Nursing Clinic Leadership Styles and Structures: A Literature Review

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Introduction

This literature review provided recommendations to a Nurse Practitioner-Led clinic that was evaluating its leadership structure. There are many different models, styles, and leadership structures. Some leadership structures require one leader, some two, and others require more than two. **Even with one leader, there are several different leadership styles, such as servant, transformational, authentic and participatory leadership.** This particular clinic had two different management leads, one focused on overseeing administration and the other was the Nurse Practitioner lead. The Board of Directors was interested in understanding which type of leadership structure would be most effective for a nurse-led clinic. "Leadership in the clinical practice environment is important to ensure both optimal patient outcomes and successive generations of motivated and enthusiastic clinicians'' (Davidson et al., 2006, p. 180).[1] The clinic was one of many that currently exists in Canada and wanted to ensure optimal patient-centred care was convenient and more personalized than traditional primary health care settings. "The complexities of interpersonal relationships within the clinical domain, and the critical issues faced by nurses on a daily basis indicate that morale, job satisfaction, and motivation are essential components in improving workplace efficiency, output and communication amongst staff" (Stapleton et al., 2007, p. 1).[2] In this setting, there was added pressure on Nurse Practitioners (NP) to support a self-sustaining organization and engage in leadership roles.

Many clinics faced retention issues, along with increased internal and external pressure to enhance quality, efficiency, and service (Taylor-Ford & Abell, 2015; Davidson, Elliott & Daly, 2006).[1,3] The fact that newly appointed leaders failed to adjust to their new roles in nursing clinics, was "making leadership transitions a topic of urgent importance in the healthcare industry" (Hill, 2007; as cited in, Taylor-Ford & Abell, 2015, p. 63).[3] The research question for this literature review was: What is the most effective leadership structure for an NP-led clinic?

Overview of the Scholarly Literature

The scope of the present literature review included effective organizational leadership and dual versus single leadership roles/models within healthcare organizations. This analysis identified the advantages and disadvantages of single, dual and shared leadership (for comparison purposes), and summarized effective organizational structures for health clinic practices. The review also examined the different leadership styles and models, some within a healthcare setting. The intent was to find evidence of best practices for leadership structures for an NP-led clinic purpose and culture.

Multiple databases of relevant peer-reviewed articles and keywords such as: 'leadership', 'one leader', 'dual leadership', 'shared leadership', 'nurse practitioner-led clinic', 'nursing', 'health care' and 'clinical leadership'. At the time, literature was sparse and there were few articles on leadership best practices, so the search was broadened to include different leadership structures or models in a healthcare setting. This included adding new search terms such as 'transformational', 'servant', 'multi-leader', 'leadership styles' and 'co-CEO's'.

This literature review used Google Scholar and library search engines to identify articles. Nine (9) articles between 2011-2017 were evaluated and had a focus on health care or a nursing organization, and the other articles (23) focused on effective leadership or management approaches. This included case studies (5), scholarly or theoretical texts for nursing (2), a culture text, leadership/management texts (2) including Northouse (2018)[4] and Daft (2018)[5], as well as articles pertaining to culture and motivation (2), managerial/educational leadership (4), clinical leadership practices (5), a multi-leader teams review, and a clinical policy document. These framed this review of academic literature on person-centred practice in nursing, clinical supervision, evidence-based approaches in nursing, and influential factors or motivation in clinical nurse roles. Two articles also focused on improvement in clinical leadership/practices, along with scholarly leadership or management articles (4), and other studies reviewed clinical leadership teams (4). Documents that provide the rationale and structure of nurse-practitioner clinic leadership were also examined, such as the job descriptions of leadership roles, the organizational structure, and a nursing clinic learning organization.

Determining the most effective leadership style and structure is also influenced by the current culture within an organization. "Leadership styles are undoubtedly influenced by the mission and type of organization, together with the beliefs and value systems of the individual, organization and broader society" (Davidson et al., 2006, p. 182).[1] In this review, we consider leadership development, styles, and structure of leadership within the scholarly literature to recommend best practices for clinical leadership. To begin, we examined leadership development and styles, including transformational leadership. Then we will compare different leadership models (e.g., single, dual and shared leadership) before closing with guidelines considerations.

Leadership Development

Case studies that examined the leadership within nursing clinics suggested best practices to implement leadership development opportunities. "We must first understand the complex phenomenon of leadership development and its impact on the leader before we can assess the impact of clinical leadership on nursing and patient outcomes" (Dierckx de Casterle et al., 2008, p. 755).[6] One case study, we reviewed, which was completed using a *Leadership*

Practice Circle Program (LPCP), aligned closely with the characteristics of the nurse-practitioner clinic we were evaluating, including, managers recently hired, high turnover, highly engaged chief operating officer/chief nursing officer (COO/CNO), and access to an experienced leadership coach (Taylor-Ford & Abell, 2015).[3] This case study took place over a period of ten months, at a small non-profit hospital in Northern California, that implemented an LPCP intervention to determine the impact on leadership competency development and turnover. Seven participants engaged in the LPCP intervention.

The LPCP was comprised of group sessions (4 hours in length that followed the same agenda and were held at an outside location), and individualized quarterly coaching sessions. Group sessions were designed for learning and development and included a consistent format: Centering & Check-In, Leadership Competency/Skill Development; Self-Reflection & Practice; Working Dialog; Coaching, Accountability, and Next Meeting (Taylor-Ford & Abell, 2015, p. 66).[3] Communication of organizational information, problem-solving of issues, and networking were also considered a benefit of the LPCP.

The case study was evaluated using the Bradberry and Greaves (2011)[7] 360° instrument (pre and post-test), along with an open-ended survey after the LPCP program, with 100% participation. In addition, pre-intervention turnover rates were compared to turnover rates one-month post-program. Findings illustrated that the skill of "developing others" showed statistically significant improvement post-intervention (p=0.0012)", and the turnover rate changed from 23% (pre-intervention) to 13% (p. 67).[7] The following thematic results were also identified: increased self-awareness, leadership presence, confidence, intentional communication, and a sense of collective goal and vision. Practicing difficult conversations was also noted as being uncomfortable but important.

The *Clinical Leadership Development Project* (CLP) was a similar intervention used in a single case study in which leadership development was evaluated over an 11-month period in which 17 multidisciplinary professionals participated (Dierckx de Casterle et al., 2008).[6] Data collection included semi-structured interviews, a focus group and observation. This study illustrated that the lead nurse became "more effective in areas of self-awareness, communication skills, performance and vision", and the nursing team benefited because "more effective leadership promoted effective communication, greater responsibility, empowerment and job clarity" (Dierckx de Casterle et al., 2008, p. 753).[6] The authors noted that it was important for participants to perceive leadership development as an ongoing, invested and interactive process. "For the clinical leader, personal development is crucial first. By developing strong self-awareness, the leader can identify his [or her] strengths and weaknesses, and thus advance towards more effective leadership" (p. 757).[6] In this way, depending on personal factors (e.g., age, character, experience, attitude or vision) appeared to determine individual differences and whether or not the individual gained from the CLP experience or not. Improvement in clinical leadership also seemed to influence "patient-centred communication, continuity of care and interdisciplinary collaboration" (p. 753).[6]

Interestingly, as a result of the CLP, the lead nurse collaborated on problem-solving and used goal-oriented communications to engage the team in positive and negative conversations. The lead also created a vision of their role of leadership, the team's interactions, and the clinics' care or outcomes combined. Team members felt more responsibility for their roles and a heightened sense of creativity within patient care. For instance, in this study the clinical leader distanced himself from participating in direct patient care which gave him greater responsibility for inpatient care. Regardless of this, the clinical leader was still recognized for having "a significant impact on patient care through his person, vision, knowledge and position" (p. 759).[6] Structure and clarity in the work environment and the clinic's caregiving process, which derived from the leader's confidence and transformational leadership qualities, was gained from participation in CLP, an interactive process that would be challenging for any clinical leader or team member.

This finding is supported by Rost's (1991) definition of leadership as an influential relationship among leaders and followers who intend real changes that reflect their mutual purposes. Rost's post-industrial leadership paradigm is characterized by collaboration, power-sharing, facilitation and empowerment (Rogers, 1991),[8] all of which can be recognized in the leadership of this case study (as cited in Dierckx de Casterle et al., 2008, p. 761).[6]

Leadership Structures

There are several different types of leadership structures and styles and choosing one for an organization, required thoughtful analysis to determine the best leadership for the culture of an NP organization. In the research reviewed, we identified an effective approach to a single lead, dual leadership roles, and shared leadership.

Single Leader

The use of a single leader within a clinical setting was discussed often in the literature examined, along with the particular style required of the leader. A few articles pointed to the importance that a leader in a clinical setting utilizes a participative approach. A participative approach required more time to ensure that all voices were heard but saves time in the long-term (K. Kirkpatrick, personal communication, May 14, 2018; Quinn, 2017).[9, 10] This was one component of the situational style of leadership, which enabled a leader to be flexible, and engaged in different approaches of leadership depending on the situation presented, and individual needs (Northouse, 2018; Daft, 2018).[4,5] For instance, a participatory approach could be used in crafting the philosophy of the clinic by involving staff, and ensuring that all members feel included and heard (Quinn, 2017, p. 57).[10] Additionally, a leader who embodies "a participatory approach … recognizes that every member of the team has an important leadership role. Part of the role of senior leaders is to encourage staff to engage in a participatory approach in their care of patients and when supporting their colleagues" (Quinn, 2017, p. 57).[10]

Another style of leadership highlighted was a visionary clinical leader. O'Rourke (2001)[11] shared that a visionary clinical leader "can simultaneously have a vigilant focus on promoting health; the capacity to build effective teams; articulate and demonstrate what others cannot see, and address immediate challenges as well as leading their team into a future which is often unknown" (Davidson et al., 2006, p. 185).[1] Florence Nightingale was an example of "commanding genius" with her visionary leadership, as described by Lord Dean Stanley (Andrews, 1929; as cited in Matthews et al., 2020).[12] She mentored nurses to expand their expertise and ensured training in good character; as "role models of compassion and empathy", and evidenced-based improvements for patient care (Matthews et al., 2020).[12]

In a clinical setting, an individual leader would also foster a culture in which employees were engaged with patients and each other, and create a welcoming culture. "An examination of their goals and strategies can help identify a model that can best lead to the reforms necessary to achieve the primary goal of increasing value by improving care" (Trastek et al., 2014, p. 378).[13] This required a clinical leader to have a vision, well-articulated and measurable goals, clearly defined roles and performance measures, to ensure staff were accountable for contributions to the clinic's culture and patient needs. Kraines (2011)[14] suggested this was done best by ensuring one LEAD's (Leverage potential, Engage commitment, Align judgment, and develop capability), via establishing accountability frameworks with all members. "Accountability is the obligation of an employee to deliver all elements of the value that he or she is being compensated for delivering, as well as the obligation to deliver on specific output commitments with no surprises" (Kraines, 2011, p. 15).[14] Clarity of role and accountability was only present when a one-to-one relationship existed between a leader and their team members (Kraines, 2011).[14] A thoughtfully chosen leadership style for an individual leader at a clinic, along with establishing well-articulated accountability structures, would translate into a healthy team commitment and culture, and ultimately, the experience patients encountered.

Dual Leadership

Co-leadership is surprisingly common in many non-healthcare-related organizations. Few articles were found using co-leadership in healthcare or nurse-led clinics. In a review article, Dust and Ziegert (2016) found that "the reciprocal interaction of co-leaders is likely to generate innovation through the complementary cognitive orientations of each leader" (p. 529).[15] If co-leaders could function well together and collaborate on ideas, they created great opportunities for an organization to advance. After reviewing 175 articles and considering the configuration-contextualization chart, Dust and Ziegert concluded that multi-leader programs may lead to role ambiguity, confusion of responsibility and conflicts of power among individuals with redefined roles in leadership.[15] "In highly urgent and complex programs it can be beneficial to have multiple leaders, although all leaders must be self-aware and continue to communicate and coordinate with all others within the system" (p. 530-1).[15]

Arena, Ferris, and Unlu (2011), discussed the occurrence of co-CEOs.[16] Their article concluded that, "If co-CEOs complement each other in expertise and in their job responsibility… there might be less need for advising by other board directors" (p. 391).[16] They defined complementarily as "the presence of off-setting skills, abilities, or experiences within the co-CEOship" (p. 395).[16] In essence, two leaders could be a great option if the leaders had separate roles and backgrounds, and could complement each other when it came to managing and leading the employees at their place of work. In nursing, this is often the case, as a *Nurse-Practitioner (NP) lead* often partnered with an *administrative non-clinical lead*, to engage clinic workers.

> The power should be equally divided between the person with administrative responsibilities and the NP who also have a clinical vision of care. We know from other projects, that the dimensions of the NP and CNS roles are underdeveloped when there is no clear leadership. In the context of interpersonal dynamics, it is also important to identify a leader that all (or almost all) team members respect who can act as a resource when conflicts arise (K. Kirkpatrick, personal communication, May 14, 2018).[9]

To implement a two-leader model, clinics are advised to choose two individuals that demonstrated complementary skills, exceptional communication, a high degree of trustworthiness and honesty (Arena et al., 2011).[16] Leaders should be in constant communication, assign and agree upon clear roles for each team member and work collaboratively to motivate members to reach the common goal(s).

Interestingly, *Powys Teaching Local Health Board* provided some indication of policies regarding the current NP-led clinic leadership structure. Clinical supervision of all staff in a clinical environment was central to a safe and effective practice (Lawrence & Labourne, 2012).[17] The key to clinical supervision was encouraging self-assessment, critical thinking and reflective skills to ensure all learnt from practice and became better at helping and caring for people.

Managerial supervision, on the contrary, was service driven and focused on "workload, functioning within the team and maintaining clarity of role, responsibilities and accountability… task-oriented, with a formal service-led agenda" (p. 10).[17]

This included performance appraisal, training and development, setting and monitoring goals, objectives, policies and procedures, and team effectiveness. In responsibility of both roles, the only difference between managerial and clinical supervisions appeared to be in caseload management and clinical/professional supervision, annual and multi-disciplinary leaves for the clinical supervisor. To be effective, the leads in these roles were required to create opportunities to dialogue and agree to the combined direction for their respective priorities (K. Kirkpatrick, personal communication, May 14, 2018).[9] In the NP-led clinic, there was some overlap between responsibilities in reviewing the Administrative lead, and the NP-led job descriptions (e.g., "to lead to track and resolve quality of care infractions, address issues, support performance evaluation and hires, etc.). Overlap was expected, however, clarity of role could be enhanced by creating responsibilities that are specific and measurable to the particular role (e.g., the Administrative lead had to collaborate with the NP lead for one-third of all their responsibilities).

Shared Leadership

In *Shared leadership in teams: An investigation of antecedent conditions and performance* (Carson et al., 2017), describe Shared leadership as, "total amount of leadership displayed by team members as perceived by others on a team" (p. 1225).[18] Shared leadership was an approach to leadership when there was no specific "head", or at the very least the top leader acted only as a coach, not a manager. Participants (n = 348) were put into 59 multi-functional teams (four to seven participants per team) to determine differences between shared leadership, team performance, internal team membership (social support) and external coaching. All teams worked for a business to assist with a current need and each had a faculty advisor as the external coach. Surveys were given to respective parties approximately two-thirds of the way during projects as well as after completion of projects. All results in the study led the authors to conclude that shared leadership yielded the best results and was best achieved through external coaching. Rather than relying solely on the leadership from an external leader, team members could rely on each other and work collaboratively. "When teams are focused on

collective goals (shared purpose), there is a greater sense of meaning and increased motivation for team members to both speak up and invest themselves in providing leadership to the team and to respond to the leadership of others" (p. 1223).[18]

Guidelines and Consideration

Clinical leadership is a growing area of scholarship, and even though some best practices identified through our literature review have been shared, there was not an agreed-upon leadership style or structure suggested for nurse-practitioner clinics. McSherry and Pearce (2016) found that "health care organizations need to identify, develop, and/or engage with leadership frameworks and/or program providers that suit their unique health care organizational culture and working environment" (p. 16).[19] This section outlines guidelines, leadership considerations and leader development practices to help members determine the most effective leadership structures for their organization.

Guidelines for Leadership Decisions

McSherry & Pearce (2016) in their paper What are the *effective ways to translate clinical leadership into health care quality improvement?* shared current literature about leadership within clinics.[19] Several definitions of clinical leadership were given and discussed; characteristics of leaders/clinical leaders, statements and rationale of clinical leaders were provided; and a guide/checklist for understanding clinical leadership was shared (McSherry & Pearce, 2016).[19]

The *Role of Nursing Leadership in Providing Compassionate Care* (Quinn, 2014), explored how leadership was expected to change as health/social care changed and how changing leadership could be applied in nursing.[10] Skills were identified for leaders, differences between leaders and managers were discussed, and a summary of all leadership styles was presented.

Leadership Considerations

The leaders and leadership approach taken would determine the culture of the organization, which in turn determines the services provided. There are three critical skills in establishing a culture: building safety, sharing vulnerability, and establishing purpose (Coyle, 2018).[20] When an organization demonstrated these skills through communication and teamwork, the culture became strong and the workplace welcoming. Leaders can be encouraged to build safety by interacting with affection and warmth and demonstrating qualities such as rapport-building, empathy, genuineness, and respect toward team members (Stapleton et al., 2007).[2]

Building Psychological Safety Considerations

Psychological safety requires a positive attitude and perspective toward individual roles, the team, and clinical operations. Attitude change is the only way to bring transformation to staff, and the whole organization and a flourishing cultures flow from a leader's support of innate human psychological needs (Deci & Ryan, 2008; Goleman et al. 2002).[21, 22] When employees were encouraged to utilize their skills to their fullest and feel psychological safety, they are motivated to deliver exceptional services (Pink, 2011).[23]

Sharing Vulnerability Considerations

Being authentic, telling the truth and owning up to the actions or outcomes a person experienced (whether good or bad), promoted vulnerability (Northouse, 2018; Coyle, 2018).[4,20] Vulnerability precedes trust, in that there is an attitude shared amongst all team members, including the leader, in which mistakes are accepted since they are part of learning and improving (e.g., Growth Mindset; Dweck, 2010).[24] When all members shared openly, their strengths and weakness, a culture of vulnerability existed where all team members reflect, were self-aware and shared. Dweck (2010) stated that accepting mistakes are human, and do not have to be internalized to define character (i.e. fixed mindset).[24] Instead, by taking risks to learn and accepting mistakes, learning led a person to explore more, improve practice and grow both personally and professionally (i.e., growth mindset). The good news is that even though some may demonstrate a fixed mindset, a growth mindset can be learned.

Establishing Common Purpose

Teams that focused on "collective goals (shared purpose)", embodied a greater sense of meaning and motivation to speak up and "invest themselves in providing leadership", while responding positively to the leadership of others (Carson et al., 2017, p. 1223).[18] By authentically engaging staff in the development of the vision, goals, controls, and philosophy of the clinic, a leader could motivate team members towards a collective purpose and effective performance. Deci and Ryan (2008) shared, that leaders who nurtured self-determination, tapped into the intrinsic motivation or personal purpose and drive that humans naturally possess.[21]

Organizational leaders could nurture self-determination or the intrinsic motivation towards a sense of purpose with team members by ensuring these three psychological needs are met: Autonomy, Competence and Relatedness.

Leadership Development

Many articles pointed to the use of leadership development programs, such as the *Leadership Practice Circle* (Taylor-Ford & Abell, 2015), and personal development and coaching that helped nursing leaders.[3] "Coaching may be a key to creating clinical work environments with good retention, work satisfaction and high-quality measures. Nurses can also learn how to self-coach, be more self-aware and develop themselves" (Stapleton et al., 2007, p. 5).[2] Clinics that instilled a practice of leadership development for all members would establish a common definition or perspective towards leadership, nurture a greater understanding of leadership approaches, and strengthen the self-awareness of each member, resulting in more effective interpersonal relations.

Conclusion

Due to the common suggestions of participatory approaches to leadership in the clinical setting, and one that was focused on patient care, a flat organizational structure would be suggested. For one leader, the chosen leadership style they embodied was essential to nurturing the culture and purpose for staff members to feel part of and buy into (Matthews, 2020; Trastek et al., 2014; McSherry & Pearce, 2016).[12, 13, 19] In dual leadership roles, complementary skills and collaborative practices needed to be both intended and measured for clinic success and survival (Daft, 2018; Dust & Ziegert, 2016; Arena et al., 2011; Kilpatrick et al., 2012).[5, 15, 16, 25] Dual leadership demands that each lead must have complementary strengths and skills, clarity in their roles/behaviours, and leadership development, and both individuals must agree and embark on developing and maintaining a culture, and relationship, of collaboration (Northouse, 2018; Lawrence & Labourne,

2012).[4, 17] Communication between the two leads must be consistent and could follow transformational leadership practices to potentially engage team members, enhance clarity, and elicit the importance of each member's role and open communication with each other (Coyle, 2018).[20]

Within the NP-led clinic, clear role descriptions that were differentiated and communicated may lead to improved leadership of the clinic, along with performance controls that are tied to the leadership development competencies provided (see Appendix A). Using a coaching framework to guide this co-leadership model, could engage staff in self-reflection and performance improvement. Sharing vision, co-creating the philosophy and culture, and establishing effective goals, performance targets and coaching practices towards improved leadership and performance would establish a strong purpose at the clinic.

Leaders who are self-aware demonstrated authentic practices and provided a model for team members' behaviours and a framework for building a culture of collaboration. Effective leadership was just one component of effective patient care. Management of clinical operations was also required and was more technical in nature which required expert power along with effective tools and techniques to manage effectively (Daft, 2018).[5] Through appropriate leadership styles and structures, and effective and efficient management practices, clinic operations would address the needs of patients and provide exceptional care to those they serve. Future research could also help to indicate the style and structures of leadership that would work best for a nurse-practitioner-led clinic.

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APPENDIX A - Clinical Leadership

To foster clinical leadership:

- Professional societies play an important role by providing an environment of collegiality, provision of leadership and mentorship and promotion of clinical excellence (Aitken 1999).
- Mentorship and clinical supervision programmes, locally and externally to institutions.
- Clinical and professional doctorates.
- Designated paths of career progression (e.g. progression of the CNC role from grade 1 to grade 3).
- Intraprofessional collaboration (e.g. collaboration between clinical nursing specialties).
- Interprofessional collaboration (e.g. models of advanced practice clinical supervision). Academic and clinical service collaboration (e.g. clinical professors of nursing described above).
- Development of skills in the affective domain as well as research and knowledge (e.g. negotiation skills and conflict resolution). (Davidson et al., 2006, p. 185)[1]

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