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Effective clinical nursing leadership in hospitals: barriers from the perspectives of nurse managers

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ABSTRACT

Aim The purpose of this study was to identify barriers to effective clinical nursing leadership in Jordanian hospitals from the perspectives of nurse managers (NMs).

Background Clinical leadership is about expertise in specialised fields and involving professionals in clinical care. Even though leadership terminology has been used in nursing and healthcare business literature, clinical leadership is still misunderstood, including its barriers.

Method This study adopted a qualitative narrative approach and recruited a purposive sample of 19 NMs and two associate executive directors of nursing from two hospitals. Data were collected through two focus group discussions and in-depth interviews and were analysed using content analysis. The study was guided by the 'Consolidated Criteria for Reporting Qualitative Research'.

Result Four themes emerged regarding barriers to effective clinical nursing leadership: (1) power differential, (2) inconsistent connectedness with physicians, (3) lack of early socialisation experiences and (4) clinical practice reform is a mutual responsibility.

Conclusion and relevance to clinical practice Barriers are detrimental to effective clinical leadership; they are associated with interdisciplinary and professional socialisation factors. Managers and academicians at all levels should immediately consider these barriers as a priority. Innovative clinical leaders should identify barriers to effective clinical leadership at the early stages. Thus, innovative clinical leadership programmes are warranted.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Multidisciplinary collaboration and staff mentoring improve patient safety and outcomes under clinical leadership (CL). CL seeks patient safety. Without management or leadership training, health professionals collaborate. Communication, self-efficacy and quality relationships help CL role transitions. The patient care synergy model matches patient needs with nurse competencies. The model trained nurses as clinical leaders and successfully matched nurse skills with patient needs in different care settings.

WHAT THIS STUDY ADDS

⇒ The findings are supported by the key informants and the majority of the literature, making them applicable to other clinical practice settings. This type of qualitative study provides comprehensive data that can aid nurse managers in planning the development of clinical nursing leadership.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ CL encountered change resistance; poor teamwork; a lack of vision and commitment at higher levels; a lack of incentives; a loss of confidence; curriculum deficiencies at the undergraduate level; insufficient communication, interdisciplinary relationships and leadership preparation; clinician scepticism; role conflict; and a lack of recognition and influence. CL both facilitates and impedes policy, organisational, team and individual levels.

INTRODUCTION

Nurses work in multidisciplinary institutions, the client's needs represent the core of the work that everyone in the healthcare team is required to do, though from each one's unique perspective.[1] The smoothness of their work with their patient occurs when each one's feelings and competencies genuinely interact with the patient's needs and with each other's contribution.[2] However, overlapping roles and dependency among them may sometimes disrupt their supportive and protective work with their patient, which may cause conflict with each other and with their patients.[3] Jordanian nurses are educated to be change agents, patient advocates, health educators and critical thinkers; however, putting these competencies into practice has been challenging, which consequently may compromise nurse managers' (NM) ability to create opportunities for them to peruse their role as effective clinical leaders.

Clinical leadership (CL) is concerned with clinical excellence through multidisciplinary work and mentoring of staff to enhance their clinical skills and impact patient safety and the quality of care outcomes.[4 5] Patient safety is emphasised as an ultimate outcome of CL. CL has not been connected to conventional management or leadership training,[6 7] it needs collective efforts of health professionals away from the formal influence of any of them.[8] Intrapersonal and interpersonal characteristics such as self-efficacy, communication and quality relationships are associated with successful role transitions to CL.[9 10] CL is integrated into the synergy model for patient care which emphasised that synergy occurs when patient needs are aligned with nurse competencies.[11] The model was adopted for training nurses as clinical leaders and found

effective in matching nurse competencies and patient care needs in various care settings.[12 13]

CL has been studied in terms of effectiveness,[10] contributing factors,[14] enacted roles,[15] perceived characteristics[5] and barriers.[16 17] The results were favourable yet challenging. For example, a systematic review reported improvement in the quality of nursing care, healthcare and optimal patient outcomes.[10] Contributing factors included individual leader-specific behaviours and practices, traits, context and practice environment, and participation in educational activities.[14] Enacted roles included faculty, clinical management/executive, specialty clinician and staff nurse.[15] The perceived characteristics of clinical leaders included approachability, effective communication, clinical skills, clinical knowledge, honesty, integrity, support for others and visibility in the clinical area.[5]

On the other hand, CL included substantial barriers such as reluctance to change; poor teamwork; lack of vision and commitment at the higher levels; lack of incentives; loss of confidence; curriculum deficiencies at the undergraduate level; inadequate communication, interdisciplinary relationships and preparation for leadership roles; clinician scepticism; role conflict[16]; and lack of recognition and influence.[17] Enablers and barriers to CL have been identified at policy, organisational, team and individual levels.[7]

The importance of effective CL to patient outcomes has been emphasised in the western literature; however, there is still a lack of studies in Jordan, making it critical to conduct this study which focused on the barriers facing effective CL as perceived by NMs.

Purpose and significance of the study

The present study aims to assess the barriers to effective CL from the perspectives of NMs. There is no documented evidence about the barriers to the engagement of nurses in CL in Jordan, which prompted the researchers to carry out this study.

This study is significant in gaining insight into the barriers confronted by Jordanian NMs and assisting them in enhancing CL among nurses. Our qualitative study is timely and needed, it answered the following research question: what are the barriers to effective clinical nursing leadership in hospitals in Jordan?

METHODS

Study design

This study used a qualitative narrative approach to construct the meaning experienced by two groups of participants. It included focus group discussions and individual interviews. Our epistemological position is in line with the relativist position that there are multiple rather than a single way to constructing understanding to barriers to CL. Braun and Clarke[18] indicated that there are multiple socially constructed and context-dependent realities. This study was also guided by the Consolidated Criteria for Reporting Qualitative Research.[19]

Settings and participants

The setting included two hospitals in Jordan, one public and one private, to ensure variation in participants' perspectives. This study employed two groups of participants. The first group, labelled primary informants, consisted of NMs to share their own personal understanding of the barriers to CL as confronted by nurses in their units. The second group, labelled key informants, consisted of associate executive directors of nursing (AEDN) who have special knowledge and status because of their leadership role: to enhance credibility and trustworthiness towards the identified barriers to CL.

We sent invitations to all NMs at the two hospitals (n=25) and to the AEDN at each hospital with the purpose of the study and the contact information of the principal investigator. The inclusion criteria were NMs, who had at least 2 years of experience in their current work and were willing to participate. We received responses from all NMs and from the AEDN. We selected a purposive sample of 19 NMs who work in the following nursing units with more than 2 years of experience: medical care units, surgical care units, paediatric care units, maternity care units, intensive care units and emergency care units. Those NMs from operating theatres and outpatient departments were excluded.

This study included 21 participants (19 NMs and two AEDNs). The majority (n=12, 57.1%) were females over the age of 35 years with a minimum of bachelor's degree in nursing and 10–25 years of experience in nursing. Most participants were married (n=17, 80.9%), and a few of them (n=5, 23.8%) had a previous experience as clinical training preceptors.

Data collection

Data collection was carried out by the use of focus group discussions and individual interviews for two reasons. Focus groups were carried out with NMs to identify key narratives of barriers to CL within each hospital, and individual in-depth interviews were carried out with AEDN as key informants to deepen and widen our understanding of barriers to CL, and to help in reducing sampling bias. This research was conducted in two stages. The first encompassed two focus groups with NMs: one included 14 NMs and the other included five NMs. The second encompassed in-depth interviews with two AEDNs to discuss early conclusions from the analysis of the focus group data.

All contacts were conducted in comfortable spacious meeting rooms at study hospitals. Two members of the research team conducted the focus group discussions and the individual interviews with AEDNs, both researchers have experience in qualitative research but were not involved in clinical work in hospital settings to avoid possible conflicts of interest. Data collection from each group started by introducing the research topic, completing a consent form and pointing to the confidentiality of the responses.

The focus groups with NMs started by the following engagement question: 'What prevents nurses from taking on a clinical leadership role?' The discussion included also the following key questions to allow NMs to explain their experiences with nurse CL:

1. What is your experience with nurses as clinical leaders in your ward?
2. What do you think inhibits clinical nursing leadership?
3. What significance do you think CL has in patient outcomes such as patient safety?
4. As an NM, how do you facilitate nurses to practise their role as clinical leaders? For example, do you match nurse competencies with patient needs when assigning nurses to patients?
5. What is your experience of support and help from physicians to nurses in their role as clinical leaders?
6. What is needed for clinical nursing leadership to be effective?

However, we planned in-depth interviews with AEDN around our early conclusions from the analysis of the focus group data. We started by the following engagement question: What are the most significant barriers that you anticipate facing nurses working at this hospital in their role as clinical leaders? We inquired about the difficulties that nurses are having with respect to the following areas: acquiring and exercising power

in decision-making, negotiating and team building, adequacy of human resources and time management.

Probing questions were asked based on participants' responses and as deemed necessary. All questions were discussed until reaching saturation. Focus group discussions and individual in-depth interviews were audio recorded after participants' permission, and transcribed verbatim; the transcripts were reviewed by two participants to ensure consistency in their understanding, and later, the results were compared with recorded notes to ensure the trustworthiness of the data. The focus group time ranged from 60 to 90 min, and the in-depth interviews from 40 to 50 min.

Data analysis

We analysed the data using inductive content analysis based on Graneheim and Lundman's[20] steps (ie, meaning unit, condensed meaning units, codes, subthemes and themes). Two researchers independently transcribed audio recordings to text. Each transcript was initially read in relation to the corresponding question, after which the texts' emerging meaning units were identified and condensed for subsequent analysis without imposing preconceived personal perspectives. A meaning unit, according to Graneheim and Lundman,[20] is a group of words, sentences or paragraphs that have elements in common with one another in terms of both content and context.

The two researchers manually coded condensed meaning units. Another two researchers discussed the identified codes; their discussion resulted in formulating the underlying subthemes, and the themes that represent the participants' genuine in-depth experience with barriers to CL.

Trustworthiness

Trustworthiness[21] encompasses credibility, dependability, transferability and confirmability. To ensure credibility of the derived themes, we used two sources of information (ie, the NMs as primary informants and the AEDN as key informants) and two methods of collecting data (ie, focus groups and individual in-depth interviews). For dependability check, all researchers had a chance to read the transcribed data word for word several times and debate and agree on the final themes that described the participants' experiences. The finalised themes were presented to three participants from each focus group discussion to check that the derived themes reflected their experience with CL. To check on the transferability of the findings, we used two hospitals from two different sectors, and the participants' responses conveyed similar findings. To achieve confirmability, we tried our best to put aside our own understanding of barriers to CL.

Ethical considerations

Informed consent was obtained from participants at the beginning of the study. The confidentiality of responses was maintained by providing participants tags with numbers, which the data collectors used to write the transcriptions. Participants were encouraged to ask questions and share their concerns; they were told that they have the right to withdraw from the study at any time if they wish so. All data were kept confidential in a locked filing cabinet, or password protected if electronic.

RESULTS

Four themes emerged regarding barriers to effective clinical nursing leadership, namely (1) power differential, (2) inconsistent connectedness with physicians, (3) lack of early socialisation experiences and (4) clinical practice reform is a mutual responsibility.

Theme 1: a power differential

Asymmetrical use of power when making decisions about patient needs

The difference in the use of power by physicians and nurses was a point of concern for NMs. They noted that an equal distribution of power in the hospital environment where groups of several professionals work together is challenging; for instance, to facilitate the needs of patients, nurses may compromise because some physicians frequently want to control and be dominant. An NM stated:

> Nurses act in their patient's best interest and use their power to promote respect and trust. However, physicians, usually practice their authoritarian decisions without giving sufficient attention to nurses' contributions. This affects the smoothness of the collaborative work between them and the credibility of nurses in front of their patients. (I4)

NMs believe that asymmetrical power represents a barrier to effective use of CL. An NM said: '*Nurses wanted to be heard and taken seriously while speaking with physicians; however, physicians' spare very limited time when willing to answer questions*' (I12). Another NM also shared:

> Patients usually recognize that nurses have to follow physicians' orders, which reinforces the image of nurses' subordination to physicians' decisions and jeopardizes their ability to act as clinical leaders. (I1)

Another NM noted that patients may bypass the nurse's presence when they talk to physicians. He said:

> Patients always prefer to connect with physicians and bypass nurses; however, they direct their frustrations at nurses when physicians were indifferent to their needs. This usually negatively impacts nurses' clinical leadership ability. (I8)

NMs admitted that the mutual efforts of health team members may fluctuate based on given situations. An NM said: '*Clinical leadership depends on mutual efforts by all concerned, however, in some situations, dominance of any of the team members may prohibit its effective use*' (I16).

Key informants noted that CL is essential; many senior nurses proved their competency as successful clinical leaders; however, obstacles may arise. One of them said:

> …, the primary accountability for the patient rests with the physician, there are instances of conflict between nurses and other health care professionals concerning the patient care needs … that are shared with many professionals. It is true that nurses are accountable for their input, but physicians have the right to question the care provided by nurses especially when the patient condition changes. (KI1)

Theme 2: inconsistent connectedness with physicians

Inconsistent collaboration and professional relations

NMs believed that physicians and nurses should unite and coordinate their efforts and consider the patient as the core of their partnership. An NM said:

> The success of the nurse as a clinical leader requires consistent collaboration, communication, and openness between physicians and nurses, though this is hard to achieve. (I3)

Another NM added the following:

> I think it is the consistent effective communication between physicians and nurses and with their patients that should count, but this is difficult to maintain at all times. (I16)

Inconsistent collaboration, communication and openness disappointed NMs. An NM said, '*I feel uncomfortable when I recognize*

some physicians' rigidity in the way they communicate with nurses' (I5).

Both key informants pointed out that collaboration is key to building teams, it is directly related to the success of all involved in patient care, as one of them said:

> … clinical leadership needs a nurturing … supportive environment. I trust that all NM are credible in creating environments to enable nurses to take control of patients' care and to gain confidence of their patients and others involved (such as patients' families and health team members), however, the collaboration of nurses may not be acknowledged by all physicians, most of the time it is not tangible. (KI2)

Theme 3: lack of early socialisation experiences

Absence of role models

NMs noted that nurses should be socialised in this role as early as possible, while still students. However, lack of early socialisation is related to the absence of well-trained role models in the clinical practice sites. The undergraduate clinical courses should emphasise how to practise effective CL. An NM said:

> When I was a student I was not trained in this role… and throughout my experience as a preceptor and then as a NM I recognized that the insufficient number of qualified staff as role models contributes to the lack of socialization of students and of the newly graduated nurses in this role. I think that clinical leadership is mastered through seniority. (I15)

Another NM added:

> The presence of students in my unit adds stress to me and my staff though they are accompanied by their own faculty members. Usually, students act as observers, sometimes it is hard to get patients' permission to be observed,… and some nurses/preceptors may not be proficient role models to learn from. (I18)

Shortage of qualified nurses

The shortage of nurses jeopardises patient safety and has an unavoidable negative influence on the quality of patient care; it was associated with poor CL. An NM said:

> …The number of nurses in my ward is not sufficient, each nurse care for 6 to 7 patients, which interferes with optimizing patient safety. This caused me stress because I have to increase my attention to the safety of patient care. (I9)

Key informants agreed that the shortage of nurses represents a critical barrier to CL. One of them said:

> … I have frequent meetings with NMs, I am aware about the shortage of nurses, this is very difficult to solve, the high attrition rate is because many of the nurses prefare to work at hospitals in nearby oil countries, … you know, they are paid better there. (KI2)

The other key informant confirmed this. He added the following:

> … shortage of staff affect load of work … the nurses at this hospital and perhaps at all hospitals in Jordan are overworked … my colleagues at other hospitals complain as well. Some of nurses my work double shifts, this rationalize why nurses may not successfully practice their clinical leadership role. (KI1)

Theme 4: clinical practice reform is a mutual responsibility

Unity of efforts needed to reform CL

NMs expressed a need to change the current situation. They admitted that they lack time to act as role models or even mentor nurses in their role as clinical leaders. An NM said:

> … Clinical leadership requires deliberate planning. The scarcity of time is an issue. It is not ethical to ignore its significance on patient outcomes. (I3)

NMs believe that such a change calls for unity of efforts among concerned officials in nursing education and practice. An NM said:

> The reform in the preparation of nurses as clinical leaders should not be a single person/institution effort. It rests upon the collective efforts of clinical and academic professionals/institutions. (I7)

Another NM added, '*I agree that collective efforts are needed between clinical and academic institutions*' (I6).

Key informants confirmed a need for reform of clinical practice; they both acknowledged a need to reconsider how students and newly graduated nurses are socialised to their role as clinical leaders. One key informant said:

> … I am aware that the students who are trained here are not allowed to touch the patient, they learn through watching, this is of course not sufficient. I believe we are all accountable about patient safety, and about providing students with better chances of clinical training… this is a mandatory need, it is the responsibility of both the clinical setting and the schools of nursing. (KI1)

DISCUSSION

This study aimed to gain more knowledge about barriers to effective clinical nursing leadership from the perspective of NMs. The literature emphasised the importance of effective CL in achieving high-quality patient outcomes, and that CL necessitates collaboration and mutual understanding between nurses and physicians to positively influence patient care.[16 21 22] In the current study, power differential appeared as a major barrier to CL. A review of concept analysis on power identified two distinct concepts: the power to versus power over.[23] 'Power to' means the knowledge, freedom and intention to do or accomplish something. However, 'power over' is a disappointing concept; it indicates that in the presence of someone powerful, someone else's freedom is likely to be reduced.[23] This study reported that physicians' control of the relationship leads to conflict; this is congruent with reported barriers to CL such as lack of interprofessional collaboration and conflict because physicians have the power of making the majority of decisions.[7]

Nurses' difficulty maintaining connectedness with physicians represented the second barrier to effective CL. Connectedness was defined as 'the state of being connected and having a close relationship with other things or people'.[24] Connectedness is linked to the ability to form healthy interpersonal connections; it has seven attributes: intimacy, sense of belonging, caring, empathy, respect, trust and reciprocity.[25]

Connectedness between patients and clinicians positively impacts patient health outcomes; it empowers, facilitates and improves treatment adherence by fostering better support for patients in understanding and managing their diseases.[25] However, if mistrust and poor communication exist between doctors and nurses, valuable patient information may not be shared, and orders may be delayed.[26] Therefore, connectedness is fundamental for achieving CL.

The third finding indicated that lack of early socialisation experiences, absence of role models and shortage of qualified nurses are barriers to effective CL. The literature noted that shortage of nurses jeopardised patient safety, fewer nurses and a high admission rate have a higher death rate[27] and absence of role models inhibits creativity and originality.[28]

The challenge of time and timing to reform CL is congruent with reported time constraints as a barrier.[21] Time management skills are deemed necessary for NMs to prioritise and complete tasks that will have the biggest influence on CL. However, NMs should take the lead and first agree on the goals and the exact changes required for developing clinical nursing leadership.

Strengths and limitations

The transferability of the findings is limited because of the qualitative nature of the context-dependent design. However, the findings are supported by the key informants, and most of them are supported by the literature, making it useful to other clinical practice settings. This type of qualitative study provides in-depth data that can assist NMs in planning for the development of clinical nursing leadership.

CONCLUSION

The current study adds to the understanding of the barriers to effective clinical nursing leadership. NMs indicated that the major barriers included: differences in professional power between nurses and physicians, the difficulty in maintaining connectedness between nurses and physicians at work, lack of early socialisation to the role of CL due to the absence of role models, and shortage of nurses, and the challenge of professional unity and timing to reform.

This study, therefore, has many implications for nursing education, practice and research. It has identified an urgent need for the collective efforts of nursing leaders at academic institutions (ie, universities) and nursing practice settings to reform current nursing education curricula, and staff development programmes aiming at successfully developing competent bedside clinical leaders. Further research is recommended about the effectiveness of CL from the perspective of bedside nurses, patients and physicians. Research is also needed to provide a full picture of the circumstances in which power differential and difficulties in nurse–physician connectedness arise.

Correction notice This article has been corrected since it was first published. Author 'Majd T Mrayyan' affiliation has been updated.

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Contributors MM developed the study conception, introduction and part of the literature methodology, did critical revisions and proofread the whole first draft of the paper. Sulimanand AA wrote part of the literature review, analysed the data and wrote the results, limitations, implications and conclusion. HYA and SA-R did the critical revisions and proofread the whole final paper. MM supervised the whole work. AA is responsible for the overall content as the guarantor.

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