Original Article

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RESONANT LEADERSHIP PRACTICES OF NURSE MANAGERS IN THE HOSPITAL SETTING: A CROSS-SECTIONAL STUDY

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ABSTRACT

Objective: analyze Resonant Leadership style among the nurse managers from the perspective of nurse managers and nurses.
Methods: cross-sectional study, carried out in a hospital in Guyana. Participants were 171 registered nurses and nurse managers. Data were collected from July to October 2020 using Resonant Leadership scale and a socio demographic questionnaire.
Results: in self-version, the total leadership rating was 38.9 for nurses and 41.6 for managers (p=0.003). The age category at most 30 are more likely to give a low rating of themselves than the age category 50 – 69 (p = 0.046). Managers scored on average 3.44 points more than nurses for the self total leadership rating.
Conclusion: resonant leadership is practiced at a moderate level and managers have higher scores. Nurse Managers can improve their leadership style.

DESCRIPTORS: Leadership. Resonant Leadership. Nursing. Nursing Staff. Hospitals.

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PRÁTICAS DE LIDERANÇA RESSONANTE ENTRE ENFERMEIROS GESTORES NO CONTEXTO HOSPITALAR: ESTUDO TRANSVERSAL

RESUMO

Objetivo: analisar o estilo de liderança ressonante entre enfermeiros gestores na perspectiva de enfermeiros e enfermeiros gestores.
Método: estudo transversal conduzido em um hospital na Guiana. Participaram do estudo 171 enfermeiros e enfermeiros gestores. Os dados foram coletados de julho a outubro de 2020 por meio da escala de liderança ressonante e de um questionário sociodemográfico.
Resultados: Na versão autorreportada, os enfermeiros pontuaram 38,9 e os gestores 41,6 (p=0,003). Os profissionais com até 30 de anos de idade tendem a se classificar com pontuações mais baixas do que profissionais entre 50 e 69 anos (p=0,046). Os gestores pontuaram 3,44 pontos a mais do que os enfermeiros na no escore total da versão autorreportada.
Conclusão: a liderança ressonante é praticada em nível moderado e os gestores apresentam pontuações mais elevadas. Os gestores podem melhorar seu estilo de liderança.

DESCRITORES: Liderança. Liderança Ressonante. Enfermagem. Recursos Humanos de Enfermagem. Hospitais.

PRÁCTICAS DE LIDERAZGO RESONANTE DE ENFERMEROS GESTORESEN EL ÁMBITO HOSPITALARIO: UN ESTUDIO TRANSVERSAL

RESUMEN

Objetivo: analizar el estilo de Liderazgo Resonante entre enfermeros gestores, desde la perspectiva de enfermeros gestores y enfermeros.
Métodos: estudio transversal, realizado en un hospital de Guyana. Los participantes fueron 171 enfermeros licenciados y enfermeros gestores. Los datos fueron recolectados de julio a octubre de 2020, mediante la escala de liderazgo resonante y de un cuestionario sociodemográfico.
Resultados: en la versión de autoevaluaciónla calificación total del liderazgo fue de 38,9 para los enfermeros y 41,6 para los gestores (p=0,003). La categoría de edad de hasta 30 años tuvo más probabilidades de otorgar una calificación baja de sí mismos que la categoría de edad de 50 a 69 años (p = 0,046). En la versión de autoevaluación del liderazgo total, los gestores obtuvieron en promedio 3,44 puntos más que los enfermeros.
Conclusión: el liderazgo resonante se practica en un nivel moderado y los gestores tuvieron puntuaciones más altas. Los enfermeros gestores pueden mejorar su estilo de liderazgo.

DESCRIPTORES: Liderazgo. Liderazgo Resonante. Enfermería. Recursos Humanos de Enfermería. Hospitales.

INTRODUCTION

The complexity of healthcare systems requires multidisciplinary teams capable of working effectively and with good relationships, measured by leaders with good relational skills[1]. As the complexity of health has increased, the need for effective and well-prepared nursing leaders has become urgent[2].

In recent years, leadership in healthcare has shown significant changes, with adoption of different leadership styles[3]. Among these styles, contemporary theories stand out for their focus on relationships and people rather than tasks, providing positive results for professionals, health services, and patients[4–5].

An important aspect of the leader that has been highlighted is emotional intelligence, the dominant feature of the resonate leader, who, in addition to acute emotional intelligence, provides appropriate feedback, stimulates the satisfaction, success, and effectiveness of the followers[6]. The concept of emotional intelligence is based on the awareness, management and use of emotions to facilitate performance[7], with synchrony between the emotions of leaders and their followers and positive effect on work relationships[8].

The resonant leader, through their emotional intelligence, maintains relationships, motivates others in the work environment, stimulates their followers, and both work together toward a common purpose[9]. Leaders with relational skills or resonant leaders work collaboratively and encourage their team[1]. Four styles are described as resonant, visionary, coaching, affiliative and democratic; while two styles are defined as dissonant, set the pace and command[10].

Resonant leadership has also been the object of study in nursing, since this leadership style has been related to more appropriate work environments, job satisfaction, job retention and better care[5].

Nurses with higher levels of the resonant leadership style demonstrate higher levels of emotional intelligence and empathy; and lower task and action failures in nursing care for hospital inpatients[11]. Furthermore, resonant leadership has a strong influence on the manager's support of the staff[12].

Whereas resonant leadership has been associated with positive effects for professionals and patients, nurses who worked for dissonant leaders reported greater exhaustion, lower levels of emotional health, less collaboration of group work, lower satisfaction, and greater unmet need for care[10].

Through the focus on relationships, resonant leadership also empowers nurses and reduces acts of incivility at work[13], enabling nurses to make decisions that impact a healthy work environment[14], on professional retention and addressing professional shortages[13]. In view of the associations between resonant leadership and positive outcomes for professionals, health facilities, and patients, developing leadership skills is important at all managerial levels of nursing. Furthermore, recruiting and retaining leaders with resonant leadership behaviors is a strategy for organizations to value and support the work of these professionals[1].

Nurses have a broad role in health systems and services, in which context it is worth highlighting the figure of the nurse manager, who acts in the direct supervision of the nursing staff and is responsible for ensuring the achievement of organizational expectations and better results for patients[15–16].

Nurse Managers have a leadership role, and are responsible for managing the unit and directly supervising the nursing staff, coordinating processes and ensuring the quality of patient care, managing staff schedules, payroll, performance reviews, and decisions related to hiring and terminating staff, among other functions[16]. Such activities require from the nurse manager, as a leader of the team, high communication skills, positive relationship building, and team support[17].

To accomplish this, nurse managers must use a leadership style or strategy that can align their own objectives, the organization's, the employees', and the patients' goals. It is important to emphasize that this leadership model has been used in developed countries, such as Canada and the United States. There is no evidence of the use if this model in Guyana, the setting of this study,

despite the importance of its dissemination. We understand that the resonant leadership style fits the activities developed by managers and also in developing countries, in their relationships with the nursing team and the work environment, thus, the purpose of this study was to analyze resonant leadership style among the nurse managers from the perspective of nurses.

METHOD

A quantitative cross-sectional approach was used to obtain the opinions of nursing personnel involved in the practice of resonant leadership among themselves and managers.

The target population for this study comprises registered nurses and managers employed at the Georgetown Public Hospital Corporation (GPHC), which is a board-controlled and managed tertiary health facility in Georgetown, the capital city of Guyana. It is the only public referral and teaching hospital in the country's public health structure. The GPHC has a bed capacity of 600 beds, six in-patient departments consisting of 24 units/wards with a total of 650 nurses.

Eligibility criteria required registered nurses and nurse managers (registered midwives, ward managers, junior and senior departmental supervisors) with more than three years of work experience. Simple random sampling was used to select the participants and the proposed sample size was 275 respondents. Of the questionnaires distributed, 171 were completed and returned for data analysis (62% response rate), composing a sample represented by 121 nurses and 50 managers.

Data were collected from July to October 2020 using the Resonant Leadership 10-item scale and a sociodemographic questionnaire with the following variables: types of respondents; gender; age; ethnicity; marital status; education; work duration; specialty; and work status.

The Resonant Leadership 10-item scale is a self-administered questionnaire that comprises of a self and supervisor version, and the questions are the same for both versions. The register nurses and managers both evaluate themselves and leaders (supervisors). Using a 5-point Likert scale (1= strongly disagree, 5= strongly agree), participants indicated the extent to which they feel their immediate supervisor displays this type of leadership behavior and themselves. The total leadership rating (TLR) varies from 10 to 50 and the higher the score, the more resonant that leader is[10].

Institutional review board approval was obtained. Prior to data collection, the participants received an explanation of the project. The questionnaire was distributed individually to the nurses and managers on the various units, and they were given time to complete the survey and same was uplifted once completed.

Descriptive analysis was used to characterize the participants. The analysis of variance (ANOVA) was used to assess whether the mean total leadership rating is dependent on particular groups within each of the demographic and work variables, using IBM SPSS software (version 23).

The Generalized additive models for location scale and shape (GAMLSS) (Stasinopoulos et' al 2007) was used, adopting as outcome variables the TLR in the self and supervisor versions. The independent variables of the study for both outcomes were Types of respondent (Nurse, Midwives, Managers), Gender (Male/Female), Age (<=30, 31-49, 50-69), Ethnicity (African, East Indian, Amerindian, Other), Marital Status (Married, Single, Divorced), Education (Diploma, BScN, Other), Length of Work (3-7yrs, 8-12yrs, 13 -17yrs, >=18yrs) and Specialty (Medical/Surgical, Critical Care, Pediatric Care, Maternal/Child).

To assess the fit of the fitted model, a diagnostic analysis was applied on the model residuals, defined by plots of residuals versus fitted values, residuals with the order of observations, density of residuals, and quantile-quantile plot (qqplot). Additionally, the Shapiro-Wilk Normality test was applied to the fitted residuals. These analyses were performed using the R program (R Core Team, 2021) version 4.0.5 and the use of the packages gamlss[18] and gamlss.tr[19]. Significance levels were set at the 5% (α=0.05).

RESULTS

Among the 171 participants, the majority were registered nurse (70.8%), female (91.8%), aged in the range of 31-49 years (48.5%), of African ethnicity (66.7%), single (56.7%), with Diploma (42.1%), working from 3 to 7 years (46.2%), in the Med-surgery and critical care (38.6%).

Tables 1 and 2, respectively, show the resonant leadership ratings made by managers about themselves, and the ratings of the nursing staff regarding their supervisor's resonant leadership, of the ten resonant leadership variables. The percentages of "strongly disagree" ranged from 0.6 to 2.9% in the "SELF" version, while in the "supervisor evaluation" version they ranged from 4.1 to 7%. The same happened with the "disagree" percentages, whose values ranged from 0.6 to 6.4% in the "SELF" version and from 7.6 to 28.7% in the "supervisor evaluation" version. It is also noted that the leaders self-evaluate themselves much better, with emphasis on the "strongly agree" responses, whose responses ranged from 18.1 to 51.5%, while the version "evaluating the supervisor" ranged from 12.9 to 26.3%.

Table 1 - Descriptive analysis of the resonant leadership scale domains as rated by managers about themselves (SELF). Georgetown, Guyana, 2021. (n=171).

Variables	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Look for feedback even when it is difficult to hear	5 (2.9)	–	43 (25.1)	86 (50.3)	37 (21.6)
Act on values even if it is at a personal cost	3 (1.8)	7 (4.1)	40 (23.4)	83 (48.5)	38 (22.2)
Focus on successes rather than failures	–	6 (3.5)	35 (20.5)	76 (44.4)	54 (31.6)
Support teamwork to achieve goals/outcomes	–	2 (1.2)	14 (8.2)	67 (39.2)	88 (51.5)
Calmly handle stressful situations	1 (0.6)	5 (2.9)	58 (33.9)	69 (40.4)	38 (22.2)
Actively listen, acknowledge, and then respond to requests and concerns	1 (0.6)	1 (0.6)	39 (22.8)	79 (46.2)	51 (29.8)
Actively mentor or coach performance of others	1 (0.6)	7 (4.1)	36 (21.1)	84 (49.1)	43 (25.1)
Effectively resolve conflicts that arise	1 (0.6)	4 (2.3)	65 (38.0)	70 (40.9)	31 (18.1)
Engage others in working toward a shared vision	1 (0.6)	3 (1.8)	32 (18.7)	82 (48.0)	53 (31.0)
Allow others freedom to make important decisions in their work	–	11 (6.4)	39 (22.8)	71 (41.5)	50 (29.2)

In order to compare nurses and managers, the mean of the TLR in the self-version was 38.9 for nurses (n = 121) and 41.6 for managers (n=50). The result is significant (p=0.003) and the nurses are more likely to rate their resonant leadership lower than the managers.

Table 2 - Descriptive analysis of the resonant leadership scale domains as rated by nurses about their supervisors. Georgetown, Guyana, 2021. (n=171).

Variables	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Looks for feedback even when it is difficult to hear	7 (4.1)	36 (21.1)	47 (27.5)	47 (27.5)	34 (19.9)
Acts on values even if it is at a personal cost	8 (4.7)	49 (28.7)	51 (29.8)	40 (23.4)	23 (13.5)
Focuses on successes rather than failures	9 (5.3)	36 (21.2)	46 (27.1)	45 (26.5)	34 (20.0)
Supports teamwork to achieve goals/outcomes	9 (5.3)	13 (7.6)	62 (36.3)	42 (24.6)	45 (26.3)
Calmly handles stressful situations	12 (7.0)	31 (18.1)	53 (31.0)	48 (28.1)	27 (15.8)
Actively listens, acknowledges, and then responds to requests and concerns	10 (5.8)	27 (15.8)	61 (35.7)	41 (24.0)	32 (18.7)
Actively mentors or coaches performance of others	12 (7.0)	32 (18.7)	58 (33.9)	43 (25.1)	26 (15.2)
Effectively resolves conflicts that arise	11 (6.4)	30 (17.5)	66 (38.6)	42 (24.6)	22 (12.9)
Engages me in working toward a shared vision	7 (4.1)	30 (17.6)	53 (31.2)	54 (31.8)	26 (15.3)
Allows me freedom to make important decisions in my work	11 (6.4)	29 (17.0)	50 (29.2)	54 (31.6)	27 (15.8)

Based on the analyses shown in Table 3, the mean TLR is dependent on age range (p = 0.046) in the self- version. Using the Tukey HSD multiple comparisons (post hoc) was observed that nursing staff in the age category at most 30 are more likely to give a low rating of themselves than the age category 50 - 69.

Except for the age, the mean TLR does not depend on the subcategories of the demographic variables, such as gender, ethnicity, marital status, and education level. In their supervisor's ratings, demographics variables do not affect the TLR values.

For the managers who evaluate themselves, the mean TLR (SELF) is dependent on work status (p = 0.014). The Tukey HSD multiple comparison (post hoc) test did not identify the particular group within work status that is different from the others. The mean TLR (SELF) do not depend on the other work variables (work duration, and specialty). In their supervisor's ratings, work variables do not affect the TLR values.

Table 3 - Comparison of managers self-assessments (SELF) and registered nurses assessments of their supervisors with demographic and work variables. Georgetown, Guyana, 2021. (n=171).

Characteristics	Categories	n	%	Self	Supervisor
				p-value	p-value
Gender	Female	157	91.8	0.794	0.120
	Male	14	8.2		
Age	At most 30	77	45.0		
	31-49	83	48.5	**0.046**	0.064
	50-69	11	6.4		
Ethnicity	African	114	66.7		
	East Indian	16	9.4	0.109	0.633
	Amerindian	7	4.1		
	Other	34	19.9		
Marital Status	Single	97	56.7		
	Married	66	38.6	0.385	0.511
	Divorced	8	4.7		
Education	Diploma	91	53.2		
	BScN	72	42.1	0.100	0.587
	Other	8	4.7		
Work Duration	3-7 years	79	46.2		
	8-12 years	53	31.0	0.323	0.608
	13-17 years	22	12.9		
	18 years and above	17	9.9		
Specialty	Med- Surgery	66	38.6		
	Critical Care	54	31.6		
	Pediatric Care	20	11.7	0.324	0.271
	Maternal-Child	28	16.4		
	Mental Health	3	1.8		
Work Status	Register Nurse	121	70.8		
	Register Midwife	27	15.8		
	Ward Manager	15	8.8		
	Junior Departmental Supervisor	7	4.1	**0.014**	0.191
	Senior Departmental Supervisor	1	0.6		

The parameters resulting from GAMLSS, presented in Table 4, show that managers scored on average 3.44 points more than nurses for the TLR SELF. In supervisor's ratings, managers on average score 7.75 points higher than nurses.

Table 4 - Parameter estimates, standard errors, significance of coefficients for managers' self-assessments (SELF) and registered nurses assessments of their supervisors. Georgetown, Guyana, 2021. (n=171).

Characteristics	Categories	Self			Supervisor		
		Estimate	Std. Error	p-value	Estimate	Std. Error	p-value
	Intercept	37.1941	1.0330	0.0000	28.9519	2.9151	0.0000
Types of respondent	Registered Nurse						
	Registered Midwives	1.2307	1.5620	0.4321	3.9982	4.1997	0.3427
	Managers	3.4354	1.5439	**0.0276**	7.7081	3.7226	**0.0402**
Gender	Female						
	Male	-0.0337	1.3320	0.9798	7.7497	4.0217	0.0559
Age	At most 30						
	31-49	0.1610	1.1416	0.8880	-0.2596	2.9318	0.9296
	50-69	3.6391	2.2755	0.1119	11.3632	6.4766	0.0815
Ethnicity	African						
	East Indian	2.1290	1.3489	0.1167	3.8244	3.8469	0.3218
	Amerindian	-1.5707	2.4789	0.5273	1.6473	6.3440	0.7955
	Other	0.9495	0.9702	0.3294	-0.7366	2.5123	0.7698
Marital Status	Married						
	Single	1.7080	0.8844	0.0554	3.0603	2.3897	0.2024
	Divorced	3.2030	2.0918	0.1279	4.5809	5.7814	0.4294
Education	Diploma						
	BScN	0.5689	0.9642	0.5561	-1.5043	2.4551	0.5410
	Other	-0.5367	2.1480	0.8030	-3.7098	5.5303	0.5034
Work duration	3-7 years						
	8-12 years	-0.3661	1.2561	0.7711	-1.1774	3.1886	0.7125
	13-17 years	-1.1545	1.7097	0.5006	-5.2440	4.3304	0.2279
	18 years and above	-3.1823	1.8876	0.0940	-3.3948	5.6759	0.5507
Specialty	Med-Surgery						
	Critical Care	1.1727	0.9306	0.2096	4.3769	2.4796	0.0796
	Pediatric Care	-0.8109	1.4151	0.5675	2.6997	3.0266	0.3739
	Maternal-Child	1.5198	1.3667	0.2680	7.0696	3.7975	0.0647

DISCUSSION

The demographic profile of the participants reflects the profile of the country's nursing workforce, which is represented by 97% women; as for age, professionals under 35 years old (59%) and those between 35 and 54 years old (33%) predominate. Nursing professionals represent 49.7% of Guyana's health workforce[20].

The nurses in this study do not recognize leadership and clinical practice as leadership, unless the nurse in question has formal status and title. When this happens, the nurse is removed from clinical practice, a scenario in which power drives the nurse away from the bedside. Nurses need to question the hegemonies taken for granted within institutions. Bedside and patient-facing nurses must be given more power and respect as leaders of the patient experience, and nurse leadership roles must be developed to allow nurses to remain clinically active[21].

The average leadership rating for Nurse Managers varied by age group, with Nurse Managers in the age group up to 30 years old being more likely to assign a low rating of themselves than in the age group 50 to 69 years old; in agreement with previous study, which pointed out the relationship between leader age and leadership effectiveness[22].

The current study shows evidence that the average rating of Resonant Leadership for register nurse is different from the rating assigned by Nurse Managers. Nurses are more likely to rate their managers' Resonant Leadership lower than the managers' own rating. This finding also accords with earlier observations, in a study that analyzed the Authentic Leadership of nurse assistants and showed that leaders rate themselves very highly in any situation, better than the assessment of those they lead[23]. This fact is also evidenced by comparing the responses to the two versions of the questionnaire, such as the item "Support teamwork to achieve goals/outcomes", in which more than half of the participants evaluated themselves very well, but less than a third considered that the leader gives this support.

Nurse Managers should continuously evaluate the perception of their team regarding their management, specifically when it comes to Resonant Leadership, because the overvaluation of such leadership model by the Manager may compromise the confidence, engagement, and consequently the satisfaction of their work team and the clients/patients assisted by such team.

A good leadership is about having not only exceptionally high levels of self-awareness, but also the ability to apply that knowledge in practice[24]. Nurse managers were demonstrated to be more empathetic or more involved than those with a Diploma. Communication, problem solving, and exercising autonomy in leadership practice were critical for nurse managers to be more engaged with their led; additionally, completing a higher education degree provided them with the opportunity to have these leadership skills[25].

In managerial practice, it is observed that health leaders primarily focus on task completion and performance management, rather than spending most of their time on creating or maintaining relationships with team members[4].

Since resonant leadership is a relationship-oriented style, leaders can institute a supportive culture in the work environment[8] and encourage hands-on behaviors among the team[26]. It is crucial that leaders build and maintain meaningful relationships that are essential for team cooperation and negotiations[4].

In the work environment, the resonant leader conveys trust and strengthens social bonds with their followers, which empowers them to meet the emotional demands that exist in the high-pressure healthcare environment. Resonant leaders' practice of emotional intelligence supports the management of their own employees' emotions, which creates a positive impact on employees' attitudes in the workplace[27].

Promoting a conscious leadership environment, with a culture of positive attitude for followers and others involved, should be a leader's effort[28]. Once employees perceive their colleagues and managers caring and helping each other, it encourages them to demonstrate socially desirable behaviors, which is a challenging task[29].

It is emphasized that emotional intelligence skills are pointed out as an essential quality of a good nurse or a good leader, although there are barriers to its development. Among the barriers, the following can be highlighted: lack of formal and continuous education and training in emotional intelligence; nurses' inadequate understanding of emotional intelligence; busy and frantic clinical environment; lack of time and shortage of human resources; culture, climate, personal experiences, roles and responsibilities of nurses in the clinical environment[30].

An important step for nurse managers is to comprehend the emotional intelligence and the opinions and demands of their staff, in order to implement training programs that strengthen emotional intelligence[30]. The findings of this study can be used to develop effective strategies around continuing education for Nurse Managers and nurses as a way of improving their leadership skills.

Limitations

Only one public hospital was used as the setting, so the data cannot be generalized. However, the results should contribute to other health scenarios to improve leadership through the adoption of innovative models such as resonant leadership.

Implication for Nursing

Overall, the findings suggest that Nurse Managers in the hospital setting can improve their leadership style by adopting strategies that will improve their performance, work environment, care, and patient satisfaction. Organizational support of leadership practice should be encouraged, as the healthcare environment needs to have leaders who demonstrate relationship-oriented leadership skills, who show concern not only for themselves, but also for their subordinates and the organization in general, and teamwork should be a priority in this context.

CONCLUSION

The findings of this study show that Resonant Leadership was practiced at a moderate level in the hospital service. Managers has higher Resonant Leadership scores, when compared to nurses, in their self-evaluation and when rating their supervisors. Resonant Leadership is not dependent on the subcategories of demographic variables except for age where TLR is dependent on the age group of the Nurse Managers. The study also concluded that Resonant Leadership is not associated with job variables, so job duration, specialty and, work situation do not affect how managers rate themselves, nor in how nursing teams rate their supervisors.

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