Supervision of care, management and leadership styles

Leonard (1999) considers that there has been a momentous development in nursing over the previous twenty years. The remit for nurses today has become considerably more multifaceted with professional attributes being of a higher standard than ever before. The task-orientated submissive approach to nursing has changed considerably (Harden 1996), to meet the greater demands on nurses for technical competence, scientific rationality with more emphasis on management and leadership skills (Department of Health (DoH) 1999). This paper will define management and leadership and consider the relevance of both to nursing practice, with the main focus being their influence towards motivation. Firstly, motivation will be discussed with reference to motivational theories. Using appropriate literature there will be allusion to various management and leadership theories and styles, and the effect they have in the clinical area will be examined. Analysis of clinical supervision and continuous professional development will be made with the inclusion of the political issues affecting communication and team building in the clinical setting.

“ Motivation refers to a dynamic, internal state resulting from the independent and joint influences of personal and situational factors. It is an individual state affected by the continuous interplay of personal, social, and organisational factors” (Nicholson et al 1995). From this definition, the author interprets this to include job satisfaction as one of the “ personal, social, and organisational factors” influencing the worker’s internal state and leading to motivation. Staff motivation is crucial to retain them as well as maintain or improve performance and productivity. The National Health Service (NHS) is a service organisation dependent on frontline nurses to deliver high quality service to the general public. If nurses are to have job satisfaction and stay in the NHS they need to be motivated, trained and rewarded adequately (Sullivan & Decker 2005).

In order to discuss motivation we must investigate what motivates employees. Finlayson (2002) conducted a literature review on morale and motivation among the NHS workforce and suggested many factors have an effect on motivation and morale in the working environment being low. There was much concern about the day-to-day effects of significant staff shortages, and the fact that many staff felt unable to do the jobs for which they had qualified (Allen 2001). One ward manager expressed the widespread view that feelings of stress and being overwhelmed were directly attributable to understaffing and working day after day ‘ above and beyond the call of duty.’ For many, staff shortages were beginning to affect the type and quality of service they could provide. This alone is detrimental in light of ‘ expert ‘ patients who are knowledgeable in their own care and expectations are higher than ever before. Typical motivations included feeling valued both

on the ward and by outside groups such as the public and media (Graham & Steele 2001) with job satisfaction, pay and reward being well documented as having an effect on morale (Bevan 2000, Collins et al 2000). The study argues that good staff morale and motivation are critical to achieving the Government's ambitious plans for modernising the NHS (DoH 1999), and shows there is evidence to suggest that healthy morale and motivation have positive impacts on patient care and outcomes (Finlayson 2002).

Maslow's (1943) motivation theory of a hierarchy of needs is the most widely established theory in the field of motivation research. The hierarchy of needs is organised in ascending order of importance to the individual for survival, from physiological, safety, and belongingness needs, to self-esteem and the need for self-actualisation. Maslow proposed that human motivation consists of fulfilling all of these needs (Maslow, 1970). Although Maslow (1943) published his theory over 60 years ago, it remains one of the leading and most popular explanations of motivation, and continues to be cited in many texts on organisational behaviour (Cole 1995, Bennett 1997, Morgan 1997, Huczynski and Buchanan, 2001). Huczynski and Buchanan question whether Maslow's theory can be dismissed as irrelevant to organisational behaviour in the 21st century, however it can be argued that his thinking remains highly influential, particularly in the recognition that behaviour depends on a range of generalised motives. Maslows theory is just one of many motivational theories developed and used by management in general and throughout the NHS. McGregor (1906-1964) and Hertzberg (1923-2000) are two other influential theorists whose proposals are still relevant and used today.

McGregor developed the Theory X and Theory Y of motivation and put it forward as two hypothesis about human nature and behaviour in the workplace. Theory X makes assumptions that individuals have an inherent dislike of work, avoiding work and responsibility wherever possible. It is known as extrinsic motivation whereby people need to be coerced with reward, directed or threatened with punishment in order for them work adequately. Their motivation at work is thought to be financial and security before anything else (Mullins 2005). The precept of theory Y is thought to be the integration of both individual and organisational goals. For example, these individuals are very ambitious, seek responsibility, and are motivated by the affiliation of esteem and self-actualisation. It is therefore the task of management to provide conditions whereby these motivational needs can be met and allow individuals to meet their own needs by meeting those of the organisation (Mullins 2005). It is assumed then that since the introduction of Project 2000 (United Kingdom Central Council for Nursing (UKCC) 1986) whereby nurses have been educated in universities, that more and more nurses will fall into the theory Y category of Mcgregors theory. Newly qualified nurses are coming to the wards highly educated, enthusiastic and aware of the numerous policies and procedures they must adhere to. If they are meeting the needs of their organisation, namely the NHS, then their self-actualisation needs amongst others will be met, and this is thought to keep them motivated and happy in their work. However, whilst government policies such as the NHS Plan (DoH 2000), and a First Class Service (DoH 1998) put pressure on nurses to reform the NHS, barriers to this are evident. Staff shortages, lack of resources and finance mean that commitment and morale are waning, even amongst newly qualified members of the team. This

suggests that if conditions do not improve dramatically, then perhaps more and more nurses will fall into the theory X category of little job satisfaction and only working for the financial security.

Hertzberg’s two factor theory is the adaptation of the 1960’s Hawthorn experiments which concluded that there were two different sets of factors affecting motivation and work, and these became known as the ‘ motivators’ and ‘ hygiene factors’. The motivators are factors such as recognition, responsibility and achievement and can be related to the higher level of Maslow’s needs. The hygiene factors are those which, if not available can cause dissatisfaction, such as working conditions, salary and job security (Mullins 2005, Hertzberg 1968). It is the authors understanding that neither Maslow’s or Hertzberg’s theories were intended solely for motivational use in the working environment, nevertheless, collectively the two theories provide a framework with a basis of how to motivate staff to work willingly and effectively. Both theories have their critics (Blackburn 1979, Mullins 2005, Vroom 1964) though it seems the intention of the theories did not have the significance that subsequent writers have put upon them. Other studies give support to the theories (Mullins 2005), and it was Maslow’s theory that had a significant impact on the design of the NHS in that the organisation would provide factors to meet all of the needs in the hierarchy. The NHS has all the signs of a bureaucratic organisation which is fundamentally hierarchical in nature. Staff are governed by a strict remit where adherence to both ward and national policies and clinical guidelines is imperative. There are many leadership and management styles evident throughout the NHS, however it is important to establish the difference between the two before discussing

the relevant styles and theories of either. It is suggested that although there are distinctions between the two (Sullivan & Decker 2005), there is an overlap which means the terms are used interchangeably.

In the past few decades, management experts have undergone a revolution in how they define leadership and their attitudes toward it. They have gone from a very classical autocratic approach to a very creative and participative approach. Ideas about management and leadership have changed considerably in recent years. People today are better educated and more articulate and can no longer be commanded in the same way as before. There needs to be much more involvement and participation at work (Stewart 1994). Lewin (1951) isolates three common leadership styles, autocratic, laissez au faire and democratic (Marquis & Huston 2000). These approaches are still apparent today (Carney 1999), and can be used interchangeably to respond to various situations (Marquis & Huston 2000). This is commonly seen in the Emergency Department whereby the author has seen leaders with a very laissez -Faire style adapt to an autocratic style in order to provide efficient and best care for the patient. Leadership should be about facilitation, delegation and appreciation. It should provide direction, inspiration and have motivational insight to enable staff to reach their objectives by various means (Alimo-Metclafe 2000).

Management according to Mullins (2005) is a generic term subject to interpretation, and takes place at all levels within an organisation. Mullins (2005) recognises that management is an ongoing active process whereby an individual becomes involved with others with the intention of assisting them to meet objectives and achieve results. A manager's role has three fundamental elements consisting of decisional, informational and interpersonal (Mintzberg 1979). Furthermore Mullins (2005) suggests that quite simply management is ' making things happen'. There are several styles and theories of leadership and management with discussion being difficult due to interchangeability of terms, furthermore, the constraints of this paper do not allow discussion in depth. For this reason, concentration will be on bureaucratic and human relations management theories seen in two different ward areas with reference to transactional, and transformational leadership.

Bureaucratic management is not dissimilar to Nightingales outdated autocratic style of management (Argyris 1964). Weber (1864-1920) introduced the theory of bureaucratic management, and although never defined, it was based upon authority and power, with a hierarchy of rules and regulations. This style of management is not as common as it used to be which as literature suggests could be due to it's demotivational characteristics (Marquis & Houston 2000). The danger of bureaucracy is that employees may feel disinterested and get bored with their prescribed tasks, particularly McGregors theory Y individuals who are ambitious and motivated by respect (Mullins 2005). Furthermore, bureaucracy is incompatible with the development of nurse's intellectual skills, such as analysis, synthesis, and abilities such as ingenuity and creativity (Argyris 1964). There are however

theory X individuals who are motivated only by reward or punishment which is a characteristic of both bureaucracy and Transactional leadership whereby the subordinate does as the manager says without question, however, they may do only what is expected of them and nothing more (Mullins 2005). The author saw this on placement whereby two of the sisters had a bureaucratic style of managing a surgical ward. Staff would be told what to do, and although allocated tasks would be completed by the end of the shift, morale was very low. Ward politics was evident with staff forming their own cliques and only communicating amongst themselves, and staff sickness was very high. A survey consisting of self-report questionnaires suggested that defensive impatient managers and unsupportive leadership are given as factors influencing nurses health and absenteeism (Jinks 2003). This had an effect on the quality of care that was given to patients because the ward was always short staffed with no time for patient contact, staff members were expected not to take breaks , communication was limited and staff offered no more than was expected of them. Ultimately, staff on this ward were not working interprofessionally for the benefit of the patient (Freeman et al 2000), which is advocated in many government papers (DoH 1997, 1998, NHS 1999) as a means to achieving the new agenda in the NHS. It was noted that students and newly qualified nurses worked well under this style of management, however, those similar to McGregors theory Y individuals who were ready to progress away from task nursing, were unsupported and staff turnover was high. The NHS is certainly not meeting Maslow’s need of self-actualisation here although as Mullins (2005) suggests, the workplace is not always where people want these needs met, nevertheless, with lack of

communication and respect on the ward, those in charge have no way of knowing the needs of their staff.

According to Mintzberg (1990), motivating staff is a key element of the manager’s role. Simple gratitude for a job well done goes a long way to encouraging staff as was seen on a very different observation ward. The Human Relations theory of management was palpable on this ward, which is an adaptation of Hertzberg’s motivation and hygiene factors. This management theory is supportive of group interaction and decision-making, and staff are motivated by economic or ego awards and supported by direction and guidance. (Joshua-Amadi 2003). The Observations ward requires a very fast, efficient and competent style of nursing. One of the Sisters on the ward has a human relations style of management as she makes time to communicate to all staff members individually on a regular basis. This is not always by prior appointment and can sometimes only be for a few minutes at a time, but the sister appears to know all of her staff and how they work best. Any new clinical evidence is shared with all staff members and their opinion valued, and every effort is made for all staff to attend any learning opportunities available to them. Keeping up to date is imperative on this ward, and due to the fact the staff are motivated and morale is high, there is very little staff sickness which enables sister to arrange CPD session on a regular basis. Staff are happy to come to work as the off duty is communicated in such a way that staff are able to request some of their shifts to fit in with their lifestyle, and as (Mullins 2005) states, if staff have ownership of the situation, they are more likely to be motivated and morale will be high. There was one circumstance seen as a political issue

on this ward whereby the effectiveness of the government paper ‘ Improving working lives’ (DoH 2000a) was challenged, and it was considered that the human relations style of management prevented it from becoming a demoralising issue. The paper promotes flexible working, and in line with this was a senior staff member working on a term time only contract. Another staff member wanted to follow suit and was declined, however, the situation was quickly diffused as the staff member was offered the opportunity to communicate with management, and consequently her hours were negotiated to meet her needs. Many of Hertzberg’s theories are being met under the human relations style of management, for example good communication and patient advocacy go some way to meeting Hertzbergs quality assurance and sense of achievement. Hearing a ‘ thankyou’ at the end of every shift is motivational and fits in with Hertzberg’s theory of recognition, however in the current climate of the NHS, morale is low and many of these needs are being neglected.

Similar to human relations management, transformational leadership is congruous with contemporary professional nursing practice and McGregors ambitious theory Y staff members (Mullins 2005). Transformational leaders commit to establishing and maintaining a relationship with their employees via two-way communication and the exchange of information and ideas. During the exchange, a transformational leader seeks to understand the employee’s values and motivations and work toward developing commonly held goals that benefit the organisation (Kohles 1995). In nursing practice, transformational leadership is clearly a pivotal factor in retaining quality staff

and optimising team performance in the delivery of quality care (Crouch 2002).

The authors ward experience of both Human relations and Bureaucratic management styles were almost as text books describe, however good management will provide variations in style to enable managers to accommodate both McGregors theory X and theory Y staff members. Human relations style is congruent with contemporary nursing, however theory X individuals will not be motivated by this style of management at all as they do not share the NHS vision for the future of nursing (Sullivan & Decker 2005). Similarly a bureaucratic style may suit theory X but will demotivate theory Y, as this style of leadership does not compliment their need for ambition and intellectual growth. This is why literature suggests that a combination of styles are needed to accommodate different personalities and a good manager will be able to do this (Sullivan & Decker 2005). Similarly, research findings by Lipley (2004) suggest that managers using both transactional and transformational leadership will have the ability to motivate higher numbers of staff.

A current leadership initiative is the Royal College of Nursing's Clinical Leadership Programme (CLP), which has funding to train nurses in clinical leadership to promote political awareness amongst team members (Lipley 2004). Political issues such as budgetary constraints, staff shortages and concerns over pay all lead to demoralisation, demotivation and overworked, stressed staff (Mason & Whitehead 2003). The NHS need to take heed as these issues have a knock on effect and could lead to a deficient quality of care and presumably litigation, however, recommendation would be that

nurses need to challenge the inequality of access and provision in order to protect themselves and their patients. A qualitative study by Joshua-Amadi (2003) suggests that staff feeling overworked and underpaid can be attributed to misunderstandings in the communication and organisational aims or of the ward objectives. It is therefore imperative that the manager recognises this and initiates communication, support and encouragement to prevent demoralisation of the team.

Communication underpins everything we do in everyday life and in professional practice (Sully & Dallas 2005). Ellis et al (2003) proclaim the effectiveness and happiness of adults is directly linked to a capacity to form satisfying relationships. Nurses communicate to attempt to comfort and educate both staff and patients and deal with difficult situations. Furthermore these skills are needed for advocacy, delegation, and to communicate rules, policies and procedures (Scammell 1990). As Henderson (2003) states, a good communicator can motivate effectively and produce a fully staffed competent ward.

It is recognised that support both formally and informally is required to keep nurses motivated and enhance quality of care and can be done by means of clinical supervision. Clinical supervision is a formal process of professional support giving individuals the ability to develop knowledge and competence (NHSE 1993). It is offered as a means of support and further education and can identify areas of poor practice. The concept of clinical supervision is part of government policy (1997, 1998), furthermore ‘ A Vision for the Future’, (DoH 1993) reiterated that clinical supervision is critical to the development of nursing practice. It is intended that clinical supervision guides rather than

dictates practice (Mullarkey et al 2001) and is seen as an informal chat with motivational qualities complimentary to the human relations style of management. Several authors have suggested that many nurses view clinical supervision as a regulatory tool linked to appraisal, censure and managerial overseeing (Butterworth and Faugier 1992, Castledine 1994) and if initiated properly can be professional, informative, educational and largely motivational. It can assist nurses to critically analyse how they work and ultimately lead to a high quality of care. Ideally clinical supervisors should be able to offer practitioners sufficient time and a non-judgemental objectivity, nevertheless this can be problematic due to lack of time and differing management styles (Cole 1999). Furthermore, other barriers to clinical supervision are that it can be seen as hierarchical in nature with staff feeling they are being watched (Butterworth & Faugier 1992), and the terminology itself implies ‘ judgement’, suggesting it could more appropriately phrased ‘ clinical support’. Cost is also an issue, as the time spent on clinical supervision may seem to be inappropriate in the current climate of the NHS where there is precious little money being spent on nurses to provide patient care. The nurse/patient ratio is difficult to get right at any time without nurses being taken off the ward for supervision. Despite many barriers, regular clinical supervision is beneficial as it identifies a nurses Continuous Professional Development (CPD) needs, and enables individuals to make plans for achievement and to keep up with the many ongoing changes throughout the NHS such as evidence-based practice (EBP), new medications and technology. Nurses are regulated by the NMC and subject to the code of professional conduct which advocates CPD to ensure nurses are up to date with their practice (NMC 2004).

Clinical governance, a framework through which NHS organisations are accountable for continually improving the quality of services, has been in place since 1996 (DOH 1998), and is committed to providing an environment where excellence can thrive. If nurses are to practice within this framework and adhere to EBP, such as the quality standards put in place by the National Institute for Clinical Excellence (NICE 2007), they must be rewarded with support and appreciation to keep them motivated to enjoy their role.

McGregor, Hertzberg and Maslow have all produced motivational theories that have influenced managers and leaders. Divergent management styles will motivate different people, but literature suggests a mixture of both human relations and transformational leadership are most admired, as they are good communicators and can adapt to motivate both theory X and theory Y individuals. Nevertheless it is clear from experience on the wards that a more bureaucratic style is needed occasionally to manage stressful or emergency situations. It is also apparent that most theory X individuals and some newly qualified staff also work well under a bureaucratic style of management. Motivation is at the heart of good management, and goes beyond praise for good work. Managers must create the conditions in which team members are motivated, and understand that all staff members are individuals and must be treated differently. Barriers to motivation have been discussed, with acknowledgement to the NHS having objectives to meet, but not providing staff with the resources to meet them, leading to demoralisation and low morale. Clinical supervision, if conducted thoughtfully, has much to offer nurses in their professional development and personal wellbeing, with the ability to motivate them and retain them in the

NHS. Furthermore, it is effective leadership that ensures the team is fit for, and delivers its objectives in this case, clinically effective, high-quality patient care.