DOI: 10.2478/pielxxiw-2022-0015

Novice nurses' leadership competence: a cross-sectional study

Kompetencje przywódcze pielęgniarek rozpoczynających praktykę zawodową – badanie przekrojowe

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STRESZCZENIE

KOMPETENCJE PRZYWÓDCZE PIELĘGNIAREK ROZPOCZYNAJĄCYCH PRAKTYKĘ ZAWODOWĄ – BADANIE PRZEKROJOWE

Wstęp. Skuteczne przywództwo w pielęgniarstwie jest kluczowym elementem systemu opieki zdrowotnej i ma zasadnicze znaczenie zarówno dla jego prawidłowego funkcjonowania, jak i bezpieczeństwa pacjenta.

Cel pracy. Ocena kompetencji w zakresie autentycznego przywództwa wśród początkujących pielęgniarek oraz związku między komponentami kompetencji przywództwa a zmiennymi socjodemograficznymi.

Metody. W badaniu wykorzystano opisowy schemat przekrojowy. Analizę przeprowadzono w 2019 roku. Do zebrania danych wykorzystano polską adaptację Kwestionariusza Samooceny Autentycznego Przywództwa – (ALSAQ-P) oraz metrykę. Analizę oparto na 133 wypełnionych ankietach.

Wyniki. Większość początkujących pielęgniarek prezentuje średni poziom kompetencji autentycznego przywództwa. Prezentują niski poziom kompetencji w zakresie relacyjnej samoświadomości. Wykazano korelację stażu pracy z przetwarzaniem moralnym. W porównaniu z kobietami mężczyźni prezentują znacznie wyższe kompetencje w zakresie autentycznego przywództwa. W porównaniu z kobietami mężczyźni prezentują znacznie wyższe autentyczne kompetencje przywódcze.

Wnioski. Należy rozwijać kompetencje przywódcze wśród rozpoczynających praktykę zawodową pielęgniarek. Działania mające na celu wzmocnienie kompetencji przywódczych kobiet są szczególnie ważnym aspektem rozwoju zawodowego pielęgniarek.

Słowa kluczowe: **pielęgniarki, kompetencje, przywództwo**

ABSTRACT

NOVICE NURSES' LEADERSHIP COMPETENCE: A CROSS-SECTIONAL STUDY

Introduction. Effective nursing leadership is a key element of the healthcare system and is essential for proper functioning and patient safety.

Aim. To explore authentic leadership competencies among novice nurses and the relationship between the competencies components and sociodemographic variables.

Methods. Using a descriptive cross-sectional design, data were collected in 2019 with the Authentic Leadership Self-Assessment Questionnaire – Polish adaptation (ALSAQ-P) and metrics. The analysis was based on 133 completed questionnaires.

Results. The majority of novice nurses presents the average level of authentic leadership competencies. They present the low level of competence in relational self-awareness domain. The correlation of seniority with moral processing has been revealed. Compared to women, men present significantly higher authentic leadership competence.

Conclusions. Novice nurses authentic leadership competencies should begin to be developed. Actions to strengthen women's leadership competencies are also an important aspect of nursing development.

Key words: **nurses, competence, leadership**

INTRODUCTION

Effective nursing leadership is a key element of the healthcare system [1]. Moreover, nursing leadership enhances job satisfaction and the well-being of nurses and, thus, contributes to staff recruitment and retention [2,3].

Northouse defines nursing leadership as a process whereby an individual influences a group of individuals to achieve a common goal. Nursing research and intervention are mainly guided by the following leadership theories: transformational leadership, emotionally intelligent leadership, and authentic leadership [4]. Transformational leadership focuses on motivating, problem-solving, and intellectual stimulation, which lead to increased followers' commitment to the mission of the organization [5]. Emotionally intelligent leadership is vital to create a supportive environment and facilitate positive empowerment processes, leading to subjective well-being [6]. However, authentic leadership is most recommended in nursing practice [7], which is a pattern of transparent and ethical leader behaviour that encourages openness in sharing information needed to make a decision while accepting input from those who follow [8]. Authentic leadership has been classified into four categories: relational transparency (e.g. says exactly what she/he means, openly admits mistakes), moral/ethical conduct (e.g. acts in accordance with her/his stated beliefs), balanced processing (e.g. takes multiple points of view into consideration), and self-awareness (e.g. asks for feedback to improve interpersonal interactions, reflects on how others see her/his personal strengths and weaknesses) [9,10].

Applying the theory and strategy of authentic leadership in healthcare has a positive result for healthcare providers in a dynamic health care system [4]. According to Kark and Shamir, if leaders are authentic, employee engagement, motivation, commitment, satisfaction, and involvement will increase [11]. Research conducted among nurses has linked authentic leadership to positive work attitudes, behaviours, support for the structural empowerment, burnout for both experienced and newly graduated nurses [12,13,14], greater work engagement [15], and reduction i n workplace bullying and turnover intention [16].

In the analyses of leadership competencies conducted so far among nurses, the need for a broader view of this issue in the context of novice nurses (defined as a nurse with less than 3 years of professional experience) is still evident [17]. Although public opinion is not accustomed to seeing nurses as leaders, and not all nurses are beginning their careers to become a leader, all nurses must be leaders in designing, implementing and evaluating, and supporting ongoing reforms for the system that will be needed [18].

AIM

The aim of the study was to explore authentic leadership competencies among novice nurses. The objectives were assessment of the level of self-assessed leadership competence of nurses in three components (self-awareness, relational transparency, and moral processing), as well as to investigate the relationship between competence components and sociodemographic variables (age, sex, length of occupational experience, and the speciality of the ward in which they work).

METHODS

Design

A descriptive cross-sectional design utilising an online questionnaire was used to fulfil the research aim and objectives. The STROBE reporting guidelines was used in both the framing and reporting of this study.

Sample

The online study was carried out among registered nurses in Poland. A convenience sample was used for recruiting. Inclusion criteria were as follow: working as a nurse not longer than 3 years and age between 21 and 26 years. A priori power analysis indicated that we needed to recruit 130 subjects to have 80% power for detecting a medium-sized effect when employing the traditional 0.05 criterion of statistical significance. In total, 170 questionnaires were returned, but inclusion criteria were fulfilled by 133 respondents. Hence, the data included the analysis based on 133 completely filled questionnaires.

Data collection

The online survey was used to collect data between June and August 2019. A link to the survey was published and shared as public post using social media, including specialised Facebook nursing groups. Data collection was performed with a questionnaire that consisted of two parts: Authentic Leadership Self-Assessment Questionnaire – Polish adaptation (ALSAQ-P) and metrics with sociodemographic data.

The original Authentic Leadership Self-Assessment Questionnaire (ALSAQ) was created by Walumbwa, Avolio, Gardner, Wernsing & Peterson [9]. This tool consists of 16 questions and forms four subscales (self-awareness, internalised moral perspective, balanced processing, and relational transparency). ALSAQ is recommended by Northouse for practical applications for self-assessment [19].

For this study, we have used a Polish version of this scale – ALSAQ-P [20], adapted and assessed the psychometric properties of the Polish language version of the ALSAQ intended for use among registered nurses. The content validity analysis revealed a need to reduce the original ALSAQ version from 16 to 13 items and from four to three subscales: moral processing, self-awareness, and relational transparency. Questions 4, 8, and 9 referred to relational transparency, questions 1, 2, 5, and 6 were related to self-awareness, while questions 7, 11, 13, 14, 15, and 16 referred to moral processing. The obtained value of the Cronbach's alpha coefficient was 0.78, 0.66, and 0.60, respectively, while for the whole ALSAQ-P this value was 0.84. Results of the internal consistency of ALSAQ-P in our study has shown that the Cronbach alpha coefficient for all components was 0.71. The Cronbach alpha for

subscale was at the medium level [21]: 0.70 for moral processing; 0.62 for self-awareness; and 0.60 for relational transparency.

The study participants ranked the questionnaire statements on a five-point Likert scale (1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree). By comparing scores on each of the components, it is possible to determinate which are stronger and which are weaker components in each category. We can interpret authentic leadership scores using the guideline in Table 1. Scores in the upper range indicate stronger authentic leadership, whereas scores in the lower range indicate weaker authentic leadership competence [19].

Tab. 1. Sociodemographic characterictic of the study sample (n=133)

Sociodemographic variable	N (%)
Sex	
Female	122 (91.7)
Male	11 (8.3)
Seniority	
up to 6 months	26 (19.5)
6 months to 1 year	51 (38.3)
1 year to 2 years	37 (27.8)
2 years to 3 years	19 (14.3)
over 3 years	0
Place of work	
Hospital	94 (70.7)
• Intensive care	16 (17)
• Surgical	34 (36.2)
• Conservative	37 (39.4)
• Other	7 (7.4)
Primary care	33 (24.8)
Nursery	2 (1.5)
Kindergarten	4 (3)

Ethical consideration

The Medical University of Warsaw Ethical Board positively assessed the study (reference number AKBE/192/2019). Participants received a cover letter explaining the study aim, terms of participation and ensuring confidentiality. They were also informed that participation was voluntary and that they could end their participation without any explanation. The responders' names were not recorded on the questionnaire, thus rendering the data anonymous. Sending the completed questionnaire was synonymous with consent to participate in the study.

Data analysis

The responses from the surveys were initially sorted and divided into Microsoft Excel. Then, the data was exported to IBM SPSS v25 for further statistical analysis.

Descriptive statistics were used to assess sample characteristics. Categorical variables were summarized as frequencies and percentages. Continuous variables were assessed for normality using the Kolmogorov-Smirnov test and expressed as the following descriptive statistics: mean, standard deviation, median, range (min-max), skewness, and kurtosis. None of the analysed quantitative variables was found to be normally distributed. Spearman's rank correlation analysis was used to measure the strength and direction of the association between two ranked variables. For comparison between the two groups of quantitative variables, the Mann-Whitney U test was used. The differences between more than two groups were compared using the Kruskal-Wallis tests. The significance factor (p-value) was also calculated for each of the examined correlations. A p-value of <0.05 was considered as statistically significant.

RESULTS

Characteristics of participants

Sociodemographic data (sex, seniority, and workplace) of analysed material (n = 133) is presented in Table 2. The mean age of the respondents was 23.7 years old (range, 21 to 26 years old).

Authentic Leadership Self-Assessment

Novice nurses presented their authentic leadership competencies as follow: low score (n = 10, 7.5%), medium score (n = 113, 85%), high score (n = 10, 7.5%). The results of the Authentic Leadership Self-Assessment in the studied group are presented in Table 3. Novice nurses feel the strongest in domain of relational transparency – 21.1% (n = 28) presented the high level of competence in this domain. They feel the weakest in the domain of self-awareness of authentic leadership (17.3%, n = 23). The specific data are presented in Tables 3.

Tab. 2. Results of the ALSAQ-P questionnaire (n=133)

Level	Moral processing	Self-awareness	Relational transparecy	Total
	N (%)	N (%)	N (%)	N (%)
Low	15 (11.3)	23 (17.3)	12 (9)	10 (7.5)
Medium	108 (81.2)	93 (69.9)	93 (69.9)	113 (85)
High	10 (7.5)	17 (12.8)	28 (21.1)	10 (7.5)

Tab. 3. Basic descriptive statistics for ALSAQ-P results (N=133)

Domain	Results' range (min-max)	M	Me	SD	Sk.	Kurt.	Min.	Max.
Self-Awareness	4-20	15.44	15	2.324	-0.071	-0.241	10	20
Moral processing	6-30	23.44	24	2.754	-0.062	0.111	17	30
Rational transparency	3-15	10.49	10	2.194	-0.004	-0.851	6	15
Total ALSQ-P	13-65	49.38	49	5.297	0.274	0.050	38	64

The relationship between authentic leadership self--assessment and sociodemographic variable.

First, we tested whether individual variables (sex, age, seniority, and workplace) correlate with ALSAQ-P results. The results of the U Mann-Whitney test regarding sex showed that, compared to women, men present

significantly higher competence in the domain of relational transparency (p = 0.012) and general ALSAQ-P results (p = 0.044).

The correlation (Spearman's correlation coefficient) of individual domains with the age of respondents did not show a significant level for self-awareness (rho = 0.076; p = 0.386), relational transparency (rho = 0.085; p = 0.331), moral processing (rho = -0.101; p = 0.249), or for the whole scale (rho = 0.034; p = 0.694).

The correlation of individual domains with seniority showed a weak and negative relationship only with moral processing (rho = -0.217; p = 0.012), which means that the greater the seniority, the lower the result obtained in the domain of moral processing. There were no correlations between seniority and self-awareness and relational transparency and for the whole scale (rho = 0.020; p = 0.820; rho = 0.101; p = 0.247, and rho = -0.047; p = 0.593, respectively).

The analysis of the workplace relationship for the presented leadership competencies did not reveal any dependence on the level of either the workplace or the specificity of the department in which the studied novice nurses work. Results regarding dependence of the place of work (hospital, primary care, nursery, kindergarten) for the self-awareness domain was H(3) = 3.858 (p = 0.277), for moral processing domain was H(3) = 4.198 (p = 0.241), for relational transparency was H(3) = 0.792 (p = 0.851) and for the whole scale was H(3) =1.352 (p = 0.717). Results regarding dependence of the hospital ward (conservative, surgical, intensive care, other) for the self-awareness domain was H(3) = 1.658 (p = 0.646), for moral processing domain was H(3) = 3.447 (p = 0.328), for relational transparency was H(3) = 4.946 (p = 0.176), and for the whole scale was H(3) = 5.238 (p = 0.155).

In addition to correlating survey results with respondent metrics, the correlation between domains was also examined. The highest correlation coefficient (rho = 0.365, p < 0.001) was obtained for the moral processing-self-awareness pair, which means that respondents who scored higher in the field of moral processing also obtained higher scores in the field of self-awareness. Other correlations between subscale presented results: self-awareness-relational transparency (rho = 0.247, p = 0.004) and relational transparency-moral processing (rho = 0.233, p = 0.007)

DISCUSSION

A significant increase in the number of authentic leadership studies has been observed since [4]. Until now, most of the research concerned various personal, professional, health, and well-being factors of the staff and factors of the work environment [8, 13] as factors influencing authentic leadership results [4]. Also, there is empirical evidence linking authentic leadership with positive patient and nurse outcomes [15].

Due to the majority of "medium" scores presented by respondents in our study, it can be stated that novice nurses have leadership competencies at the average level. However, self-awareness was the least-rated domain. Our results are in line with the results obtained by Kunecka among master's nurses. Such results could create difficulties in fulfilling the professional nurse's role, and therefore, if they want to look after the patient professionally, and collaborate with other healthcare specialists, they require intensive work on their leadership skills [22]. Nurses leadership competence is needed at every level and across all settings. To be more effective leaders, nurses need to possess two critical sets of competencies: a common set and a more specific set. The first set can serve as the basis for any leadership opportunity and includes, among others, knowledge about the system of providing care, how to work in teams, how to effectively cooperate in various disciplines, the basic principles of ethical care, how to be an effective patient spokesperson, theories of innovation and the basics of improving quality and safety. The second, more specific set is tailored to a particular context, time, and place. It might include learning to be a full partner in a health team in which members of different professions account for each other for improving quality and reducing unwanted adverse events and treatment errors [23]. These competencies are also recommended by the American Association of Colleges of Nursing as essential for baccalaureate programs [18]. Therefore, leadership skills should be strengthened as soon as nursing education begins, and training programs should be based on leadership competencies [24]. Every nurse must take the initiative to act autonomously, make decisions, and develop in daily practice.

Our study revealed that respondents present the highest results in the domain of relational transparency. This is likely because young nurses are open and honest in presenting themselves to others. They are also open in communication and true in relations with others [19], traits that are much needed during their adaptation process at the beginning of their practice. Moreover, Jaworski, Panczyk, Skubek, Zarzeka & Gotlib revealed a correlation between the relational transparency leadership skills of midwives and the level of their satisfaction with their work, which could be crucial for the remaining in the profession [25].

Self-awareness turned out to be the weakest domain among studied novice nurses, which means that novice nurses do not fully understand themselves; they are not able to determine their strengths and weaknesses. They have not found who they really are and what their basic moral values are. The more self-conscious a person is, the more authentic he/she is [19]. Therefore, among others, weakly developed self-awareness of leadership competence might cause difficulties in choosing a career path. Alongside developing appropriate leadership competencies among novice nurses, they also need to pursue their professional aspirations; employees are looking for career mapping opportunities, goal setting, and formal mentoring [26]. The role of the teacher and professional mentoring in vocational adaptation were also indicated as key aspects of effective vocational training by other authors [27,28]. Also, Wong & Laschinger revealed that behaviours demonstrating primarily self-awareness and moral processing are important; people who have a strong value

system are not afraid to present and demonstrate it openly [29]. Their ethical standards underlying the decisions ensure communication and transparency of their actions. Healthcare workers involvement in decision making, and combining these decisions into individual goals encourages the improvement of work results [29].

In our study, men presented a significantly higher level of leadership competencies and a higher level of competence in the relational transparency domain. That means that they present more open attitudes for saying exactly what they mean and admitting mistakes openly. In earlier studies, gender has been indicated as an important factor for leadership, especially in the highly male-oriented societies, such as Korea [30] and Saudi Arabia [31]. In European cultures, the advantage of leadership competencies among male nurses might result, among others, from the fact that they are still a minority of nurses' population. Therefore, their sense of self-confidence and perception by colleagues can create conditions for the development of leadership competence. Moreover, studies according to the state of women in leadership positions within the Western health care industry found that although nursing is a female-dominated profession, there is still an under-representation of women in top leadership roles [32, 33].

In our study, we have revealed that the greater the seniority is, the lower the result obtained in moral processing as a domain of leadership. Given that the respondents were a group of young people who are just starting their apprenticeship, the differences in age were not so large between them. Nevertheless, previous studies on nursing leadership have demonstrated many demographic variables, such as age, level of education, and years of experience influencing nurses' willingness to lead [34]. Laschinger, Wong, MacDonald-Rencz et al. detected a negative relationship between age and willingness to lead and suggested that nurses above 35 years old present decreased willingness to pursue a leadership role [35]. Considering the above, even if young nurses are more willing to lead, this is insufficient, especially in the context of the presented level of competence in this field [35].

Nursing is a key part of the ever-changing healthcare environment. Therefore, developing effective nurse leaders is a priority [36]. Leadership is an indispensable factor in creating strong working environments in nursing [13], which is crucial during the serious healthcare problem, such as a worldwide nursing shortage. Therefore, when considering changes in strengthening nursing leadership competences, it should be remembered that "leadership is not the private property of a small group of charismatic men and women. Leadership is a process that anyone who plans to bring out the best of themselves and others can benefit, which is the essence of professionalism in the profession of a nurse" [37].

Although meticulous methods have been used in this study, there are limitations. First, there is a small amount of research related to authentic leadership among novice nurses. Only English and Polish language studies were included, which could exclude other potentially significant studies. Internal consistency at medium level was presented in two out of the three subscales. The sociodemographic part of the questionnaire did not include the question about education, so we only know that the respondents were registered nurses. The narrow age range of the respondents did not allow an analysis of the dependence of leadership competencies on the age of nurses, and the analysis of dependence with seniority is based only on the range of 36 months. In the Polish version of the ALSAQ, leadership competencies are assessed in three subscales, differently than in the original version (four subscales), which might make it difficult to compare the results with the research of other authors.

CONCLUSIONS

1. Our results showed that novice nurses presented the average level of authentic leadership competencies, which should start to be developed during undergraduate education and strengthened during professional practice. The activities should be focused on developing all domains of authentic leadership, with particular emphasis on the domain of self-awareness.
2. Actions to strengthen women's leadership competencies are also an important aspect of nursing development.
3. Our results complement the growing knowledge of authentic leadership in nursing, suggesting the need of developing strategies to address novice nurse's and nursing students leadership competencies and to use them to educate future leaders and managers, which will result in a greater commitment to the work, higher job satisfaction, and better patient outcomes.

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Manuscript received: 08.09.2021
Manuscript accepted: 18.01.2022

Translation: American Manuscript Editors