Leadership in the elderly care home sector

Nadeem Moiden looks at a range of leadership methods and their use in a healthcare sector facing new challenges

THE STUDY OF LEADERSHIP has preoccupied researchers over the past 60 years and, not surprisingly, has attracted considerable sponsorship from organisations wanting to identify what differentiates particularly effective leaders from the rest. Literature pertaining to leadership in the elderly care home sector is lacking.

Care homes currently exist in an environment characterised by turbulence, increasingly complex problems, and growing internal and external competition. New leadership models are emerging that are less concerned with understanding how best to manage order and predictability, and more with predicting who can best ensure survival in this constantly changing environment.

This paper analyses and evaluates research into different leadership styles and suggests future leadership trends. Research into related areas are also considered and used to develop an understanding of the effects of leadership styles on healthcare workers. First, considered is research on leadership styles and how they affect nurses’ perception of quality of care, job satisfaction, work attitudes, absenteeism, behaviour, interaction, flexibility and effectiveness. Second, is workplace-based research and the value of emotional support.

Leaders and leadership styles

Dunham and Klafehn (1990) studied nurse leaders identified by their peers and subordinates as ‘excellent’, and determined whether the skills they used were associated with transactional or transformational leaders. They suggested that transactional leaders acted as caretakers who had no vision for the future and no overtly shared values, while excellent nurse leaders had transformational skills and qualities and were perceived to have them by staff.

Dunham and Klafehn also compared the data with those from a similar study by Bass (1985) which looked at nurse executives. The results revealed that the scores were higher in the Bass study. In general therefore, only nurse executives show very high levels of transformational leadership.

Dunham and Klafehn also suggested it was crucial to choose when to use the transactional techniques of contingent reward and management by exception and when to use the transformational techniques of charisma, consideration and intellectual stimulation.
Transformational leadership is usually considered an in-built personality characteristic rather than something that can be learned and then switched on and off at will.

Using charisma in leadership involves several elements, including communicating positive self-esteem, focusing on people, having a vision, and promoting and implementing the vision (Davidhizar 1993). Similarly, Achenbach and Shepard (1990) conducted a descriptive study using questionnaires to compare the experiences, educations and styles of 22 nurse leaders, which classified their leadership styles as authoritarian, democratic or laissez-faire. Nineteen of the leaders identified themselves as democratic, two as authoritarian, and one as laissez-faire. Most reported that the more clinically experienced leaders were better prepared for their leadership roles, that concern for accomplishing tasks was balanced with concern for the people who do them, and that democratic leadership was the most successful style but was not always appropriate.

However, Achenbach and Shepard's study is limited because the results are relevant only to the practice area in which they were conducted, although they can be used to inform research in other areas. From studies by Dunham and Klafehn, and Achenbach and Shepard, it is found that leaders with transformational skills and qualities, and who show concern for staff, are viewed as particularly effective.

Kivimaki (1996) suggested that yearly appraisals between supervisor and employee can improve leadership. Kivimaki's research investigated whether these appraisals improved goal clarity, quality of feedback and how innovative staff were, and whether they elicited more satisfaction with the supervisors' leadership styles. Appraisals were found to improve perceived feedback but did not affect the perceptions of goal clarity or innovativeness, or the level of elicited satisfaction with management style.

A major advantage of this and other field studies in comparison to those made in laboratory conditions, has been their realism and external validity. Field studies are carried out in real-life situations and so need not be extrapolated from artificial conditions. The control of field studies, however, is rarely as tight as it can be in laboratory studies.

As in most real-life organisational studies, in Kivimaki's it was impossible to assign subjects randomly to different groups, even though randomisation is an important principle in studies. Consequently, potential differences between the study groups in other respects may have confounded the results.

Although Kivimaki focused on simple hypothesis testing, the findings showed that appraisals could be recommended at least to those leaders who can communicate interactively with their staff but who have problems in providing sufficient feedback. In other respects, however, appraisals may not be beneficial.

Prenkert and Ehnfors (1997) carried out an empirical study of the influences of transactional and transformational leadership on organisational effectiveness. The study subjects were all nurse leaders or assistant nurse leaders at a medium-sized hospital in Sweden. They modified a multi-leadership questionnaire developed by Bass by using Likert-type scales and named it the 'leadership-nursing-effectiveness questionnaire'.

The study showed low mean scores on organisational effectiveness and transactional leadership but high mean scores on high quality nursing care and transformational leadership. But the results suggested that the degree of transactional and transformational leadership had a small or insignificant connection with organisational effectiveness in the hospital organisation that was studied.

The study did not support the statement that organisational units exposed to high degrees of transactional and transformational leadership at the same time show a high degree of organisational effectiveness, as has been shown in studies elsewhere (Lucas 1988, 1991).

The study is nevertheless of value since Prenkert and Ehnfors suggested that the theory of transactional and transformational leadership is independent of cultural and organisational settings. But their study is limited by the way in which transactional and transformational leadership, as well as organisational effectiveness, were measured, and other factors that can influence all three may...
not have been accounted for. Further research is needed to clarify these indications in more general settings, perhaps with a larger sample.

Boumans and Landeweerd (1993) studied the relationship between leadership and nurses’ well-being. In their study of 561 nurses from 16 general hospitals in the Netherlands, the influence of two leadership styles, social and instrumental, upon the reactions of nurses to their work situations was examined, in terms of job satisfaction, health complaints and absenteeism. The effects of the separate and combined styles were studied.

The results indicated that social leadership contributed positively to the reaction of nurses to their jobs. Instrumental leadership, on the other hand, led to health complaints. The analysis of data involving combined leadership styles showed that nurses were most satisfied if their leaders paid attention to both. It also emerged that nurses’ preferences of leadership styles depended on their need for autonomy. Therefore, it was concluded that leadership style can engender positive nurse attitudes towards work.

A similar study by Gruenfeld and Kassum (1973) demonstrated that leaders who pay attention to both the social and task-structuring aspects of their leadership could best achieve high degrees of job satisfaction among the nurses they led. Due to the limited number of studies on this subject, no unequivocal conclusions on such combined styles can be drawn. However, it can be said that the influence of social and instrumental styles of leadership is fairly limited.

These and other studies are relevant to the elderly care home sector because they take into account the views of staff and their satisfaction with the leaders. They consider appraisals – which also encourage interactive communication, the main aspect of successful leadership, organisational effectiveness through leadership style, and the importance of job satisfaction, productivity, absenteeism, turnover rates, and the need for further research into leadership styles. Most importantly, they show concern by leaders for their staff as well as for ensuring that the job at hand is completed to high standards, and that leaders can do so by promoting a balance between work and personal life.

Leadership in health care

Burns (1978) stressed the importance of remembering that leaders lead other people, not things. The control of things is an act of power, not leadership. Zaleznik (1992) argued that there is a need for competent leaders and a longing for great leaders, and that leaders differ in motivation, personal history and in the way in which they think and act. Hersey and Blanchard (1982) observed that leaders differed in their ability to vary their styles in different situations and that some seem limited to one basic style. As a result, rigid leaders tend to be effective only in situations with which their styles are compatible. Other leaders can modify their behaviours to fit more than one basic style.

Leaders are flexible if they can be effective in several situations. They demonstrate a wide range of leadership styles or the maximum flexibility appropriate to the situations they face (Hersey and Blanchard 1982). Research into effectiveness and flexibility has shown more variation between the managers than their leadership styles (Goldenberg 1990).

A study by McNeese-Smith (1993) showed how leaders can significantly affect employee productivity, job satisfaction and commitment. Leaders have to develop leadership skills that are basic to effective management and use them to complement their own styles. Furthermore, research by Nakata and Saylor (1994) on leadership style and staff nurse job satisfaction showed that staff nurses want their own leadership skills to approach a participative group style with more involvement in decision-making processes. Participative group style leaders use staff ideas and ask for opinions on matters about which the staff desire a more democratic and collaborative decision-making style. Sources of job satisfaction, such as responsibility, autonomy, advancement opportunities and pleasant work environments, can be related to leadership style. Sources of job dissatisfaction linked to management style include poor planning, poor communication and inadequate explanation of decisions that affect the nursing unit. Nakata and Saylor’s study showed that the closer a perceived leadership style is to being participative, the higher the level of job satisfaction.
Research by Moss and Rowles (1997) also showed that leaders can affect staff job satisfaction by using appropriate leadership styles. Their study of 683 staff nurses in three US hospitals showed that staff nurse job satisfaction clearly improves as leadership nears the participative style. No single style is appropriate in all situations (Blankenship et al. 1989, Achenbach and Shepard 1990). McNeese-Smith's study is related directly to Moss and Rowles' research, as it concerns leadership styles and job satisfaction, decision-making involvement and staff performance.

Pryer and Distefano (1971) studied the effect of leadership behaviour in three groups of nurses: 20 registered nurses, 39 nursing auxiliaries and 40 psychiatric aides. From this study it is apparent that, for each group, social leadership is associated with several dimensions of job satisfaction. Task-structuring leadership appeared to be associated with staff satisfaction only in the nurse and psychiatric aide groups. O'Hanlon-Nicholas (1991) found that registered nurses want structure, guidance and clear goals balanced their leaders having human relations skills too. The literature emphasises the importance of job satisfaction, productivity, absenteeism and turnover rates, and the need for further research into leadership styles as they relate to these factors (Lucas 1988, 1991, Duxbury et al. 1984).

Factors influencing performance
There are several factors affecting performance at work, stress being one of them. Several studies have revealed that the stresses involved in performing emotional labour under conditions that undermine performance can alienate staff from their jobs and their personal identities as feeling human beings (Hochschild 1983).

Satyamurti (1981) argued that the stresses experienced by staff are rooted in the imbalance between the demands that are placed on them and the resources they have to carry them out. He further argued that the practical and emotional problems experienced by clients could be traced back to their own chronic material deprivation. This forced staff to tackle these problems through individually focused strategies aimed at changing their clients' behaviour or providing them with emotional support. Therefore workers find their workplaces in many ways detrimental, unsatisfactory and stressful (Handy 1990). Handy's study found that the stress that mental health nurses face cannot be understood fully without interpreting the ways in which people participate in mental healthcare. Taylor (1995) stated that people with more social support develop better coping strategies to deal with stress.

These studies in stress fall within the radical humanist, or structuralist, perspective as defined by Burrell and Morgan (1979), and share several common features. First, they all take the relationship between social groups as the key unit of study and use the insights provided by this focus to appreciate individual experiences better. Second, they emphasise that subjective experiences of stress cannot be understood fully through either a theoretical stance that isolates individual experience from its context or an approach which regards people as mere puppets of inexorable structural forces. Third, they argue that contradictions in society and organisations are reflected in people's fragmentary and ambiguous understanding of their situations (Giddens 1984, Bowden 1994). Fourth, they suggest that these unintended outcomes tend to undermine the efficacy of people's coping strategies, and so increase their subjective experiences of stress (Hingley and Cooper 1986, Newton 1989). Finally, they use in-depth qualitative data to demonstrate the complex unfolding of these processes over time.

Nursing is considered a stressful profession (Ootim 2001). According to Schmeider and Smith (1996), shift work may contribute to stress relating to family life, an association that has encouraged the introduction of flexible working. The time has surely come for leaders to think carefully about the quality of support provided to staff working in health care (Ootim 2001). While physical needs are being met in line with health and safety at work legislation, balancing the personal and work lives of staff demands understanding from their leaders. If people do not enjoy their work or feel valued, all the mission statements, quality circles and team building exercises in the world will not achieve high performance (Wedderburn Tate 1999).
Conclusion

The key to effective leadership is knowing how to use the right styles in each situation. Most leaders feel that the democratic style of leadership is the most successful but is not always appropriate. Results from other leadership studies suggest that authoritative leadership leads to health complaints and that staff are most satisfied if leaders use both styles. It is clear that different staff with varying needs of autonomy prefer different styles of leadership. Many leaders also believe that style is an important determinant of staff reactions to their work as revealed in levels of job satisfaction, health complaints, absenteeism and other indicators of well-being.

Observant and sensitive leaders can remark on incidents and solicit comments that help promote understanding between staff. If leaders fail to understand the feelings of individuals, openly admitting a lack of understanding invites further exploration and leads to trusting relationships between leaders and staff. The outcomes from the related studies can be used to develop leadership in the elderly care home sector where conditions are changing dramatically due to the implementation of the Care Standards Act (2000). Leadership development is crucial as time and effort put into valuing and motivating staff can only have a positive benefit for client care, which is a real need in the elderly care home sector.

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References