

# Effects of Nursing Leadership and Work Environment Management

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**ABSTRACT:** *While healthcare experiences an economic slowdown, demanding job conditions, imminent leadership retirements and expected staff vacancies are critical, initiatives are being introduced to maintain efficient leadership and optimum patient results. However, there is still a gap in whatever is known about the relationship among nursing leadership and outcomes of the patient. Published study papers in English only which analysed nurses' leadership activities in formal leadership roles and patient results were chosen from 5 online bibliographic databases. For all including research, qualitative analyses, data retrieval and interpretation were performed. A total of 15 research met and maintained our inclusion requirements. Present research supports associations between optimistic forms of collaborative leadership and improved patient interaction and reduced patient mortality, drug failures, lack of restriction and hospital-acquired infection. The results record proof of a favourable association between relational leadership and a range of outcomes for patients, while prospective research of leadership models that explore processes of effect on outcomes is warranted. Efforts by organisations and people to build expertise in change and partnerships improve corporate approaches for optimizing patient care. The goal was to explain the results of a longitudinal research analysis investigating the connection between the activities of nursing leadership and the experiences of patients.*

**KEYWORDS:** *Evidence based Practice, Environment, Leadership, Management.*

## INTRODUCTION

Highly skilled nursing practitioners were viewed as experienced risk-takers driven by an overarching ideology in conducting regular operations and as effective proponents for nursing and personnel welfare. Nursing practitioners will be good champions for workers because they become risk-takers in creating safe work conditions. Workplaces are important settings for addressing the employees' mental, physical, social and economic well-being. There is a link between occupational wellness and workers welfare and safe workplaces are associated with safer patients. Organizations of unsafe workers rising have an expense burden from high absenteeism rates, employee participation but poor job efficiency, productivity loss, work-related injuries, high stress levels and high frequency of health-related litigations. Comprehensive Balanced Corporate Change workplaces provide health awareness care, smoking / alcohol / drug prevention services, wellness and workout routines, safe food access, weight loss initiatives, tension reduction, backup Care, prevention, early detection and critical disease screening. Sadly, behaviour-oriented organizational interventions have achieved only marginally good outcomes [1].

Conversely, occupational wellness systems promote decreased absenteeism, better productivity driven employees, reduced employee wellbeing issues and conflicts over labour arrangements, increased output, enhanced corporate results, increased prosperity, and improved public profile. Sustainable occupational wellness strategies are important and can involve organizational development; effective health and safety policies and records; informal supportive ties and corporate culture; Orientation, preparation and job-learning support; effective handling of human resources; strong communications; marketing; multidisciplinary collaboration; and multi-method assessment. Weak management and leadership styles; aggressive, protective, unsupportive behaviour; lack of supervision and

guidance; control; and lack of acknowledgement of achievements have been described as major stressors. And, on the other hand, Positive workforce engagement programs, such as mutual business goals, learning incentives, job growth, pay systems, flexibility, Strategies on engagement and leadership, wellness and well-being services for workers, workplace satisfaction, transparent types of management and involvement and Empowerment approaches associated with progressive leadership encourage safe environments based on workers. The following leadership characteristics were described as important by Magnet hospital nurse leaders: open, constructive, communicative, versatile, strong listener, truthful, active, informed, optimistic, compassionate and visible; these traits empower people to seize control [2].

Several researchers came to a conclusion, the bottom-up and top-down strategy for introducing an advancement in nursing may be a positive. The top-down will work with a predefined concept, particularly if the idea has been previously developed, implemented in the enterprise, and if strong system-wide implementation is necessary. That can be terribly effective if staff at the front line were engaged in the regulatory framework and pilot test. The bottom-up methodology helps front-line staff to play a significant role in defining problems and development plans. This encourages innovative staff responsibility and efficient adaptation to specific settings. Under this situation, the members of risk-takers exercise participatory strategy and constructive leadership. Professional councils of nurses have been established to decentralize activities and help employ staff. Popular councils include Council of Administration, Council of Policy and Practice, Council of Efficiency, and Council of Science and Education [3].

Significant evidence has been introduced over the past decade that the characteristics of nursing work environments, particularly nursing staff, are linked to patient outcomes, which include risk factors and patient mortality like medication errors, hospital-acquired infections, pressure ulcers and falls. Successful nurse leaders maintain proper training and other services are in order to deliver secure treatment and optimum results for the patient. Professional nurse executives at the corporate level lead to policy strategies by engaging in decision-making at the senior level and their willingness to affect how nursing is performed and respected. Front-line supervisors involve nurses at hospital and unit level in decision-making around patient experience and personnel, quality management programs, and continuing development experiences to enhance optimal service performance. The recent economic crisis, health and safety issues correlated with challenging work conditions, more executives entering retirement, and expected shortages of workers are questioning healthcare leaders' capacity to support, let alone enhance, patient care rates. Successful nursing leadership is vital to promoting strategies for progress in the struggle for institutions to render procedures more cost-efficient and increase results, recruit and maintain high-performing personnel and be more receptive to patient needs [4].

This research aims to explain the results of a systematic analysis of literature studies that explores the association among activities of nursing leadership and outcomes of the patient.

## **LITERATURE REVIEW**

It was considered that excellent organizational systems were flat with autonomous nursing divisions that had good nursing presence within the organizational framework. The nursing supervisor worked at the organisation's corporate level and deferred to the chief executive. Many hospital officials are now dealing with new hospitals being constructed or current buildings being revamped to fit modern technologies, various groups of patients and more intimate and family-oriented rooms instead of multi-bed units. Researchers suggested that

members ought to extend their scope of power and participation by engaging with boards of directors to achieve recognition of plans and to seek consent for capital funding; engage with elected representatives to receive legislative and financial support; and network with the other nurse leaders to acquire best practice examples and finished initiatives that demonstrated promising results. A project framework needs to be established that clarifies authority structures, contact lines and decision-making, and responsibilities and goals [4].

Several health care practitioners created and validated alternative methods of clinical provision by including nurses and other health care professionals in various positions around the treatment spectrum. That include the 10-Bed Hospital Model, Agile Group Self-Organized Model, Primary Care Team Model, Integrated Patient Care Engagement Model, Home Health Model, Adaptive Care Model, and Acuity customizable Beds Model. Researchers noticed that these modern models elevated the position of registered nurse (RN) to manager of primary care from admission to discharge and sometimes back into the society. They are sharpening patient emphasis. Treatment is handled by the nurse and guided by the patient. Engagement of patients and their relatives is included. Medical transfers and hand-offs are smoothed and medical treatment is monitored after hospital discharge. Improved use of advanced testing, calculation and training methods. Technology is getting used to reducing labour-intensive paperwork, increasing coordination through exposure to knowledge and reducing actions and waste time. The simulations are driven by result estimation [5].

It was critical that caregivers be engaged early and frequently in the design and development of the new models. Replicable approaches have been identified that provide hospice treatment, emergency professional facility services and all-inclusive treatment for disabled persons. Researchers indicate that modern theory of organization assumes an organization to be an integrated system with integrated parts. There is not one suitable hierarchical framework, owing to the complexities and increasing situations. The architecture will help organize efforts to meet the aims of the organization. To solve the ever-changing challenges, institutions must be creative, adaptive, and robust. Good management strategies were viewed as participative, promoting and valuing employee input at all rates within the company. Nursing members were clear, open and dedicated to good contact. For teaching hospitals, patients showed higher expectations of safety, health benefits and flexibility of everyday life practices than patients for community hospitals. In surgical patients this was considered rather than for medical patients, which could indicate a disparity in the treatment needed [6].

In units with a higher proportion of casual staff, patients showed greater expectations of health benefits indicating that compliance with job conditions may affect patient care. Several papers on medical personnel, nurse-to - patient ratios, workforce composition, patient performance, clinical support, job organisation, doctor-nurse coordination, work atmosphere and partnerships to standard of treatment and nurse efficiency, including but not limited to: American Nurses Association, were reported during the year 2002. Researchers find the significant causes for resignations were reorganization and other adjustments. Organizational complexity, hierarchy, hierarchical leadership and inadequate access to knowledge have been shown to restrict control and exacerbate discontent, absenteeism and burnout [6].

Staff have been finding lacking leadership, training and growth incentives, access to knowledge, and promotion opportunities. A theoretical paper on the value of loyalty and trustworthiness, leadership, collaboration, continuity and mentoring has been written by scholars. She speaks about the role of managers shaping the society by establishing the ideal beliefs, principles and actions and through communicating. Trust and work satisfaction is significant predictors of loyalty and remaining will. Researchers in Australia have found positive connection among morale and interaction of the team, discussion, professional

recognition and less abuse of patients. Researchers believe that a strong level of leadership is the potential to promote confidence of workers. Acknowledgement of accomplishments and good results should be utilized to facilitate retention. Management engagement, participatory management, transformational leadership, collaboration, communication, open and effective members all led to work satisfaction, nurse productivity and positive care for patients [7].

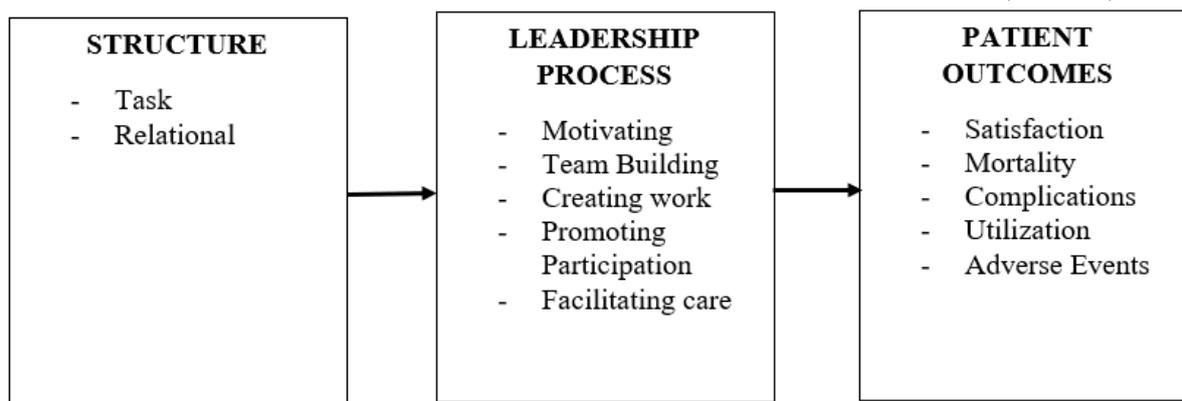
#### *Conceptual Framework:*

A conceptual model was built for the research analysis based on the system structure process outcome (SPO) (see Figure 1). This system includes three analytical domains: (1) systemic or context variables composition, (2) structures for organizing and promoting patient care procedures, and (3) treatment effects. Initially defined as a structure for conceptualizing the aspects of the field in healthcare, researchers postulated that each of these key dimensions was a sufficient prerequisite for the next one. Structures provide an impact on the systems and results. The SPO structure has been widely used to analyse relationships among institutional organizational features such as nursing personnel or leadership, and results of nurses and patients. Researchers describe the SPO framework in this review to analyse the links among outcomes of patients and leadership. As a framework, it has segregated the leadership style of nurse members in organizations. Leadership was loosely described as “the mechanism through which an entity tries to actively manipulate another person or community to accomplish a objective” [8].

Therefore, researchers classified leadership either as hierarchical or task-oriented. Experts clarified that leadership types can be generally defined as strategies that concentrate on individuals and partnerships (relationally oriented) to accomplish shared objectives or as types that concentrate on (task-oriented) systems and activities. The degree to which leaders adopt an approach to public relations, display empathy and reverence for followers, demonstrate gratitude and encouragement, and are sincerely concerned for their wellbeing. Transformation leadership, for example, is a type of relational leadership in which followers have confidence and reverence for the leader and are inspired to move above standard job standards in order to meet organizational objectives [9].

Leaders often vary in their emphasis or concentration on the aims of the organization and the methods for reaching those goals. Many with a clear mission orientation identify and coordinate followers' tasks, concentrate on objectives, processes, and development, create well-defined contact lines, and are likely to maintain their distant from the followers mentally. An illustration of a task-oriented approach is transactional leadership that stresses the trade or commercial interaction that takes place between members, subordinates and followers to do the job. The task of the transactional leader is primarily to identify the desires of followers and to track their fulfilment of the position. The process definition within the context has been described as the systems or frameworks of leadership through which members may relate to patient results. Examples of such processes can include promoting working environments that facilitate optimal healthy patient treatment, establishing transparent dialogue with staff to uphold consistent levels of service, or cultivating supportive partnerships with staff that encourage job engagement. Outcome takes into account the measurable care outcomes and researchers focused exclusively on outcomes for patients [10].

Patient results is described as results representing patient death, outcomes relating to patient protection such as occurrence of serious accidents affecting patients (e.g. nosocomial infections, falls) or problems during hospitalization, expectations of patient satisfaction with treatment, and utilization of health services such as duration of stay.



**Fig. 1 illustrates the model of systematic review of Nursing Leadership**

## METHODOLOGY

### *Design:*

Design included empirical findings that explored the association between nursing leadership and single or multiple patient results in all forms of healthcare settings. Leadership or personality characteristics of personality types, attitudes, competencies, or habits is assessed as self-reported by members, direct leadership assessment, or followers' assessments of leading behaviours. A leader of a health care system has been described as a nurse in a structured leadership capacity at any stage (e.g. first line, middle and/or senior leadership / management roles) and who supervises other nurses. Clinical leadership trials of clinical nurses, leadership learning systems assessment or leadership tool research were omitted. Except certain reports that explored the correlation between leadership and patient results recorded or derived from institutional datasets as direct evaluation of patient outcomes. Reports in medical results reported by nurses or workers is left out. There was no limitation on the scope of the research, and papers were examined written in English only. Researchers provided quantitative analysis of the relationship between leadership and patient results, and statistically checked.

### *Sample:*

Five Bibliographic online databases were searched: Scientific Quest Complete, ABI Notify Dateline, Cochrane Systematic Review Database (CDSR), MEDLINE, ERIC, EMBASE, CINAHL and PsychINFO. A summary of the search strategy is given in Table 1. In the last analysis some of the repositories have updated but the architecture uses almost the same references as in the last examination. The reviews of Nursing Science, Nursing Planning, Nursing Leadership, The Leadership Review, Journal of Organizational Practice and Journal of Nursing Administration as well as the bibliographies of papers listed to be used in the study.

**Table 1 illustrates the online searched database for the study of Nurse Leadership**

Search Database	Terms to be searched – Quality of Healthcare, Leadership, Nurse, Outcomes of Patients.	Results found (Total number of researches)
Academic Search Complete	(TI or MM leadership) AND (TI outcome* OR MM 'Healthcare' OR MM	2781

	'outcomes of Nursing') AND TX nurse	
ABI Inform Dateline	(Leader) AND (Nurses) AND (Outcomes of Patients)	55
EMBASE	(Nurse) AND (Leadership) AND (Research) AND (Quality of Healthcare)	3436
PsychINFO	(Healthcare Quality)(MESH) AND (Nurse)(MESH) AND (Leadership) (MESH)	1889
ERIC	'Leadership' OR 'Healthcare Quality' AND 'Patient Outcomes'	216
Manual search		8
Total		8385
Total Reviewed		116

*Instrument:*

The primary researcher and a research assistant reviewed search method names and abstracts of the papers listed. Reports that theoretically meet our inclusion requirements, and where inadequate evidence was accessible to render a determination on inclusion, were collected and analysed by the primary author and a study assistant for significance. The same quality assurance methodology was used to evaluate the analytical consistency of the final collection of publications which was modified and used in the original analysis and then used in other reported systemic analyses. Each research was twice checked by the lead author for accuracy. The adapted methodology was used for assessing each study's research architecture, collection, calculation, and statistical analysis. The method contains 13 requirements, and a minimum of 13 valid points for all 12 parameters may be given (Table 2). 11 things were rated as 0 = unfulfilled or 1 = achieved, and the result calculation item was rated as 2. Studies were then graded according to summed-point values as: strong (9–13), moderate (4–8) and low (0–3).

**Table 2 illustrates the brief study of quality assessments which includes the previous review studies**

<b>Fulfilling Criteria</b>	<b>YES</b>	<b>NO</b>
Used probability sampling	4	14
Prospective studies	19	0
Sample drawn from more than one site	14	4
Appropriate/justified sample size	5	13
Anonymity protected	18	1
Response rate >50 per cent	7	11
Valid measure of leadership	18	1
Effects (outcomes) were	13	5

observed rather than self-reported		
Reliable measure of leadership	19	0
Theoretical model/framework used	12	6
Management of outliers addressed	4	14
Correlations analysed when multiple effects studied	17	1

#### *Data Collection:*

The study researcher collected data from all provided articles and a research assistant double-checked for accuracy. Information were extracted on the author of the report, article, region, research intent and concerns, theoretical context, nature, environment, topics, sampling process, measuring instruments, reliability and validity, interpretation, leadership measures, patient effect measures, significant and non-significant outcomes, discussion and recommendations. For the 12 studies maintained in this revised study, Appendix S1 contains data extraction along with the data from the many studies described in the previous analysis.

#### *Data Analysis:*

Leadership was classified as partnership or task-oriented, utilizing content analysis and the logical structure as a reference, and patient results were sorted into thematic categories based on their specific characteristics and our previously established categories of performance. Second, researchers identified patterns of relationships within each thematic category between relational or task-focused leadership styles and changes in specific patient outcomes. For starters, we looked into increasing leadership styles were more correlated with different results such as patient satisfaction, and if patient satisfaction as a consequence of leadership style improved or decreased. The associations identified were evaluated between the different types or behaviours of leadership and the results by group and importance ( $P < 0.05$ ). They also analysed studies for mechanisms in which leadership affected results that were either measured or addressed in studies and grouped into specific characteristics-based themes.

## **RESULTS AND DISCUSSION**

Server and hand searches produced 8385 titles / abstracts, of which 116 were listed after the title and abstract analysis as potentially significant. One of the 116 studies was a reported journal article (McCutcheon) of one of the seven studies retained in the preceding analysis (Doran) which researchers received from a study database as a source. Investigators omitted the paper plus 90 others, leaving just 12 experiments after evaluating the study the met our selection criterion. They applied these 12 papers to the seven publications maintained in the previously published systematic analysis (Wong & Cummings) and identified the features of all 15 research that were included. Such papers reflect 15 initial experiments, with the exception of the (Capuano) report that was focused on the (Houser) analysis utilizing the same computational model, gathering data on the same variables in another environment and then applying the results to the (Houser) sample and checking the model over again. Between 2000 and July 2015, all 15 experiments were released and all but 4 were performed in the United States; the rest were done in Canada ( $n = 2$ ) and Norway ( $n = 2$ ).

The research reflected a number of treatment settings: hospital inpatient critical care centres (n=11), nursing homes (n=3), dialysis clinics (n=2), ambulance departments (n=2), health care services (n=1), and neonatal intensive care clinics (n=1). Given the number of environments the results have been collected. The research groups involved patients (n=8), patients and administrators (n=5), a cross-section of health-care practitioners comprising clinicians (n=1), a mix of nurses, support clinicians and unlicensed medical workers (n=1) and nursing supervisors (n=1). More information on the features of all 15 studies listed can be contained in Appendix S1.

The qualitative consistency of the papers in dispute is listed in Table 2. All items used a cross-sectional template and of the 15 papers published, 13 (90 percent) were classified as strong and 2 (10 percent) were classified as mild. The benefits of the study included the fact that the bulk (n = 14.96%) used accurate and relevant methods, were multi-site trials (n = 10.76%), had reasonable sampling scales (n = 12.85%) and recorded multi-effect effects (n = 13.90%). Leadership was assessed in all but one sample, by asking followers to assess their formal leader's leadership style. Observed leadership activities measured by supporters of a leader relate more successfully to building the value of leadership assessment than participant self-report, since self-report assessments are prone to prejudice in relation to social desirability. 5 (25 per cent) research used only self-report indicators for patient results, including patient satisfaction. Many other success indicators for patients were prospectively obtained in the analysis or retrieved from institutional repositories. 13 (88%) studies documented using multi-variate analysis, including multiple regression, regression models, hierarchical linear modeling (HLM), or structural equation modeling (SEM). The category / organizational standard in 17 experiments was the unit of measurement for leading and patient results. Weaknesses of studies found in the quality appraisal referred specifically to participant participants, treatment of outliers, clear use of a philosophical or analytical context, response levels and reliability of the monitoring research for the measures used. Just 4 (8%) of studies recorded using random sampling and 8 (55%) registered less than 50% answer times.

In these tests, leadership was assessed as patterns, attitudes, competencies, and habits of leadership. Study-wide leadership principles or trends include transformational / transactional leadership, collaborative, participatory or cooperative leadership activities, task-oriented or relationship-oriented communication, resonant communication, leadership capabilities and assistance, confidence in leadership and optimistic leadership attitudes. An abstract definition of leadership was used as the foundation for the leadership component in 7 experiments (40 per cent). Researchers transformational leadership methodology was used in two studies transformational leadership activities paradigm was used in two other studies resonant leadership, the Bonoma-Slevin leadership model and the conceptualization of mission vs. relationship-oriented leadership by Bass and Stogdill was included in one of three experiments. Bass and Avolio's Multifactor Leadership Questionnaire (MLQ) (n=2 studies) and Kouzes Leadership Activities Inventory (LPI) (n=2 studies) were the most widely employed devices.

For the research, leadership measurements were developed in two studies: one used items from other structured tests to test task-and relationship-oriented leadership, and the other used items to assess leadership confidence. Leadership has been assessed in seven studies utilizing a portion or sub-scale of multidimensional job background steps. Nonetheless this pattern was apparent in the more recent quest in 5 of the 12 retained reports. The most widely used metric (n = 3 studies) was Aiken and Patrician 's Nursing Job Index (NWI-R) sub-scale

manager ability and help and in 3 studies managers help sub-scales of Patient Protection Situation in Health Organizations study.

An empirical data on the linkages between nursing leadership and patient results was reviewed in this systematic review by expanding the examination parameters of the previous study to include research conducted between 2000 and 2015. Following our first comprehensive analysis, the 12 new articles conducted nearly twice the amount of research directly investigating the interaction between nursing leadership and a range of patient results. The majority of the 15 studies included represents promising developments in study architecture and methodology. Many trials were multi-site, various methods of research were introduced, more sophisticated methodological techniques were utilized and the partnership leadership and patient results were studied in a broader range of clinical environments, while the remainder were carried out in acute care. What was alarming was the fact that fewer than half of the research utilized specific leadership models, very few studies explored leadership processes affecting outcomes, over-reliance on cross-sectional structures and significant variability in patient experiences and clinical settings precluded greater integration in findings.

The results reinforce the claim that certain types of health experiences are favourably correlated with social leadership strategies. The Donabedian SPO model offered a helpful guide to organizing results outlined in a diagram showing possible linkages between hierarchical or task-oriented leadership, leadership strategies, and three outcomes with which observations were validated with terms of number of studies and direction of influence. The results demonstrated a crucial association between organizational leadership and avoidance of harmful effects, namely, medication mistakes, likely by the impact of members on human resource factors that could be related to aspects of health treatment, workforce competence, attrition, absenteeism, overtime and health ratios. Findings for restriction use and hospital-acquired infections also provided positive patterns. Effects on mortality results were high in 2 of 5 studies indicating a major negative association between leadership and patient mortality.

This critical connection may indicate that good nursing leadership is crucial for developing work settings, with sufficient standards of manpower, services, and treatment procedures that assist nurses in avoiding needless deaths. Finally, both emotional and task-oriented leadership and patient satisfaction shared a major positive interaction. This result could suggest that certain aspects of each style are required to maintain treatment processes that lead to happier patients, such as consistent quality of care and perceptions of function as well as working relationships in partnership.

## CONCLUSION

Through this paper a increasing body of study results are established related to the connection between nursing leadership and patient outcomes. Nonetheless, the prevalence of cross-sectional studies and the variation of factors, samples / settings, and leadership indicators in patient results indicate that there is little empirical evidence to endorse particular leadership models that forecast specific outcomes. The latest research validated conclusions from the previous study of the supportive associations between models of relational leadership and patient satisfaction and better results for patient health. Furthermore, the latest literature shows a strong association between hierarchical management styles and lower patient mortality, decreased drug failures, limited usage and hospital-acquired infections. Potential prospective and interventional trials of more complex and randomly chosen populations shall be performed in a number of environments. Furthermore, designing and evaluating better empirical leadership models and influencing processes on patient results is needed to advance

understanding of the diverse structural and multivariate effects on the partnership among outcome of patients and leadership management.

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