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Developing leadership practices of head nurses

Usha Marath[1,*] and Ramachandra[2]

[1]Professor cum Principal, Lisie College of Nursing, Lisie Hospital, Ernakulam, Kerala, India.

[2]Additional Professor cum Head of Department of Nursing, NIMHANS, Bangalore, Karnataka India.

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ABSTRACT

Current research reveals that head nurses/ ward in chargers are routinely placed into front-line leadership roles with little formal preparation. The purpose of this study was the development, implementation, and evaluation of a nurse leader development program for nurse leaders at a selected hospital located in Ernakulam, Kerala, India. This study involved a mixed method approach with a quasi-experimental design. The intervention consisted of a leadership development package delivered to a convenience sample of nurses in managerial positions. Leadership attributes was quantified, both pre/post interventions, through the administration of the Leadership Practices Inventory (LPI).The findings of the study revealed that the leadership development package could bring in significant improvement in the leadership practices of the head nurses.

Introduction

Scholars in various disciplines have defined leadership as the driving force in the success or failure of any organization. [1&2] Health care system is increasingly becoming complex and more difficult to manage with each passing decade. [3] Leadership and management in nursing directly influence the quality of healthcare provided to patients and therefore directly impacts upon patient outcomes. [3-5] Although the literature contains only limited information concerning the actual role of the charge nurse, several studies have defined the primary accountability as that of a decision-maker.[6, 7-9] Literature supports that job satisfaction is related to nurse manger's leadership style. Transformational leadership style was associated with higher levels of job satisfaction.[10] Other studies have shown that effective nurse leaders are capable of transforming environments to support more open communication, increased educational opportunities, nurse empowerment and autonomy, and shared responsibility in decision-making processes that improve nurse and patient outcomes.[11-13]

Working as a nurse leader requires complex skills and competencies that could affect not only staff, but also patients.[11] Frontline nurse leaders are responsible for decision-making not only related to patient care, but also for decisions that will affect the staff and daily operations. Each of these is affected by the nurse's education or work experience.[14] Without proper education, training, and mentoring, nurse leaders may struggle in their roles, which can contribute to decreased nurse satisfaction and poor patient outcomes.[15&16] Grossman and Valiga [17] stated significant leadership in nursing is necessary if patient care outcomes have to improve. Nursing leaders, even without experience, can learn to use a transformational leadership style that focuses on influencing followers and developing subcultures in which positive relationships are formed between leaders and staff.[6] Developing future nurse leaders is one of the greatest challenges faced by the nursing profession.[18] Powerful leadership skills are needed by all nurses—those providing direct care to those in top management positions. Anyone who is looked to as an authority (e.g., a nurse taking care of a patient) or who is responsible for giving assistance to others is considered a leader. [18] The literature also highlights that despite nurses' action to undertake leadership initiatives within changing health care organizations, the relevance of nurses' work continued to be unrecognized by others.[19-21] In order to gain a higher profile and independence in practice so as to achieve their goals of health care, nurses need to look at explicating their leadership practices.[22&23] Ultimately articulation of nursing practice through a leadership perspective could create a clearer understanding of the value of nursing within the health care system.[22&23] The main aim of this paper is to find the impact of a leadership development package (LDP) on leadership practices of head nurses working in the clinical settings as reported by the participants and also as observed by the others. And it was also to determine the satisfaction of participants with the leadership development package.

Methodology

The following hypotheses were tested;

H1 -Mean Self-rated scores for each of the five leadership practices will increase significantly from pretest to posttests for head nurses in the experimental group compared to those in the control group as measured by the LPI at 0.05 level of significance.

H2-Mean Observer rated scores for each of the five leadership practices will increase significantly from pretest to posttests for head nurses in the experimental group compared to those in the control group as measured by the LPI at 0.05 level of significance.

H3-There is a significant difference between mean self rated scores and mean observer rated scores of the five leadership practices for head nurses as measured by the LPI at 0.05 level.

The study involved a mixed methods approach.

Tele: +919497039262

E-mail address: ushamarath@gmail.com

A mixed methods study is an approach that collects, analyses, and integrates quantitative and qualitative data in a single study in order to resolve research problems based on the epistemology of pragmatism.[24&25] When used in combination, both quantitative and qualitative data yield a more complete analysis and complement each other. Such a design strengthens the reliability and validity of the research through corroboration and mutual assurance.[26] As the main purpose of the study was to find the impact of leadership development package on leadership practices of head nurses, a quasi experimental design was utilized for the study to collect the quantitative data. A pre test multiple posttest control group design was found to be suitable. As there was a high chance for contamination of intervention all the participants in one institution acted as the experimental group and all the participants of the other institution acted as the control group. Hence randomization was not feasible. A multiple posttest was selected in order to ascertain the long term effects of the treatment. A descriptive design was selected to find the satisfaction of participants with the LDP.The study used a convenience sampling technique. Two leading and prominent hospitals in private sector were selected as per the convenience and permission was obtained from the management to conduct the study in their respective institution**.** Thirty head nurses or ward in charges who volunteered for the study on first come basis from selected hospitals were the study participants in the control and experimental group. All participants in the experimental group of head nurses who were willing to attend the focus group discussion were included in the discussion to find their satisfaction with LDP. The tools used for data collection included; Demographic information tool, to collect information regarding selected demographic variables of the participants. The technique of data collection was self report. In order to assess the leadership practices Leadership Practice Inventory (LPI) by Kouzes and Posner's self and observer rated [27-30] was used. Permission was obtained to use the LPI self and observer for the study from the publisher. Focus group discussion was based on eight questions which guided the investigator to gather qualitative data on the perception of participants in the experimental group regarding their satisfaction with the LDP and the outcomes of their participation in the leadership training program. The focus group discussion was recorded for future analysis and interpretation. Validity and reliability of the tools were established prior to the commencement of the study.

The intervention was the LDP based on Kouzes and Posner five leadership practices which were as follows: model the way (MTW), inspire a shared vision (ISV), challenge the process (CTP), enable others to act (EOA) and encourage the heart (ETH).[31] The Leadership Development Package consisted of four parts; Part A – Module 1 dealt with meaning and significance of leadership, difference between management and leadership and myths of leadership. Part B – Module 2 Know yourself which included orientation to LPI and 360 degree feedback to participants. Part C- Five Exemplary Leadership Practices which includes Module 3 – Model the way, Module 4 – Inspire a shared vision, Module 5- Challenge the process, Module 6- Enable others to act and Module 7 – Encourage the heart. Part D- Journey to continued leadership development which included Module 8 the self development activities for continued leadership development. The LDP was administered for four days, one day per week for four weeks using various teaching/ training techniques; self assessment, structured learning activities, skill building learning activities, group activities, reflective thinking, and ongoing self learning. After informed consent was obtained from the participants, the Demographic information tool, the Pretest self report (LPI-Self) and three Pretest observer scales (LPI-Observer) were distributed to all the participants. Written instruction was provided to them regarding the method of collecting observer reported data (LPI-Observer). The researcher collected the completed demographic tool and LPI self from the participants. The head nurses/ ward-in-charges were instructed to collect LPI-Observer from the nursing superintendent, one from the staff nurse working in her unit and one from a peer group member. All participants were instructed to hand over the completed three LPI-Observer instruments within three days. This was followed by the administration of intervention (LDP) as per the protocol to participants in the experimental group on the fourth day and it was not administered to the participants in the control group. Posttests (O2, O3 and O4) were administered on day 30, day 90 and day 180 after the last day of intervention. LPI-Self was administered to participants of both experimental and control group and three observer scales (LPI-Observer) were given to them to be completed and handed over to the researcher from the same observers within three days as done earlier. A focus group discussion was held on the last day of intervention with the participants of the experimental group in groups of 10, after obtaining the consent, to gather qualitative data on their perception of outcomes and their satisfaction with the LDP.

The one sample Kolmogorov-Smirnov test (Z-statistic) was applied to test for a normal distribution and it was found that the mean LPI scores for the five leadership practice were normally distributed for the whole sample as per the Z scores. The parametric statistics used in this study was the independent sample paired t' test, to analyze the difference between means of two groups of values to determine whether they were different by chance or another factor. The significance for all statistical analysis was set at 0.05 level to minimize the significant results that were due to chance. Observer ratings were averaged for each leadership practice resulting in one observer score for each participant at each time-period. Thematic analysis was performed on the qualitative data collected from focus group discussion.

Results

Demographic profile of head nurses

The demographic questions provided adequate information to identify the sample as representative of head nurses which was the need of this study. The age of the participants ranged between 32 to 56 years, with the majority in the experimental group (56.7 %) and in the control group (63.3 %) falling between the ages of 41 and 50 years of age. Majority of the participants had only a diploma in nursing in both the experimental (76.7%) and control (86.7%) group, 16.7 % in the experimental group and 10% in the control group held a Post Basic B.Sc Nursing degree and only 6.6% in the experimental group and 3.3% in the control group had a B.Sc Nursing qualification, and none held a master's degree in nursing. Sixty percent of the participants in the experimental group and 40% in the control group had more than 15 years of experience, Majority of head nurses were employed in the current position for a period between 11 to 15 years and in the current organization for a period more than 15 years in the experimental (60%) and control group (40%). None of the head nurses had undergone any formal leadership training program.

Rank order of the five leadership practices of head nurses

For the head nurses the Leadership Practices Inventory was used to measure the five leadership practices both as self and observer rated. Each of the five practices was scored based on responses to behavioral statements measured on a 10-point Likert-scale. The mean score for each of the five leadership practices was on a 6- 60 point scale. A higher value represented more frequent use of the leadership behavior. The rank order of the five leadership practices from first to fifth were for enable others to act, encourage the heart, model the way, challenge the process and last was for inspire a shared vision based on the mean self rated pretest scores for head nurses in both experimental and control group respectively. Hence it shows that the leadership practices were ranked in a similar manner by head nurses in both the groups.

for the participants in both experimental and control group of head nurses. But the other two leadership practices inspire a shared vision and challenge the process were ranked as fourth and fifth for head nurses in the experimental group and vice versa for the head nurses in the control group. As reported by observer, the rank order of the five leadership practices was almost similar for both the group except for inspire a shared vision and challenge the process.

Comparison of mean self rated leadership practice scores of head nurses

An independent sample paired t test was computed to find the difference between the mean self rated pretest scores and the mean self rated posttest scores of head nurses in experimental and control group which is presented in table 1 and 2 respectively.

Table 1. Mean, paired SD and SEM difference, t value and level of significance of the pretest and posttest scores of head nurses in the experimental group as rated by self. N-30.

Leadership Practices	Self rating	Mean	Paired difference SD	SEM	Paired t-value	Level of Significance
Model the way	Pretest	41.03				
	Post test 1	43.83	1.90	0.34	-8.06	.001*
	Post test 2	46.76	3.53	0.64	-8.89	.001*
	Post test 3	49.50	4.17	0.76	-11.10	.001*
Inspire a shared vision	Pretest	37.86				
	Post test 1	41.00	2.08	0.37	-8.25	.001*
	Post test 2	45.33	3.55	0.64	-11.48	.001*
	Post test 3	47.83	4.59	0.83	-11.87	.001*
Challenge the process	Pretest	39.40				
	Post test 1	41.26	1.87	0.34	-5.46	.001*
	Post test 2	44.67	2.89	0.52	-8.83	.001*
	Post test 3	46.13	3.47	0.63	-10.61	.001*
Enable others to act	Pretest	45.30				
	Post test 1	47.13	2.29	0.41	-4.38	.001*
	Post test 2	50.70	3.48	0.63	-8.47	.001*
	Post test 3	52.40	4.42	0.80	-8.78	.001*
Encourage the heart	Pretest	42.76				
	Post test 1	46.90	3.28	0.60	-6.88	.001*
	Post test 2	50.60	3.83	0.69	-11.19	.001*
	Post test 3	52.66	4.65	0.85	-11.64	.001*

df-29 * Significant at 0.05 level

Table 2 Mean, paired SD and SEM difference, t value and level of significance of the pretest and posttest scores of head nurses in the control group as rated by self.N-30

Leadership Practices	Self rating	Mean	Paired difference SD	SEM	Paired t-value	Level of significance
Model the way	Pretest	44.33				
	Post test 1	44.66	1.34	0.24	-1.35	.186
	Post test 2	37.66	7.89	1.43	4.65	.001*
	Post test 3	43.60	2.11	0.38	1.89	.068
Inspire a shared vision	Pretest	41.66				
	Post test 1	42.13	1.38	0.25	-1.84	.075
	Post test 2	33.66	9.82	1.79	4.45	.001*
	Post test 3	42.30	2.57	0.47	-1.34	.189
Challenge the process	Pretest	42.13				
	Post test 1	42.46	1.34	0.24	-1.35	.186
	Post test 2	33.60	7.24	1.32	6.45	.001*
	Post test 3	42.66	2.31	0.42	-1.26	.217
Enable others to act	Pretest	47.30				
	Post test 1	47.06	1.25	0.22	1.02	.315
	Post test 2	39.06	8.48	1.54	5.31	.001*
	Post test 3	46.53	2.32	0.42	1.80	.082
Encourage the heart	Pretest	45.43				
	Post test 1	45.60	1.11	0.20	-0.81	.420
	Post test 2	38.46	8.84	1.61	4.31	.001*
	Post test 3	45.70	2.58	0.47	-0.56	.576

df-29 * Significant at 0.05 level

Testing of H1- Mean Self-rated scores for each of the five leadership practices will increase significantly from the pretest to posttests, for head nurses in the experimental group compared to those in the control group as measured by the LPI at 0.05 level of significance.

In table1 the mean self rated post test scores of head nurses in experimental group showed a significant increase from pretest through the posttests for the five leadership practices at 0.001 level. Whereas in table 2 there was a significant decrease in the second mean self rated posttest scores for the five leadership practices and no significant change was noted for first and third mean self rated posttest scores for the five leadership practices. Hence H1 was accepted. Thus it shows that the LDP was found to be effective in improving the leadership practice scores of head nurses as rated by them.

Comparison of observer rated leadership practice scores of head nurses

An independent sample paired t test was computed to find the difference between the mean observer rated pretest scores and the mean observer posttest scores of head nurses in experimental and control group which is presented in table 3 and 4 respectively.

Testing of H2- Mean observer rated scores for each of the five leadership practices will increase significantly from the pretest to posttest, for head nurses in the experimental group compared to those in the control group as measured by the LPI at 0.05 level of significance.

Table 3 Mean, paired SD and SEM difference, t value and level of significance of the pretest and posttest scores of head nurses in the experimental group as rated by observers. N-30

Leadership Practices	Observer Rating	Mean	Paired difference SD	SEM	Paired t value	Level of Significance
Model the way	Pretest	41.41				
	Post test 1	43.21	1.17	0.21	-8.40	.001*
	Post test 2	43.93	1.82	0.33	-7.57	.001*
	Post test 3	44.64	1.87	0.34	-9.42	.001*
Inspire a shared vision	Pretest	39.38				
	Post test 1	41.24	1.74	0.31	-5.86	.001*
	Post test 2	41.43	2.19	0.40	-6.11	.001*
	Post test 3	42.13	2.44	0.44	-6.17	.001*
Challenge the process	Pretest	39.14				
	Post test 1	40.76	1.52	0.27	-5.84	.001*
	Post test 2	41.38	1.59	0.29	-7.67	.001*
	Post test 3	41.75	1.84	0.33	-7.76	.001*
Enable others to act	Pretest	43.82				
	Post test 1	46.40	1.73	0.31	-8.13	.001*
	Post test 2	47.51	2.22	0.40	-9.08	.001*
	Post test 3	48.11	2.48	0.45	-9.47	.001*
Encourage the heart	Pretest	42.12				
	Post test 1	45.67	2.18	0.39	-8.92	.001*
	Post test 2	47.35	2.90	0.53	-9.87	.001*
	Post test 3	47.97	3.14	0.57	-10.17	.001*

df-29* Significant at 0.05 level

Table 4 Mean, paired SD and SEM difference, t value and level of significance of the pretest and posttest scores of head nurses in the control group as rated by observers. N-30

Leadership Practices	Observer Rating	Mean	Paired difference SD	SEM	Paired t value	Level of Significance
Model the way	Pretest	40.78				
	Post test 1	40.38	1.30	0.23	1.66	.106
	Post test 2	40.28	0.94	0.17	2.88	.007*
	Post test 3	40.12	1.30	0.23	2.74	.010*
Inspire a shared vision	Pretest	38.07				
	Post test 1	37.42	1.34	0.24	2.66	.012*
	Post test 2	37.65	0.91	0.16	2.50	.018*
	Posttest 3	37.32	1.36	0.24	3.00	.005*
Challenge the process	Pretest	39.39				
	Post test 1	38.65	1.21	0.22	3.33	.002*
	Post test 2	38.68	1.20	0.21	3.22	.003*
	Post test 3	38.49	1.35	0.24	3.64	.001*
Enable others to act	Pretest	43.57				
	Post test 1	43.57	1.04	0.91	-0 .01	.986
	Post test 2	43.37	1.09	0.19	0.96	.341
	Post test 3	43.44	0.93	0.17	0.74	.464
Encourage the heart	Pretest	43.14				
	Post test 1	43.59	1.37	0.25	-1.80	.081
	Post test 2	43.30	0.93	0.17	-0.93	.358
	Post test 3	43.52	1.47	0.26	-1.42	.164

df -29 * Significant at 0.05 level

Table 3 shows that the mean observer rated posttest scores of head nurses in experimental group for the five leadership practices showed a significant increase from the mean observer rated pretest scores whereas from table 4 the mean observer rated posttest scores of head nurses in the control group showed a significant decrease for the leadership practices for all the mean observer rated posttest scores of challenge the process, inspire a shared vision and the second and third mean observer rated posttest scores for model the way and there was no significant difference for the other mean observer rated posttest scores of other leadership practices. Hence the hypothesis H2 was accepted. It can thus be concluded that as rated by observers the intervention was effective in improving the five the leadership practices of the head nurses.

Comparison of mean self rated scores and mean observer rated scores for the five leadership practices of head nurses

One of the objectives of the study was to find the difference in the self rating and observer rating of head nurses regarding the five leadership practices before and after the administration of LDP. The comparison was made using the mean pretest scores and third mean posttest scores (O4) for the five leadership practices as rated by self and observers for the head nurses and is presented in table 5 and 6 respectively.

Table 5 Mean self and observer pretest scores, paired difference of SD and SEM, t value for the leadership practices of head nurses.

N-60

Leadership Practices	Mean self Pretest Score	Mean observer Pretest Score	Paired difference SD	SEM	t-value	Level of Significance
Model the way	42.68	41.09	6.88	0.88	-1.78	.079
Inspire a shared vision	39.76	38.72	7.11	0.91	-1.13	.262
Challenge the process	40.76	39.26	6.73	0.87	-1.72	.090
Enable others to act	46.30	43.69	6.26	0.80	-3.22	.002*
Encourage the heart	44.10	42.63	7.44	0.96	-1.53	.131

df- 59 *** Significant at 0.05 level**

Table 6 Mean self and observer posttest scores, paired difference of SD and SEM, t value for the leadership practices of head nurses.

N-60

Leadership Practices	Mean self Posttest Score O4	Mean observer Posttest Score O4	Paired difference SD	SEM	t-value	Level of Significance
Model the way	46.55	42.38	4.88	0.63	-6.60	.001*
Inspire a shared vision	45.06	39.72	5.64	0.72	-7.32	.001*
Challenge the process	44.40	40.12	5.06	0.65	-6.54	.001*
Enable others to act	49.46	45.77	4.92	0.63	-5.80	.001*
Encourage the heart	49.18	45.74	5.18	0.66	-5.13	.001*

df-59 *** Significant at .05 level**

Testing of H3- There is a significant difference between mean self rated scores and mean observer rated scores of the five leadership practices for head nurses as measured by the LPI at 0.05 level.

From table 5 the leadership practice, enable others to act had shown a significant difference between the mean self rated pretest score and the mean observer rated pretest score, the other four leadership practices did not show any significant difference. But in table 6 the five leadership practices had shown a significant difference between the mean self rated third posttest scores and the mean observer rated third posttest scores, thus indicating that there was a significant difference in the ratings of self and observers during the final posttest of head nurses. The head nurses had rated themselves higher than their observers during the third posttest time period.

It can be thus inferred that the head nurses have rated themselves to be performing all the five leadership practices more frequently after the implementation of the LDP.

Focus group discussion with Head Nurses

A focus group discussion in three groups of ten subjects was held on the last day of intervention for the experimental group head nurses. Following six major themes and sub themes were evident from the focus group discussion with head nurses.

Theme 1- Achievement by participating in this program

- Majority of the participants supported that they had gained a lot of new information on leadership qualities, competencies, and the five leadership practices. Majority of the nurses voiced that they were able to understand themselves better**.** "I got a better picture of where I stand as a leader." "My self evaluation was low but my observer evaluation was high which in a way boosted my self confidence as a leader."
- Majority of the head nurses reported that they were able to implement the leadership practices in the area of work. "I was able to motivate and encourage my staff to go ahead with new developments in my unit." "I am able to understand others better."

Theme 2- Satisfaction level after attending the LDP

- All the participants were highly satisfied with the LDP, as they found it easy to implement in the practical situation. "Till date we did not know how to improve our leadership skills but the LDP has helped us to improve our leadership skills a lot."

Theme 3- Struggling with leadership situation and difference in the way the situation is handled after the LDP

- Main sources of dissatisfaction at work place situation voiced by majority of head nurses were

1. The frequent turnover of the staff,
2. Unavailability of experienced and dedicated staff nurses,
3. Lack of attitude among the new generation staff nurses,
4. Generational gap all leading to lack of teamwork,
5. Lack of coordination,
6. Lack of motivation in achieving quality patient care.

- Many of the problems were still present but the head nurses said that the program helped them to view the challenges and they were able to communicate with the management and the staff what was needed. The staff was motivated, guided and encouraged to work in team to attain the vision of the hospital. "The institution is giving us support to enhance the performance of the ward staff."

Theme 4- Additional support which is needed to develop leadership skills

- Opportunity needs to be provided to all so that they will be able to exercise their leadership skills.
- The management needs to support head nurses in all activities with adequate motivation, encouragement and rewards..
- Management should have a positive attitude towards nurses and they should be involved in various decision making process.
- Nurses should be deputed for such training program regularly.
- Nurses need to be respected and given their due recognition.

Theme 5- Participation in future programs of leadership

- All head nurses agreed that they would be attending such program in future as it helps them to learn new things and develop new skills.

Theme 6- Suggestion and feedback of the LDP

- Majority of the participants voiced that the LDP was very good, interesting, and easy to understand and practice. "Very interesting, earlier we did not know how to improve our leadership skills but this program has shown us a path that we need to follow." "The activity sessions were very interesting and did not know how time passed by."
- To reduce theory portion in the LDP and supplement it with video clippings of successful leaders and their qualities.

Discussion

Leadership practices of head nurses

The five leadership practices were ranked in almost a similar order by head nurses and their observer with the leadership practices enable others to act, encourage the heart and model the way ranked as first, second and third respectively. Challenge the process was ranked as fourth and last was for inspire a shared vision for all the participants except the control group with vice versa ranking as rated by observers for control group participants. The findings of the present study have been supported by similar findings in other studies. Abaan and Duygulu in a study of one hundred thirty staff nurses from 35 units in the largest Ministry of Health Hospital in Ankara, Turkey (64% response rate) reported that the most frequent leadership practice was Modeling, closely followed by Enabling and Encouraging, and then Challenging and Inspiring.[32] Blair among forty-eight clinical executive leaders from 12 different states, all members of the American Organization for Nurse Executives, found that the most frequently engaged in leadership practice was Enable, with Model and Encourage next, and then Inspire and Challenge.[33] In some studies leaders and observers differed on all five leadership practices. Leaders reported more frequency in the leadership practices than that reported by their observers, but the rank order between the two groups was identical.[34]

The findings about the importance of enabling others to act, and encouraging the heart according to the researcher, was not unexpected given the nature of nursing and the need for these leaders to provide an environment that will enable their staff to deliver nursing care to patients. Also not unexpected, was the importance of modeling the way for if the nursing leaders don't 'walk their talk' and role model the behaviors that they value, no one will be ready to follow them. Nurse leaders are encouraged to incorporate such leadership practices as enabling others to act, encouraging the heart, and modeling the way. These three leadership practices were described as the most common behaviors among EI nurse leaders.[35]

But it was found that the leadership practice, challenge the process and inspire a shared vision were ranked lower by both head nurses and their observers. This could be because of the nature of their work responsibilities or because these two

leadership practices are the least culturally-specific of the set of leadership practices. The culture of nursing educational programs tends to generate cohorts of nurses who were docile, obedient, dedicated to the hospital, and willing to work cheaply.[36] Even the nursing superintendents themselves were usually docile and obedient, avoiding confrontation with the medical and administrative hierarchy at all costs.[36] A similar culture is present in the Indian setting where it has been observed that nurses are seldom involved in the decision making process by the management and are considered subordinate to the doctors.

Impact of leadership development package on leadership practices of head nurses

From the results of the study it can hence be concluded that as reported by the head nurses and their observers the intervention was effective in improving all the five the leadership practices. A number of previous studies have used a pretest/posttest design to evaluate leader behavior changes following participation in a leadership development program and these produced varying results. Cummings, et al., reviewed 24 studies. Nine of the 24 studies were related to the effectiveness of educational interventions in developing leadership behaviors in nursing. All nine studies used some type of pre/post measurement of leadership skills and competencies. All of the studies reported an increase in skills and competencies when rated by self or by others. Two of the three studies reported long term effects 3 months following education and one demonstrated positive results at 6 and 12 months. Finally, leadership training programs were mostly found to be effective, not just in bringing about short-term change, but also in the long term.[37]

In yet another study, O'Toole Eileen measured the change in behavior in the workplace as a result of attending a four day (32 hrs) hospital leadership program. The participants completed the Leadership Practices Inventory at the start of the program, and again between three months to one year after attending the program. The findings revealed that there was a statistically significant improvement on scoring from the pre-test to the post-test which prove that the leadership program was successful in changing behavior at the workplace.[38]

In this study the increase in leadership practice scores over time, when compared to the control group's results prove the effectiveness of LDP in improving the five leadership practices of head nurses. In this respect the current study extends earlier studies by highlighting the role of LDP in increasing leader behavior scores.

Satisfaction of head nurses with LDP

The findings of the focus group discussion with head nurses were similar to those reported in other studies. Geore et al [39] in a study involved interviews with a panel of nurses at three, six, and twelve month's post-completion of the shared leadership concepts program (SCLP). Nurses reported increased personal self-growth over time after training. "They were more aware of how their leadership behavior had changed, how it affected how they acted, and areas to further improve over time. They reported less stress, were able to participate in committees, and served as resources to other staff more effectively. They saw themselves as having more negotiation skills, better relating to others, and being more accountable for and aware of the health care system as a whole.[39]

Olson [40] in a study of Leadership Development in the Regional Institute for Health and Environmental Leadership (RIHEL) interviewed RIHEL fellows who reported specific utilization of the five exemplary leadership practices as well as collaborative processes taught during the program, being more self-aware and reflective in their approach to leading, being more intentional and conscious about the practices they utilized and why, and more confident in their leadership practices. Further observations from the interviews noted: "Even some participants who had lower or negative total LPI change scores could articulate specific practices that had changed for them and self-awareness came in many forms for the fellows."[40]

Conclusion

A number of limitations need to be taken into consideration, like a lack of a universal definition of 'effective' leadership which impacts the robustness and generalization of findings. Also the testing of effectiveness of leadership development program was through a cross-sectional approach, and thus it remains unclear as to how this learning subsequently proved beneficial in practice. It should also be noted that leadership development is complex and affected by many variables. The educational program may not be the only variable effecting a change. Other variables that might have had an impact would be outside readings, other formal education, type of leadership position held, the organizational climate, or the ongoing nurses' strike. Another limitation is that the groups were only from two selected settings and may not be a true representative of head nurses in other geographical locations. Hence generalization of the findings needs to be done with caution. The most obvious caution when it comes to interpreting these findings is that it is impossible to be certain about how respondents actually behave versus how they say they behave, even though the use of ratings from observers in this study goes a long ways toward reducing that potential gap, and minimizing self-report bias; the fact remains.

The findings confirmed that the leadership development package was instrumental in bringing significant changes in the five leadership practices of participants. The participants were highly satisfied with the LDP as it helped them to improve their knowledge regarding leadership, have a better understanding of oneself and helped to improve their leadership practices.

Leadership in healthcare systems involves leadership at both the micro level and macro level or the organizational and departmental levels and generally concerns setting the direction for the broader health system and with creating possibilities for success and helping people to achieve goals.[41] Nursing leadership has been identified as a key attribute of a healthy professional practice environment.[42] An RN licensure implies a certain amount of leadership skills as delegation and supervision of others are a part of the job description. Clinical leadership concerns leadership at the level of clinical care and is about facilitating evidence-based and effective local care and improved patient outcomes.[41] In India thirteen competencies of RN has been stated; one of this is to display leadership, management, and quality improvement (Indian Nursing Council, 2011).[43] Like nurses in other part of the world, Indian nurses need to efficiently manage the critical problems of complicated patients. They are expected to demonstrate high clinical and leadership competencies. Leadership is not a quality that is emphasized in nurse's training, nor is it an ability that comes naturally to most nurses.[44]

Based on the study findings some of the recommendations proposed were development of a national nursing leadership framework which should take cognizance of the clinical leadership development needs of nurses with best evidence

from the literature. Robust theory and research on interventions to develop and promote viable nursing leadership for the future are needed to achieve the goal of developing healthy work environments for health care providers and optimizing care for patients. In addition to this, the financial costing need to be undertaken so as to ascertain a full cost benefit analyses of leadership development program.

If nurses are to survive in a health care system that fails to recognize nursing's contribution, nurses need to communicate clearly, common understandings of their leadership among professional groups. Nursing needs leaders who are strong, resilient, and effective. The challenge for nursing profession is therefore to produce nurse leaders who can develop people with vision and entrepreneurial capability so that they can improve health care and meet the needs of a rapidly transforming health care system.

Ethical clearance was obtained from the Institutional Ethics Committee. Separate permission was obtained from each setting for the study. Informed consent was obtained from each participant of the study. They were made fully aware of the confidentiality and anonymity of the responses which would be given, including the fact that the researcher would use the data for research purpose only. For the focus group discussion the participants were assured that the data would be recorded and after analysis the data would be erased.

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