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Leadership competencies of first-line nurse managers: a quantitative study

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Abstract

Purpose – This paper aims to examine the leadership competencies of first-line nurse managers (FLNMs) at the unit level in the eastern region of Ghana.

Design/methodology/approach – The paper is a quantitative cross-section design.

Findings – Nurse managers exhibited a moderate level of knowledge and ability to apply leadership competencies. Gender, rank, qualification, professional experience, management experience and management training jointly predicted the leadership competencies of FLNMs [(R^2 = 0.158, p = 0.016]. However, only management training was a significant predictor in the model.

Practical implications – Inappropriate leadership competencies have severe consequences for patients and staff outcomes. This situation necessitates a call for a well-structured program for the appointment of FLNMs based on competencies.

Originality/value – This study is the first in Ghana which we are aware of that examined the leadership competencies at the unit level that identifies predictors of leadership competencies.

Keywords Leadership competencies, Nurse managers, First-line nurse managers

Paper type Research paper

Declarations Ethics: Approval to conduct the study was obtained from Noguchi Memorial Institute for Medical Research (CPN 023/17–18) before the start of the research. Official permission to gather data was sought and received from the management of the hospitals. Written informed consent was granted by all the respondents.

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Data analysis and interpretation: YP and JAA.

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Background

Health-care systems across the world have become complicated and confronted with several multifaceted challenges including increasing workload, inadequate staffing and the rising cost of care (AL-Dossary, 2017; Asamani *et al.*, 2016). As the largest health-care professionals, nurses are often at the center of these issues. Consequently, health-care managers are constantly searching for the "best" approach to enhance both staff and patient outcomes amid these challenges (Asamani *et al.*, 2016). In addressing these challenges and other health-care-related issues, nurse managers are required to exhibit practical leadership.

Leadership is a process whereby people are influenced by an individual to work toward the attainment of a mutually agreed goal willingly and enthusiastically (Cummings *et al.*, 2018). On the other hand, management is defined as "the pursuit of organizational goals efficiently and effectively by integrating the work of people through planning, organizing, leading, and controlling the organization's resources." (Kinicki and Williams, 2018). Given the nature of health care, managers are required to provide leadership, as well supervision and coordination of health-care activities. In this study, leadership is operationally defined as a process whereby an individual leads a group of people by applying his or her leadership knowledge and ability to translate organizational goal(s) into action for optimum performance. To achieve this call for effective display of leadership competencies.

Leadership competencies are "the ability to inspire individual and organizational excellence, create a shared vision and successfully manage change to attain an organization's strategic ends and successful performance"(Hahn and Lapetra, 2019). According to Chase (2010), leadership competencies are the knowledge and ability to direct the operations of an organization using skills and behaviors to enlist the support of individuals or groups in the achievement of a shared goal. Chase (2010) identified leadership competencies as a significant domain of competencies essential at all levels of management. Heinen *et al.* (2019) also acknowledged leadership competencies as an important tool that frontline nurse managers can use to initiate changes in nursing to affect the attitudes of their subordinates.

First-line nurse managers (FLNMs) are essential to any health-care organization. Their functions are complex, vital, and often tricky. FLNMs' primary duties are to ensure the delivery of quality and safe care (Ofei *et al.*, 2018) and serve as the bridge between the top management and nurses. They are also in charge of building and maintaining healthy and safe working environments, which has a positive impact on both staff and patient outcomes and reduces mortality rates in all health care systems (Alomairi *et al.*, 2018). This significant position is characterized by varying degrees of rigor and scope (Erjavec and Starc, 2017), which require FLNMs to possess the requisite leadership competencies to ensure efficiency and effectiveness at the unit.

According to Chase (2010), FLNMs need fourteen leadership competencies, that is, "decision making, power and empowerment, delegation, change process, conflict resolution, problem-solving, stress management, research process, motivational strategies, organizational unit work, policy and procedure, staff education, time management, and interdisciplinary care coordination". Chase (2010) emphasized that any nurse manager deficient in knowledge and ability to apply these leadership competencies loses the chance of being a successful manager as the position is dynamic and challenging.

As asserted by Mosley and Pietri (2015), delegation is essential in managing the unit as many nurses assume managerial responsibilities without formal training. Delegation allows FLNMs to distribute and entrust activities and related authority to their subordinates. However, they retain accountability for the task, ensuring tasks are accomplished safely and correctly (Yoon *et al.*, 2016). The ability to allow nurses to participate in the management of

the unit actively prepares them adequately for the future, though the process must be well-structured, done cautiously, and when the right condition prevails with the right supervision (Ofei *et al.*, 2020a, 2020b). Undoubtedly, delegation has the potential to build competencies and resilience of inexperienced nurses, thus promoting confidence and increased performance (Dudley *et al.*, 2021). The challenge with delegation is that many FLNMs do not evaluate and reward performance or give adequate feedback to the delegates, whereas some also ignore supervision of the delegated tasks (Tompkins, 2016). One obvious challenge with delegation in Ghana is the blatant lack of well-established organizational methods and procedures for delegation in the health system (Ofei and Paarima, 2021a, 2021b). Hence, in most instances, there is lack of a well-structured coordination and communication during delegation, as well as a lack of properly defined duties and spheres of authority (Ofei and Paarima, 2021a, 2021b). Again, the act of delegation requires an emotional maturity which apparently is rare even among successful persons. Due to the absence of policy on delegation in most institutions, the work experience of FLNMs has not taught them the practice. Thus, FLNMs are reluctant to take that risk involved in depending on others. Another challenge with delegation is that the FLNM should be organized to plan work in advance to delegate appropriately.

Conflict resolution has been identified as a unique leadership competency that FLNMs require to effectively manage conflicts that may arise at the unit (Mueller and Vogelsmeier, 2013). Conflict feels uncomfortable and awkward to many, it is an inevitable part of life and is prevalent among nurses at the unit which can negatively affect patient care. FLNMs' ability to effectively resolve conflicts that ensue at the unit is one endeavor crucial to all managerial work (Ofei *et al.*, 2020a, 2020b). However, many FLNMs at the unit are not endowed with conflict resolutions skills to enable them effectively manage conflicts hence, resorting to ineffective measures such as avoidance and accommodation, which allow other professionals and junior colleagues alike to brand them as ineffective leaders (Ofei and Paarima, 2021a, 2021b)

Several studies have also cited decision making as a key leadership competency through which all the responsibilities and activities of FLNMs are accomplished (Roshanzadeh *et al.*, 2019; Salmela *et al.*, 2017). Decisions of FLNMs have a significant impact on care coordination, workflow, patient safety and staff well-being (Chisengantambu-Winters *et al.*, 2020). Thus, decisions made at the wrong time, and the wrong place are substantial and can become expensive for health-care delivery (Siirala *et al.*, 2016). Therefore, FLNMs need to clarify what decisions are made at the unit to elicit the necessary support from their subordinates. The challenge with decision-making among FLNMs is the lack of engagement. Decisions are solely made by FLNMs without consultation and colleagues have to just accept them without complaints.

Earlier researchers have reported a positive association between leadership competencies and improved performance as well as the sustainability of health-care institutions (Lega *et al.*, 2013). Similarly, Asamani *et al.* (2016) reported a significant correlation between nurse managers' leadership competencies and nurses' perceived productivity at the unit. Given this positive impact of leadership competencies, it is essential to strengthen the capabilities of FLNMs and empower them to develop and maintain these competencies for optimum health-care delivery (Asamani *et al.*, 2016; Kantanen *et al.*, 2017). However, studies originating from advanced health-care systems have reported a moderate level of leadership competency among nurse managers (García *et al.*, 2020; Kantanen *et al.*, 2017). Similarly, Munyewende *et al.* (2016) reported moderate leadership competencies score among South African clinical nurse managers.

In this study, we defined FLNM as a registered nurse or midwife who has officially been appointed to head a ward/unit irrespective of his/her professional rank. In Ghana's health system, they are appointed by executive nurse managers and their duties include supervising, directing, organizing and coordinating the work of nursing staff at the unit level. However, because the entry-level of professional nursing in Ghana is a diploma, there are countless nursing units with nurses in the lower ranks as unit-level managers. Also, due to the geographical location of some hospitals, nurses with higher certification and ranks refuse posting to these hospitals therefore, those in the lower ranks who accept posting to these hospitals assume unit-level managerial positions. Despite their limited management and professional expertise, they are required to provide effective leadership at the unit level.

To accomplish these essential roles require leadership competencies to navigate and efficiently manage dwindling health care resources (Paarima *et al.*, 2020b). Despite these significant roles of FLNMs, it is intriguing to know that most of them are appointed based on clinical expertise and long service with little or no consideration to competence (Ofei *et al.*, 2019; Paarima *et al.*, 2020a, 2020b). Also, there is no research information assessing and measuring the leadership competency of FLNMs in Ghana. Therefore, this study aimed at examining the leadership competencies of FLNMs at the unit level in the Eastern Region of Ghana. The study objectives were to examine the leadership competency level of FLNMs at the unit level and to examine the influence of demographic characteristics on the leadership competencies of FLNMs at the unit level

Theoretical framework

Though several competencies' theories exist, we used Katz's conceptual framework. Katz's conceptual framework originally has three distinct dimensions: technical, conceptual and human relationship competencies (Katz, 1974). Chase used the Katz framework to investigate nurse managers' competencies and identified two additional competencies; thus, leadership and financial management competencies (Chase, 2010). Technical competencies refer "to the proficiency when working with tools, based on specific knowledge, in a particular field of work" (Paarima *et al.*, 2020a, 2020b). Technical competencies are important for "operational level managers, less important for middle managers, and least important for executive managers". Human relationship competencies are the "proficiency when working and relating with people based on one's knowledge of people and how they behave, operate in groups, the way to effectively communicate with them, and their feelings, attitudes, and motives" (Paarima *et al.*, 2020a, 2020b). Human relationship competencies are vital to all the levels of management (Ofei *et al.*, 2020a, 2020b). Conceptual competencies are the "ability to think through the ideas or concepts that form the foundation of the organization, its vision, and goals" (Paarima *et al.*, 2020a, 2020b). These competencies are essential for executive managers, less significant for middle managers, and least important for operational-level managers. But lower-level managers need to develop and demonstrate conceptual competencies to be promoted to higher managerial positions. Leadership competencies are the "ability to engage and motivate others in followership using personal mechanisms of strategic planning, significance, relationships, aspirations, and courage" (Chase, 2010). Leadership competency is ultimately about creating a way for people to contribute to making something extraordinary happen (Chase, 2010) and is essential at all levels of management. Financial management competencies are "management related to the financial structure of the company and therefore to the decisions of source and use of financial resources, that is reflected in the size of the financial income and/or charges" (Chase, 2010) and important for all managers. According to Paarima *et al.* (2020a, 2020b), any manager deficient in each competency loses the chance of being a successful manager.

Chase's conceptual framework was used to guide a bigger study that investigated the managerial competencies of FLNMs in Ghana. The framework was selected over others because its constructs best accommodate the study objectives. It has expansive variables of assessing the technical, conceptual, human relationship, leadership, and financial management skills which was the main purpose of the big study. The technical, human, conceptual and financial management dimensions have already been reported (Paarima *et al.*, 2020a, 2021). Therefore, this paper is reporting only the leadership domain aspect of the study to give the full picture of the situations in Ghana. The leadership domain of the Chase framework has fourteen variables namely decision making, power and empowerment, delegation, change process, conflict resolution, problem-solving, stress management, research process, motivational strategies, organizational unit work, policy and procedure, staff education, time management and interdisciplinary care coordination.

Ghana's health-care system

Ghana operates a three-level health-care delivery system. At the top (tertiary level) are the Teaching Hospitals that are autonomous and serve as national referral facilities. They are mandated to provide excellent services, take care of complex conditions, train health professionals and conduct research. Each Tertiary Hospital is linked with a public university to enhance its functions. There are also Regional Hospitals that are mandated to provide a secondary level of specialized health-care services. They serve as referral facilities for each of the 16 administrative regions of Ghana. Regional Hospitals are required to provide health services to about two million populaces.

At the district level, is the primary health care made of the district hospitals, health centers and the community-based health planning and services (CHPS) compounds. The district hospitals serve as referral centers at the district level. They are mandated to provide emergency and basic health care to about 200,000 population. The district level is further divided into subdistricts. Health care at the subdistricts is delivered by the health center, which provides promotive, preventive and basic curative services. Their catchment area covers up to about 20,000 inhabitants. At the bottom of the district/primary health, hierarchy are the community-based health planning and services (CHPS) compounds, whose key strategy is the provision of basic primary health-care services in the communities (Asamani *et al.*, 2019). Their principal mandate is to provide preventive services and treatment of minor ailments using over-the-counter medications to about 750 households or a population of about 5000. Additionally, there are also government own specialized hospitals, quasi-government hospitals and private-for-profit health-care facilities (Asamani *et al.*, 2019).

Nurses are the single largest health professionals constituting about 60% of the total workforce in Ghana's health system (Asamani *et al.*, 2019). Nursing administration is organized at three functional levels: the top level, the middle level and the unit level (Ofei *et al.*, 2020a, 2020b). The top (executive) nurse managers are responsible for making organizational strategic decisions and developing strategic plans for the entire organization. The middle-level nurse managers are heads of departments, that make tactical decisions and plans for the department as well as manage the work of unit-level nurse managers, whereas the unit-level nurse managers are in the wards operating as operational managers in the health-care facility (Ofei and Paarima, 2021a, 2021b). The first-level nurse managers manage all the activities in the unit, coordinating all the activities of the nurses, other health professionals and the support staff. They make operational decisions and plans for the department and are considered first-line managers.

However, FLMNs sometimes feel overwhelmed by competing values and demands efficiency and quality. Inability to effectively address these competing demands will result in loss of confidence and trust in them and the organization which can result in staff dissatisfaction. Given this, FLNMs are required to effectively handle challenges and problems that arise at the unit level. They need to show responsiveness and support their staff by ensuring a favorable work environment that will encourage trust and open communication where the safety and wellbeing of staff are prioritized. Their ability to develop a friendly environment in which nurses feel valued and supported will enable them to be inspired and show organizational commitment leading to improved performance. To accomplish these essential roles, call for effective leadership competencies. Therefore, our study was centered on the unit-level managers (FLNMs) who constitute the greater proportion of health-care managers in Ghana's health system. The FLNMs were purposefully chosen because of their pivotal role in the delivery of quality health care in Ghana. While this study with FLNMs, the paper focus is to investigate leadership due to series of problems that continually occur in the FLNM role.

Methods

Design

The research investigated the leadership competencies of FLNMs using the quantitative cross-sectional design. This design allows the researcher to collect original data that is sufficient for generalization to the population of interest (Polit and Beck, 2014).

Setting

We conducted the study in the Eastern Region of Ghana. Ghana is in West Africa and is bordered to the north by Burkina Faso, to the west by Côte d'Ivoire, to the east by Togo, and to the south by the Gulf of Guinea and the Atlantic Ocean. Ghana occupies a total landmass of 92,099 Square miles (238,535 km^2). Ghana has 16 administrative regions and 260 district assemblies with an estimated population of 30,000, 000.

The Eastern is in the southern part of Ghana. The region is the third most populated with a total population of 3,244,834, representing 10.4% of Ghana's population in 2019. It is the sixth-largest region occupying a landmass of 19,323 km^2. The region has 26 administrative districts with Koforidua being the regional capital. We conducted the study in ten public district hospitals constituting 42% of hospitals in the region (GHS, 2015). The hospitals are Koforidua Regional Hospital in the New Juaben Municipality, Presbyterian Hospital in the Kwahu Afram Plains North District, Kwahu Government Hospital in the Kwahu South District, Holy Family Hospital Kwahu West Municipality, Kibi Government Hospital East Akim District, Saint Dominic Hospital in the Kwaebibirem district, Nsawam Government Hospital Nsawam Adoagyire municipality, St. Joseph Hospital in New Juaben municipality, Suhum Government Hospital Suhum Municipality and Akuse Government Hospital in the Lower Manya Krobo District.

These hospitals comprised one regional hospital, one specialized hospital and eight district hospitals which were chosen purposefully to represent both primary and secondary levels of health care in the region. They were also selected to represent the two largest health-care agencies in the region, Ghana Health Service and the Christian Health Association of Ghana. We chose the region and the hospitals for the study because most of these hospitals are in rural and peri-urban towns whose proximities are far from the national capital with inadequate social amenities.

Population and sampling technique

All FLNMs in the ten hospitals were eligible to participate in the study. FLNMs at least with one year of management experience who agreed to take part in the study were all included. We excluded top (executive) level managers, trainee nurses, national service personnel and nurses who were not FLNMs. We used a census approach in administering the questionnaires. A census approach is a "data collection method that allows the researcher(s) to collect data from all elements of the accessible population and to investigate one or more characteristics of those elements" (Polit and Beck, 2014). We chose this approach to enable us to have an adequate representation of each hospital since FLNMs are not many.

Data collection tool and procedure

We adopted the Nurse Managers Competencies Instrument (Chase, 2010). The instrument was slightly modified to suit the study's aim and objectives. The questionnaire has five dimensions (technical, conceptual, human, leadership and financial management), but this study adapted only the leadership dimension. The leadership competency dimension had 14-items. The original instrument is measured on a four-point Likert scale (1 to 4) however, in this study, the authors modified the instrument into a five-point scale (1 = poor, 2 = fair, 3 = Good, 4 = very good 5 = excellent).

We obtained consent to modify the instrument from Linda K. Chase the originator of the instrument via lindachase2619@gmail.com/Ichase@iuhealth.org. In this study, the fifth point was added to indicate the highest level of knowledge and ability to apply the competencies, which is consistent with earlier authors using the instrument in similar studies (Karathanasi *et al.*, 2014; Paarima *et al.*, 2020, 2021). The questionnaire was clustered into sections A and B. Section A gathered data on participants' sociodemographic characteristics, whereas section B gathered data on the leadership competencies of nurse managers.

Once official consent was obtained from the management of each hospital, the researchers proceeded with the data gathering process. We allocated each hospital with a specific number of questionnaires based on the strength of FLNMs. At the unit/ward level, each FLNM was approached individually. After an extensive explanation of the study's purpose and objectives, those who accepted to take part in the study were given a voluntary consent form to sign, after which the questionnaires were given out. Due to the busy schedules of FLNMs, the questionnaires were given to them to complete at their convenience. The study recorded a 98.4% response rate. We used three months for data gathering, from January to March 2018.

Ethical clearance

The Ethics committee of the Noguchi Memorial Institute for Medical Research (023/17–18) approved this current study. We also obtained official permission from the hospitals' management. The study had neither psychological, physical nor emotional harm to participants as it was nonexperimental, and the questionnaire did not contain variables that may cause fear or anxiety in participants. Participating in this current study was exclusively voluntary. Each participant was appropriately briefed on the research purpose. The right to withdrawal from the study at any time without assigning a reason(s) was explained. To maintain anonymity, we did not collect any identifying biodata of the study participants. Participants signed consent before the authors commenced the administration of the questionnaire. Confidentiality was maintained throughout the study by ensuring that participants' rights were protected, and information divulged to researchers was not disclosed to unauthorized persons.

Validity and reliability

We maintained the validity of the instrument mainly through content and face validity. To maintain face validity, the questions were arranged to reflect the study objectives. Content validity was ensured through a thorough conceptualization of the constructs to adequately capture the content domains. We also made sure research objectives are precise and have been captured adequately by the questionnaire. Again, the instrument was also validated by nursing administration and management experts. To safeguard reliability, the instrument was pre-tested at a different hospital with fifteen FLNMs. The outcome of the pretest was used to correct grammatical mistakes and to adjust areas of ambiguity. The overall Cronbach's alpha coefficient of the original instrument was 0.92 and the overall knowledge of competency was 0.883 whereas the ability to apply the competency was 0.803. In this study, the overall Cronbach's alpha coefficient of instrument was 0.97, knowledge of competency 0.930, and ability to apply competency 0.944. Because we modified the instrument to a five-point scale, a psychometric analysis was performed. The Cronbach's alpha coefficient of knowledge of competency ranged from between 0.922 and 0.930 whereas that of the ability to apply competency ranged between 0.751 and 0.758 which is considered acceptable (Polit and Beck, 2014). Details are presented in Table 1.

Statistical analysis

We analyzed data using descriptive and linear regression analyses. Participants' characteristics and leadership competencies were summarized, and results presented in frequencies, percentages, means, and standard deviations using descriptive statistics. Multiple linear regression analysis was conducted to determine the influence of participant characteristics (rank, gender, qualification, professional experience, management experience and management training) on leadership competencies. Scores were interpreted as 1-very low, 2-low, 3-moderate, 4-high, 5-very high. Higher scores showed a higher level of leadership competencies among the nurse managers.

Results

Participants' characteristics

Females accounted for 73.6% (n = 89) of the 121 (100%) nurse managers, while males accounted for 24.7% (n = 30). Most of the participants (n = 66, 54.6%) were between the ages of 30 and 39. In addition, 38.8% (n = 47) of the participants had the title of Nursing Officer. Furthermore, first-degree holders made up 47.9% (n = 58) of the participants, while master's degree holders made up just 7.4% (n = 9). Finally, most of the participants (n = 21, 17.4%) work in specialist units/wards. Table 2 provides more details.

Leadership competencies of first-line nurse managers

The average score of knowledge of leadership competencies was 3.91 (SD = 0.60) and the ability to apply the competencies was 3.76 (SD = 0.66). The highest-rated leadership competency was knowledge of delegation (mean = 4.15, SD = 0.73) and ability to apply delegation (mean = 4.03, SD = 0.83). This competency was followed by knowledge of conflict resolution (mean = 4.09 SD = 0.68) and the ability to apply conflict resolution (mean = 4.03, SD = 0.06). The lowest score of leadership competency was knowledge of research process (mean = 3.35, SD = 0.96) and ability to apply the research process (mean = 3.18, SD = 0.95). Details are illustrated in Table 3.

Statement Knowledge of competency	Scale mean if item deleted	Scale variance if item deleted	Corrected item-total correlation	Cronbach's alpha if item deleted
Decision-making	50.63	60.938	0.731	0.924
Power and empowerment	50.82	59.429	0.767	0.922
Delegation	50.6	62.984	0.497	0.930
Change process	50.92	59.095	0.724	0.924
Conflict resolution	50.71	58.487	0.762	0.922
Problem solving	50.66	59.911	0.744	0.923
Stress management	50.98	60.333	0.589	0.928
Research process	51.38	60.941	0.530	0.930
Motivational strategies	50.96	58.536	0.715	0.924
Organizational unit work	50.66	61.041	0.622	0.927
Policy and procedure	50.92	60.873	0.701	0.925
Staff education	50.66	60.356	0.717	0.924
Time management	50.72	60.238	0.693	0.925
Interdisciplinary care coordination	51.05	59.044	0.683	0.925
Leadership knowledge	*54.74*	*69.396*	*1.000*	*0.930*
Ability to apply competency				
Decision making	100.99	325.953	0.779	0.757
Power and empowerment	101.3	321.815	0.796	0.753
Delegation	101	326.774	0.630	0.758
Change process	101.33	318.505	0.807	0.751
Conflict resolution	101.19	323.021	0.759	0.755
Problem solving	101.14	325.046	0.709	0.756
Stress management	101.5	322.516	0.700	0.755
Research process	101.84	325.456	0.618	0.757
Motivational strategies	101.42	318.944	0.798	0.751
Organizational unit work	101.12	322.108	0.765	0.754
Policy and procedure	101.36	324.533	0.793	0.756
Staff education	101.12	323.504	0.760	0.755
Time management	101.15	321.883	0.781	0.753
Interdisciplinary care coordination	101.42	320.284	0.717	0.753
Leadership ability	*52.51*	*86.724*	*1.000*	*0.923*

Table 1. Cronbach's alpha coefficient of knowledge and ability to apply leadership competencies

Variable	Frequency (n)	(%)
Gender		
Male	30	24.7
Female	89	73.6
Missing values	2	1.8
Total	121	100
Age		
20–29	10	8.3
30–39	66	54.6
40–49	10	8.3
50–59	25	20.7
≤60	1	0.8
Rank		
Staff Nurse	4	3.3
Senior Staff Nurse	17	14
Nursing Officer	47	38.8
Senior Nursing Officer	30	24.9
Principal Nursing Officer	23	19
Total	121	100
Qualification		
Certificate	15	12.4
Diploma	20	16.5
Post Basic	19	15.7
First degree	58	47.9
Masters	9	7.4
Total	121	100
Unit		
Emergency	6	5
Maternity	16	13.2
Surgical	11	9.1
Medical	23	19
Theatre	10	8.8
Out-patient department	10	8.8
Children	9	9.4
Specialized unit	21	17.4
Others	15	12.4
Total	121	100

Source: Field data, 2018

Table 2. Participants characteristics

The influence of leadership competencies of first-line nurse managers

The results in Table 4 shows that, participant characteristics (gender, rank, qualification, professional experience, management experience and management training) together accounted for 15.8% of the variance in leadership competencies [$R^2 = 0.158$, $F_{(6, 95)} = 2.781$, $p = 0.016$]. However, a more detailed examination of the predictors showed that only management training was statistically significant ($p = 0.001$) in the regression model.

Discussion

Participant characteristics

Participants within the age group of 30–39 years bracket constituted the majority. Our finding agrees with the average age of nurses in Ghana, which is projected to be between the

Statement	N	Knowledge of competency Mean	SD	Ability to apply competency Mean	SD	Mean difference
Leadership competencies (Mean score)	*117*	*3.91*	*0.60*	*3.76*	*0.66*	*0.15*
Decision-making	*121*	*4.09*	*0.68*	*4.03*	*0.70*	*0.06*
Power and empowerment	121	3.89	0.80	3.72	0.84	0.17
Delegation	*121*	*4.15*	*0.73*	*4.03*	*0.83*	*0.12*
Change process	119	3.82	0.86	3.72	0.95	0.10
Conflict resolution	121	4.03	0.88	3.84	0.85	0.19
Problem solving	120	4.08	0.76	3.88	0.81	0.20
Stress management	121	3.75	0.90	3.53	0.92	0.22
Research process	*121*	*3.35*	*0.96*	*3.18*	*0.95*	*0.17*
Motivational strategies	121	3.79	0.93	3.62	0.96	0.17
Organizational unit work	121	4.07	0.78	3.90	0.85	0.17
Policy and procedure	120	3.82	0.74	3.66	0.76	0.17
Staff education	121	4.07	0.77	3.91	0.82	0.16
Time management	121	4.00	0.80	3.86	0.87	0.14
Interdisciplinary care coordination	121	3.72	0.92	3.64	0.99	0.08

Source: Field data 2018

Table 3. List of nurse manager leadership competencies (Chase, 2010)

age of 25–40 years (Asamani *et al.*, 2019, 2020). This finding suggests a young cohort of nurses in Ghana's health-care system. It implies that these FLNMs might possess limited or no leadership competencies. This may stem from the fact that some FLNMs are in the Staff Nurse and Senior Staff Nurse ranking with limited management and professional experience. Furthermore, 73.6% of the participants were female which reinforced the assertion that nursing is a women-dominated profession. This view is gradually shifting, with many males in Ghana preferring nursing as a career.

Most of the participants were in the Nursing Officer's designations. This suggests that, depending on their starting grade, most of the participants have served for 3 to 5 years or more. This contradicts the findings of Ofei *et al.* (2018), who found that most participants were Senior Staff Nurses. Even though both studies were performed in Ghana's Eastern Region, Ofei *et al.* (2018) conducted their research in three hospitals with 45 nurse managers,

Predictors Model	Unstandardized coefficients B	Std. Error	Standardized coefficients Beta	*t*	*p*-value	95.0% Confidence Interval for B Lower	Upper
(Constant)	134.829	11.764		11.46	<0.000	111.454	158.205
Gender	−3.696	4.212	−0.093	−0.88	0.383	−12.065	4.673
Rank	2.063	2.256	0.122	0.914	0.363	−2.42	6.545
Qualification	−2.932	2.994	−0.111	−0.98	0.330	−8.881	3.018
Professional experience	0.16	0.35	0.082	0.458	0.648	−0.536	0.857
Management experience	−0.853	0.62	−0.197	−1.38	0.172	−2.084	0.378
Management training	−12.624	3.497	−0.355	−3.61	*0.001*	−19.573	−5.676
$R^2 = 0.158$, $F_{(6, 95)} = 2.781$, $p = 0.016$							

Notes: Dependent variable: Total leadership competencies, Criterion level: 0.05

Table 4. The influence of nurse manager characteristics on leadership competencies

while this current study used 121 FLNMs in ten health-care facilities. The finding is also inconsistent with the Ghana Health Service job description of nursing and midwifery staff which requires that a nurse manager should be at least a Senior Nursing Officer (Ghana Health Service, 2005). This means that most of the participants in this study are not qualified to be occupying these key positions. However, because of the prevailing environment, they are forced to assume the responsibilities of FLNM without the necessary experience and competencies. The situation can have severe consequences on patient and staff outcomes. The study found a different level of educational background which illustrates the entry-level of professional nursing in Ghana. As asserted by Ofei *et al.* (2020a, 2020b) and Paarima *et al.* (2020a, 2020b), the educational level of FLNMs can greatly affect their appreciation of leadership at the unit level.

Leadership competencies of first-line nurse managers

Leadership is a critical concept in nursing since health-care delivery even at the small unit is immeasurably complex (Asamani *et al.*, 2016; Paarima *et al.*, 2020a, 2020b) and the appropriate leadership competencies are required to avoid errors, waste and confusion. The study found a moderate level of leadership competencies among FLNMs. This finding means that the FLNMs exhibited satisfactory leadership competencies at the unit. FLNMs in Ghana are faced with several challenges including poor work environment, inadequate remuneration, and leadership challenges. This information partially explains the moderate leadership competencies among participants in this current study. Several studies have reported similar findings (Asamani *et al.*, 2016; Ofei *et al.*, 2014; Karathanasi *et al.*, 2014). These studies attributed the moderate level of leadership competencies to a lack of mentorship, coaching, leadership training and experiential learning.

The current study further revealed a high knowledge and ability to apply delegation. This implies that FLNMs in this recent study effectively delegate responsibilities to their subordinates in the unit. The researchers observed that FLNMs do delegate with the appropriate authority and resources, but improvement would be appreciated. Delegation in nursing is crucial in managing the unit as most nurses assume management roles without formal training. Therefore, FLNMs must allow subordinates to take active roles in managing the unit to prepare them adequately for the future, though the process must be structured and done cautiously (Paarima *et al.*, 2020b). Delegation can effectively be used as a form of succession planning for nurses if managed well. FLNMs should be encouraged to delegate when the prevailing conditions are right. Researchers in Denmark and Saudi Arabia have reported similar findings (Sabri Gassas, 2017; Riisgaard *et al.*, 2016).

Also, nurse managers had high knowledge and ability to apply conflict resolution at the unit. This finding suggests that nurse managers have the needed skills in conflict resolution. As nursing units are human societies, conflicts are inevitable. However, poor management of conflict has been linked to low morale, decreased productivity, job dissatisfaction, financial loss for organizations and poor workflow (Moeta and Du Rand, 2019). Therefore, resolving conflicts that arise at the unit level is an essential endeavor critical to all FLNMs. In dealing with challenges that occur at the unit, FLNMs must be competent, experienced and able to relate well with their staff. Ganz *et al.* (2014) reported a similar finding in Israel. However, the result is inconsistent with the work of Moeta and Du Rand (2019) in which unit-level FLNMs in South Africa appeared to have challenges in dealing with conflict between individuals or generally in the unit and intervened inappropriately.

Effective decision-making is an essential leadership competency in nursing. FLNMs' ability to make effective clinical decisions is the most crucial factor affecting the staff and patient outcomes (Chisengantambu-Winters *et al.*, 2020). FLNMs in this current study

showed higher decision-making skills. This finding implies that FLNMs can effectively gather, process and prioritize critical patient information to choose the best nursing actions, implement and evaluate the outcomes. If nurses can participate in the decision process, it would enhance their confidence, competence, improve care and increase their organizational commitment. Participating in decision-making deepens democratic values, increases team spirit, stimulates the work environment as well as improves staff satisfaction and productivity. This finding conforms to the work of Asiri *et al.* (2016) which affirmed that an effective decision-making process significantly predicted nurses' commitment and performance among Saudi nurses.

Research has a tremendous impact on professional nursing practice, thus rendering it an essential component of the FLNMs competencies (Tingen *et al.*, 2009). Even though research is critical in nursing care, participants in this current study showed moderate knowledge and ability to apply the research process. The finding suggests that nurse managers exhibit a satisfactory level of the research process. It is, therefore, essential that FLNMs acquire the necessary skills, knowledge, and attitudes towards research to enable them to lead their staff in conducting and utilizing research findings in health-care delivery. This information calls for future directions to help nurses build and maintain research skills. The finding is inconsistent with the work of Lehane *et al.* (2019) and Migliore *et al.* (2020) which reported a high level of clinical research competencies among nurses.

The current study revealed that participant characteristics (gender, rank, qualification, professional experience, management experience, and management training) accounted for 15.8% of differences in the leadership competencies of FLNMs. However, only management training statistically contributed to the model. This finding implies that training in management improves leadership competencies. Thus, management training build-up FLNM competence and confidence. Periodic training of FLNMs and adequate preparation for this position are very relevant and hospitals must be encouraged to provide systematic training. A structured in-service training, as well as mentorship and coaching, should be encouraged at the unit level to help young nurses build their leadership competencies by learning from experienced nurses. Also, hospitals should support current and potential nurse managers to take leadership and management courses as approved by the GHS.

Although this finding may not be new in the advanced health-care settings, it is a vital finding in the context of Ghana where the appointment of nurse managers is based on clinical expertise and long service with little or no consideration to competencies and management/leadership training.

This finding is congruent with a US study by Anderson (2016) in which attending a management academy significantly predicted the managerial knowledge and skills of military nurse managers. The call for nurses to receive leadership and management training before they assume management positions are in the right direction as well as the development of better remuneration packages to boost their worth to the hospital. In addition, all the predictors identified only 15.8% of the variance, a greater proportion of the variance remains unknown. This calls for further studies to establish whether other factors may account for FLNMs' leadership competencies.

Conclusion

The study investigated the leadership competencies of FLNMs in the Eastern Region of Ghana. The study identified that FLNMs are essential stakeholders in addressing the myriad of nursing and health-care challenges. Therefore, FLNMs must possess the relevant and appropriate leadership competencies to enable them to address these challenges. The findings showed that FLNMs exhibited all the leadership competencies of the Nurse

Managers Competency Instrument. The results also demonstrated that age, gender, qualification, professional experience, managerial experience, and training in management explained a substantial proportion of the leadership competencies of FLNMs. However, only managerial training contributed to the model. A well-structured educational, experiential, and mentorship programs are required to provide a framework for leadership development for FLNMs.

Implications for nursing management

Generally, we found a satisfactory level of leadership competencies among FLNMs. This finding implies a need for improvement in these competencies to effectively create a favorable work environment for quality and safe patient care. Training in management explained a significant portion of FLNMs' leadership competencies. This implies that nurses need training in management before or after their appointment as FLNMs. This training will equip them with adequate knowledge, abilities, and skills to navigate the increasingly complex health-care environments. This situation necessitates the identification of potential nurse managers and their adequate preparation through regular training in leadership and management.

Study strength and limitation

As far as the author knows, this is the first study to investigate the leadership competencies of FLNMs in Ghana. However, due to its limitations, the research results should be interpreted with caution. The study was conducted only in the Eastern Region of Ghana using a self-reported questionnaire. Therefore, the results may vary in other regions of Ghana. However, the selected hospital has the characteristics of Ghanaian health-care facilities.

Like all other theories and models of leadership, the Chase framework has some weaknesses. First, the framework lacks key skills such as inspiration, innovations, teamwork and goal(s) setting among other critical skills needed for effective leadership. The lack of these critical skills may be due to the fact; the framework is not a leadership framework but rather nurse managers competency framework. Therefore, the findings of this study should be interpreted in the context of nurse managers' competencies as outlined in Chase Nurse Managers Competencies (Chase, 2010).

Recommendation for future studies

The authors recommend future studies to consider using mixed-method and other theoretical approaches in examining leadership competencies in health care.

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