−0.153	−0.080	−0.114	−1.846	−0.201	−1.458	−0.158	0.873	0.205	0.729	0.171
Job band	−0.027	−0.048	−0.027	−0.049	−0.610	−0.082	−0.611	−0.082	0.166	0.048	0.167	0.048
Supervisory role	−0.324	−0.174	−0.038	−0.020	−7.566*	−0.308	−3.479	−0.142	2.092	0.184	0.577	0.051
Time working in health	−0.079	−0.191	−0.070	−0.169	−0.937	−0.172	−0.809	−0.148	0.749	0.297	0.702	0.278
Time working in trust	−0.057	−0.108	−0.063	−0.119	−0.158	−0.023	−0.240	−0.035	0.006	0.002	0.036	0.011
Time in SG programme	0.111*	0.195	0.069	0.120	1.700*	0.226	1.089	0.145	−0.502	−0.144	−0.275	−0.079
DLA			0.046**	0.372			0.656**	0.404			−0.243*	−0.323
R^2	0.124		0.232**		0.198*		0.324**		0.150*		0.231*	
F	1.672		3.166*		2.906*		5.041**		2.071*		3.149*	
ΔR^2	0.124		0.107**		0.198*		0.126**		0.150*		0.081*	
ΔF	1.672		14.670**		2.906*		19.659**		2.071*		11.077*	

Note: $N = 116$.

*$p < .05$; **$p < .001$

TABLE 3 Demographics of interview participants ($N = 15$)

Participant	Sex	Age range (Years)	Job band	Length of time involved in the SG programme (Months)
P1	Female	40–44	7	49–60
P2	Female	55–59	8a	13–24
P3	Female	55–59	2	73–84
P4	Female	25–29	5	1–12
P5	Female	30–34	2	13–24
P6	Female	25–29	5	25–36
P7	Female	20–24	2	1–12
P8	Female	65–69	3	1–12
P9	Female	35–39	3	1–12
P10	Female	50–54	5	13–24
P11	Female	50–54	6	1–12
P12	Female	30–34	5	1–12
P13	Female	40–44	4	1–12
P14	Female	60–64	5	1–12
P15	Male	45–49	7	1–12

Participants also expressed appreciation in being given opportunities to make a difference through their work, which led to a sense of personal meaning and fulfilment that increased their job satisfaction.

> *'I liked seeing something can make a change…I don't know other jobs that can do that'*. (P3)

3.2.4 | Sense of belonging and commitment to the organisation

Through the interactions that distributed leadership facilitated, participants felt more connected to the wider organisation as it provided them opportunities to network and work with staff from other departments and job roles.

> *'Getting to know people from different areas and specialities do make you feel more committed to the Trust'*. (P6)

Through the sense of belonging and connectedness they experienced, some participants verbalized that it influenced their decision to stay in the organisation and the profession.

> *'It has definitely affected my decision to stay'*. (P5).

3.2.5 | Challenges associated with SG

While participants were generally more engaged, empowered, satisfied and committed to the organisation, a few challenges relating to the implementation of SG appeared to influence distributed leadership outcomes.

First, participants who were new to SG verbalized inadequate onboarding information that resulted in a lack of common understanding and communication regarding the purpose, structure and processes of SG. This appeared to affect their motivation and ability in executing ideas that were beneficial to patients, staff and the organisation.

> *'We don't know what we don't know. So, I don't know what we should be asking…communication could be better'*. (P11)

While participants generally enjoyed their involvement in SG, a few of them expressed challenges in terms of conflicting priorities and time pressures in managing their formal job roles and SG responsibilities, which influenced their job satisfaction and mental well-being.

> *'You're given a small amount of time in your rota to do it. But people expect you to be answering emails and chasing things up…it becomes an added responsibility or stress'*. (P6)

Although there were structures and processes in place to support SG efforts, a few participants commented that the slow progression and laborious efforts involved in executing SG projects affected their motivation and commitment in completing projects expediently to maximize outcomes.

> *'When I was going through procurement…you have to chase the application…that's another month wasted…so you feel like you want to give up'*. (P5)

4 | DISCUSSION

Quantitative results suggest that distributed leadership through SG significantly increased employee engagement and job satisfaction and significantly decreased staff's turnover intentions. Qualitative findings were consistent with quantitative results, presenting a unique perspective from the NHS Trust on how SG increased work and professional engagement, and empowered staff by giving them a voice to share their ideas and confidence to implement these ideas to improve patient, staff and organisational outcomes.

Findings from this study showed that being involved in distributed leadership tasks significantly increased employee engagement by 10.7% above that explained by demographic variables such as time in the SG programme. A systematic review by Beirne (2017) supports this, highlighting that a key feature of distributed leadership is in effective employee engagement that contributes to valuable outcomes such as patient safety. De Brún et al., (2019) explain that because distributed leadership changes the traditional hierarchical leadership structures and extends the influence of multiple voices within the organisation, this results in increased engagement and positive change. As SG validates the efforts and opinions that staff brings, this facilitates psychological safety and a sense of meaning and purpose, which enhances employee engagement (Gruman & Saks, 2011).

As engagement is critical in addressing the current and projected shortage of nurses (West, Bailey, & Williams, 2020), it is recommended that hospitals incorporate processes and systems that encourage staff's active involvement in sharing ideas that can bring positive impact to patients, staff and the organisation (Hussain et al., 2018). It is also imperative that a psychologically safe environment is created for staff to share innovative ideas that are validated, and to provide opportunities and resources for them to execute their ideas to increase engagement and improve professional practice (Edmondson et al., 2016).

Findings from this study showed that SG empowered participants in making positive changes in the organisation. Using Kanter's (1993) theory of structural empowerment, Moore and Hutchison (2007) explain that distributed leadership increases participants' access to information and resources that aid their job, provides relevant support, widens their social network and gives them opportunities for professional development and growth. Because participants have increased access to knowledge, this naturally increased their confidence, motivation and self-direction towards developing themselves professionally (Bradbury-Jones et al., 2010; Friend & Sieloff, 2018).

As access to information, support and resources are important contributors to structural empowerment (Spencer & McLaren, 2017), it is essential that SG provides the relevant information and support required to empower staff in executing their ideas and projects. To address challenges of a lack of common understanding and communication regarding the purpose, structure and processes of SG, it is recommended that SG programmes implement an onboarding process to provide staff with relevant information about the programme, provide direction on where to get resources and support, and help facilitate the building of connections beyond their appointed SG council, which will set staff up for early success (Carucci, 2018). Moreover, as high-quality leader–member exchanges have been found to increase engagement and empowerment at work (Aggarwal et al., 2020), SG council meetings should facilitate meaningful conversations that validate staff's contributions, showcase ways in which their contributions have made a difference and increase confidence in their capabilities to deliver beneficial patient and organisational outcomes.

As the UK health care staff consistently struggle with stress due to heavy workloads and feelings of being devalued (Senek et al., 2020), this study's findings are pertinent in addressing issues of disempowerment in the workplace. To address the increasing rates of burnout within the UK health care sector, it is recommended that organisations be transparent in their processes, increase engagement with their staff, increase management support and share information that will be helpful in facilitating staff work and enhance empowerment at the workplace. Where possible, organisations should also invest efforts in developing staff professionally and provide sufficient management support to create a positive work environment that enhances staff empowerment, which would further increase organisational performance (Markos & Sridevi, 2010). To ensure that SG processes do not have a countereffect in slowing down the execution of ideas resulting in more work and stress, it is imperative that SG processes be reviewed regularly, streamlined and communicated to enhance the efficiency of practice (Bohman et al., 2017).

Additionally, results from this study showed that distributed leadership significantly increased job satisfaction by 12.6% above demographic factors and that staff empowerment also contributed to the increase in job satisfaction. Participants' positive appraisal of their work was found to increase job satisfaction, which was congruent with Bagozzi's (1992) attitude–intention–behaviour model, which explains that behaviour is a result of an individual's cognitive appraisal of various work domains leading to a positive emotional response to work (Zeinabadi, 2010). Moreover, literature asserts the integration of employee engagement, staff empowerment and job satisfaction such that when staff feel empowered and are engaged in dialogue to share their ideas for improvement, they often exhibit more creativity in problem-solving, which is beneficial in transforming organisations (Zhang & Bartol, 2010).

As job satisfaction has been shown to have an important role in reducing turnover (Fasbender et al., 2019), hospitals that implement SG should plan efforts around celebrating the successes of staff's contributions (Nursing Times, 2016) as it increases job satisfaction and provides staff with a sense of meaning and achievement, which contribute to behaviours that benefit patients, staff and the organisation (De Clercq et al., 2019).

As presented in the results, SG was found to significantly reduce turnover intention by 8.1% above demographic factors. Literature has long proven job satisfaction to be a significant predictor of turnover intention in the health care sector (Jones, Warren, & Davies, 2015). Although qualitative findings did not

explicitly highlight this relationship, participants' reports of feeling a sense of belonging and being valued as a staff member have been shown to increase organisational commitment (Dávila & García, 2012). Han et al., (2010) explain that because distributed leadership facilitates shared decision-making, it increases participants' psychological ownership in sharing their knowledge with their colleagues and fosters a strong sense of belonging, which increases organisational commitment. Moreover, findings suggest that organisational commitment and loyalty increased when participants got to know their colleagues better. Lee and Kim (2011) argue that because organisational attitudes and behaviours are socially constructed, an expansion of one's social network can inadvertently increase organisational commitment.

In view that an increase in job satisfaction can reduce turnover intentions, it is advisable for organisations to be mindful in engaging staff on issues that motivate and increase their satisfaction at work through interventions such as SG. Actions should also be taken to reduce conflicting priorities and time pressures that staff may experience due to their involvement in SG as it can lead to counterproductive outcomes of decreased well-being and burnout (Van de Heijden, Mahoney, & Xu, 2019). As SG is a voluntary appointment, clear processes should be outlined to allow staff to opt out and hand over their responsibilities if required (Johnson et al., 2016). Regular reviews should also be conducted to assess staff's desire to continue in SG to maximize effectiveness and delivery of positive outcomes (Demirkiran et al., 2016).

4.1 | Limitations

While this study provides insight on how distributed leadership influences employee outcomes through SG, several limitations are observed. First, while the measures used in this study were reliable and valid, there was a lack of studies validating these measures in the UK context, which may have resulted in the inflation of statistical models.

Second, although the DLA scale is one of the most current and reliable tools in measuring a participant's involvement in leadership tasks, it was limited in its scalability in determining whether participants had low or high DLA. This possibly impeded the depth of analysis and interpretation of results in relation to employee engagement, job satisfaction and turnover intention.

While efforts were made to include participants with a range of experience in SG, majority of participants had less than 24 months' experience in the programme, which may result in potential biases in the results.

5 | CONCLUSION

In summary, this study can be considered one of the first in providing valuable insights on how distributed leadership in the form of SG influences health care staff, specifically in the domains of employee engagement, empowerment, job satisfaction and turnover intentions in a UK context. As employee engagement, staff empowerment, job satisfaction and turnover intentions are concepts that are intricately connected, this study provides hope in utilizing distributed leadership to address the struggles the NHS face in meeting the growing demands of recruiting and retaining quality DCNS to enhance care delivery.

Although the UK is in its infancy stage in rolling out SG across health care systems and more research can be conducted to explore its effectiveness, efforts such as the development of a national SG council provides hope in implementing distributed leadership as a solution to enhance employee outcomes and improve patient care within the nursing profession (NHS England, 2019). To further encourage the implementation of SG across the wider UK health care system, knowledge management processes can be set up to facilitate sharing of best practices, success stories and learning outcomes during health care conventions and events to increase buy-in (Intezari et al., 2017). Rotation programmes can also be leveraged for more experienced nurses to share their knowledge and experiences and help in the initial setting up of SG structures and processes for health care organisations that indicate interest in implementing distributed leadership (Thompson et al., 2004).

To further enhance the quality and effectiveness of data for similar studies, researchers may consider collecting organisational data such as organisational health survey results and actual turnover rates and triangulating these data during the analysis phase. With the triangulation of data, practitioners and legislators will be better equipped in formulating practical interventions for implementation of distributed leadership at the workplace.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

Findings from this paper suggest that distributed leadership in the form of SG is a promising solution to address high turnover and staff shortages in the UK and beyond. In addition to encouraging the adoption of distributed leadership in hospitals, nurse managers can provide staff with equal opportunities in contributing ideas and solutions that improve patient care and enhance the effectiveness of hospital policies, processes and practices. Nurse managers can also use distributed leadership as an opportunity to enhance staff development by empowering them to lead new and innovative approaches to advance health care and staff well-being. In advocating distributed leadership, staff will feel more empowered to champion and execute ground-up initiatives, possibly increasing their engagement, job satisfaction and commitment to the organisation. Through these, issues of high turnover, staff shortages and job retention can be better addressed.

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Conflict of Interest

All authors would like to declare that there was no conflict of interest pertaining to this research study.

Ethical Approval

The Research Ethics Committee of the University of Nottingham, Faculty of Medicine & Health Sciences, approved this study with Reference Number: 268–1903.

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REVIEW ARTICLE

WILEY

Professional autonomy in nursing: An integrative review

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Abstract

Aim: To summarize knowledge of professional autonomy in nursing.

Background: Professional autonomy is associated with experienced meaningfulness of the work. This refers to participation in decision-making and the ability to influence working practices.

Evaluation: In an integrative review, relevant studies were retrieved from four databases. Quality was systematically evaluated using critical appraisal tools. PRISMA guidelines were followed. Inductive content analysis was used to analyse current knowledge of the focal subject.

Key issues: The search identified 27 relevant studies published between 2000 and 2019. Elements describing nurses' professional autonomy were independence in decision-making and ability to utilize one's own competence. Themes relating to nurses' professional autonomy were shared leadership, professional skills, inter- and intra-professional collaboration and healthy work environment.

Conclusion: Understanding the multidimensional nature of professional autonomy is essential to create attractive work environments. It is important to enable nurses to participate in decision-making and develop nursing through shared leadership to enhance the recruitment and retention of a skilled workforce.

Implications for Nursing Management: The findings have anticipated utility for supporting nursing practice and nurse leaders' understanding of approaches to foster nurses' professional autonomy.

KEYWORDS

integrative review, nurse, professional autonomy

1 | INTRODUCTION

There are substantial nursing shortages globally, which are predicted to grow. The World Health Organization (WHO) estimates that nine million additional nurses and midwives will be needed by 2030 (WHO, 2020). Thus, it is essential to recruit more nurses and retain them in the profession to create a sustainable workforce. Various factors can promote their recruitment and retention, including monetary rewards and diverse intangible rewards related to working conditions and relations. The latter are known to include factors that enhance professional autonomy (Both-Nwabuwe et al., 2020; Watkins et al., 2016).

2 | BACKGROUND

The meaning of nursing autonomy is multidimensional, as diverse elements have been recognized, and it has been arguably confounded with various similar concepts, like independence, self-governance and accountability (Keenan, 1999; Kramer et al., 2006). Two widely recognized categories of nursing autonomy are clinical and professional autonomy. According to Oshodi et al. (2019), the clinical autonomy of staff nurses who provide direct patient care refers to their ability to act beyond standard practice and make decisions regarding individual patients' care.

Professional autonomy, the focus of this review, may be applied to either the profession or individual nurses. It has been treated as participation in decision-making regarding care of individual patients and, more broadly, development of care processes to improve nursing quality and patient safety (Varjus et al., 2011). Other elements that have been recognized include the ability to influence working practices and conditions (Watkins et al., 2016). It is reportedly associated with meaningfulness of work, which is promoted by autonomy in performing and scheduling work, clinical decision-making and the freedom to perform nursing work according to nurses' own judgement (Both-Nwabuwe et al., 2020). Nurses are reportedly more satisfied with their work, occupationally committed and psychologically empowered when they can prioritize, schedule and pace tasks (AllahBakhshian et al., 2017; Giles et al., 2017). Thus, it can also lead to better quality of work (Boamah et al., 2018) and impressive nursing outcomes (AllahBakhshian et al., 2017; Burke & Flanagan, 2018).

3 | AIM

The aim of the study was to summarize knowledge of professional autonomy in nursing. The following research questions were specifically addressed:

1. What are the elements of nurses' professional autonomy?
2. What factors are related to nurses' professional autonomy?

4 | METHODS

4.1 | Design

Integrative review methodology was applied in efforts to obtain a comprehensive description of current knowledge and robust foundations for future knowledge generation (Whittemore & Knafl, 2005). This enables inclusion of representations of focal phenomena by authors who applied different methods. The approach involved steps based on Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines and a four-phase flow diagram (Moher et al., 2009).

4.2 | Search strategy

An initial limited search of CINAHL, PubMed, Scopus and PsycINFO databases was undertaken to identify studies on the focal topic in July 2019. Search strategies and terms were selected in consultation with an information specialist. The structure of the research question and search strategy followed PICo (Population–Phenomena of Interest–Context). The following combinations of relevant terms, formed using the Boolean terms AND and OR, were applied in searches of all the databases: (nurse OR "nursing staff") AND ("professional autonomy" OR "clinical autonomy") AND ("decision mak*" OR "making decisions") AND (nursing OR "patient care" OR "professional role") (File S1).

4.3 | Inclusion and exclusion criteria

Inclusion criteria were empirical studies with quantitative or qualitative designs, in English, and published in peer-reviewed journals with an available abstract between January 2000 and July 2019. Studies meeting these criteria were excluded if they focused on other types of health care professionals or nursing students, explored patients' autonomy, concerned practice in medical establishments other than hospitals, concerned nurses' practice and roles in prescribing medicines or explored nurses' empowerment without connection to autonomy.

4.4 | Search outcome

In the first phase of the review, searches of the four databases identified 1,065 potentially relevant studies. After removing duplicates, 582 remained. In the second phase, titles and abstracts were screened. In this step, 498 studies were excluded because they did not meet the inclusion criteria or were not available. Additional studies were also identified through scrutiny of references in retained articles, seven identified articles were closely examined, and two of them were selected. In total, 91 studies were promoted to the third phase, which involved full-text assessment and resulted in exclusion of a further 64 studies. Finally, 27 studies remained and were included in the quality appraisal (Figure 1).

4.5 | Quality appraisal

A team of four independent reviewers was assembled, and each of retained studies was critically appraised in three phases by two reviewers. Following the PRISMA guidelines and more specifically, the JBI checklists for analytical cross-sectional studies and qualitative research (Joanna Briggs Institute, 2017) were used for critical appraisal of 20 and seven of the studies, respectively. All differences in quality assessment were clarified to reach a decision on the quality of each study. Missing data were accepted and assessed as 'unclear', so there

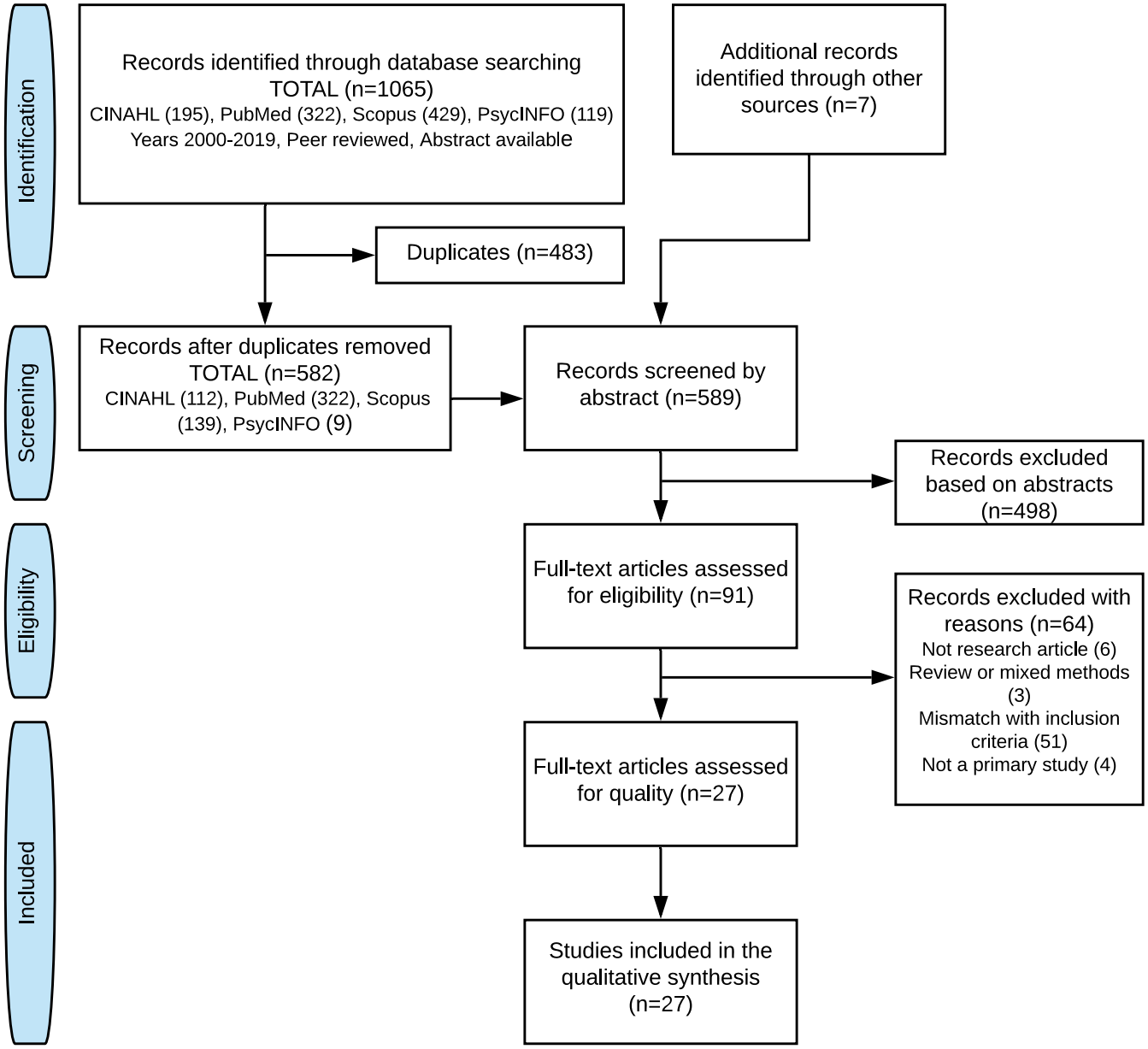

FIGURE 1 Flow chart of the study screening process, based on PRISMA guidelines (Moher et al., 2009).

was no contact with the original researchers. Each study was scored using a quality appraisal tool with answer option 'yes' assigned one point and options 'no' or 'unclear' assigned zero points. Based on this scoring, studies were classified as follows: excellent (>75.1%), some limitations (50.1%–75%) and several limitations (≤50%). All the studies were included in a qualitative synthesis (Files S2 and S3).

4.6 | Data extraction

To extract essential data and results relevant to the research questions and establish the generalizability of results (Munn & Aromataris, 2014), the reviewers entered a brief summary of the purpose of each study, its design, participants and context, data collection method and outcome into an Excel spreadsheet (Table 1).

4.7 | Data synthesis

Selected studies were subjected to inductive content analysis, based on the research questions and aim of the review. The data-organising process included open coding and creation of themes. Similar contents were classified as sub-themes and then synthesized into main themes (Elo & Kyngäs, 2008). This provided a systematic approach to assess current knowledge and understanding of nurses' professional autonomy (Figure 2).

TABLE 1 Purpose, design, participants and context, data collection method and outcome of each of the 27 studies included in the review

Study	Purpose	Design	Participants and study context	Data collection methods	Outcome	Quality (JBI)
Abdolmaleki et al. (2019) Iran	To explore the relationship between professional independence and moral distress in nurses working in emergency departments.	Descriptive correlation study Cross-sectional survey	173 nurses in the emergency departments in five educational public hospitals	Questionnaire Professional Nursing Autonomy Scale PNAS (Schutzenhofer et al)	The level of professional autonomy among emergency departments' nurses was low and moral distress moderate. A negative relationship was found between professional independence and frequency of moral distress. Professional autonomy was related to frequency and intensity of moral distress and age-predicted moral distress.	Excellent
Attree (2005) United Kingdom	To investigate nurses' perceptions of standards of nursing practice and present their perceptions of their governance, especially lack of control over factors that affect everyday practice standards	Grounded theory	142 nurses in the medical, surgical and elderly wards of three acute hospitals	Semi-structured focus group interviews	Nurses were dissatisfied with their governance over factors that they believed influence nursing practice standards. Perceived lack of control over matters affecting practice standards generated occupational dissatisfaction, demoralization and frustration.	Excellent
Berti et al. (2008) Brazil	To describe newly graduated nurses' perceptions of their professional autonomy and perceptions of the decision-making process in caregiving	Grounded theory	15 newly graduated nurses from different sectors of a public state hospital	Focal group interviews	Two main phenomena emerged from the results: perceptions of the fragility of nurse and patient autonomy and movement towards the strengthening of nurses' and patients' autonomy	Excellent
Budge et al. (2003) New Zealand	To explore the New Zealand nursing situation and determine whether aspects of the work environment are associated with health status.	Cross-sectional survey	225 nurses in one general hospital	Questionnaire: Nursing Work Index-Revised NWI-R (Aiken & Patrician)	The New Zealand hospital environment was characterized by less autonomy and control but better nurse–physician relations than in US hospitals. More positive ratings of three workplace attributes were associated with better health status of the nurses. The results indicated that nurses' relations with physicians, administrators and other departments mediate associations between autonomy, control and health status	Several limitations
Cajulis and Fitzpatrick (2007) USA	To describe and determine the level of autonomy of nurses providing care to an adult patient population in acute care settings.	Cross-sectional survey	54 nurses in different specialty areas in a large metropolitan hospital	Questionnaire: The Dempster Practice Behaviours Scale	The overall mean autonomy score of this study indicates a high level of autonomy of the nurses. 41% of participants reportedly had very high levels of autonomy, 31.5% extremely high levels and 19% moderate levels. Demographic variables of age, experience, educational level, basic nursing preparation, certification and specialty had no significant relationship with autonomy scores	Excellent
Duffield et al. (2009) Australia	To assess aspects of the work environment related to nurses' job satisfaction, satisfaction with nursing and intention to leave in public sector hospitals in New South Wales, Australia, and the importance of the nursing unit manager's role	Cross-sectional survey	Nurses in 80 medical and surgical units	Questionnaire: Nursing Work Index-Revised NWI-R (Aiken & Patrician)	Nurses who were intending to remain in their job were more likely to be satisfied, older, have dependents, experiencing good leadership and to have allied health support on the ward. Most nurses reported being satisfied with their profession and a lower proportion reported satisfaction with their current position. Work environment factors (including autonomy, control over practice and nursing leadership) were significant predictors of job satisfaction	Several limitations

(Continues)

TABLE 1 (Continued)

Study	Purpose	Design	Participants and study context	Data collection methods	Outcome	Quality (JBI)
Farrell et al. (2017) United Kingdom	To examine nurses' roles within nurse-led chemotherapy clinics	Ethnographic study	13 nurses in four cancer units in different geographical areas of the UK	Non-participant observation and semi-structured interviews	There were great disparities between nurse-led chemotherapy clinics even if there were similarities in clinical skills training and prescribing. Disparities included the number of patients seen within each clinic, operational aspects, nurses' autonomy, scope of practice and clinical decision-making abilities. The differences highlighted four levels based on nurses' autonomy and scope of clinical practice. This was strongly influenced by medical consultants	Excellent
Foley et al. (2002) USA	To describe nurses' characteristics and their work environment at two military hospitals, identifying factors important for job satisfaction such as autonomy, control over practice and nurse–physician relationships and assessing nursing expertise	Descriptive design Cross-sectional survey	185 nurses in eight units of two military hospitals	Questionnaire: Nursing Work Index-Revised NWI-R (Aiken & Patrician)	Autonomy, control over practice and nurse–physician relationship scores were above midpoint for all respondents, indicating positive work environments in both of the hospitals studied. Scores from the clinical expertise instrument were clearly above midpoint, indicating a desirable level of clinical expertise	Excellent
Garon et al. (2009) USA	To describe the nurses' perspective and experience of change in the care delivery model and skill mix in an intermediate care unit	Descriptive qualitative design	11 nurses in an intermediate care unit in a large non-profit community hospital	Semi-structured focus groups interviews	The results highlighted two main themes: autonomy and control; and interdependence. The nurses emphasized increased satisfaction with the care delivery model. Results confirmed that autonomy, control, connection with the patient, peer and interdisciplinary support and respect are important for staff nurses	Some limitations
Georgiou et al. (2017) Cyprus	To explore nurse–physician collaboration and potential associations with nurses' autonomy and pertinent nurses' characteristics in adult intensive care unit in Cyprus	Descriptive correlational study	163 nurses in five intensive care unit in four public hospitals	Questionnaire: Autonomy Scale VAS (Varjus et al.)	Collaboration and satisfaction about care decisions scale (CSACD) scores implied low levels of collaboration and satisfaction with care decisions. Scores were significantly lower for male participants. CSACD scores correlated positively with experience, professional satisfaction and autonomy scores	Excellent
Iliopoulou and While (2010) Greece	To describe Greek critical care nurses' views on professional autonomy and its relationship with job satisfaction and other work-related variables, such as personal and work-related characteristics, role conflict and role ambiguity	Cross-sectional survey	431 nurses in 23 public hospitals in Athens, Greece	Questionnaire: Professional Nursing Autonomy Scale PNAS (Schutzenhofer et al.)	Nurses reported acting moderately autonomously. Higher levels of autonomy were reported by female nurses and older nurses. Appointment level, type of critical care unit and registration with a professional organisation were independently associated with autonomy. Positive moderate associations were found between autonomy and job satisfaction, role conflict and role ambiguity. There was no relationship between job satisfaction and role conflict and role ambiguity	Excellent

(Continues)

TABLE 1 (Continued)

Study	Purpose	Design	Participants and study context	Data collection methods	Outcome	Quality (JBI)
Inoue et al. (2017) Japan	To examine how hospital patient-safety procedures affect nurses' job satisfaction, investigating the association between perceived autonomy and hospital patient-safety procedures and job satisfaction	Cross-sectional survey	537 nurses in 10 private hospitals in or near Tokyo or Osaka, Japan	Questionnaire: Own instrument (Inoue et al.)	Structural equation modelling revealed statistically significant associations between factors regarding hospital patient-safety procedures and nurses' self-perceived autonomy and job satisfaction. Nurses' perceived autonomy in the workplace enhanced their job satisfaction and positive perceptions of hospital patient-safety procedures promoted job satisfaction. Some styles of chief nurses' leadership regarding patient safety restricted nurses' independent and autonomous decision-making and actions, lowering job satisfaction	Some limitations
Karanikola et al. (2014) Cyprus	To investigate the level of moral distress and potential associations between moral distress indices and nurse–physician collaboration, autonomy, professional satisfaction, intention to resign and workload among Italian intensive care unit nurses	Cross-sectional survey	566 nurses in ICUs in Italy	Questionnaire: Autonomy Scale VAS (Varjus et al.)	There were two main findings. First, a moderate-to-high intensity of moral distress in Italian ICU nurses, despite a rather low frequency of morally distressing events. Second, an association between the hardness of moral distressing experiences and poor nurse–physician collaboration and dissatisfaction regarding care decisions	Excellent
Kerzman et al. (2015) Israel	To explore nurses' attitudes towards expanding nurses' authority and the relationships between these attitudes and job satisfaction aspects, professional characteristics and demographics	Cross-sectional survey	899 nurses in 89 internal medicine, surgery and geriatric departments in three major medical centres in Israel	Questionnaire (Shirom et al)	There were positive attitudes towards the expansion of nurses' authority and moderately positive attitudes towards interpretation of diagnostic tests in selected situations. Nurses' satisfaction from professional autonomy and work relations were the most strongly explanatory factors for their attitudes towards expansion of nurses' authority. Young nurses tended to be more positive regarding changes in nurses' professional authority	Excellent
Luiking et al. (2015) Netherlands	To explore changes in clinical autonomy and personal norms and values for planned change and emergent change implementation of an innovation, for example intensive insulin therapy	Prospective comparative study Cross-sectional survey	Two separate groups of nurses ($n = 32$ in team 1 and $n = 47$ in team 2) in one ICU	Questionnaire: Professional Nursing Autonomy Scale PNAS (Schutzenhofer et al.)	At starting point, the measurements did not differ. After implementation, clinical autonomy was increased in the emergent change team and decreased in the planned change team. There were decreased hierarchic scores and increased developmental and rational scores for the emergent change team. The hierarchical and group scores were increased in the planned change team. Learning as a team did not vary between the teams	Excellent
Maharmeh (2017) Jordan	To describe critical care nurses' experiences of autonomy in their clinical practice	Descriptive correlational design Cross-sectional survey	110 nurses in six ICUs in two hospitals in Jordan	Questionnaire: Autonomy Scale VAS (Varjus et al.)	Most of the critical care nurses had perceived autonomy in their decision-making and participation in decisions to take action in their clinical settings. ICU nurses could independently develop their own knowledge. The nurses' autonomy in action and acquired knowledge were influenced by a number of factors such as gender and working environment	Excellent

(Continues)

TABLE 1 (Continued)

Study	Purpose	Design	Participants and study context	Data collection methods	Outcome	Quality (JBI)
Mrayyan (2004) Jordan	To explore nurse managers' role in enhancing hospital staff nurses' autonomy	Comparative descriptive survey Cross-sectional survey	317 nurses in the USA, Canada and the UK (from 23 nursing listservs)	Electronic Questionnaire (Blegen et al.)	Nurses perceived their autonomy to be at a moderate level and they had more autonomy in making decisions regarding patient care than making operational decisions at unit level. Nurses who had autonomy in patient care decision-making also had more in unit operation decision-making. Nurse managers' actions had a strong relationship with nurses' autonomy. Three important factors that decreased nurses' autonomy were autocratic management, doctors and workload	Excellent
Mrayyan (2005) Jordan	To examine American nurses' work autonomy and autonomy over patient care and unit operation decisions	Cross-sectional survey	300 nurses in the United States (from two clinical listservs)	Electronic Questionnaire (Blegen et al.)	Nurses perceived their autonomy to be at a moderate level and they had more autonomy in making patient care decisions than in operational decisions at unit level. Nurses' experience, education and time commitments influenced their work autonomy	Excellent
Papathanassoglou et al. (2005) Greece	To examine critical care nurses' perceived contribution to clinical decision-making, degree of autonomy in technical tasks and factors related to practice autonomy in in Greece. The study aimed to construct and validate a new instrument for assessing practice and clinical decision-making autonomy among ICU nurses	Exploratory descriptive correlational study Cross-sectional survey	803 nurses in 53 ICUs in 41 acute hospitals in Greece	Questionnaire: Own instrument (Papathanassoglou et al.)	The ICU nurses' autonomy scores were moderate. The highest autonomy was attributed to basic technical tasks. Male gender and higher education were predictors of higher autonomy overall and bachelor degree graduates scored higher in decisional autonomy. Experience in ICUs and type of ICU were important determinants of decisional autonomy	Excellent
Rafferty et al. (2001) United Kingdom	To explore the relationship between interdisciplinary teamwork and nurse autonomy, and its effects on patients and nurses, and nurse-assessed quality of care	Cross-sectional survey	5,006 nurses in surgical or medical settings in 32 hospitals in the UK	Questionnaire: Nursing Work Index-Revised NWI-R (Aiken & Patrician)	Professional autonomy was positively correlated with perceived quality of delivered care and job satisfaction. A weak but significant difference in perceived level of teamwork was detected between full-time and part-time nurses, but no significant differences related to type of contract, specialty of unit, shift length or job title. Nurses with higher teamwork scores were more likely planning to stay in their current job and had lower burnout scores. Strong associations were between teamwork and autonomy, nurse-assessed quality of care and its improvement over the last year.	Excellent
Shohani et al. (2018) Iran	To assess nurses' perspectives of their professional autonomy in Iran	Cross-sectional survey	150 nurses in three general hospitals	Questionnaire (Blegen et al.)	Most of the nurses reported that they had high levels of professional autonomy. There were significant relationships between the nurses' professional autonomy and their age, education and work experience	Some limitations

(Continues)

TABLE 1 (Continued)

Study	Purpose	Design	Participants and study context	Data collection methods	Outcome	Quality (JBI)
Skår (2010) Norway	To clarify the meaning of nurses' experiences of autonomy in work situations	Qualitative hermeneutic study	11 nurses in medical, surgery and rehabilitation wards, nursing homes and community care settings in Norway	In-depth interviews and focus group interviews	Four themes regarding nurses' experiences of autonomy in work situations emerged: Having a holistic view, Knowing the patient, Knowing that you know and Courage. Nurses must be knowledgeable and confident to gain autonomy in nursing practice	Excellent
Smith et al. (2006) Canada	To explore the extent to which magnet hospital characteristics (management support, nurse–doctor and nurse–manager relationships, professional autonomy and responsibility) contribute to hospital nurses' job satisfaction in Canada	Cross-sectional survey	123 nurses in 13 hospital in north-western Canada	Questionnaire: Own instrument (Smith et al.) Structured interview	Hospitals in northern and rural western Canada have some magnet characteristics. Management support and nurse–manager relations are important for nurses' job satisfaction. Nurses' views of management were fairly negative, an issue that management needs to address. Nurses' ability to work professionally and autonomously is important for their job satisfaction	Some limitations
Stewart et al. (2004) Canada	To enable nurse managers to recognize strategies to support and enhance autonomous practice based on clinical nurses' understanding of autonomy	Qualitative hermeneutic study	43 nurses in medical–surgical units, critical care units and diagnostic laboratories, outpatient clinics and nurse educators	Focus group interviews	Autonomy described as nurses' ability to accomplish patient care goals in a timely manner by using their knowledge and skills to understand and contribute to the plan of care, assess patient needs and conditions, effectively communicate concerns and priorities regarding patient care and access, and coordinate the resources of the multidisciplinary team	Excellent
Varjus et al. (2003) Finland	To describe ICU nurses' experiences of autonomy in their work in Finland	Cross-sectional survey	172 nurses in eight ICUs in Finland	Questionnaire: Own instrument (Varjus et al.)	Three bases of autonomy were recognized: knowledge base (independence, right and responsibility in decision-making), action base (independence, right and responsibility in actions) and value base (independence, right and responsibility in values). Most participating nurses felt they had more autonomy in decision-making and actions concerning patient care than in decision-making and actions concerning the ICU as a whole. Nurses' work experience increased their autonomy	Excellent
Wang et al. (2011) China	To investigate baccalaureate-prepared nurses' perceptions of the concept and practices of clinical decision-making in China	Qualitative exploratory study	12 baccalaureate-prepared nurses in three acute medical units, two acute surgical units and one ICU in one hospital in China	Semi-structured interviews	Functional perspectives of clinical decision-making and perceived autonomy in clinical decision-making were two main themes identified. Both main themes had sub-themes: emphasizing a full understanding of the patient's health status, undertaking appropriate nursing judgements and problem solving, relying on doctor's instructions, making judgements on a doctor's orders and making decisions independently in emergency care	Several limitations

(Continues)

TABLE 1 (Continued)

Study	Purpose	Design	Participants and study context	Data collection methods	Outcome	Quality (JBI)
Özturk et al. (2006) Turkey	To understand nurses' perceptions of organisational factors related to their job satisfaction and motivation in Turkey	Cross-sectional survey	250 nurses and 40 nurse leaders in a training and research hospital in Turkey	Questionnaire: Own instrument (Özturk et al.)	A third of the nurse leaders and 20% of the staff nurses reported being satisfied with their job. According to Hackman and Oldman's work design model, participants saw the five core job dimensions (skill variety, task identity, task significance, autonomy and feedback) as important to nurses. Nursing was described as hard and challenging but participants also found it meaningful and as providing opportunities to use their skills and abilities	Several limitations

5 | RESULTS

5.1 | Characteristics of the included studies

Included 27 studies were conducted in 17 countries. In 20 studies, quantitative, cross-sectional designs were used, and in the other seven, qualitative, explorative and descriptive designs and hermeneutic approaches were applied. The quality of studies was generally high: 19 were classified as excellent, four as having some limitations and four as having several limitations (Table 1).

5.2 | Elements of nurses' professional autonomy

Two themes were found to describe nurses' professional autonomy: *independence in decision-making* and *ability to utilize one's own competence*, as summarized in the following section.

5.2.1 | Independence in decision-making

The freedom to make patient care decisions and work independently is crucial as it reportedly allows full utilization of nurses' knowledge and abilities (Budge et al., 2003; Duffield et al., 2009; Smith et al., 2006). Important elements of independence in work include the abilities to make independent decisions in the best interests of patients (Georgiou et al., 2017; Karanikola et al., 2014; Maharmeh, 2017; Stewart et al., 2004; Varjus et al., 2003), solve problems without orders, take nursing actions (Abdolmaleki et al., 2019; Berti et al., 2008; Georgiou et al., 2017; Karanikola et al., 2014; Stewart et al., 2004; Varjus et al., 2003) and organise unit operations (Varjus et al., 2003). Corresponding responsibility for one's own decisions and accountability for their consequences are also important (Attree, 2005; Cajulis & Fitzpatrick, 2007; Farrell et al., 2017; Garon et al., 2009; Georgiou et al., 2017; Karanikola et al., 2014; Skår, 2010; Stewart et al., 2004; Varjus et al., 2003; Wang et al., 2011). Further major aspects include control over practices, including organising one's schedule, prioritizing tasks during shifts, coordinating patient care and generally 'running the show' in their units (Attree, 2005; Berti et al., 2008; Duffield et al., 2009; Garon et al., 2009; Stewart et al., 2004).

In summary, important aspects of professional autonomy and associated advantages that are widely recognized in the reviewed studies include having authority over oneself, freedom to make clinical decisions, with accountability, and act in accordance with the decisions (Attree, 2005; Kerzman et al., 2015; Rafferty et al., 2001; Skår, 2010).

5.2.2 | Ability to utilize one's own competence

Utilization of personal competence has been recognized importance for nurses' autonomy, including choice of one's own approach

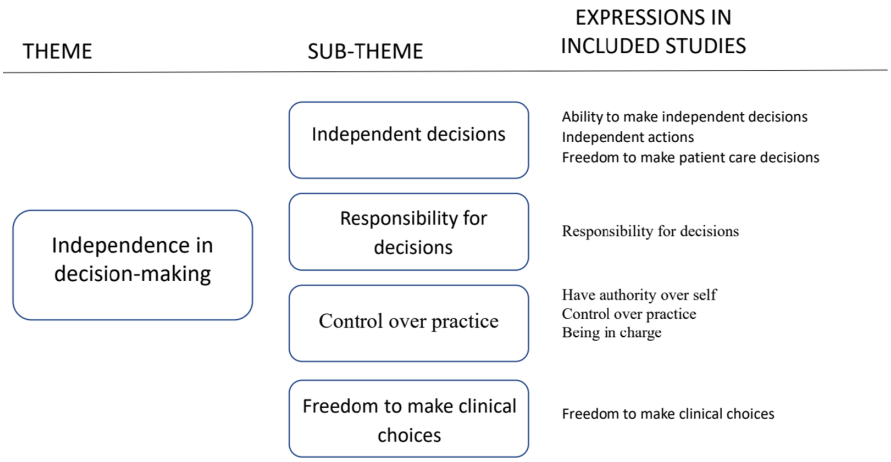

FIGURE 2 An example of content analysis

in nursing (Rafferty et al., 2001; Varjus et al., 2003). Competence emerges in many ways, but in order to utilize their own competence, nurses must reportedly be able to assess needs for care and act in a timely fashion (Berti et al., 2008; Farrell et al., 2017; Garon et al., 2009; Maharmeh, 2017; Skår, 2010; Stewart et al., 2004; Wang et al., 2011). Moreover, nurses who act autonomously participate in problem solving (Garon et al., 2009; Özturk et al., 2006) and influence patient care through effective communication of concerns (Georgiou et al., 2017; Karanikola et al., 2014; Maharmeh, 2017; Stewart et al., 2004; Varjus et al., 2003).

Accountability for maintaining competence is also an essential part of professional autonomy. In addition to use of nursing knowledge and skills, both Varjus et al. (2003) and Özturk et al. (2006) concluded that nurses' responsibility for developing their knowledge and skills is important elements.

The ability to utilize one's own skills increases with work experience (Berti et al., 2008; Cajulis & Fitzpatrick, 2007; Garon et al., 2009; Skår, 2010; Stewart et al., 2004; Varjus et al., 2003). However, personal qualities also influence personal competence, and some nurses are inherently more autonomous than others (Attree, 2005; Berti et al., 2008; Stewart et al., 2004). In addition, status in nurses' multiprofessional teams clearly must be sufficient, and ideally equal, in order for them to act independently (Berti et al., 2008; Duffield et al., 2009; Garon et al., 2009; Stewart et al., 2004). Freedom and responsibility to act in accordance with one's own values is another highlighted part of nurses' ability to utilize their competence, and hence professional autonomy (Georgiou et al., 2017; Karanikola et al., 2014; Maharmeh, 2017; Varjus et al., 2003).

5.3 | Factors related to nurses' professional autonomy

Four themes regarding factors related to nurses' professional autonomy were identified: *shared leadership*, *professional skills*, *inter- and intra-professional collaboration and healthy work environment*. Key aspects of these relationships are summarized in the following sections.

5.3.1 | Shared leadership

Shared leadership has obvious importance for autonomy as it provides nurses' more possibility to exert influence in their workplace than traditional hierarchical leadership, and a voice regarding practices within their wards (Attree, 2005). Supportive management has significant positive effects on nurses' professional autonomy, according to findings that cooperation between the chief nurse and staff nurses is essential, and that good managers support nurses in their work (Budge et al., 2003; Duffield et al., 2009; Iliopoulou & While, 2010; Inoue et al., 2017; Karanikola et al., 2014; Mrayyan, 2004), extend nurses' authority and show appreciation (Kerzman et al., 2015; Stewart et al., 2004).

In contrast, autocratic management reduces nurses' professional autonomy. According to interviewed nurses, such managers control their work, make decisions at a higher level and constantly monitor them (Attree, 2005; Berti et al., 2008). Unclear or strict organisational rules, lack of specific policies and supportive authority from their organisation also reportedly reduce their professional autonomy (Abdolmaleki et al., 2019; Attree, 2005; Inoue et al., 2017; Wang et al., 2011). Another highlighted negative factor is being given control in an illusory, lip-service fashion (Attree, 2005; Stewart et al., 2004).

5.3.2 | Professional skills

Personal competence is an important aspect for the development of nurses' professional autonomy. It includes knowledge, clinical skills and the ability to make decisions and act (Berti et al., 2008; Farrell, 2017; Rafferty et al., 2001; Stewart et al., 2004). Education increases nurses' professional autonomy, and experience (time spent in nursing and in present position) is an autonomy-promoting factor (Berti et al., 2008; Georgiou et al., 2017; Iliopoulou & While, 2010; Maharmeh, 2017; Mrayyan, 2004, 2005; Papathanassoglou et al., 2005; Shohani et al., 2018; Varjus et al., 2003).

Various personal abilities also reportedly contribute to nurses' utilization of professional skills and expression of professional autonomy. These include a sensitive and humble attitude to constant

learning, recognition of personal limitations and confidence in their knowledge (Berti et al., 2008; Stewart et al., 2004).

5.3.3 | Inter- and intra-professional collaboration

A good nurse–physician relationship that promotes nurses' autonomy is collegial, equal and communicative (Abdolmaleki et al., 2019; Garon et al., 2009; Stewart et al., 2004). Multiprofessional teamwork and cooperation among staff and respect among coworkers without authoritarian impositions also seem to increase nurses' professional autonomy (Berti et al., 2008; Luiking et al., 2015; Rafferty et al., 2001), while physicians' power to decide and disrespect from them has opposite effects. Other major negative factors are nurses' knowledge being ignored or not valued (Abdolmaleki et al., 2019; Berti et al., 2008; Farrell et al., 2017; Stewart et al., 2004) and associated inequalities in roles in the work community, particularly subordination to physicians (Attree, 2005; Mrayyan, 2005; Wang et al., 2011).

5.3.4 | Healthy work environment

Nurses' autonomy is apparently promoted by a safe work environment with a friendly and peaceful atmosphere including good team spirit without conflicts or teasing, and defined unit protocols to follow (Berti et al., 2008; Farrell et al., 2017; Garon et al., 2009; Georgiou et al., 2017; Stewart et al., 2004). Adequate resources are also important (Duffield et al., 2009; Kerzman et al., 2015). Hence, heavy workloads and too little time to complete tasks reportedly cause moral distress and reduce professional autonomy (Abdolmaleki et al., 2019; Özturk et al., 2006; Stewart et al., 2004), while time spent with patients (Maharmeh, 2017; Mrayyan, 2005; Papathanassoglou et al., 2005) and possibilities to get to know patients and respond to their needs enhances it (Kerzman et al., 2015; Skår, 2010).

6 | DISCUSSION

This integrative review summarizes current knowledge of elements of nurses' professional autonomy and factors related to it. Identified themes in the examined literature illustrate the multidimensional nature of professional autonomy. Oshodi et al. (2019) adduced that when staff nurses discussed autonomy, they usually meant clinical autonomy rather than professional autonomy. The findings clearly indicate that clinical autonomy is part of professional autonomy in nursing and strongly associated with decision-making in patient care. However, in clinical practice nurses also follow physicians' orders and work within rules, so comprehensive autonomy is not possible. In this respect, it should be noted that all professionals must follow national and local laws and regulations, as well as specific ethical codes. In parts of practice that are constrained by regulations and ethical codes, but not necessarily by physicians' orders, there is much greater scope for autonomy.

One reason for variation and mixed-use of clinical autonomy and professional autonomy might be that the instruments used in cross-sectional studies had been developed due to the concept of autonomy. Sharper distinction between clinical and professional autonomy would be helpful, and it is important to recognize that the two have been confounded, to varying degrees, and both definitions and measurements of professional autonomy have varied (Gagnon et al., 2010). Thus, this is largely a measurement issue, the instruments are measuring the same dimensions just name the concepts differently.

Many included studies found that work experience promotes utilization of nurses' competence and professional autonomy through control over practice, as well as abilities to make decisions, act independently and follow their own nursing values. This is a cause of concern, because nurses' retirement and turnover rates are increasing, while shares of recent graduates and young nurses in the work community are growing. Thus, nurses with strong work experience and ability to act autonomously may not always be present.

Strong contributory factors reported in studies include shared leadership, which provides nurses the possibility to exert influence, and supportive leaders who empower nurses. This is corroborated by several studies elsewhere (e.g. Boamah et al., 2018; Kramer et al., 2007; Oshodi et al., 2019). Kramer et al. (2007) concluded that nurse managers should provide support, opportunities to increase competence and both reward and sanction their professional autonomy. However, nurses cannot be autonomous if their authority is not sufficiently extended. We found that organisational constraints including autocratic management, unclear or strict organisational rules, hierarchy and lack of control over practice are detrimental to realization of professional autonomy, confirming previous research (AllahBakhshian et al., 2017). According to Oshodi et al. (2019), nurses' professional autonomy is more pronounced in exceptional situations such as emergencies, when senior members of staff are not available. Thus, nurses are not necessarily granted professional autonomy in practice, and it may strongly depend on the situation. This kind of culture does not promote autonomy of nurses either generally or individually. Based on these findings, we conclude that nurse leaders should create and maintain work environments where nurses are aware of their expectations and responsibilities, which do not change in different situations. Clear job descriptions for nurses and tenure plans for their professional growth are also helpful.

Another factor that has well-established effects on nurses' professional autonomy is collaboration with physicians. Ultimately, nurses who feel empowered through collaboration with physicians are more likely to think critically and provide high-quality care (AllahBakhshian et al., 2017). The reduction of nurses' autonomy by their historically subordinate role to physicians was one of the sub-themes linked to poor cooperation and nurses' unequal roles in the working community identified in the reviewed studies, and it has been highlighted elsewhere (AllahBakhshian et al., 2017; Traynor et al., 2010). To counter this, nurses should be considered equal members of care teams and supported accordingly by the top management of their organisations.

Finally, the same elements of nurses' professional autonomy and sets of factors related to it were identified in studies published during a period of almost 20 years. We found no clear changes in the recognized importance of any factor with time during this period, which confirms that nursing culture changes very slowly.

6.1 | Limitations

Despite use of a careful search strategy, some studies may have been missed. Some relevant articles may clearly have been excluded by the decisions to limit the initial search to available abstracts and studies written in English. A further limitation is that researchers still have differing views on how the concept of professional autonomy should be defined and understood (Maranon & Isla Pera, 2019; Varjus et al., 2011). In addition, the included studies were highly heterogeneous. They had widely varying designs, applied 10 different instruments and had widely varying numbers of participants. This complicated the combination of results and synthesis of findings, which thus should be interpreted cautiously.

7 | CONCLUSIONS

Understanding the multidimensional nature of professional autonomy is essential to create attractive work environments, and opportunities for nurses to work autonomously need support. Shared leadership is spreading slowly, and there is still strong hierarchy in health care organisations. It is important to enable nurses to participate in decision-making, and the planning and development of nursing through shared leadership to enhance the recruitment and retention of a skilled workforce. In addition, nurses should be considered equal members of the care team and nursing as an independent profession should be valued equally with medicine in practice, even if there are legal restrictions in their professional autonomy. Finally, nurses' roles are constantly changing, so future research should include identification of additional dimensions presented by the rapidly evolving digital health care context to promote nurses' professional autonomy.

CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

IMPLICATIONS FOR NURSING MANAGEMENT

The findings may assist efforts to support nursing practice and empower nurses to act autonomously, which is important in order for nurses to utilize their knowledge and abilities fully. In addition, by broadening understanding of nurses' professional autonomy the findings may help to enhance the quality of nurse management, attractiveness of work environments and nurses' well-being.

ETHICAL APPROVAL

No ethical approval was required for this review paper.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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ORIGINAL ARTICLE

WILEY

Hospital nurses experiencing day-to-day workplace incivility: A diary study on the benefits of daily social support

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Abstract

Aim: The present study investigated the adverse effects of daily experienced incivility and the positive role of daily social support during the workday in predicting daily emotional exhaustion after work and vitality and positive affect at bedtime.

Background: Despite the broad knowledge of the impact of experienced incivility in different occupations, little is known about day-to-day nurse incivility, much less in the hospital context.

Method: After completing a general questionnaire, hospital nurses ($n = 96$) completed a diary questionnaire twice a day for five consecutive workdays ($n = 480$ diary observations). The diary design had two levels: 5-day repeated measures (Level 1, day level) nested in persons (Level 2, person level) using an experience-sampling methodology.

Results: Multilevel hierarchical analyses showed that incivility during the workday increased emotional exhaustion after work ($t = 3.00$, $p = <0.05$) and reduced vitality ($t = -2.48$, $p = 0.05$) and positive affect ($t = -2.23$, $p = 0.05$) at bedtime. However, daily social support during the workday was a crucial job resource that directly benefited hospital nurses' daily wellbeing ($t = 5.19$, $p = 0.01$ vitality; $t = 4.89$, $p = 0.01$ positive affect) and buffered the adverse effects of daily workplace incivility ($t = -2.33$, $p = 0.05$).

Conclusion: The within-person approach of our findings suggests that supportive practices can reduce day-to-day incivility spirals.

Implications for Nursing Management: Nurse managers can promote a civility culture within their units using in service training programmes at work.

KEYWORDS
diary study, emotional exhaustion, hospital nurses, nurse incivility, social support

1 | INTRODUCTION

Nurses experience workplace incivility and suffer from its detrimental consequences (Layne et al., 2019). Unlike bullying, workplace incivility is a subtle form of interpersonal mistreatment whose distinctive characteristic is an ambiguous intent to harm the target (Andersson & Pearson, 1999). An example of nurse incivility can be an episode in which a nurse target receives disrespectful comments or is ignored by another nurse colleague or supervisor—the actor of incivility—while other nurses observe this uncivil interaction (Guidroz et al., 2010). Workplace incivility is not always easy to identify. For this reason, nurse managers can play a key role in promoting safe and healthy workplaces, fostering intervention strategies to recognize and react to incivility within nurse groups (Kile et al., 2019). For example, efforts

are undertaken to promote an environment of social support and to report and share the incivility experience (Shen et al., 2020), as well as to provide respectful communications as part of the culture of the units (Sherrod & Lewallen, 2021).

The present diary study captures day-to-day fluctuating hospital nurses' behaviour and experiences in their natural setting. In particular, our research design takes temporal dynamics to explore the direct relationships of daily experienced incivility and daily social support during the workday, as well as the moderation of daily social support during the workday on daily emotional exhaustion after work and daily vitality and daily positive affect at bedtime (Ohly et al., 2010). In line with previous studies, this design allows us to capture within-person processes among hospital nurses using a time course of measurement and, thus, control for temporal fluctuations and different situational contingencies over time (i.e., Haluza et al., 2019). Most of the research on nurse incivility has been conducted using cross-sectional designs. However, we used an experience-sampling methodology (ESM), which implies that nurses report in situ on their current thoughts, feelings and behaviours by offering a better understanding of day-to-day incivility spirals. This methodology provides insights into how relevant variables that occur within the work environment (i.e., incivility) influence hospital nurses' wellbeing after work and at bedtime. This methodology also enhances ecological validity, examines within- and between-person hospital nurses' processes and reduces retrospective hospital nurses' recall biases (Fisher & To, 2012). Moreover, the use of multiple measures during five workdays also helps reduce the common-method variance caused by the sole use of self-report measures (Podsakoff et al., 2003).

1.1 | Daily workplace incivility in the context of nursing

Workplace incivility has caused a significant corpus of knowledge. Currently, incivility is known to affect behaviour but also elicits biological responses (Cortina et al., 2021). Workplace incivility has been mainly assessed using questionnaires, but interviews and other qualitative techniques have also been used (Vasconcelos, 2020). However, its daily effects in nursing have barely been investigated. Because of its subtle and ambiguous nature, a more nuanced examination over a period of days using a within-person approach to capture specific daily effects in natural scenarios would be important (Hershcovis et al., 2020).

To our knowledge, only two diary studies in nursing use ESM. The first study showed that nurses' daily experience of incivility was related to their daily burnout level, whereas interpersonal justice strengthened the incivility–burnout relationship (Campana & Hammoud, 2015). The second study revealed that difficulties in emotional regulation increase the effects of daily incivility on female nurses' daily fatigue and positive affect at night (Blanco-Donoso et al., 2019). To build on this knowledge, the present diary study posits that nurse incivility has direct and negative effects on their daily levels of emotional exhaustion after work and daily vitality and daily positive affect at bedtime. Thus, we propose the following hypothesis.

> **Hypothesis 1.** Daily experienced incivility during the workday will be positively related to (H1a) daily emotional exhaustion after work and negatively related to (H1b) daily vitality at bedtime and (H1c) daily positive affect at bedtime.

1.2 | Daily social support: The role of nurse managers

Another key theme is to better explore what nurse managers can do to deal with day-to-day incivility spirals within units (Taşkaya & Aksoy, 2021). Nurse managers can promote a healthy work environment to reduce nurse-to-nurse incivility from colleagues within units in hospitals by creating supportive practices of respect and appropriate behaviour, as opposed to incivility (Smith et al., 2018). Therefore, daily social support from colleagues and managers within the same units offered during the workday might be a crucial job resource that helps hospital nurses reduce the negative effects of day-to-day incivility spirals (Liu et al., 2021). However, these daily relationships remain unknown.

Although no diary studies use ESM to explore the effects of daily social support on nurses' wellbeing, this topic is awakening interest in researchers. In fact, the study conducted by Blanco-Donoso et al. (2015) revealed that day-level emotional demands at work had a direct relationship with nurses' vigour at work and their vitality at home. Therefore, nurse managers that promote social support practices within the workgroup might have direct benefits on hospital nurses' wellbeing. Based on this concept, our diary study explores the direct effects of daily social support from colleagues and managers during the workday as a predictor of the level of hospital nurses' emotional exhaustion after work and daily vitality and daily positive affect at bedtime. Thus, we propose the following hypothesis.

> **Hypothesis 2.** Daily social support during the workday will be negatively related to (H2a) daily emotional exhaustion after work and positively related to (H2b) daily vitality at bedtime and (H2c) daily positive affect at bedtime.

In addition, the literature considers daily social support during the workday as a job resource that might limit the impact of daily experienced incivility by acting as a moderator that buffers the negative effects of daily hospital nurses' experiences of incivility (Pow et al., 2017). Thus, daily social support from colleagues and managers during the workday might moderate the relationship between daily experienced incivility during the workday and daily emotional exhaustion after work and daily vitality and daily positive affect at bedtime. This moderating role might buffer the negative effect of daily experienced incivility during the workday in two ways: (1) reducing hospital nurses'

daily emotional exhaustion after work and (2) increasing hospital nurses' daily vitality and daily positive affect at bedtime. Therefore, we propose the following hypothesis.

> **Hypothesis 3.** Hospital nurses with higher levels of daily social support during the workday will show lower levels of daily emotional exhaustion after work on days when they experience more workplace incivility at work (buffering effect) as opposed to lower levels of daily social support during the workday.

> **Hypothesis 4.** Hospital nurses with higher levels of daily social support during the workday will show higher levels of (H4a) daily vitality at bedtime and (H4b) daily positive affect at bedtime on days when they experience more workplace incivility at work (buffering effects) as opposed to lower levels of daily social support during the workday.

Based on the conceptual framework by Andersson and Pearson (1999), the incivility spiral refers to a process in which incivility can cycle and potentially escalate into increasingly intense because a target reacts with negative affect and desire for reciprocity, changing from victim to instigator. Thus, the day-to-day nurse incivility spirals experienced during the workday might affect nurses' wellbeing by increasing daily emotional exhaustion after work and reducing daily vitality and daily positive affect at bedtime. In addition, these incivility spirals can break the healthy environment within units. Therefore, the daily supportive role of nurse managers interrupting incivility spirals within their units might be essential. The present diary study addresses these gaps and, using ESM, aims to test the adverse effects of daily experienced incivility and the positive role of daily social support during the workday in predicting daily emotional exhaustion after work and daily vitality and daily positive affect at bedtime among hospital nurses over five consecutive workdays, controlling gender and age—similar to previous studies (Blanco-Donoso et al., 2019) (see Figure 1).

2 | METHOD

2.1 | Participants

Based on methodological recommendations for diary designs and ESM, we estimated a sample size near hundred participants who focused on predictors at the person level and 5 days repeated measures per participant that focused on predictors at the day level (Ohly et al., 2010; Scherbaum & Ferreter, 2009). We retained data for participants who provided full daily data for all five workdays to assure that the momentary assessments are representative of participants' individual experiences and are not biased towards days with extreme experiences (Gunthert & Wenze, 2012). Furthermore, we performed a power analysis for the sample size calculation and found that 384 or more measurements are needed to have a confidence level of 95%, resulting in a final sample of 96 participants who provided 480 diary observations (96 participants at Level 2, person level × 5 diary observations at Level 1, day level, which is higher than the needed sample size). Most of the participants were females (87.5%) and had a mean age of 39.28 years ($SD = 12.87$). Participants first completed the general questionnaire to estimate the baseline (Level 2, person level) and then the diary questionnaires to estimate the daily fluctuations

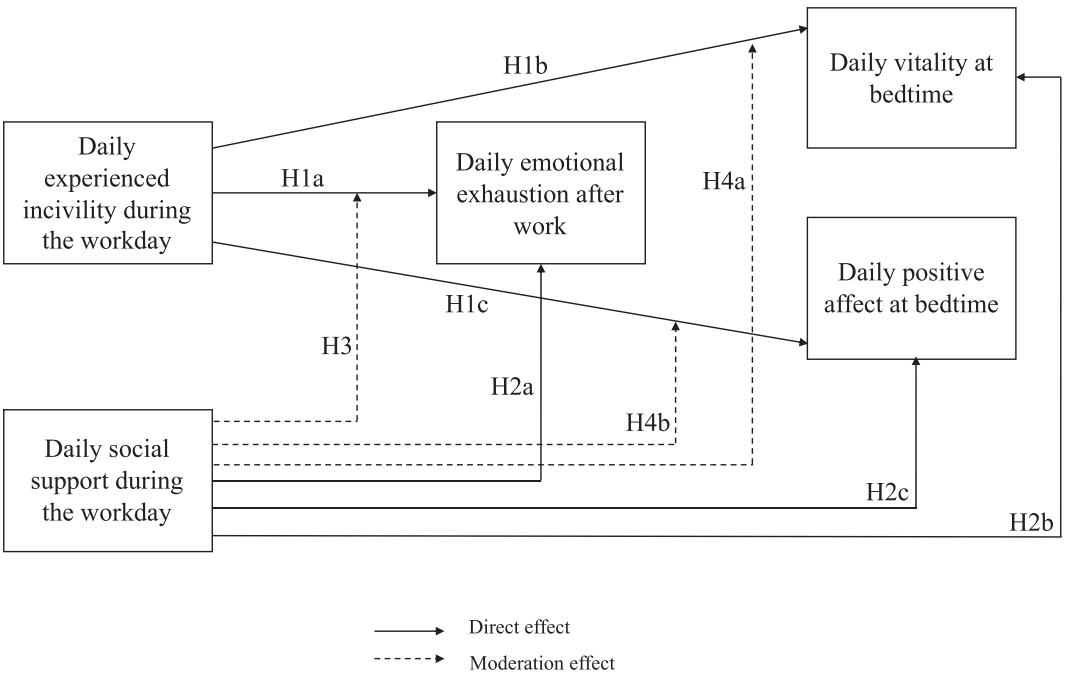

FIGURE 1 Research day-level model. *Note*: The gender and age of the hospital nurses were controlled

(Level 1, day level) over five consecutive workdays two times per day (immediately after work and at bedtime).

2.2 | Data collection procedure

Participants were recruited from hospitals in southern Spain by approaching researchers to their work units and using the snowball sampling technique of nurse-to-nurse data collection. All participants had the following inclusion criteria: (a) to be working with a schedule of five consecutive days during a working week to ensure they could fill in diary questionnaires and (b) to have more than 6 months of professional experience to guarantee that they were professionals instead of practitioners. After they expressed their willingness to voluntarily participate in the study, researchers gave them an envelope containing (a) a letter describing the objective of the study, instructions about the completion of the surveys, and a code to preserve anonymity; (b) two letters of the informed consent form (i.e., researchers' and participants' copies); and (c) general and diary paper-based questionnaires, and explained these contents. The Ethics Committee in Human Research (CEIH) of the University of Jaén approved this study (Number: NOV.17/2.PROY).

2.3 | Measures

Both general and diary questionnaires included the same measures to collect data and the same answer categories. Daily measures of predictor (i.e., daily experienced incivility and daily social support during the workday) and criterion variables (i.e., daily emotional exhaustion after work and daily vitality and daily positive affect at bedtime) were modified from the corresponding general scale to the specific diary moments (Ohly et al., 2010). At the day level (Level 1), daily experienced incivility and daily social support during the workday were assessed after work—immediately on leaving work—and referred to that specific workday. Daily emotional exhaustion was measured immediately after work on leaving work, and daily vitality and daily positive affect were reported at bedtime. At the person level (Level 2), we assessed gender, age and a person's general level of criterion variables (Blanco-Donoso et al., 2015).

2.3.1 | Daily experienced incivility during the workday

We used the Workplace Incivility Scale (Cortina et al., 2001) to measure daily fluctuations in the frequency that participants had experienced uncivil behaviours in their job. The scale consists of seven items with a five-point Likert scale, ranging from 1 (*never*) to 5 (*most of the time*). Sample items include 'Today, during my work, my supervisor or coworkers paid little attention to my statement or showed little interest in my opinion'. Cronbach's alpha ranged from .87 to .92 for the daily measure in this study.

2.3.2 | Daily social support during the workday

These were assessed with six items from the Job Content Questionnaire (Karasek et al., 1998) to measure the daily frequency of coworking with three items (i.e., 'Today, at work the people I work with collaborated to get the job done') and another three items to evaluate supervisor support at workday (i.e., 'Today, at work my supervisor got people to work as a team'). Items were rated on a 4-point scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). Cronbach's alpha ranged from .84 to .88 for the daily measure in this study.

2.3.3 | Daily emotional exhaustion after work

This was assessed using four items from the subscale of emotional exhaustion of the Nursing Burnout Scale (NBS; Moreno-Jiménez et al., 2000). Items were rated on a 4-point scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). Participants indicated the degree to which they felt daily exhaustion. An example item is 'At this moment, after my workday in nursing, I feel emotionally drained from my work'. Cronbach's alpha for the general measure was .87 and ranged from .87 to .89 for the daily measure in this study.

2.3.4 | Daily vitality at bedtime

We used four items of the vitality subscale of the Spanish adaptation of Ryff's Psychological WellBeing Scales (Ryff, 1989) by Díaz et al. (2006). This subscale assessed the degree to which participants felt physically and mentally energetic. Items were rated on a 6-point scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). Daily vitality was modified such that the items referred to the present moment at bedtime (i.e., 'At this moment, I feel alive and vital'). Cronbach's alpha for the general measure was .89 and ranged from .91 to .94 for the daily measure in this study.

2.3.5 | Daily positive affect at bedtime

We measured positive affect with five items of the short version of the Positive and Negative Affect Schedule (PANAS; Mackinnon et al., 1999; Spanish version by Robles & Páez, 2003). This scale is based on Watson et al. (1988) and assesses the degree to which participants felt positively. Items were rated on a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). An example item is 'At this moment, I feel inspired'. Cronbach's alpha for the general measure was .86 and ranged from .92 to .97 for the daily measure in this study.

2.4 | Strategy of analyses

We conducted multilevel hierarchical analyses for each criterion variable (Nezlek, 2012). A hierarchical linear modelling approach was used

to test our four hypotheses because the collected data simultaneously included variables from two levels: days (Level 1, day level; $N = 480$ diary observations) nested within persons (Level 2, person level; $N = 96$ participants). Variables evaluated at the day level (Level 1) consisted of 5-day repeated measures using ESM to examine within-person processes. Variables evaluated at the person level (Level 2) consisted of measurement of the general level that examines between-person variations (Hox, 2010). We conducted main effects to test the direct effects of daily experienced incivility during the workday (Hypothesis 1) and daily social support during the workday (Hypothesis 2) on criterion variables and interaction effects to test the moderating role of daily social support during the workday on the relationships between daily experienced incivility during the workday and daily emotional exhaustion after work, daily vitality at bedtime and daily positive affect at bedtime (Hypotheses 3 and 4). To analyse the two-level data set, we used MLwiN Version 2.28 software.

Based on Ohly et al. (2010), we centred the predictor (daily experienced incivility and daily social support during the workday) and outcome variables (daily emotional exhaustion after work, daily vitality and daily positive affect at bedtime) at the day level (Level 1) using the person-mean centring method. The person-mean considers the mean score across days for each participant and is the only appropriate method for the interpretation of within-person effects. We centred the control variables (gender, age and a person's general level of criterion variables) at the person level of Level 2 at the grand-mean centring method, which considers the mean scores of all of the participants. This procedure allows all of the variance between subjects to be eliminated to ensure that it does not influence the interpretation of the results.

3 | RESULTS

3.1 | Descriptive and preliminary analyses

Before testing our hypotheses, we presented in Table 1 the sociodemographic and occupational characteristics of the participants. Moreover, we estimated the intraclass correlation (ICC) coefficient to examine the total variance at the day level (within-person variation). All criterion variables showed coefficients higher than 25%. The results showed that 29.2% of the variance in daily emotional exhaustion after work, 32.3% in daily vitality at bedtime, and 32.9% in daily positive affect at bedtime can be attributed to within-person variation across the 5 days, which supports the usage of multilevel analysis (Fisher & To, 2012). Table 2 displays the means, standard deviations, Cronbach's

TABLE 1 Sociodemographic and occupational characteristics of the study population ($N = 96$ hospital nurses)

		N	Percentage
Gender	Male	12	12.5
	Female	84	87.5
Age (years)	21–30	37	38.5
	31–40	17	17.7
	41–50	17	17.7
	51–60	21	21.9
	>61	4	4.2
Partner	Married or living with partner	77	80.2
	Single	15	15.6
	Divorced	3	3.1
	Widowed	1	1.0
Children (number)	None	44	45.8
	1	11	11.5
	2	34	35.4
	3	6	6.3
	4	1	1.0
Education	Degree	65	67.7
	Master	31	32.3
Professional experience in the position (years)	≤5	50	52.1
	6–10	8	8.3
	11–15	11	11.5
	16–20	10	10.4
	21–25	4	4.2
	>26	13	13.5

Note: Numbers are representative of Spanish figures.

alphas and bivariate correlations. All correlations between the general and day-level criterion variables were significant, supporting the use of a hierarchical linear modelling approach (Hox, 2010).

3.2 | Hypothesis testing

We conducted four multilevel models predicting daily emotional exhaustion after work (Table 3), daily vitality at bedtime (Table 4) and daily positive affect at bedtime (Table 5) as outcome variables. In Model 1, we entered the control variables (i.e., gender, age and the outcome general level). In Model 2, we entered the main effect of daily experienced incivility during the workday as a predictor variable to test H1a, H1b and H1c. In Model 3, we entered the main effect of daily social support during the workday as a predictor variable to test H2a, H2b and H2c. In Model 4, we entered the interaction term to test H4a and H4b. For the significant moderating effect, we calculated simple slope tests to examine the pattern of the interaction (Preacher et al., 2006).

As a measure of effect size, following the recommendations from Singer et al. (2003), we computed pseudo-R^2. This statistic is used to quantify the incremental variance in the criterion variable that is predicted by adding a new set of predictors to a given model. In our study, all predictor and control variables entered in the models predicting emotional exhaustion after work explained 72.5% of the variance at Level 1 [.181 − (.164/.181) = −.725] and 18.9% of the variance at Level 2 [.435 − (.107/.435) = .189]. All predictor and control variables entered in the models predicting daily vitality at bedtime explained 34.2% of the variance at Level 1 [.575 − (.527/.575) = −.342] and 63.4% of the variance at Level 2 [1.203 − (.684/1.203) = .634]. Finally, all predictor and control variables entered in the models predicting daily positive affect at bedtime explained 48.4% of the variance at Level 1 [.444 − (.412/.444) = −.484] and .4% of the variance at Level 2 [.907 − (.819/.907) = .004].

Regarding Hypothesis 1, hospital nurses' daily experienced incivility during the workday was significant and positively related to emotional exhaustion after work ($\beta = .20$, $SE = .07$, $t = 3.00$, $p < .05$) (H1a) and negatively related to daily vitality at bedtime ($\beta = -.29$, $SE = .12$, $t = -2.48$, $p < .05$) (H1b) and daily positive affect at bedtime ($\beta = -.23$, $SE = .10$, $t = -2.23$, $p < .05$) (H1c). As seen in Model 2 of Tables 3, 4 and 5, the results of computing the differences of their log likelihood statistic of −2 X Log showed that all models significantly improved over the previous one. Therefore, the results systematically supported the main effects of daily experienced incivility during the workday on all outcome variables. Figure 2 shows the multilevel results of the study.

Regarding Hypothesis 2, the results supported H2a, H2b and H2c. Daily social support during the workday was significant and negatively related to emotional exhaustion after work ($\beta = -.31$, $SE = .06$, $t = -5.28$, $p < .01$) (H2a) and positively related to daily vitality at bedtime ($\beta = .54$, $SE = .10$, $t = 5.19$, $p < .01$) (H2b) and daily positive affect at bedtime ($\beta = .45$, $SE = .09$, $t = 4.89$, $p < .01$) (H2c). Moreover, Model 3 showed the best model fit in predicting all criterion variables (see the difference of −2 X Log of Model 3 in Tables 3–5). As predicted, the results systematically supported the main effects of daily social support during the workday on all outcome variables.

Furthermore, the results supported Hypothesis 3. As seen in Model 4 of Table 2, there was a significant interaction between daily experienced incivility during the workday and daily social support during the workday ($\beta = -.28$, $SE = .12$, $t = -2.33$, $p < .05$) in predicting emotional exhaustion after work (see Figure 3). Simple slope tests showed that hospital nurses with higher levels of daily social support during the workday showed lower levels of emotional exhaustion after work on

TABLE 2 Means, standard deviations, Cronbach's alphas and bivariate correlations ($N = 96$ hospital nurses; $N = 480$ diary observations)

	M	DT	α	1	2	3	4	5	6	7	8
1. General emotional exhaustion[a]	2.06	.72	.87	–							
2. General vitality[a]	4.36	1.07	.89	−.32**	–						
3. General positive affect[a]	4.29	.60	.86	−.44**	.46**	–					
4. Daily experienced incivility during the workday[b]	1.27	.50	.87–.92 (.90)	.32**	−.16**	−.19**	–				
5. Daily social support during the workday[b]	3.20	.63	.84–.88 (.85)	−.33**	.35**	.31**	−.48**	–			
6. Daily emotional exhaustion after work[b]	2.11	.79	.87–.89 (.88)	.73**	−.28**	−.30**	.35**	−.38**	–		
7. Daily vitality at bedtime[b]	3.22	1.33	.91–.94 (.93)	−.25**	.54**	.26**	−.10*	.34**	−.34**	–	
8. Daily positive affect at bedtime[b]	2.74	1.16	.92–.97 (.95)	−.23**	.40**	.24**	−.1	.31**	−.32**	.74**	–

Note: Daily experienced incivility during the workday and daily social support during the workday were assessed immediately upon leaving work, referred to the present workday. Daily emotional exhaustion was measured after work immediately upon leaving work, and daily vitality and daily positive affect were reported at bedtime. α = Cronbach's alpha. For diary measures, mean between 5 days (in parentheses) and range is displayed.

[a]Level 2, person-level variables.

[b]Level 1, day-level variables.

*$p < .05$. **$p < .01$.

TABLE 3 Multilevel estimates for models predicting daily emotional exhaustion after work ($N = 96$ hospital nurses; $N = 480$ diary observations)

	Null model			Model 1			Model 2			Model 3			Model 4		
Variables	**Estimate**	**SE**	**t**	**Estimate**	**SE**	**t**	**Estimate**	**SE**	**t**	**Estimate**	**SE**	**t**	**Estimate**	**SE**	**t**
Intercept	2.11	.07	3.17	2.16	.06	37.17	2.16	.06	37.17	2.16	.06	37.17	2.15	.06	37.10
Gender[a]				−.08	.08	−1.00	−.08	.08	−1.00	−.08	.08	−1.00	−.09	.08	−1.10
Age[a]				−.00	.00	.00	−.00	.00	.00	−.00	.00	.00	.00	.00	.00
General emotional exhaustion[a]				.79	.06	14.38***	.79	.06	14.38***	.79	.06	14.38***	.79	.06	14.35***
Daily experienced incivility during the workday[b]							.20	.07	3.00*	.10	.07	1.44	.04	.07	.64
Daily social support during the workday[b]										−.31	.06	−5.28**	−.27	.06	−4.43**
Daily experienced incivility during the workday × daily social support during the workday[b]													−.28	.12	−2.33*
−2 X Log(lh)	788.94			673.80			664.88			638.00			632.58		
Difference of −2 X Log				115.14			8.92			26.89			5.42		
df				3***			1**			1***			1*		
Level 1 intercept variance (SE)	.18 (.01)			.18 (.01)			.18 (.01)			.17 (.01)			.16 (.01)		
Level 2 intercept variance (SE)	.44 (.07)			.11 (.02)			.11 (.02)			.11 (.02)			.11 (.02)		

Note: Daily experienced incivility during the workday and daily social support during the workday were assessed immediately upon leaving work, referred to the present workday. Daily emotional exhaustion was measured after work immediately upon leaving work, and daily vitality and daily positive affect were reported at bedtime. Gender is coded as 1 = male nurse, 2 = female nurse.

[a]Person-level variables.

[b]Day-level variables.

*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 4 Multilevel estimates for models predicting daily vitality at bedtime ($N = 96$ hospital nurses; $N = 480$ diary observations)

	Null model			Model 1			Model 2			Model 3			Model 4		
Variables	**Estimate**	**SE**	**t**	**Estimate**	**SE**	**t**	**Estimate**	**SE**	**t**	**Estimate**	**SE**	**t**	**Estimate**	**SE**	**t**
Intercept	3.22	.12	27.53	3.26	.14	23.64	3.26	.14	23.64	3.26	.14	23.64	3.27	.14	23.85
Gender[a]				−.08	.20	−.40	−.08	.20	−.40	−.08	.20	−.40	−.07	.19	−.35
Age[a]				.00	.01	.43	.00	.01	.43	.00	.01	.43	.00	.01	.43
General vitality[a]				.68	.09	7.64**	.68	.09	7.64**	.68	.09	7.64***	.69	.09	7.82***
Daily experienced incivility during the workday[b]							−.29	.12	−2.48*	−.11	.12	−.95	−.04	.12	−.35
Daily social support during the workday[b]										.54	.10	5.19**	.49	.11	4.51**
Daily experienced incivility during the workday x daily social support during the workday[b]													.38	.23	1.69
−2 X Log(lh)	133.74			1283.43			1277.30			1251.07			1248.23		
Difference of −2 X Log				47.32			6.12			26.23			2.85		
df				3***			1*			1***			1		
Level 1 intercept variance (SE)	.58 (.04)			.58 (.04)			.57 (.04)			.53 (.04)			.53 (.04)		
Level 2 intercept variance (SE)	1.20 (.19)			.69 (.12)			.69 (.18)			.70 (.12)			.68 (.11)		

Note: Daily experienced incivility during the workday and daily social support during the workday were assessed immediately upon leaving work, referred to the present workday. Daily emotional exhaustion was measured after work immediately upon leaving work, and daily vitality and daily positive affect were reported at bedtime. Gender is coded as 1 = male nurse, 2 = female nurse.

[a]Person-level variables.

[b]Day-level variables.

*$p < .05$. **$p < .01$. ***$p < .001$.

TABLE 5 Multilevel estimates for models predicting daily positive affect at bedtime ($N = 96$ hospital nurses; $N = 480$ diary observations)

	Null model			Model 1			Model 2			Model 3			Model 4		
Variables	**Estimate**	**SE**	**t**	**Estimate**	**SE**	**t**	**Estimate**	**SE**	**t**	**Estimate**	**SE**	**t**	**Estimate**	**S**	**t**
Intercept	2.74	.10	26.85	2.68	.15	18.24	2.68	.15	18.24	2.68	.15	18.24	2.58	.15	17.57
Gender[a]				.11	.21	.52	.11	.21	.52	.11	.21	.52	.11	.21	.53
Age[a]				−.01	.01	−1.00	−.01	.01	−1.00	−.01	.01	−1.00	−.01	.01	−1.13
General positive affect[a]				.45	.16	2.75*	.45	.16	2.75*	.45	.16	2.75*	.45	.16	2.75*
Daily experienced incivility during the workday[b]							−.23	.10	−2.23*	−.08	.10	−.76	−.06	.110	−.58
Daily social support during the workday[b]										.45	.09	4.89**	.44	.10	4.56**
Daily experienced incivility during the workday × daily social support during the workday[b]													.09	.20	.43
−2 X Log(lh)	1204.54			1195.04			119.14			1166.74			1166.55		
Difference of −2 X Log				9.50			4.90			23.40			.18		
df				3*			1*			1***			1		
Level 1 intercept variance (SE)	.44 (.03)			.44 (.03)			.44 (.03)			.41 (.03)			.41 (.03)		
Level 2 intercept variance (SE)	.91 (.14)			.81 (.13)			.82 (.13)			.82 (.13)			.82 (.13)		

Note: Daily experienced incivility during the workday and daily social support during the workday were assessed immediately upon leaving work, referred to the present workday. Daily emotional exhaustion was measured after work immediately upon leaving work, and daily vitality and daily positive affect were reported at bedtime. Gender is coded as 1 = male nurse, 2 = female nurse.

[a]Person-level variables.

[b]Day-level variables.

*$p < .05$. **$p < .01$. ***$p < .001$.

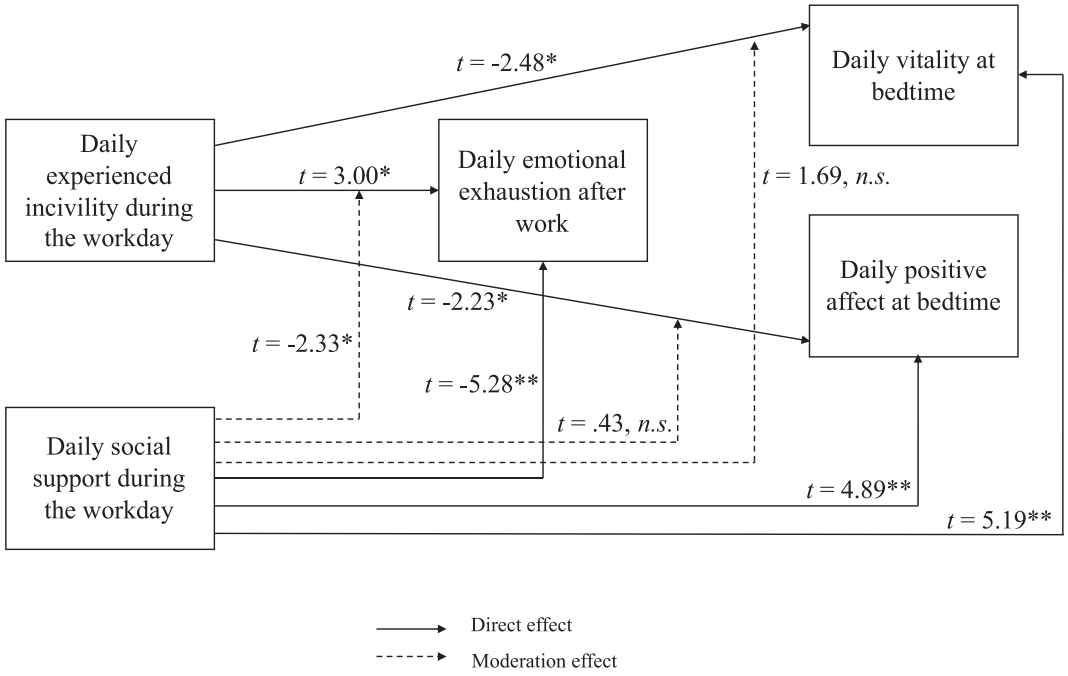

FIGURE 2 Results of the multilevel hierarchical analyses. *Note*: The gender and age of the hospital nurses were controlled. *$p < .05$. **$p < .01$. *n.s.*, not significant

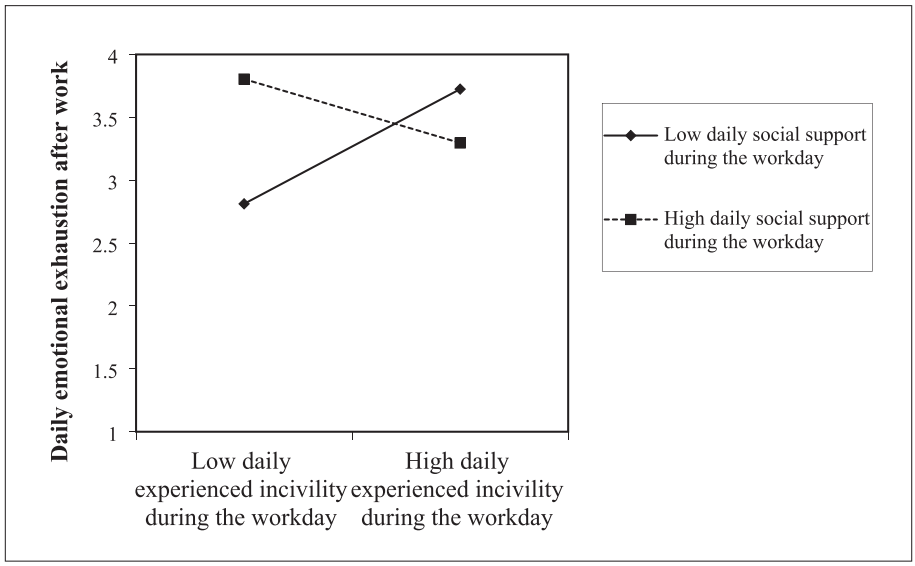

FIGURE 3 Interaction effects of daily experienced incivility during the workday and daily social support during the workday in predicting daily emotional exhaustion after work

days when they experienced more workplace incivility at work ($\gamma = -1.09$, $SE = .50$, $z = 2.18$, $p < .05$), as opposed to lower levels of daily social support during the workday ($\gamma = -.43$, $SE = .23$, $z = -1.87$, *n.s.*). Therefore, daily social support during the workday buffered the negative effect of daily experienced incivility during the workday by reducing hospital nurses' daily emotional exhaustion after work.

The results did not support Hypothesis 4. No significant interactions occurred between daily experienced incivility during the workday and daily social support during the workday in predicting daily vitality at bedtime ($\beta = .38$, $SE = .23$, $t = 1.69$, *n.s.*) and daily positive affect at bedtime ($\beta = .09$, $SE = .20$, $t = .43$, *n.s.*). Therefore, daily social support during the workday did not buffer the negative effect of daily experienced incivility during the workday by increasing hospital nurses' daily vitality at bedtime (H4a) and daily positive affect at bedtime (H4b).

4 | DISCUSSION

In this diary study, hospital nurses' daily experiences of incivility seriously impacted nurses' wellbeing, whereas daily social support from

colleagues and managers during the workday reduced the impact of this negative effect. Nurse incivility increases daily emotional exhaustion after work and reduces daily vitality and daily positive affect at bedtime. In contrast, daily social support as a supportive job resource during the workday directly promotes the opposite daily processes. The implications of these findings show that daily social support is central to reducing the day-to-day incivility spirals on hospital nurses, which is especially important for nurse managers who can install supportive daily practices within the risk groups in hospital nurse units.

Under the spiralling effect of incivility in the workplace (Andersson & Pearson, 1999), this study highlights the negative impact at the individual hospital nurse level on a day-to-day basis, fostering detrimental consequences for hospital nurses' wellbeing during the off-job time. Our results show that daily experiences of incivility are present in hospital nurses, which installs a climate of nurse-to-nurse disrespectful interactions. According to the framework of Andersson and Pearson (1999), our study revealed that this interpersonal process, which occurs day-to-day, not only impacts hospital nurses' wellbeing (i.e., increasing daily emotional exhaustion after work and reducing daily vitality and daily positive affect at bedtime) but also affects the culture of the unit, fostering a toxic dynamic of relationships within the workgroups. Considering the high prevalence of workplace incivility among nurses (Taşkaya & Aksoy, 2021), our results support previous evidence of similar diary studies and remark on the necessity to better acknowledge its theoretical interpersonal mechanisms in nursing (Blanco-Donoso et al., 2019; Campana & Hammoud, 2015; Zhou et al., 2019).

This diary study highlights the importance of negative interactions among hospital nurses. From the point of view of interpersonal relationships, our study systematically showed that daily social support emerged as a key job resource within the nursing health care context. Specifically, multilevel results showed that direct effects through daily social support during the workday were negatively related to daily emotional exhaustion after work and positively related to daily vitality and daily positive affect at bedtime. Using an ESM, our findings support evidence about the direct benefits of social support, which is a potential job resource in reducing nurses' stress and burnout and fostering nurses' positive affect (Liu et al., 2021). The present research also demonstrates that the contribution of social support during the workday is even clear at the day level, supporting its beneficial effects on nurses' functioning and wellbeing.

A major contribution of this research is the protective role that daily social support plays for hospital nurses' emotional exhaustion. The literature has well documented the protective role of social support for individuals (Lopez-Zafra et al., 2019). Our study goes much further by analysing the moderating role of daily social support during the workday among hospital nurses and found that a buffering effect through the negative effect of daily experienced incivility during the workday reduced daily emotional exhaustion after work when hospital nurses experience high levels of daily social support during the workday. From the framework of Andersson and Pearson (1999), this result suggests that daily social support from colleagues and managers can be a significant element of the tipping point of the spiral, acting as an inhibitor instead of facilitating nurse-to-nurse workplace incivility.

4.1 | Limitations and future research

Despite the contributions of the present study, it has several limitations. The first limitation stems from the self-report measures. Second, nurses were recruited from several hospitals via snowball sampling; however, other sampling techniques could be used to render sociodemographic characteristics uniform in future research. Moreover, it could be interesting to explore each hospital separately or even to test differences between centres to determine whether differences exist among their nurses. Future studies could further test whether multilevel mediation of daily social support during the workday exists for predicting outcome variables. However, future studies could also examine the direct effects of daily emotional exhaustion after work on daily vitality and daily positive affect at bedtime and test the mediation and moderation of daily emotional exhaustion after work on hospital nurses' wellbeing at bedtime at home. Including these recommendations in future studies could provide a better understanding of the daily spiral of nurse incivility.

5 | CONCLUSIONS

Our study enhances both the theoretical and practical contributions to the current literature about nurse incivility. The within-person approach of our findings reveals temporal dynamics by means of hospital nurses who experience incivility during the workday reporting higher levels of emotional exhaustion after work, as well as a decrease in their levels of daily vitality and daily positive affect at bedtime. Daily social support that colleagues and managers of the units offer to hospital nurses suffering from incivility reduces its negative consequences on their levels of wellbeing. This study showed the benefits of the within-person approach through the usage of diary designs and ESM. This methodology allows researchers to capture day-to-day nurses' processes of interpersonal relationships that occur during the workday and to explore how these workplace processes impact their individual level of day-to-day wellbeing. Working in civilized and supportive environments improves their wellbeing-related daily outcomes.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

Nursing always faces challenges in a socially changing context. Given the multiple demands that nurses must face in their daily practice, hospitals can only provide efficient patient quality and safety when they consider the nurses' day-to-day incivility experiences, implying needed changes from a systems perspective.

By turning a work environment into a healthy workplace, nurse managers play a crucial role in the creation and maintenance of civil behaviour and good practices of interpersonal mistreatment nurses' professionals (Smith et al., 2018). Nurse managers who play a leadership role within their units can reduce incivility that occurs day-to-day by providing social support for nurses. Our findings show that daily social support during the workday is a powerful job resource that might limit the negative impact of daily experienced incivility. Additionally, training programmes at work and in service should educate nurses in civil behaviours at work. To date, the evidence suggests the use of a combination of educational training about workplace incivility, training on effective responses to uncivil workplace behaviours and active learning activities to practice newly learned communication skills to assist nurses in improving their ability to manage incivility in the workplace (Armstrong, 2018).

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICS STATEMENT

The Ethics Committee in Human Research (CEIH) by the University of Jaén approved this study (Ethical Approval Number: NOV.17/2. PROY).

DATA AVAILABILITY STATEMENT

The data presented in this study are available on request from the corresponding author.

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ORIGINAL ARTICLE

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Nurse-to-nurse horizontal violence in Chinese hospitals and the protective role of head nurse's caring and nurses' group behaviour on it: A cross-sectional study

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Abstract

Aims: This study aimed to analyse the prevalence of nurse-to-nurse horizontal violence in Chinese hospitals and examine the effects of head nurse's caring and nurse's group behaviour on horizontal violence.

Background: Horizontal violence is a serious global problem affecting the nursing profession, but little is known of the issue in Chinese hospitals. Increasing evidence has showed that leadership and group factors are important in facilitating horizontal violence. Whether the head nurse's caring and group behaviour perceived by nurses has protective effects against horizontal violence remains unclear.

Methods: A cross-sectional online-based questionnaire study was performed in seven general hospitals in Hubei Province, China. Data related to the demographic information, horizontal violence, head nurse's caring and group behaviour were collected. Descriptive analyses, chi-squared tests and logistic regression were used for data analysis.

Results: In total, 1942 valid questionnaires were collected, with a 92.70% effective response rate (1942/2095). Of those, 59.1% (1148/1942) of respondents had experienced horizontal violence at least once in the previous 6 months. Covert negative behaviours were more frequently reported. Compared with the low level, moderate and high levels of the head nurse's caring showed a lower risk of horizontal violence (odds ratio [OR] = 0.400, $p < .001$; OR = 0.128, $p < .001$); moderate and high levels of group behaviour also showed a reduced risk (OR = 0.601, $p < .001$; OR = 0.221, $p < .001$).

Conclusion: Horizontal violence is common among Chinese nurses. The head nurse's caring and maintaining a good climate of nurses' group behaviours could serve as protective factors for preventing horizontal violence.

Implications for Nursing Management: This study helps nursing managers identify which specific negative behaviours occur frequently and require special attention. It suggests that nursing managers attach importance to improving their caring ability towards nurses and to creating an amicable climate of group behaviour to buffer against horizontal violence.

KEYWORDS
caring, group behaviour, head nurse, horizontal violence, nursing staff, hospital

1 | INTRODUCTION

Horizontal violence (HV), a kind of interpersonal conflict, is a serious global problem in the nursing profession (Blair, 2013; Doo & Kim, 2020; Rosi et al., 2020). It affects all areas of nursing: For the victims, HV can result in low self-esteem, depression, self-hatred and feelings of powerlessness and even cause physical health problems; for the health care organizations, HV leads to impaired personal relationships and lack of cooperation, toxic working environments, poor patient outcomes, increased turnover and financial damage; and for society, HV reduces the attractiveness of nursing profession and intensifies the shortage of nursing human resources, especially in the context of global aging (Embree & White, 2010; Pien et al., 2019; Woelfle & McCaffrey, 2007). Therefore, it is worth exploring any solutions to HV.

Nursing scholars, mainly in Western countries, have examined the incidence of HV among nurses based on its definition, prevalence, causes and strategies to combat it; however, there is little known internationally of HV in Chinese hospitals. Prior studies have identified variations of negative behaviours in workplace in different cultural contexts (Karatuna et al., 2020; Terzioglu et al., 2016). There are nine major cultural clusters (Confucian Asia, Southern Asia, Middle East, Anglo, Latin Europe, Eastern Europe, Nordic Europe, Latin America and Sub-Saharan Africa) in the world (Karatuna et al., 2020). Confucian culture originated in China and deeply influenced the Chinese people. Chinese working culture emphasizes collectivism, cooperation, protecting face and performance orientation and promotes the ideas of Confucian benevolence, which may lead to HV in the Chinese cultural context having different characteristics from those of other countries (Cheng et al., 2017; Karatuna et al., 2020; Leong & Crossman, 2016). Thus, conducting a well-designed survey on HV in Chinese hospitals will contribute to the worldwide understanding of this problem.

Another research issue that is not yet clear but worth exploring is the role of head nurse's caring and nurses' group behaviours on HV. It is well known that the head nurse and nursing colleagues are the long-term colleagues of every staff nurse in the workplace. Wilmot and Hocker (2017) found that intrapersonal perceptions were the foundation for conflicts such as HV. Whether the degree of caring by the head nurse and group behaviour of other nurses could serve as the protective factors against HV remains unclear. Clarification of this issue will assist in combating HV and is of great significance.

2 | BACKGROUND

HV refers to any hostile, aggressive and harmful behaviour by a nurse or a group of nurses towards a co-worker or group of nurses via displaying negative attitudes, actions, words and/or other behaviours at the same hierarchical levels in an organisation (Embree & White, 2010; Longo & Newman, 2014; Taylor, 2016). Woelfle and McCaffrey (2007, p. 126) defined HV as 'interpersonal conflict' among nurses. This term is often used interchangeably with bullying in the nursing literature, but there are subtle differences in the meaning. Bullying is described as being more deliberate and repetitive and can occur across a power gradient, whereas in HV, it has been emphasized that the violence occurs among the workers at the same status and HV is not required to be repeated over time (Longo & Newman, 2014; Vessey et al., 2009). In this study, we focus on HV.

Diverse sources have shown that the prevalence of nurse-to-nurse HV varies across different areas. In the United States, the prevalence of nurse-to-nurse HV ranged from 25.3% to as high as 87.4% (Dunn, 2003; Sellers et al., 2012). One survey in New Zealand revealed that over 50% of the staff nurses in their first practising year recognized that they were undervalued by other nurses (McKenna et al., 2003). Morrison et al. (2017), in Jamaica, found that 96% of registered nurses had been exposed to HV, and three quarters rated the exposure as moderate to severe. Ayakdaş and Arslantaş (2018), in Turkey, reported that 47% of nurses had suffered HV. Bambi et al. (2014), in Italy, found that 79.1% of nurses had experienced some form of HV at least once, whereas 22.4% experienced HV at least weekly. A survey performed in Spain showed that 74.2% of nurses had experienced HV at least once in the previous 6 months (Topa & Moriano, 2013). However, little is known about nurse-to-nurse HV in Chinese hospitals. Scholars have pointed out that the occurrence of HV in the nursing profession is related to the local

culture (Bambi et al., 2018). Chinese Confucian philosophy is a typical representative of the Eastern culture, which has a profound impact on the Chinese people. The ideas of collectivism and benevolence are highly valued by individuals and organizations in this kind of culture (Cheng et al., 2017). The question of whether nurse-to-nurse HV is less prevalent in Chinese hospital may thus be raised, together with the characteristics of HV in this context. This is a meaningful research topic worthy of exploration.

To date, there still is a global lack of systematic and effective prevention and management measures against HV. Exploring effective protective factors to prevent HV may assist in reducing its incidence. According to the Society Ecosystems Theory, human behaviour involves multiple systems (i.e., micro, mezzo and macro systems) in the social environment, in which the nurse managers and co-workers form the mezzo system (Johnson, 2011; Zastrow et al., 2017). Increasing evidence has shown that leadership and group factors play important roles in facilitating HV; that is, HV is not just a binary issue between the victim and the perpetrator (Fontes et al., 2019; Kaiser, 2017; Samsudin et al., 2020; Topa & Moriano, 2013).

In China, the head nurse is the first-line nurse manager in an individual department and directs the other nursing staff in the performance of the nursing tasks in a ward. A recent study conducted by Kaiser (2017) found that the behaviours of the nursing leader can have a significant impact on the level of negative behaviours among the nurses. Nowadays, caring has been increasingly positioned as one of the core concepts for an evolved nursing science (Watson, 2009). Some scholars have described caring as an affect, a feeling of compassion or empathy towards the recipient of care, and consider that the staff nurses' perceptions of nurse managers' caring influenced their job satisfaction and well-being (Cortis & Kendrick, 2003; Kostich et al., 2020; Turkel & Ray, 2004). To date, it is still not known whether the head nurse's caring as perceived by nurses can significantly affect the occurrence of HV.

Another important variable used in the present study was the nurse's group behaviour. Group behaviour is defined as collaboration and consensus in a group according to Stone's integrative model for organizational climate of staff working conditions (He et al., 2011; Stone et al., 2005). Nursing staff work as a group in a unit to provide the nursing care for patients. A previous study by Topa and Moriano (2013) identified that group support as a negative predictor of HV. In the same vein, researchers have underlined that work group factors create a favourable atmosphere for occurrence of HV (Blackstock et al., 2018; Crawford et al., 2019; Hutchinson et al., 2010; Topa & Moriano, 2013).

Based on this evidences, we hypothesized that the more positively nurses perceived the head nurse's caring and the nurses' group behaviour, the less HV would occur. However, as yet, there is no direct evidence to support this hypothesis. Bridging this gap will help nurse managers and policymakers recognize the importance of caring for subordinates and develop more effective approaches at the organizational level to mitigate HV. Therefore, the purpose of this study was to (a) investigate prevalence of nurse-to-nurse HV in Chinese hospitals over a 6-month period and to analyse it in terms of different demographics and (b) to examine the protective role of the head nurse's caring and nurses' group behaviour on HV from the perspective of HV victims.

3 | METHODS

3.1 | Study design

A cross-sectional online-based questionnaire study was performed from 1 January to 31 January 2021. Four tertiary general hospitals and three secondary general hospitals from Wuhan, the capital of Hubei Province, and three prefecture-level cities located in the south-east, south-west and the north of Hubei Province were selected as target hospitals using a convenience sampling method, with a total of 4500 eligible nursing staff meeting the study criteria. The study was reviewed and approved by the Ethics Committee.

3.2 | Participants

According to previous studies, the HV rate in general hospitals was 78.2% (Xie et al., 2019). The sample size was calculated using the following formula: $n = z^2_{1-\alpha/2} p(1-p)/d^2$, where n is equal to the minimum required sample size, α is equal to type I error (0.05), $z_{1-\alpha/2}$ is equal to level of confidence (1.96), p is equal to parameter for sample calculation (78.2%) and d is equal to margin of error (0.03). Based on this formula, a sample size of 728 anticipated for the study. Considering the 15% dropout rate, the final minimum sample size was 857. The inclusion criteria of the participants were as follows: registered nurses working in a hospital, who agreed to take part in the anonymous survey and who had worked in the clinical nursing unit for at least 6 months. Nurses with leadership positions (such as head nurses and nurse administrators) were excluded from the samples. An informed consent form which explained the study's purpose, risks, benefits, anonymity, voluntary participation and the right to withdraw participation was distributed to the participants before their participation.

3.3 | Data collection

The data were collected using a self-reported questionnaire via the service of Wenjuanxing (https://www.wjx.cn/). Informed consent forms and the survey link were distributed to every clinical department through WeChat and Tencent QQ group with the assistance of nursing administrators of the nursing department from the recruited hospitals. WeChat and Tencent QQ are the two most popular instant chat tools in China and are widely used in work. Each participant filled in the questionnaire through clicking the survey link or scanning the QR code. Only one questionnaire was allowed from each IP address. All questions were set as compulsory. If there was any missing item, the respondents would be reminded when he or she submitted their survey. Only when they had completed all the questions could they

submit the survey successfully. Their participation was both voluntary and anonymous.

3.4 | Measures

3.4.1 | Demographic characteristics

Data concerning gender, age, years of working experience, marital status, education, contract status, professional title, type of unit and hospital level were systematically collected.

3.4.2 | Horizontal violence

The Chinese version of the nurse-to-nurse Negative Acts Questionnaire was used. This was developed by Li (2011) based on the English version of the Negative Acts Questionnaire-Revised (Einarsen et al., 2009). The questionnaire included 19 items, containing 8 items of overt type behaviours and 11 items of covert type behaviours. It was developed to measure the exposure of nurses to HV within the previous 6 months, with the various response alternatives: '1 = *never*', '2 = *very rarely*', '3 = *almost once a month*', '4 = *almost once a week*' and '5 = *almost every day*'. The respondents were instructed to consider the behaviours of only fellow nurse co-workers and exclude the behaviour of their supervisor or nonnursing individuals (such as physicians and patients). The Chinese version of the nurse-to-nurse Negative Acts Questionnaire has been substantiated for validity and reliability, and the internal reliability of Cronbach's alpha coefficient was found to be .95 in the previous study (Li, 2011; Wang et al., 2018). Cronbach's alpha coefficient was .98 in this study.

3.4.3 | Head nurse's caring

The head nurse's caring was measured using a 36-item Chinese version of the Caring Assessment Tool-administration, which was originally developed on the basis of the American nursing population by Duffy and adapted and validated by Peng et al. (2020) for use with Chinese nurses (Watson, 2009). There were two items that were deleted from the original English version in the process of cross-cultural adaptation. The scale had three different dimensions: decision making, human respect and noncaring behaviours, which were designed to capture staff nurses' perceptions of their managers, using a 5-point Likert-type response scale (1 = *never*; 2 = *rarely*; 3 = *occasionally*; 4 = *frequently*; and 5 = *always*). The respondents were asked about the degree of caring they had perceived from the head nurses in the workplace. Ten items were intentionally worded negatively to minimize the chance of errors. The available options were reverse coded during analysis to prevent misinterpretation. The higher the score, the more the caring was perceived by nurses from head nurses. Cronbach's alpha coefficient was found to be .97 in this study. The extreme group analysis method was used to classify the level of head nurses' caring: The scores equal to and below quartile 1 were classified as 'low' levels, the scores in the range between quartile 1 and quartile 3 were classified as 'moderate' level, and scores equal to and above quartile 3 were classified as 'high' levels.

3.4.4 | Nurses' group behaviour

An eight-item subscale derived from the Nurse's Organizational Climate Scale was used to measure nurses' group behaviour. The total scale was developed by He et al. (2011) based on the theoretical framework of Stone's integrative model of health care working conditions on organizational climate and safety. The respondents indicated their agreement using a 4-point Likert-type response scale: 1 = *strongly disagree* to 4 = *strongly agree*. Higher scores indicated a better group behaviour in the organisation. Cronbach's alpha coefficient of this subscale was .95 for the present study. The level of group behaviour was categorized as 'low', 'moderate' and 'high' levels using the same way as the classification of the degree of caring of the head nurse.

3.5 | Data analysis

The data were analysed using IBM SPSS Statistics software Version 21.0 (IBM Corp., Armonk, NY, USA). According to the previous study (Xie et al., 2019), we treated the dependent variable, HV, as a binary variable (yes and no). If the respondents chose 'never' on all 19 items, that is, the score equalled 19, they were judged to be 'no, they haven't suffered HV'. If the total score was greater than 19, they were judged to be 'yes, they have suffered HV'. The demographic variables, head nurse's caring and group behaviour perceived by the nurses were treated as independent variables.

Descriptive statistics were used to analyse the demographic characteristics of the respondents, as well as the frequency and percentage of HV. A chi-squared test was conducted to test the potential association between nurses with and without HV in the terms of various demographic characteristics. Significant factors of demographic characteristics and the target variables (head nurse's caring and nurses' group behaviour) were modelled into the logistic regression analysis to estimate the effect of selected potential factors on HV. Univariate and multivariate logistic regression analyses were conducted to calculate unadjusted odds ratio (OR) and adjusted OR, respectively, by using enter method. All tests were two sided with a significance level of .05.

4 | RESULTS

4.1 | Sample demographic characteristics

Among the 4500 eligible staff nurses, a total of 2095 consented to participate in the study, resulting in an overall response rate of 46.6% (2095/4500). After double-checking the data, 153 questionnaires

were deleted because the respondents did not meet the inclusion criteria or the response was illogical. Finally, a total of 1942 respondents were included in the analyses, with a valid response rate of 92.70% (1942/2095). The respondents were aged 20–58 years (M = 30.32, SD = 6.30), and their working experience in the nursing profession ranged from 1 to 39 years (M = 8.65, SD = 6.71). Other demographic details are shown in Table 1. The result of the chi-squared test showed that there was no statistically significant difference in the demographic variables between the group that experienced HV and the group that did not experience HV, except for the different unit types ($\chi^2 = 17.070$, $p = .017$).

4.2 | Prevalence of nurse-to-nurse HV over the previous 6 months

A total of 1148 (59.1%) of respondents had experienced some form of nurse-to-nurse HV at least once during the previous 6 months, and 156 (8.0%) nurses reported being subjected to it at least weekly. The total score of respondents in this study ranged from 19 to 95 (M = 25.17, SD = 11.04). Of the 19 items, withholding information, ignoring opinions and spreading of gossip/rumours were the most frequent negative behaviours, and they were all covert behaviour. Repeated reminders of one's errors or mistakes were the most frequent overt type of negative behaviours. The specific scores for each item and the frequency ranking of each negative behaviour have been shown in Table 2.

4.3 | Predictive effect of head nurse's caring and nurses' group behaviour on HV

In this study, the total scores of the head nurse's caring ranged from 55 to 180 (M = 147.25, SD = 25.81), and nurses' group behaviour ranged from 8 to 32 (M = 27.67, SD = 4.91). Multivariate logistic regression analysis indicated a reduced risk of HV for nurses with higher levels of head nurse's caring and group behaviour (Table 3). Compared with the low level of head nurse's caring, the moderate and high levels showed a low ORs (OR = 0.400 and OR = 0.128, respectively). Compared with the low level of group behaviour, the moderate and high levels also showed lower ORs (OR = 0.601 and OR = 0.221, respectively). The findings indicate that head nurse's caring and group behaviour had moderate to strong negative association with HV and indeed played a protective role against HV. A significant chi-squared test ($\chi^2 = 533.885$, $p < .001$) and a non-significant Hosmer and Lemeshow test ($\chi^2 = 6.247$, $p = .620$) supported the model as well. Following the Nagelkerke R^2, the model explained 32.4% of the variance in exposure to HV behaviour.

5 | DISCUSSION

The current study measured the prevalence of HV over a 6-month period among staff nurses at the seven general hospitals in Hubei Province of China, involving a large sampling survey of 1942 respondents, and thus makes a significant contribution to the ever-increasing global information on HV in nursing profession. The study also examined the predictive effects of head nurse's caring and nurse's group behaviour on HV from the perspective of HV victims.

In this study, 59.1% of ($n = 1148$) nurses reported HV experience at least once, which is lower than the 74.2% who reported being subjected to HV in Spain, the 79.1% in Italy and the 87.4% in New Jersey, but higher than the 47% in Turkey and the 34% in New Zealand (Ayakdaş & Arslantaş, 2018; Bambi et al., 2014; Dunn, 2003; McKenna et al., 2003; Topa & Moriano, 2013). Meanwhile, the percentage of nurses in this study who experienced HV at least once a week was significantly lower than the finding of 22.4% among Italian nurses (Bambi et al., 2014). A possible explanation for this might be that different countries and organizations have different cultures in terms of power distance, collectivism, and performance orientation (Karatuna et al., 2020). Confucian culture attaches much importance on performance orientation, which may increase the work-related stress, thus increasing the risk of exposure to HV (Karatuna et al., 2020; Topa & Moriano, 2013). However, it also values harmony with others, and organizations in this culture have a lower power distance, which may reduce the occurrence of HV. The interplay of these impacting factors results in a moderate level of HV experienced by Chinese nurses compared with other countries. Another possible reason for this variation may be attributed to the presence of different psychological tools and threshold standards to measure HV (Bambi et al., 2018). To date, there is no uniform definition of the term HV, which leads to some differences in measurement. Further research is needed to standardize a clear operational definition and develop a unified measuring tool for HV assessment.

What is surprising is that no significant differences were found in terms of gender, age, seniority, marital status, education, contract status, professional title or hospital level between the group with HV and the group without HV in our sample. Obstetrics/gynaecology and emergency room/outpatient units had higher risks of HV compared with the medicine unit in this study. This finding is partially consistent with the review of Bambi et al. (2018) who showed that gender, age, seniority and nursing education are not related to nurse-to-nurse HV, but differs from that of Xie et al. (2019) who found that gender, marital status, professional title and seniority were associated with HV among Chinese nurses. The result further confirms that nurse-to-nurse HV has different characteristics in different organizations and regions.

This study reveals that covert type of HV behaviours was more common than overt types among Chinese nurses, which is consistent with the data reported in other similar studies (Bambi et al., 2014; McKenna et al., 2003; Xie et al., 2019). This may be related to the female-dominated nature of the nursing profession. Females are generally thought to be good at using indirectly aggressive strategies because successful indirect aggression can be very effective and it is difficult to identify the perpetrator, which could help the perpetrator to effectively avoid counter-attacks (Strandmark & Hallberg, 2007). Another possible explanation is that nurses are reluctant to have face-

TABLE 1 Demographic characteristics and variations of two groups among different characteristics ($N = 1942$)

Characteristics	*n* (%)	Group with HV ($n = 1148$)	Group without HV ($n = 794$)	χ^2	*p*
Gender					
Male	70 (3.6)	44	26	0.421	.516
Female	1872 (96.4)	1104	768		
Age (years)					
20–25	447 (23.0)	242	205	7.251	.123
26–30	760 (39.1)	454	306		
31–35	399 (20.5)	247	152		
36–40	203 (10.5)	120	83		
≥41	133 (6.9)	85	48		
Years of experience					
≤3	419 (21.6)	232	187	3.212	.201
4–10	1006 (51.8)	602	404		
≥11	517 (26.6)	314	203		
Marital status					
Unmarried	687 (35.4)	401	286	0.248	.883
Married	1215 (62.6)	723	492		
Widowed and divorced	40 (2.0)	24	16		
Education					
Secondary or advanced diploma	404 (20.8)	229	175	1.247	.280
Bachelor's degree or above	1538 (79.2)	919	619		
Contract status					
Permanent	761 (39.2)	463	298	1.544	.219
Temporary	1181 (60.8)	685	496		
Professional title					
Nurse	496 (25.5)	273	223	5.442	.066
Nurse practitioner	1031 (53.1)	616	415		
Nurse-in-charge and above	415 (21.4)	259	156		
Type of unit					
Medicine unit	546 (28.1)	310	236	17.070	.017*
Surgical unit	408 (21.0)	238	170		
Obstetrics/gynaecology	128 (6.6)	87	41		
Paediatrics	96 (4.9)	50	46		
Emergency room/outpatient unit	197 (10.2)	132	65		
Intensive care unit	174 (9.0)	108	66		
OR/PACU	146 (7.5)	91	55		
Other	247 (12.7)	132	115		
Hospital level					
Tertiary hospital	1373 (70.7)	821	552	0.901	.361
Secondary hospital	569 (29.3)	327	242		

Abbreviations: HV, horizontal violence; OR, operation room; PACU, postanaesthesia care unit.
*$p < .05$.

to-face interpersonal conflicts with their colleagues because Chinese people concerned about face-saving under the influence of Confucian culture.

Moreover, the findings indicated that head nurse's caring and a good climate of nurse's group behaviour were indeed two negative predictors of HV, which supported the hypotheses tested. These relationships may partly be explained by the cultural value that Chinese people believe in reciprocity. That is, when nurses perceive that their efforts and gains are balanced in interpersonal relationships, benign interpersonal interactions will continue, thereby reducing the

TABLE 2 The specific scores for each item and the frequency ranking of each negative behaviour ($N = 1942$)

Rank[a]	No.	Type	Item	Mean ± SD	1 *n* (%)	2 *n* (%)	3 *n* (%)	4 *n* (%)	5 *n* (%)
1	1	Covert	Other nurse withholding information that affects your performance	1.53 ± 0.78	1166 (60.0)	618 (31.8)	88 (4.5)	53 (2.7)	17 (0.9)
2	13	Covert	Having your opinions ignored	1.45 ± 0.71	1257 (64.7)	566 (29.1)	69 (3.6)	38 (2.0)	12 (0.6)
3	5	Covert	Spreading of gossip and rumours about you	1.44 ± 0.75	1299 (66.9)	517 (266)	66 (3.4)	41 (2.1)	19 (1.0)
4	11	Overt	Repeated reminders of your errors or mistakes	1.39 ± 0.71	1370 (70.5)	458 (23.6)	60 (3.1)	41 (2.1)	13 (0.7)
5	4	Covert	Having key areas of responsibility removed or replaced with more trivial or unpleasant tasks	1.39 ± 0.73	1383 (71.2)	437 (22.5)	61 (3.1)	45 (2.3)	16 (0.8)
6	3	Covert	Being ordered to do work below your level of competence	1.39 ± 0.77	1411 (72.7)	400 (20.6)	59 (3.0)	49 (2.5)	23 (1.2)
7	2	Overt	Being humiliated or ridiculed in connection with your work	1.28 ± 0.67	1442 (74.3)	380 (19.6)	62 (3.2)	38 (2.0)	2.0 (1.0)
8	6	Covert	Being ignored or excluded by other nurse	1.34 ± 0.68	1452 (74.8)	390 (20.1)	53 (2.7)	33 (1.7)	14 (0.7)
9	18	Covert	Given too much responsibility without appropriate supervision	1.32 ± 0.66	1479 (76.2)	361 (18.6)	61 (3.1)	30 (1.5)	11 (0.6)
10	14	Covert	Practical jokes carried out by other nurse you do not get along with	1.33 ± 0.70	1481 (76.5)	346 (17.8)	56 (2.9)	42 (2.2)	13 (0.7)
11	16	Covert	Pressure not to claim something to which by right you are entitled (e.g., sick leave, holiday entitlement and travel expenses)	1.33 ± 0.71	1501 (77.3)	313 (16.1)	74 (3.8)	39 (2.0)	15 (0.8)
12	8	Overt	Being shouted at or being the target of spontaneous anger	1.30 ± 0.67	1510 (77.8)	330 (17.0)	58 (3.0)	30 (1.5)	14 (0.7)
13	12	Overt	Persistent criticism of your errors or mistakes	1.28 ± 0.66	1552 (79.9)	292 (15.0)	51 (2.6)	37 (1.9)	10 (0.5)
14	7	Overt	Having insulting or offensive remarks made about your person, attitudes or your private life	1.28 ± 0.67	1563 (80.5)	280 (14.4)	49 (2.5)	36 (1.9)	14 (0.7)
15	15	Covert	Excessive monitoring of your work	1.27 ± 0.67	1570 (80.8)	271 (14.0)	54 (2.8)	33 (1.7)	14 (0.7)
16	17	Overt	Being the subject of excessive teasing and sarcasm	1.27 ± 0.65	1572 (80.9)	279 (14.4)	46 (2.4)	34 (1.8)	11 (0.6)
17	10	Covert	Hints or signals from other nurses that you should quit your job	1.20 ± 0.59	1683 (86.7)	178 (9.2)	45 (2.3)	26 (1.3)	10 (0.5)
18	19	Overt	Threats of violence or physical abuse or actual abuse such as pushing or spitting on you	1.16 ± 0.55	1747 (90.0)	123 (6.3)	38 (2.0)	25 (1.3)	9 (0.5)
19	9	Overt	Being intimidated by other nurses	1.16 ± 0.56	1749 (90.1)	120 (6.2)	34 (1.8)	31 (1.6)	8 (0.4)

Note: 1 = *never*; 2 = *very rarely*; 3 = *almost once a month*; 4 = *almost once a week*; and 5 = *almost every day*.
Abbreviation: SD, standard deviation.
[a]The rank was calculated on the basis of the sum of the frequency of Options 2–5. The higher the sum of the frequency, the higher the negative behaviour item was ranked.

likelihood of HV. Although nursing managers may not be directly involved in the HV incidents, they set the tone and expectations in the work environment, which was found to be associated with HV (Lewis & Malecha, 2011). If head nurses show a caring attitude towards their subordinates, they will set a good example for the staff nurses to care for each other, which may create a healthy environment and act as a buffer to HV (Kostich et al., 2020). The findings of this study are promising because they highlight the importance of nurse managers' caring ability for subordinates, which is in accordance with the core concept of nursing profession and provide new insights to solve the problem of HV among nurses. Further work is encouraged to confirm the results in other cultural contexts.

5.1 | Study limitations

Several limitations are associated with this study. First, because this study used a self-reported survey method based on respondents' own

TABLE 3 Logistic regression analysis with the potential factors ($N = 1942$)

	Univariate logistic regression			Multivariate logistic regression		
Potential factors	**Unadjusted odds ratio**	**95% CI**	***p***	**Adjusted odds ratio**	**95% CI**	***p***
Type of unit (reference: medicine unit)						
Surgical unit	1.066	[0.822, 1.382]	.630	1.209	[0.894, 1.637]	.218
Obstetrics/gynaecology	1.615	[1.074, 2.429]	.021*	1.249	[0.777, 2.007]	.359
Paediatrics	0.827	[0.536, 1.278]	.393	0.856	[0.522, 1.404]	.539
Emergency room/outpatient unit	1.546	[1.098, 2.176]	.012*	1.065	[0.729, 1.569]	.751
Intensive care unit	1.246	[0.878, 1.768]	.218	1.124	[0.749, 1.686]	.573
OR/PACU	1.260	[0.866, 1.833]	.228	1.137	[0.738, 1.752]	.560
Other	0.874	[0.646, 1.182]	.381	1.001	[0.704, 1.424]	.995
Head nurse's caring (reference: low level ≤129)						
129 < moderate level < 172	0.240	[0.179, 0.321]	.000***	0.400	[0.290, 0.553]	.000***
High level ≥172	0.050	[0.036, 0.069]	.000***	0.128	[0.087, 0.187]	.000***
Group behaviour (reference: low level ≤24)						
24 < moderate level < 32	0.368	[0.280, 0.484]	.000***	0.601	[0.444, 0.814]	.001**
High level ≥32	0.087	[0.066, 0.114]	.000***	0.221	[0.160, 0.306]	.000***

Abbreviations: CI, confidence interval; OR, operation room; PACU, postanaesthesia care unit.
*$p < .05$. **$p < .01$. ***$p < .001$.

subjective perceptions on HV, the prevalence of nurse-to-nurse HV may not be completely accurate due to possible misunderstanding of the questions included in the survey. Further research could increase the amount of data from various collection sources, including participant observation or in-depth personal interviews. Second, although the current study was a multicentre cross-sectional study from the different regions in Hubei, it only included samples of staff nurses from seven hospitals. So, the results may not be generalized to nurses in other areas, indicating the need to replicate the study with nurses in other areas and hospitals. Third, the HV questionnaire directed the respondents to recall the negative behaviours they had suffered in the previous 6 months, which may have led to recall bias. Finally, causal inferences could not be made due to the cross-sectional data, and further research is needed to explore the exact relationship among nursing managers' caring, group behaviour and exposure to HV.

6 | CONCLUSION

The findings from this study make several contributions to the current literature. First, compared with other countries, the prevalence of HV over a 6-month period among nurses in Chinese hospitals was found to be moderate, with general demographic variables such as gender, age and working experience not found to affect HV in the present cultural contexts, which indicate that future research among Chinese nurses needs to pay attention to additional variables. Second, a high level of caring from head nurses and group behaviour from co-workers were found to be protective factors to against nurse-to-nurse HV. These two factors may serve as effective methods for nursing managers and policymakers to prevent HV in the future.

7 | IMPLICATIONS FOR NURSING MANAGEMENT

This study may help nursing managers worldwide to learn about the status quo of nurse-to-nurse HV in Chinese hospitals and have a better understanding of the cultural differences related to HV. Another implication of the present study is that it helps the nursing managers identify which specific negative behaviours have a high prevalence and require special attention. Moreover, this study recommends that nursing managers might mitigate the occurrence of HV through significantly improving their caring ability towards nurses and creating an amicable climate of group behaviour. Last but not least, it suggests that hospital managers and policymakers should recognize the importance of the head nurses' caring ability for subordinates and include it as an indicator in their performance appraisals.

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CONFLICT OF INTERESTS

All the authors declare no conflicts of interest in this study.

ETHICS STATEMENT

The study was reviewed and approved by the Ethics Committee of Tongji Medical College, Huazhong University of Science and Technology (No. S323).

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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ORIGINAL ARTICLE

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Aggressive incidents in home care services and organizational support: A cross-sectional survey in Switzerland

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Abstract

Aims: To explore the available organizational structures addressing aggressive incidents towards home care services staff.

Background: Organizational structures how professional caregivers deal with care recipients' aggressive incidents.

Methods: An explorative cross-sectional survey using the Violence Experienced by Staff (German version revised) and the Impact of Patient Aggression on Carers Scale was conducted. Data from 852 health care professionals in the German-speaking part of Switzerland were collected between July and October 2019. Multiple logistic regression models were used to investigate associations. The STROBE-Checklist was used as the reporting guideline.

Results: Organizational support and management support in home care services were generally rated high and found to cause a significant decrease in negative feelings. Some self-rated skills regarding aggression management were linked to a decrease in perceived burden after aggressive incidents, whereas others increased the perceived burden.

Conclusion: Organizational structures including official procedures for affected professional caregivers should be established in home care services. This should contain efficient reporting systems and aggression management training for the specific setting.

Implications for Nursing Management: The study highlights the importance of organizational support regarding aggressive incidents in the home care setting as well as of aggression management training.

KEYWORDS
home care, survey methodology, community health, gerontology, violence

1 | BACKGROUND

Care recipients behaving aggressively with professional caregivers is a common phenomenon in the health care setting (Paschali et al., 2018; Yu et al., 2019). Investigations in the home care settings show that aggressive behaviour against professional caregivers occur often in the home care setting as well (Hanson et al., 2015; Schablon et al., 2018). Schnelli, Ott, et al. (2021) found that 14.8% of clients availing home care services display verbally or physically aggressive behaviour towards caregivers and that such behaviours were linked to cognitive impairment. Home care services have gained importance due to demographic changes worldwide (Genet et al., 2012). However, home care services face specific challenges such as increasing demand for care for people with dementia (Genet et al., 2012). Care for persons with dementia is often rewarded by aggressive behaviour against professional caregivers (Paschali et al., 2018; Schnelli, Mayer, et al., 2021; Yu et al., 2019). However, there is a lack of research regarding this phenomenon in the professional home care setting. Therefore, this study's research interest was directed towards aggressive behaviours in the home care setting.

The consequences of aggressive behaviour against professional caregivers include stress and burden, often resignation from the job, and post-traumatic stress (Paschali et al., 2018; Schnelli, Mayer, et al., 2021). Consequences of aggressive behaviour on behalf of the clients cause disturbances in the professional relationship and provoke increased fixations or assault from professional caregivers (Heckemann et al., 2017). Research could show ways to reduce such consequences after aggressive incidents. An important aspect that influences the perceived burden in the context of aggressive behaviour is team culture and support from the management (Heckemann et al., 2020). A positive team culture means the opportunity to discuss aggressive incidents in the team during informal conversations (Heckemann et al., 2020). Health professionals often seek support from their team members after surviving aggressive incidents (Edward et al., 2014; Heckemann et al., 2020).

Although support from colleagues is helpful, receiving support from the management was identified as being crucial as well (Schnelli et al., 2019). Support from the management includes an active role of the team leader. This means encouraging the team members to complete reporting forms, talking to affected professionals, and offering further measures such as case reviews or psychological support according to the affected person's needs. Additionally, management support includes promoting the employer's attitude to protect the staff and not take aggressive incidents as a "normal part of the job" (Heckemann et al., 2020; Schnelli et al., 2019). Poor support from management results in non-reporting of aggressive behaviour, even if a reporting system is available (Edward et al., 2014). Further reasons for non-reporting include the fear of being seen as oversensitive or existing horizontal violence such as harassment from team colleagues (Edward et al., 2014). Reporting systems allow analysing aggressive incidents systematically and, thus, implementing changes on an organizational level to prevent them in the future. Hence, it is necessary to address the reservations and barriers to reporting. Aggression management training leads to increased confidence, improved attitude and skills, and knowledge of risk factors of aggressive behaviour (Heckemann et al., 2015).

In Switzerland, aggression management training is part of nursing education. Further standardized aggression management trainings for health care organizations are available for inpatient settings (OdASanté, 2017). These trainings include following contents: defence techniques, verbal de-escalation techniques and information about the development of aggressive behaviour (Netzwerk für Aggressionsmanagement im Gesundheits- und Sozialwesen [NAGS], 2015).

Research from inpatient settings such as hospitals, long-term care institutions or psychiatry departments show that organizational support positively affects the consequences of aggressive incidents as well as their prevention (Edward et al., 2014; Heckemann et al., 2015). Organizational support includes the general attitude in the organization towards prevention and defusion of aggressive incidents, which has a supportive effect. This is reflected in, for example, the available reporting systems, and whether the staff is obligated to report incidents, and the official responses to reported incidents. Responses include established case reviews and free availability/offer of psychological support after aggressive incidents to professional caregivers (Schnelli et al., 2019). Regarding reporting systems, it is important that professional caregivers are able to report the incident anonymously if they wish and do not have to fear negative consequences of their report (Schnelli et al., 2019). Further, availability of concepts around prevention and dealing with aggressive behaviour, frequent aggression management trainings and refresher trainings and the opportunity to call safety staff or police for instrumental support in challenging situations are aspects of organizational support that help professional caregivers to deal with aggressive incidents (Heckemann et al., 2020; Schnelli et al., 2019).

Organizational support, team support, management support and aggression management training are crucial factors that prevent negative feelings after aggressive incidents in inpatient settings. There is insufficient corresponding research for home care services despite their unique organizational structure and the fact that aggressive incidents occur in the professional home care as well and are set to increase in the future with an increasing number of persons with dementia seeking home care, a clear gap that motivated this study. Based on insights from research in inpatient settings, the study aimed to gain knowledge of the existing organizational structures around aggression management in home care services. The following research questions guided the study:

- What organizational and management support structures are in place in home care services to support professional caregivers in dealing with their client's aggressive behaviour?
- How do these structures perceive the negative feelings experienced by professional caregivers after aggressive incidents?
- What are the training conditions for the professional caregivers in home care services and how far do they affect the negative feelings in the caregiver after aggressive incidents?

2 | METHODS

Due to the lack of existing research on organizational structures in home care services regarding aggression management and training, an explorative cross-sectional design was chosen. The Strengthening the Reporting of Observational Studies in Epidemiology Checklist (STROBE) for cross-sectional studies was chosen as the reporting guideline (von Elm et al., 2007).

2.1 | Sample/participants

The participants were adult (older than 18 years) professional caregivers working in home care services in the German-speaking part of Switzerland. Professional caregivers working in home care services of all educational levels were included: registered nurses, health specialists (a 3-year apprenticeship with a focus on basic care that ends with a diploma, but a health specialist does not have the competencies of a nurse), nursing assistants (a marginal education of 17 days' theoretical content and a 2-week practice session that ends with a certificate) and house aides (same education as nursing assistants, but with a focus on working to support households). Persons with different education (e.g. social workers) or similar education (those who work as nursing assistants) were also included, and so were persons working in direct contact with clients during nursing assignments. A total of 24 home care organizations participated in the study.

In line with the exploratory approach of the project, a convenience sampling strategy was applied. The home care service associations of non-profit organizations as well as those of the for-profit organizations in the German-speaking part of Switzerland were asked to spread the news of the study through their network. Further, the study proposal was presented in meetings of the operational managers and spread through the professional network of the research team. Interested organizations contacted the main author for further information. The contact person, either an operational manager or a nursing expert, received instructions to provide an envelope containing a prepaid and addressed answer envelope, the hard copy of the survey and an information sheet to the employees of the home care service and to inform them in a team meeting regarding the participation of the organization in the study. They were instructed not to put pressure on employees regarding participation. The following inclusion criteria were used: age over 18 years, working in direct contact with clients and working in a participating home care service.

2.2 | Data collection

Data were obtained using the Survey of Violence Experienced by Staff (German version revised) (SOVES-G-R) (Hahn et al., 2011; McKenna, 2004), which contains the Impact of Patient Aggression on Carers Scale (IMPACS) (Needham et al., 2005). Data were collected between July and October 2019. A total of 1923 hard-copy questionnaires were provided to the contact persons of the organizations. This number was the total of adult employees working in direct contact with the clients in the participating home care service organizations, that is, the number of potential participants. The contact persons delivered the questionnaires to the participants, who were assured of anonymity and voluntary participation by the project team information sheet. This sheet, as well as the hard copy of the questionnaire, mentioned that by completing and returning the questionnaire, the participants provided their consent. The participants were instructed not to provide any identifying personal information in the questionnaire. The questionnaires were marked with a specific code for each organization.

The information sheet also stated that the participants had 2 months to answer the survey. After a month, the research team sent a reminder to the contact persons of the organizations, along with the number of the returned questionnaires. The contact persons reminded the potential participants to complete the questionnaire using the usual information sources of the specific organization (mail, meeting or information sheet). The data from the questionnaire hard copies were transferred into an SPSS file using a codebook. To ensure the correctness of the data, a double-entry check was made on 10% of the data set: The error rate was 0.2%.

2.3 | Instruments

We used the SOVES-G-R (Hahn et al., 2011; McKenna, 2004), which includes socio-demographic data as well as the IMPACS (Needham et al., 2005). It is the appropriate instrument for this investigation because it contains questions regarding organizational support, team support, management support, aggression management training and burden after aggressive incidents.

SOVES contains 65 questions across eight sections. Originally developed by McKenna (2004) and tested for content validity by the European Violence in Psychiatry Group (McKenna, 2004), SOVES was translated into German and validated by Hahn et al. (2011). This survey was also used in a long-term care facility in Switzerland (Zeller et al., 2012). To meet specific issues of the home care setting, we adapted SOVES-G-R regarding wording, influencing and triggering factors (Section D) and specific measures (Section E). Face validity was tested with a nurse, a health specialist and a nursing assistant working in home care services. Marginal changes were made based on the feedback received. In this manuscript, a total of 34 questions from Sections A and F–H were included.

General information on the participants were assessed with SOVES-G-R Section A, such as socio-demographic data, with one yes/no question and eight objective-type questions. The consequences of aggressive incidents were assessed with Section F of SOVES-G-R, which also includes IMPACS, an instrument to measure negative feelings after experiencing aggressive behaviour. Section F explores the consequences of aggressive incidents and consists of two yes/no questions (regarding fear and sick leave), one

subjective-type question to describe what factors lead to fear, one objective-type question with four choice options regarding the form of sick leave after an aggressive incident, three questions with an exit option (e.g. no threat experienced) and a 5-point Likert scale with each to assess the experience of burden (1 = *not upsetting* to 5 = upsetting) and a multiple-choice question to assess the support needed. Needham et al. (2005) had conducted IMPACS psychometric testing with satisfying results (Cronbach's alpha = 06.–0.78). It consists of 10 items on 5-point Likert scales (1 = *never* to 5 = *always*) with higher scores representing more negative feelings (Needham et al., 2005).

Organizational support, team support and management support were explored with the SOVES-G-R Section G, which assesses organizational support as well as documentation and reporting of aggression events with five statements regarding staff and management support on a 5-point Likert scale (1 = *completely agree* to 5 = *completely disagree*), two yes/no questions and two objective-type questions on documentation, official procedures and reporting systems.

Aggression management training was explored with Section H that assesses training in aggression management and consists of 10 statements regarding skills measured on a 4-point Likert scale (1 = *very good* to 4 = *not good*), one yes/no question and one objective-type question.

The SOVES-G-R sections not included in this study are described briefly: Section B assesses the form of aggression experienced during work time; Section C assesses the frequency, perpetrator and form of aggression experienced within the last 12 months; Section D assesses the aggressive incidents experienced within the last 7 working days; and Section E assesses which measures were taken quickly and from a long-term perspective after an aggressive incident. At the end of the survey is a free text field named 'personal remarks and amendments' for additional comments.

2.4 | Ethical considerations

The study was reviewed and approved by the responsible ethics committee (Project ID: 2019-00502 EKOS: 19/041).

2.5 | Data analysis

Variables were analysed using descriptive statistics (frequencies). After an explorative analysis of the data set, multiple regression models were calculated for assessing relationships between organizational support (self-rated skills) and perceived burden or negative feelings after an aggressive incident. Associations between self-rated skills and received aggression management training were investigated using logistic regression. Assumptions were checked, and outliers (cases with standardized absolute residuals greater than three) were eliminated. We conducted the statistical analysis using IBM SPSS Statistics (Version 25). A level of significance of 0.05 was assumed.

3 | RESULTS

From the 1923 questionnaires sent out, 874 were returned, or a response rate of 45.4%. We excluded 22 (2.5%) questionnaires from analysis either because the cover pages were missing ($n = 1$), less than 50% of the questionnaire was answered ($n = 13$) or socio-demographic data were not provided ($n = 8$). The final sample of 852 questionnaires (44.3%) was used for data analysis.

3.1 | Description of the organizations and participants

A total of 24 home care service organizations with employees ranging from 23 to 319 participated in our study. Table 1 illustrates the socio-demographic data of the participants. The mean response rate was 55.6%, ranging from 4.0% to 92.0%. The two organizations that did not allow filling the questionnaire during working hours had a response rate of under 30.0%. Whereas a majority of the participating organizations had under 50 employees ($n = 12$), eight organizations had 51–150 employees, and the rest ($n = 4$) had more than 150 employees. Four of the participating organizations were located in rural, five in urban and 15 in suburban areas. Two organizations were for-profit organizations, and the rest, non-profit.

3.2 | Organizational structures

A third (33.3%, $n = 284$; missing: $n = 18$; 2.1%) of professional caregivers reported that an official procedure for employees affected by aggressive behaviour was in place at the home care service they worked for. Meanwhile, 17.1% ($n = 146$) reported no official procedure, and 47.4% ($n = 404$) reported that they were not aware of any available official procedure. The documentation of aggressive behaviour was mostly done in the written nursing report (88.3%, $n = 708$, missing: $n = 5$; 0.6%,). About 5% ($n = 43$) of the participants reported a protocol being followed in their organization to document aggressive behaviour, and 22.1% ($n = 188$) reported the availability of an official reporting system. Of the latter, 179 persons answered the question on reporting aggressive incidents: 46.9% ($n = 84$) reported all or nearly all of the incidents, whereas 53.1% ($n = 95$) reported half or less of the aggressive incidents.

A total of 61.5% ($n = 524$) of the professional caregivers stated that support was available at the workplace in general, whereas 61.4% ($n = 523$) reported that specific management team support was available. Nearly half of the participants (49.9%, $n = 425$) said that support from team colleagues was available, 27% ($n = 230$) said employees were reluctant to discuss aggressive behaviour at the workplace, and 12.8% ($n = 109$) said it was difficult to receive support at the workplace in general. Table 2 illustrates the correlation of the items regarding organizational support and the IMPACS items (negative feelings after aggressive incidents). Significant associations

TABLE 1 Socio-demographic characteristics of the participants

Socio-demographic characteristics		Total ($n = 852$)		
		n	(%)	Missing
Sex	Female	818	96.0	$n = 2$; 0.2%
Age (years)	18–29	121	14.2	
	30–45	250	29.3	
	>45	479	56.2	$n = 2$; 0.2%
Education	Nurse	397	46.6	
	Psychiatric nurse	20	2.3	
	Health specialist	210	24.6	
	Nursing assistant	131	15.4	
	House aid and others	80	9.4	$n = 14$; 1.6%
Working experience (years)	0–4	83	9.7	
	5–9	145	17.0	
	10–15	175	20.5	
	>15	442	51.9	$n = 7$; 0.8%
Level of employment	<50%	300	35.2	
	50%–79%	225	26.6	
	80%–100%	320	37.6	$n = 7$; 0.8%
Time of direct contact with care recipient (in relation to total work time)	<30%	91	10.7	
	30%–60%	288	33.8	
	>60%	461	54.1	$n = 12$; 1.4%

Source: Schnelli, Mayer, et al. (2021).

between the items 'support of the management is available', 'support of team colleagues is available', 'difficulty of receiving support at the workplace', 'employees are reluctant to discuss aggressive behaviour at the workplace' and 'support is available at the workplace' with IMPACS items were found. The IMPACS item 'I have a guilty conscience regarding the patient' resulted in no significant correlation with the items regarding organizational support. None of the five aspects of organizational support after aggressive incidents remained in the ANOVA model with 'I have a guilty conscience regarding the patient', and therefore, this item is not illustrated in Table 2.

3.3 | Aggression management training

Our survey found that 48.7% ($n = 415$; missing: 1.3%, $n = 11$) participants received aggression management training during their professional education or their work time as a professional caregiver. None of the house aides or the nursing assistants had received aggression management training. Therefore, the results regarding aggression management training do not involve these persons. Aggression management training was rated as unimportant, slightly important or moderately important by 26.2% ($n = 220$, missing: 1.6%, $n = 14$) and as important or very important by 72.5% ($n = 618$) of the participants. The self-rated skills regarding aggression management strategies are illustrated in Table 3. The skills 'knowledge on physical defence techniques', 'ability to confront patients with their aggressive behaviour' and 'ability to address the needs of persons who show aggressive behaviour' were rated the lowest.

A logistic regression model to find out if self-rated skills are associated with received aggression management training was built. The results of the logistic regression are illustrated in Table 4. Those with better knowledge of physical defence techniques ($p = .000$) as well as the ability to perceive their behaviour in dealing with aggressive patients ($p = .013$) were significantly more likely to have had training and were the only remaining items in the model. There was no significant association between the rating of the skills and aggression management training received in most items.

The analysis found that some skills influence the perception of the burden, especially after verbally aggressive events (Table 5). However, some of the higher rated self-perceived skills engraved the perceived burden after verbally aggressive incidents. Only the self-perceived skills 'ability to seek conversation with the patient with aggressive behaviour' ($B = -.287$, $p = .047$, F_{model}: 3.191 corr. $R^2 = 0.013$, df: (2; 344), $p_{model} = .042$, $n = 347$) and 'ability to set boundaries' ($B = .301$, $p = 0.32$, F_{model}: 3.191 corr. $R^2 = 0.013$, df: (2; 344), $p_{model} = .042$, $n = 347$) had a significant influence on such burden after physically aggressive incidents; there were none for experiencing threats.

TABLE 2 ANOVA: Organizational support and IMPACS

		Support available at the workplace	Support from the management is available	Support from team colleagues is available	Employees are reluctant to discuss aggressive behaviour in the workplace	It is difficult to receive support at the workplace	p_{model}	df	Adj. R^2	*F*	*n*
I have feelings of anger towards the institution I work in	B[a]		−.169	.109		.106		1			
	p		.001	.009		.001	.000	426	.171	23.220	432
I experience a disturbance in the relationship with the patient	B[a]	−.281				-.094		1			
	p	.000				.058	.000	436	.037	9.334	439
I avoid contact with the aggressive patient	B[a]	−.299						1			
	p	.000					.000	431	.071	33.888	433
I feel sorry for the patient	B[a]				−.131			2			
	p				.001		.000	433	.034	8.600	436
I feel insecure at work	B[a]	−.213						1			
	p	.000					.000	427	.041	19.455	430
I feel that I have to deal with society's problems	B[a]		−.234		.101			2			
	p		.000		.023		.000	434	.048	12.029	437
I feel insecure in working with the patient	B[a]				−.115	.134		1			
	p				.003	.001	.000	435	.030	7.758	439
I have feelings of being a failure	B[a]	−.116						1			
	p	.019					.012	429	.012	6.352	432
I feel ashamed of my work	B[a]	−.046						1			
	p	.013					.013	418	.012	6.292	421

[a]Regression coefficient (IMPACS: 1 = *never*, 5 = always; organizational support: 1 = *totally disagree*, 5 = *totally agree*).

TABLE 3 Self-rating of skills in aggression management

Organizational support (*total n = 852*)	Good or very good		Not good or bad		Missing
	n	%	*n*	%	
Ability to seek conversation with the patient with aggressive behaviour	653	76.6	167	19.6	*n* = 32, 3.8%
Ability to protect oneself against physical assaults	643	75.5	177	20.8	*n* = 32, 3.8%
Ability to set boundaries	632	74.2	187	21.9	*n* = 33, 3.9%
Ability to demonstrate that aggressive behaviour will not be tolerated	618	72.5	200	23.5	*n* = 34, 4.0%
Ability to address the needs of aggressive patients	595	69.8	223	26.2	*n* = 34, 4.0%
Ability to show appreciation towards the aggressive person	625	73.4	183	21.5	*n* = 44, 5.2%
Ability to confront aggressive patients about their behaviour	464	54.5	350	41.1	*n* = 38, 4.5%
Knowledge on physical defence techniques	350	41.1	476	55.9	*n* = 26, 3.1%
Ability to perceive one's behaviour in dealing with aggressive patients	708	83.1	109	13.3	*n* = 35, 4.1%
Ability to show understanding of the situation of the aggressive patient	675	79.2	135	15.8	*n* = 42, 4.9%

TABLE 4 Association of aggression management training and self-rated skills

	B[a]	Wald	*p*	Exp(B)	Confidence interval (95%)
Associated self-rated skills to received training					
Knowledge of physical defence techniques	−0.655	25.545	.000	.519	0.419–0.644
Ability to perceive one's behaviour in dealing with aggressive patients	−0.387	7.742	.013	.679	0.500–0.921

Note: Backward stepwise according to likelihood ($n = 707$; Hosmer–Lemeshow test: $p = 0.164$, Nagelkerkes $R^{2:}$ 0.101, classification of prediction: 61.4%; $X^2(2) = 55.584$, $p = .000$, 1 = *very good*, 2 = *good*, 3 = *not good*, 4 = *bad*).
[a]Regression coefficient.

4 | DISCUSSION

To our knowledge, this is the first investigation that surveyed organizational, management and team support and aggression management training conditions and their effect on the negative consequences of aggressive incidents in home care services. It found that availability of organizational support and aggression management conditions reduced negative feelings or burden after aggressive incidents.

Regarding organizational support, there was a lack of availability of reporting systems or internal concepts to prevent or deal with aggressive incidents, in line with the insights received from inpatient settings (Heckemann et al., 2020). A third of the participants reported an established official procedure to deal with aggressive incidents, and 22.1% said there was an official reporting system available, yet the reporting rate in the latter case was poor at under 50%. This conforms to the current literature, confirming that reporting of aggressive incidents is low (Edward et al., 2014). Reasons for non-reporting in inpatient settings are high administrative burden and a lack of time, the fear of stigma after reporting an incident or of no reaction on reporting (Edward et al., 2014; Schnelli et al., 2019). Based on our data, it remains unclear why the reporting rate in the home care setting is poor, and further research on that topic is suggested. As our survey found a poor reporting rate of aggressive incidents, one can suggest that reporting systems are not well established. The importance of measures to aid the implementation of reporting systems has been emphasized by studies in the acute hospital setting (Hahn et al., 2012; Schnelli et al., 2019). In home care settings, the implementation of a reporting system is possibly more challenging because professional caregivers are not physically present in the organization, and therefore, the personal information on the reporting systems is difficult (Genet et al., 2012).

Another aspect regarding organizational support found in the survey was that the general attitude of an organization that makes the employees feel they receive support if they need it leads to reduced negative feelings after aggressive incidents: Availability of support in the workplace is strongly linked to fewer feelings of 'disturbance of the relationship', 'avoidance of contact with the aggressive patient', 'insecurity at work', 'being a failure' and 'shame', whereas difficulties in receiving support at the workplace provoke feelings of 'anger' or 'insecurity' when working with the patient.

In line with research from inpatient settings, the survey identified the support of the management as crucial in the prevention of

TABLE 5 ANOVA abilities and perceived burden after verbally aggressive incidents

Self-rated skills		Burden after verbally aggressive incidents
Ability to seek conversation with the patient with aggressive behaviour	B[a]	*Not in the model*
	p	
Ability to protect oneself against physical assaults	B[a]	.160[b]
	p	.091
Ability to set boundaries	B[a]	*Not in the model*
	p	
Ability to demonstrate that aggressive behaviour will not be tolerated	B[a]	.234[b]
	p	.015
Ability to address the needs of aggressive patients	B[a]	.271[b]
	p	.009
Ability to behave appreciatively towards the aggressive person	B[a]	.211[b]
	p	.042
Ability to confront aggressive patients about their behaviour	B[a]	−.265[b]
	p	.004
Knowledge of physical defence techniques	B[a]	−.194[b]
	p	.010
Ability to perceive own behaviour in dealing with aggressive patients	B[a]	
	p	
Ability to show understanding for the situation of the aggressive patient	B[a]	.165
	p	.077

Note: (adj. $R^2 = 0.108$, F_{model}: 7.471, $df_{model} = (7; 369)$, $p_{model} = .000$, n = 377).

[a]Regression coefficient (self-rated skills: 1 = *very good*, 2 = *good*, 3 = *not so good*, 4 = bad).

[b]Due to the direction of the scales, the signs are to be interpreted as follows: Negative implies higher burden; positive implies lower burden.

negative feelings after aggressive incidents (Heckemann et al., 2020). Availability of support from the management significantly reduces 'anger' and the feeling 'to deal with society's problems' after aggressive incidents. Feelings such as 'anger', 'disturbance of the relationship', 'insecurity' or 'shame' as a perceived consequence of aggressive behaviour might influence the interaction between the professional caregiver and the care recipient, worsening the aggressive behaviour (Richter, 2012). These insights substantiate that organizational and management support is crucial in the primary as well as secondary prevention of aggressive behaviour against professional caregivers. This is also in line with theoretical approaches on person-centred care. McCormack and McCance's (2016) person-centred care model establishes that the care environment, such as the workplace, is a crucial aspect of successful caregiving. They state that shared decision-making, effective staff relationships and supportive organizational systems are necessary to provide person-centred care. An organization aiming at person-centred care delivery, therefore, should establish a positive safety culture and provide organizational support. Another aspect of the care environment in a person-centred care model is the presence of effective staff relationships (McCormack & McCance, 2016), which might be influenced on the interpersonal exchange after aggressive incidents and therefore requires the availability of team support. In this study, we investigated the 'reluctance to discuss aggressive incidents', which yielded ambivalent results. On the one hand, this reluctance seemed to reduce feelings of compassion and insecurity in working with the patient, whereas on the other hand increasing the feeling of having to deal with society's problems. Interestingly, 'receiving support from team colleagues' is strongly associated with an increased feeling of 'anger' after aggressive incidents. This result hints that unguided discussions between team colleagues might increase negative feelings against the care recipient. In the light the results of Schnelli, Ott et al. (2021), which disclose that staff with lower education is mostly used in the case of clients with aggressive behaviour, these insights highlight the need for guided reflexive processes. Guided reflexive processes such as case reviews might help reframe the aggressive incidents experienced. Based on these results, an extension of conducting case reviews is indicated in home care services. A lack of professional guided interpersonal discussion of aggressive incidents might decrease the chances of questioning one's actions when working with the patient, decreasing the quality of care.

Questioning one's actions can also be part of aggression management training. Aggression management training was also part of the survey and the results of this study are in line with results from inpatient settings (Heckemann et al., 2015): Less than half of the participants (48.7%) had received aggression management training during their education or work time. However, self-rated skills regarding aggression management were high, but the skills need to be reviewed closely because it is important to include any potential discrepancy between self-rated skills and potentially lower actual skills. The review of self-rated skills and actual skills is an important aspect in intervention development to address aggression management in home care. Increased self-rated skills of 'perceive their behaviour in dealing with aggressive incidents' and 'knowledge of physical defence techniques' were significantly associated with the group that received aggression management training. These results are partly in line with Heckemann et al. (2015), highlighting the positive effect of aggression management training on confidence, attitude, skills and knowledge. However, as Heckemann et al. (2015) state, aggressive management training might not lead to decreased aggressive incidents, but to reduced perceived burden after experiencing aggressive incidents and to increased team resources to deal with the incidents. Our study found that the most sought skills were not positively associated with the group who received aggression management training. This indicates that aggression management training is not sustainable. However, most of the survey participants (72.5%) marked training as important or very important, highlighting its benefits. Aggression management training must be refreshed at regular intervals to ensure sustainability, a practice not being followed by home care services.

It was also found that increased self-rated skills in aggression management might reduce the perceived burden after aggressive incidents, whereas other increased self-rated skills enhance the

perceived burden significantly. The skills 'addressing the needs of the patient', 'acting appreciatively', 'demonstrating that aggressive behaviour is not tolerated' and 'to set boundaries' are associated with decreased perception of burden after aggressive incidents. The finding underlines the importance of knowing one's boundaries and communicating them. The skills 'acting appreciatively' and 'addressing the needs of the patient' during aggressive behaviour indicate a person-centred nursing attitude that might improve well-being during and after aggressive incidents. A constructive way to deal with the situation by 'acting appreciatively' or 'addressing the needs of the patient' might lead to a positive end to the situation, reducing the burden. Aggression management training and nursing education must specifically address these skills in the future. The skills 'confronting aggressive patients with their behaviour' and 'knowledge of physical defence techniques' increased the perceived burden and seem to be of a more confrontative nature. These skills do not address specific situations and, when used, lead to more burden after aggressive incidents. The safety of a physically present team in the background is not assured in the home care setting, indicating that these strategies increase burden instead of decreasing it. Such aspects in the development of future aggression management training must be addressed, with a focus on specific conditions in home care settings. The conditions in home care services should be improved to provide person-centred and need-oriented care while supporting the employees.

4.1 | Limitations

We conducted an explorative cross-sectional survey using a convenience sample that is not representative. Our sample is comparable to the entirety of professional home caregivers in Switzerland, although registered nurses were over-represented (Bundesamt für Statistik, 2020). This indicates that better-educated nurses are more likely to consider the topic relevant because they have more resources gained from their nursing practice. The survey studies which structures for organizational support in the organizations are available; however, the results focus on the German-speaking part of Switzerland, making the transferability of the results possible with caution. Our results are partly in line with research in the field of aggression management and its lack around home care settings. This study with an exploratory approach gains basic insights on the topic; however, further research is necessary to strengthen these insights.

5 | CONCLUSION

Home care services in the German-speaking part of Switzerland have established organizational support structures. However, reporting systems or official procedures are present in very few organizations, and the reporting rate is only under 50%. Therefore, home care organizations should implement such structures urgently and carefully. Organizational and management support can lead to reduced negative feelings after aggressive incidents, underlining the importance of a positive safety culture and promoting guided interpersonal exchange between professional caregivers. Aggression management training should be further established in nursing education, with refreshers tailored to specific situations in home care settings. Aggression management training should especially focus on constructively learning from aggressive behaviour. Further research on organizational structures in home care services with a focus on aggression management and the implementation of aggression management concepts is necessary to improve the situation for professional caregivers and the care recipient regarding the occurrence and consequences of aggressive behaviour.

6 | IMPLICATIONS FOR NURSING MANAGEMENT

Leadership in home care services must have a positive safety culture, and regular and specific aggression management training on the agenda. Additionally, the implementation of further measures like reporting systems or regular case reviews is necessary. To implement such measures, specific strategies that address the nature of home care services should be developed. The specific nature of home care services means that staff is not regularly in the spatial structures of the organization and staff exchange is reduced. This makes it challenging to ensure the flow of information regarding client situations or even implementation of innovations.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

ETHICS STATEMENT

The study was reviewed and approved by the Ethics Committee Eastern Switzerland, Project ID: 2019-00502 EKOS: 19/041.

AUTHOR CONTRIBUTIONS

Study design: AS, AZ, HM and SO; data collection: AS; data analysis: AS and SO; manuscript preparation: AS, AZ, SO and HM.

DATA AVAILABILITY STATEMENT

Data available only on request due to privacy restrictions.

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