Original Article

Situational leadership style adopted by nurses in the hospital field

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ABSTRACT

This study aimed to analyze Situational Leadership styles adopted by hospital nurses and their association with their personal and professional profile. This is a quantitative and descriptive study and the Hersey and Blanchard leadership model was used with nurses who work in hospitals. Data were collected through sociodemographic questionnaire and the Leadership Effectiveness and Adaptability Description. The more directive leadership style focused on persuasion was the most present. The activity sector showed a significant relation to the leadership style (p=00.1), demonstrating approximation between assistance and leadership profile. Although the population is composed of young group with a short time of performance, the predominance of the Coaching leadership style may limit the creativity and potential of team members for the focus to be focused on the task. Strategies to achieve high levels of maturity, can assist nurses in adopting more flexible leadership practices.

Descriptors: Nursing Administration Research; Leadership; Professional Practice; Health Services.

INTRODUCTION

For Nursing, leadership is a process by which nurses influence others' actions for the determination and achievement of objectives, seeking to promote change in their daily practice, with a view to improving the quality of care provided to the user[1]. In the Brazilian context of most health services, the nurse is recognized as a leader by being the coordinator of the nursing staff and manager of the units and hospitals, being recognized as a professional of reference[2].

International studies point to the need to strengthen the leadership in nursing through leadership

development programs. Leadership has been associated with improved organizational culture, personal satisfaction, better interpersonal interaction and trust between leaders and team[3-4], and, most importantly, it has improved the outcomes related to patient care[5].

When performed positively, it raises the quality of care provided to the user, as this is significantly influenced by the leader and the way he/she manages the environment, human or technical service[6] and still considers that the satisfaction and trust when performing the daily working processes are directly influenced by the leadership relations[7]. Leadership style is the behavior pattern that a person shows when seeking to influence other people's activities[8]. In this sense, Situational Leadership emerges as an integrating concept, which aims that the subject appropriates his/her leadership process[8].

For this study, the theoretical framework of Hersey and Blanchard was used, named Situational Leadership (SL), which is based on four styles of leadership, namely Directing, Coaching, Supporting and Delegating, which consist of a task behavior and relationship combination. The task behavior is the extent to which the leader directs persons, telling them what, when, where and how to do a specific task. The behavior directed to the relationship considers the leader's ability to communicate, listen and support his/her contributors[7].

Research[6,9-11] in different countries have considered the influence of leadership styles as a strategy to qualify the care to the user and family when it is of high quality, permeated by trust, good communication, respect and reciprocity[3]. On the national scene, the SL has been studied and identified as qualifying strategy to lead processes[1,3], since its application is one of the ways to facilitate learning about leadership and training of nurses leaders[1].

Therefore, the questions of this study were: What are the SL styles adopted by nurses in hospitals? How do personal and professional profile as well as vocational training (academic and CHE) influence the nurse's leadership?

Thus, this study aimed to analyze the Situational Leadership styles adopted by nurses in a hospital network as well as their association with personal and professional profile.

METHOD

This is a quantitative study and was conducted in three hospitals that make up the hospital network of high complexity in the South of Brazil. The selected scenarios stand out as a benchmark in several areas of complexity. Together, the hospitals have more than 500 hospital beds.

As statistical consulting, after applying the sample test for this number, the sample should be composed of 87 participants. By the interest of increasing the confidence interval, the sample was expanded to 104 nurses, ensuring a margin of error smaller than 5% and 95 confidence interval.

As inclusion criteria, we decided that: the participants should have employment status as nurses and work in different shifts. Only eight professionals were excluded due to sick leave and the individuals hired as trainee, as they work under the supervision of a nurse, featuring the working process as training. Participants

performed their activities in care and management sectors, as follows: Inpatient Units (IU); Surgical Center (CC); Sterilized Material Center (SMC). Nurses from other areas also participated: Special Units (SU), for which it was grouped the Infection Control Services Related to Health Care (SCIRAS, in Portuguese); Permanent Education Service in Nursing (SEPE, in Portuguese); Hospital Center of Epidemiology (NHE, in Portuguese); Central of Reception and Transplantation of Organs and Tissues (CIDOTH, in Portuguese); and Outpatient Units (OU), which included: Urgency and Emergency, Chemotherapy, Radiotherapy, Orthopedics and Traumatology and Diagnostics Service. For data collection, we asked the participants to fill a Sociodemographic Questionnaire to characterize the profile and the Leadership Effectiveness and Adaptability Description (LEAD) – Description of Effectiveness and Leader Adaptability –, which was developed at the Center for Leadership Studies at Ohio University[12]. The use of the tool was based on the adaptation made to the nursing area[13].

LEAD consists of 12 "situations" with four action alternatives, and the participants should choose one of the actions that best fits their leadership behavior in the presented situations. Categorization as the leadership styles followed the LEAD conversion tool.

The tool categorizes leadership styles in: Directing (S1), in adopting this profile, the nurse defines the activity, how, when and where it should happen and constantly supervises the execution of the task; Coaching (S2), the nurse explains the activity to be performed, listens to the collaborator carefully and tries to convince him/her the most appropriate way in order to accomplish the task; Supporting (S3), the nurse allows the collaborator to participate in decision-making, that is, share ideas and alternatives to solve a given problem; and Delegating (S4), for which the collaborator decides how, when and where do things about a specific task, which implies low behavior to the nurse for both task and relationship[1,7-8].

Data were collected from June to August 2014 *in loco*, after permission of the institutions and prior appointment. For the analysis and organization of findings, these were double typed and tabulated in a *Microsoft Excel 2010* program (*Microsoft Corp.*) and subjected to statistical analysis using the *Statistical Package for Social Sciences* program (SPSS), version 21. Categorical variables were presented in absolute and relative frequency and, the numeric variables, in average and standard deviation. The chi-square test was used to compare groups of participants by institutions as categorical variables. The significance level was 0.05 (5%) for significant differences.

The study was in accordance with the Brazilian standards for human research. As determined, it was guaranteed participants anonymity, confidentiality, the right to withdraw from the study, free access to the data according to their interest, after both parties signed the Free and Clarified Consent Term (in duplicate). The study was submitted and approved by the Ethics Committee of the Santa Casa da Misericórdia of Pelotas (approval n. 200/2013). Researchers will save the findings for five years.

RESULTS

Study participants were nurses working in three hospitals, which have together 112 hired and

registered nurses; however, 104 professionals (92.85%) participated, 65.18% of the sample worked in hospital I and 12.50% in hospital III, totaling all registered nurses (n=73/n=14, respectively). Hospital II had at the time of data collection 25 nurses, of these, 17 participated in the study (22.32% of the sample).

To better illustrate the participants of the study, Table 1 was used.

Table 1: Demonstrative of nurses, according to selected institutions and participation in the study. Chapecó, SC, Brazil, 2015.

Hospital	Total of professionals	%	Participants of the study	%
H - I	73	65.18	73	100
H - II	25	22.32	17	68
H - III	14	12.50	14	100
Total	**112**	**100**	**104**	**92.85**

There was a predominance of women among the participants (n=90-86.5%), average age 32.1±6.5 years, age group between 21 ├30 years (n=48-46.2%), most of them work in hospitals between 1 ├5 years (n=38-36.5%).

As for the training profile, the predominant graduation time was 1 ├5 (n=46-44.2%) and representative part of the sample (n=86-82.7%) has a specialization course, while only 3.8% of professionals have a Masters' degree (n=4).

Concerning the activity sector, 63.5% (n=66) work in Inpatient Units and 73.1% (n=76) have positions such as care nurses, of which 29.8% (n=31) work in the morning shift. It was observed that 76.9% (n=80) did not work in other places and the same percentage works 44 hours per week. It is worth noting that all participants in the study have employment contract governed by the Consolidation of Labor Laws (CLT).

Table 2 allows distribution identification of all participants by sociodemographic and professional characteristics.

By analyzing the SL style adopted, the study showed the prevalence of S2 style (Coaching), with which 68.2% of participants (n =71) self-identified. Following, the highlights were the self-reported participants in S1 (Directing) (n=18-17.3%) and participants with S3 (Supporting) (n=10-9.6%). The other participants have assimilated more than one style and no participant expressed the S4 (Delegating).

Table 3 allows us to understand the distribution of nurses by adopted leadership style, noting that: in H-1, S2 (Coaching) covered 58.9% of participants (n=43); in H-2, 88.2% (n=15); and in H-3, 92.9% (n=13).

Returning to Table 1, the activity sector has a significant relationship with respect to the leadership style adopted by nurses (*p*=00.1). S2 leadership style (Coaching) had a higher prevalence among nurses from sectors OU, SMC/CC and IU, with 68.3% (n=71). S1 (Directing) prevailed in the EU, self-reported by 22.2% (n=18) of nurses. S3 (Supporting) was present in 9.6% (n=10) of the sample and had a higher incidence in the OU (n=2-11.1%).

Table 2: Profile of nurses of the hospital network. Chapecó, SC, Brazil, 2015.

Variables	H - I (n=73)		H - II (n=14)		H - III (n=17)		Total (n=104)		Value p*
	n	%	n	%	n	%	n	%	
Gender									**0.662**
Female	61	83.6	14	100	15	88.2	90	86.5	
Male	12	16.4	0	0	2	11.8	14	13.5	
Age Group									**0.863**
21-30	33	45.2	6	42.9	9	52.9	48	46.2	
31-40	30	41.1	7	50.5	7	41.2	44	42.3	
41-50	9	12.3	1	7.1	1	5.9	11	10.6	
51-60	1	1.4	0	0	0	0	1	1	
Working time									**0.310**
<1 year	15	20.5	5	35.7	5	29.4	25	24	
1/May	27	37	6	42.9	5	29.4	38	36.5	
5/Oct	16	21.9	2	14.3	5	29.4	23	22.1	
>10	15	20.5	1	7.1	2	11.8	18	17.3	
Activity sector									**0.001**
IU	45	61.6	8	57.1	13	76.5	66	63.5	
CC and SMC	9	12.3	3	21.4	0	0	12	11.5	
SU	7	9.6	1	7.1	0	0	8	7.7	
OU	12	16.4	2	14.3	4	23.5	18	17.3	
Type of leading position									**0.217**
Management	1	1.4	1	7.1	0	0	2	1.9	
Coordination	24	32.9	0	0	2	11.8	26	25	
Assistance	48	65.8	13	92.99	15	88.2	76	73.1	
Working time									**0.412**
Morning	17	23.3	6	42.9	8	47.1	31	29.8	
Evening	19	26	4	28.6	3	17.6	26	25	
Nightly	20	27	3	21.4	5	29.4	28	26.9	
SH	17	23.3	1	7.1	1	5.9	19	18.3	
Other agreements									**0.305**
Yes	16	21.9	4	28.6	4	23.5	24	23.1	
No	57	78.1	10	71.4	13	76.5	80	76.9	
Weekly worked hours									**0.497**
≤44	57	78.1	10	71.4	13	76.5	80	76.9	
45-65	10	13.7	2	14.3	1	5.9	13	12.5	
66-85	4	5.5	2	14.3	1	5.9	7	6.7	
>85	2	2.7	0	0	2	11.8	4	3.8	

* Relationship of variables and Situational Leadership styles – Pearson's chi-square test.

Tablel 3: Situational Leadership Styles. Chapecó, SC, Brazil, 2015.

Variables	S1 – Directing (n=18)		S2 – Coaching (n=71)		S3 – Supporting (n=10)		S.* – Secondary (n=5)		p Value
	n	%	N	%	N	%	n	%	
IU	11	16.7	46	69.7	7	10.6	2	3	0.001
CC/SMC	3	25	8	66.7	1	8.3	0	0	
SU	4	50	2	25	0	0	2	25	
OU	0	0	15	83.3	2	11.1	1	5.6	
Total	18	17.3	71	68.3	10	9.6	5	4.8	

* The styles may be used alone or not. If used in a composition, they are classified as secondary [9-10].

DISCUSSION

There was the predominance of women among participants, convergent feature with national[14-15] and international[3,9,11,16] surveys. The identified age group met the latest information released by the Federal Council of Nursing, which points out that the Nursing staff is considered young with 63.9% of professionals

aged under or equal to 40 years[14].

Contrary to what SL Theory presents, which describes being easier young persons to reach S3 (Supporting) and S4 (Delegating)[8] styles, nurses' self-analysis was more in style S2 (Coaching). However, in the study there was no significant relationship between leadership styles and the participants' age ($p>0.05$).

The absence of nurses in the delegating style suggests the difficulty of sharing tasks with the team and can demonstrate the fragility of health professionals in the management of people and their perception of the organizational commitment. The adoption of the delegating style could contribute to the unity and involvement of the team around an objective, reflecting as a potentiating factor of opportunities for strengthening the institution and professionals.

The predominant adoption of S2 (Coaching) was also found in other studies in the hospital setting[1,9], suggesting a pattern of leadership that is influenced by the complexity of the work in these locations and the need for quick decision making by nurses with low interaction with the other members of the work team. It is noteworthy that the adoption of directive styles may negatively influence the expectations of collaborators on the leader[16-17] and lead to the erosion of trust between them[18]. The adopted style influences job satisfaction as each style is exercised or not according to the situational context of nursing work and the various aspects surrounding it, as well as the net of relationships and behaviors.

It is understood, in general, that nursing assistants and technicians expect the leader to take join actions with the team, in the development of activities, construction of routines and decision-making, promoting satisfaction in the working process[2,3,18], aspects that sometimes contradict directly the Coaching style and approaches Supporting or delegating styles.

Still, it is noteworthy that small part of the participants self-identified the S3 (Supporting) style, which is more self-reported by younger nurses according to the SL Theory. Scholars[19] draw attention to the significant impact of nursing leaders at the forefront in providing high quality care, including their fundamental influence on the long-term sustainability on the improvement of nursing practices. In this regard, leaders are encouraged to perform to meet the organization's priorities and have clear expectations of the nursing staff.

The dominance of S1 (Directing) and S2 (Coaching) styles indicates the importance of continuing education to the teams, complementing them with higher and lower training time as well as professionals with different ages, in the pursuit of strengthening leadership. To ensure the development of skills needed to exercise leadership, nurses need to have easy access to education through contemporary educational programs and high quality to strengthen the clinical and directive skills[20].

As for the double employment bond, this was reported by a small portion of the sample (23.1%), which is rare among Brazilian nurses[15]. In part, this finding can be justified by the high weekly workload of participants. Considering that nursing work requires interaction with users in pain, suffering and disease, uninterrupted shifts, on Saturdays, Sundays and holidays, poor working conditions, a lot of responsibility and underappreciated[15].

Regarding training, it should be noted that 81.7% of nurses graduated after instituted the National Curriculum Guidelines (DCN, in Portuguese) for undergraduate Nursing courses, in 2001, which are based on management competencies, including leadership. Most of them had expertise and only 3.8% had a master's degree, a usual data due to the significant number of professionals who have expertise only, and due to the largest contingent of nurses who are masters and doctors acting in university hospitals and federal institutes.

On the international scene, leadership is an essential relational skill in nursing. Evidence in the literature has shown that in institutions where leadership was effectively taught there was a positive impact in practice. It is necessary greater investment in the training of leadership in an integrated way to the Nursing curriculum; educational institutions should encourage the development of leadership programs, and seek greater integration between health services in order to promote improvements in practice and organizational culture[3,21].

However, in the studied population, the activity sector was the only variable that had a significant relationship with the adopted leadership style. The leadership style S2 (Coaching) was predominant in the OU, SMC/CC and IU, as also found in other studies[1,6,9].

In the nursing performance in care facilities, research[1,6,21] indicate that the practice of leadership is positively influenced by the care dominance, excellence in clinical practice is considered a key factor for the acceptance of the nurse as leader. Statistical findings indicate that nurses in the investigated scenario, although close to the direct care to the user, unlike what literature mentions, have adopted styles that disfavor the dialogic leadership, stepping away from the work team. Despite the youthfulness of the participants and the short time of performance, the leadership adopted by nurses already signals weakness, because tasks are the centrality in the professional practice of the participants.

These data indicate the need to provide opportunities for leader nurses, recognition strategies of their profile, given that the situational leader is required minimal skills, including the ability to diagnosis, flexibility and know how to work in teams[7]. When considering the SL model, there is no right or wrong, because it relies on the fact that there is no single appropriate leadership style for any situation[1,7-8]. However, it should be emphasized that the nurse's performance, as a leader, should be linked to the establishment of healthy interpersonal relationships that prioritizes, in addition to activities, the worker's well-being. Therefore, the development of leadership cannot be understood as an individual responsibility, as to its success, investments are essential for both educational institutions and health services.

The nurse leader can adopt different behaviors and actions in order to empower and engage the group in the care process, articulate and collectively, establishing open communication channels and developing participatory processes of leadership, sensitive to the staff needs[16,21]. However, the professional needs conditions to exercise his/her leadership in order to understand the working process that permeates their daily lives, recognizing the peculiarities of each collaborator and his/her unit, setting goals and trying to reach them with the effective help of the team. This process should be facilitated with the aid of the institution through education, as well as from guaranteeing workers in adequate quantity and good working conditions.

FINAL REMARKS

The results showed the predominance of Coaching style among nurses in the hospital setting, emphasizing the importance of discussing the adoption of a directive style, which evidences focus to the task, which can limit the creativity and potential of the members team's. Despite the population stands out as young and with little time of performance, leadership adopted by nurses already signals weakness, and the tasks have gained centrality in their practice.

The finding goes against the empowerment of those involved regarding their working process, defended by the SL theory. This can interfere negatively in the leadership processes in the hospital environment, since the prevalence of adopting directive styles refers to the coercive power, in which the leaders do not inspire their collaborators.

However, the adoption of SL styles is directly related to the maturity of the team members, their willingness to assume responsibility for directing their own behavior, and therefore it is understood as a study limitation the lack of data on the collaborators' perceptions, as well as information relating to nurses working process, which could strengthen the assessment, especially regarding the adoption of directive styles and the workplace, since it can influence the lead process.

Therefore, the use of strategies to achieve high levels of maturity is essential, providing opportunities to nurses and professionals to develop their activities independently and that there is high level of trust among members of the nursing staff.

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