Coaching: a reference model for the practice of nurse-leaders in the hospital context*

LIDERANÇA COACHING: UM MODELO DE REFERÊNCIA PARA O EXERCÍCIO DO ENFERMEIRO – LÍDER NO CONTEXTO HOSPITALAR

LIDERAZGO COACHING: UN MODELO DE REFERENCIA PARA EL EJERCICIO DEL ENFERMERO-LÍDER EN EL CONTEXTO HOSPITALARIO

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ABSTRACT

The objectives of the present study was to evaluate the leadership of nurses by using the coaching strategy as a managerial tool, and identify, measure and analyze the acquisition of competencies from the view of nurse-coaches. This is a descriptive, cross-sectional, exploratory and field study that was performed using a quantitative approach. Situational Leadership was selected as the theoretical framework and the research instrument was submitted to statistical and content analyses and was applied on 11 nurse leaders of a large scale private general hospital located in São Paulo. The results showed that participants gained new knowledge, confirmed the Situational Leadership model as the recognized being a coach leader, with a style that is mainly aimed at tasks and people, according to the situation involved, and pointed out the following skills as determinant of coaches: communication, giving and receiving feedback, assigning and gaining power and having an influence. Finally, the attitudes reflected the practice of coaching.

DESCRIPTORS

Leadership
Nursing
Management of human resources in a hospital
Professional competence

RESUMO

O presente estudo teve por objetivos avaliar a liderança exercida pelas enfermeiras com uso do *coaching* como ferramenta gerencial, identificar, mensurar e analisar à aquisição de competências percebidas pelas enfermeiras que atuam como coaches, Trata-se de um estudo descritivo, transversal, exploratório e de campo, com abordagem quantitativa. A Liderança Situacional foi selecionada como referencial teórico e o instrumento de pesquisa foi submetido a análises estatísticas e de conteúdo, aplicado em 111 enfermeiras líderes em um hospital geral, privado, de grande porte da cidade de São Paulo. Os resultados evidenciaram que houve incorporação de novos conhecimentos, confirmaram o modelo de Liderança Situacional ao reconhecer ser líder *coach*, tendo o estilo predominantemente orientado às tarefas e às pessoas, segundo a situação envolvida, e ainda, indicaram como habilidades preponderantes do *coach*: a comunicação, dar e receber *feedback*, dar e ganhar poder e exercer influência, que as atitudes refletiram o exercício o liderança *coaching*.

DESCRITORES

Liderança
Enfermagem
Administração de recursos humanos em hospitais
Competência profissional

RESUMEN

El estudio objetivó evaluar el liderazgo ejercido por enfermeras con uso de *coaching* como herramienta gerencial, identificar, mensurar y analizar la adquisición de competencias percibidas por enfermeras que actúan como coachs. Estudio descriptivo, transversal, exploratorio, de campo, con abordaje cuantitativo. El Liderazgo Situacional se seleccionó como referencial teórico y el instrumento investigativo fue sometido a análisis estadísticos y de contenido, aplicado a 111 enfermeras líderes en hospital general privado de gran porte de San Paulo. Los resultados evidenciaron que hubo incorporación de nuevos conocimientos, confirmaron el modelo de Liderazgo Situacional al reconocer al líder *coach* teniendo un estilo predominantemente orientado a tareas y personas, según la situación involucrada, y también indicaron con foco en las habilidades preponderantes del *coach*: comunicación, dar y recibir *feedback*, dar y ganar poder y ejercer influencia; que las actitudes reflejaron el ejercicio de liderazgo *coaching*.

DESCRIPTORES

Liderazgo
Enfermería
Administración de recursos humanos en hospitales
Competencia profesional

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INTRODUCTION

Leadership is an important factors, which generates and applies energy to people, giving them direction and synchronizing their efforts. In fact, it represents the fundamental indicator of a company's potential as, differently from financial results, which merely indicate the company's past position, strong leadership makes a good company become even better, to the same extent that weak leadership reduces and, over time, destroys its potential[1].

In hospital institutions, as managers, nurses need preparation to take up leading roles, which is a basic condition to seek changes in their daily practice, with a view to guaranteeing the quality of patient care delivery, conciliating organizational objectives with nursing team needs.

The nursing work process is developed through teamwork and, therefore, nurses are expected to have the competencies needed for leadership practice, influence skills to work enthusiastically towards goals identified as serving the greater good[2].

To achieve the transformation of nurses into coaching leaders, at the study unit, a preparation process called *Leadership Program: Coaching* was developed. Some inquiries about the results of using the coaching tool at the institution, where the lead author works, made her question: what are the characteristics of nurses serving as coaches? How do nurses perceive their action in Coaching Leadership practice? How can results be achieved through the use of the Coaching tool? Based on these inquiries, the goal of this study was to assess the results of using the Coaching tool in the development of nurses as leaders at a hospital institution that adopted it. This permits assessing the competencies the nurses perceived in Coaching leadership practice.

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Coaching Leadership is a new direction health organizations follow and innovative among Brazilian nurses. Hence, studying it in our reality is both timely and necessary, in view of the few existing studies.

Thus, we agree with authors who believe that nursing leadership needs to be better understood and applied, so as to permit actions that reach higher efficacy standards in patient care delivery[3].

THEORETICAL BACKGROUND

Situational Leadership is a theoretical proposal developed by Hersey and Blanchard, who affirm that this model recommends the non existence of a better leadership style, that is, the leader needs to use different styles that can be adapted in view of the variables present in each specific situation[4].

According to these authors, leadership is *a process of influencing a person or group's activities to achieve a goal in a given situation*. In this approach, leaders are able to adapt their behavior style to the needs of the people led and to the situation.

A person's leadership style is defined as the behavioral pattern (s)he manifests when attempting to influence other people's activities, as acknowledged by these other people[3]. This concept involves a combination of two types of task and relationship behaviors:

Task behavior: is what leaders adopt to organize and define the functions of their group members (led), to explain the activities each member should perform, when, where and how they need to be performed; to set well-defined standards of work organization, use of communication channels and means to do the right things.

Relationship behavior: is what leaders follow to maintain personal relations between them and their group members (led), opening up communication channels, providing socio-emotional support and being flexible with behaviors.

Another fundamental concept of Situational Leadership refers to the maturity of the persons led, defined as *people's ability and willingness to assume the responsibility to direct their own behavior*[4].

In this concept, the authors also include that, the more mature the follower, the less intense the leader's use of authority should be and the more intense the orientation towards the relationship. On the opposite, immaturity should be managed through the autocratic use of authority, with little emphasis on the relationship. Leaders vary their style of behavior in four types, in which the task behavior and relationship behavior variables are associated. These types are called as follows:

E1 – determine – strong emphasis on task and weak on relationship.

E2 – persuade – strong emphasis on task and relationship.

E3 – share – weak emphasis on task and strong on relationship.

E4 – delegate – weak emphasis on task and relationship

Regarding the maturity of the persons led, two dimensions are also taken into account: maturity for work, related to knowledge and technical skill; and psychological maturity, which refers to the willingness or motivation to do something. These maturity dimensions should be analyzed with regard to a given situation.

Thus, for effective leadership, leaders need to be clear on the situation they want to influence, to assess the maturity of the persons led in the situation and correctly choose what style to use.

In the situational leadership model[4], other authors[5] also highlight that Situational Leadership is used as a structure to provide leaders with the orientation they need to exercise Coaching Leadership.

The principles of situational leadership present in Coaching Leadership establish that leaders (coach = who conducts the process) should adjust their leadership styles to the readiness (ability and willingness) of the people they lead (coachee = who is conducted) to perform a given task, to the intensity of task behavior (direction) and to the commitment to the relationship (support) the leader provides. The essence of Coaching is competency development to achieve goals. Therefore, Situational Leadership was chosen as the theoretical background, because we believe that it offers nurse leaders the necessary support to develop the persons they lead.

OBJECTIVES

To assess the leadership nurses practice using Coaching as a management tool and to characterize the nurses who act as Coaching leaders in terms of gender, age, professional education, time of work at the institution, function and work shift; to identify, measure and analyze the knowledge, skills and attitudes of nurses serving as coaches in leadership practice.

METHOD

This is a descriptive and cross-sectional exploratory field study with a quantitative approach and a non-experimental research design.

The study was carried out at Unit I of a large, private hospital network in São Paulo City.

The study population included 132 nurses prepared to participate in the study through the accomplishment of the "Leadership Development Training Program", according to the guidelines of the Coaching tool. In this group, 111 (84.1%) were nurses from Unit I of the research institution who answered the research instrument.

Data were collected through a questionnaire containing 32 closed and open structured questions, addressing the fundamental points of the nurse Coaching leaders' knowledge, skills and attitudes, divided in three parts: Part I – Characterization of study population; Part II – Data on nurses' knowledge about leadership and Coaching and Part III – Data on the skills and attitudes the nurses practice in Coaching Leadership. In the latter, the intention was to unveil the nurses' attitude through a six-point Likert scale: never, rarely, not always, almost always, always and does not apply, representing agreement and disagreement with the statements on the fundamental points of Coaching Leadership.

The interval scale aims to measure people's judgments, opinions, perceptions and attitudes towards a certain phenomenon. Hence, the suggested answers are quantitative, and the scale is constructed with assertions that are measured gradually, with varying intensity levels – strong/weak or positive/negative sense[6].

With a view to better adapting the measurement instrument to the reality the researcher expected, the instrument was submitted to a pretest during the elaboration phase, the questionnaire was applied to five nurses who presented the same inclusion conditions established in the study, in August 2005.

After identifying the best way to use the instrument, the most adequate vocabulary for the questions and after guaranteeing that the instrument would permit measuring the study variables, the necessary adjustments were made in the questionnaire before the start of data collection.

The study complied with Resolution 196, issued on October 10th 1996. Before data collection, approval was obtained from the Institutional Review Board at São Paulo Federal University – UNIFESP on August 26th 2005, CEP 0886/05.

Data were collected between August 27th and September 25th 2005, in five phases, which were:

1st Phase: The researcher contacted the research subjects and requested their voluntary participation, indicating her availability to clarify any doubts; *2nd Phase*: Potential research subjects received the Informed Consent Term to get to know the study objectives, conditions to complete the research instrument and guarantees offered during and after the accomplishment of the research; *3rd Phase*: The researcher received the Informed Consent Term properly signed by the respondents; *4th Phase*: The researcher provided the nurses who agreed to participate with the questionnaire and asked them to answer and return it to her within ten days; and *5th Phase*: Return of completed questionnaires.

Data analysis

Data to characterize the population and those found in the structured questions were treated based on groups and submitted to appropriate statistical tests. Advice was sought from a statistician. In descriptive analysis, qualitative variables were summarized as simple and relative frequencies (percentages) and quantitative variables expressed as means, medians, standard deviations, first and third quartiles, minima and maxima. The reliability of the scale, based on the questionnaire items, was assessed through Cronbach's alpha. To confirm the adequacy of the items' grouping in subscales, factor analysis was applied, using the main components method and SPSS for Windows, version 11.0. for calculations.

Application of content analysis process

To analyze the five open questions in the questionnaire, the content analysis process was used[7]. According to the cited author, content analysis is a set of techniques to analyze communications, using systematic and objective proce-

dures to describe the contents of messages to obtain indicators, either quantitative or not, that permit inferences on knowledge about the message production and reception conditions. It is characterized by the ability to achieve the analysis of meanings. The material obtained from the respondents was analyzed and developed around three chronological phases: pre-analysis; material exploration and result treatment, including inference and interpretation of meanings.

RESULTS AND DISCUSSION

The obtained results are presented descriptive and analytically, related with the leadership actions of nurses who serve as Coaching leaders at the study hospital.

Characteristics of Nurses serving as Coaching Leaders

Out of 152 nurses working in the study field, 132 could participate in the research, according to pre-established inclusion criteria. Of this group, 116 answered the questionnaire, corresponding to 87.8% of all participants. The answers of 111 (84%) respondents were considered valid.

It was observed that 106 (95.5%) participants were women, confirming the information found in research populations regarding graduated Nursing professionals. In view of the predominance of female professionals, however, one may say that an upward trend exists in the number of male representatives among nurses, as confirmed by data from the São Paulo Regional Nursing Council, COREN - SP* ; these show that, between 2000 and 2005, the number of active male nurses increased from 1.802 to 3,347, respectively.

Regarding the nurses' function in the hierarchical structure of the study institution, 95 (85.6%) participants were nurse leaders, followed by 7 (6.3%) nurse heads, 5 (4.5%) nurse supervisors and 4 (3.6%) permanent education nurses. As for the work shift, almost half, 53 (47.7%), worked night shifts, including both shifts (night I and night II).

The mean age found was 35.1 years (SD=8 years), ranging from 25 to 50 years. Graduation time was 11.5 years (SD= 6.6 years), ranging from 2.5 to 27.8 years. As for time working at the institution, the average indicated 6.7 years (SD= 5 years), ranging between 2 months and 24.7 years.

Data on the nurses' academic education revealed that most, 92 (82.9%) had a graduate degree, 11 (9.9%) of whom took a *Stricto Sensu* Master's program and 81 (72.9%) a specialization course. The importance of nurses' self-development is highlighted in competency acquisition to orient and conduct professional activities.

Nurses should permanently update their knowledge after graduating and institutions should invest in professional development. Reciprocity should exist between learning opportunities offered and contributions and interventions to improve nursing practices[2]. Hence, the importance of constant knowledge acquisition and skills development is highlighted for the study population's professional career.

Knowledge of Coaching Nurse Leaders

In this item, results are described regarding Coaching Leadership aspects according to the research participants' perception on knowledge about their practice.

Out of 111 research subjects, 96 (86.4%) answered the question about the understanding of the leadership concept, with 69 (62.2%) understanding leadership as the process of exerting influence on people's behavior to reach goals in certain situations and 17 (15,3%) defined it as the process of transforming a person's or an organization's behavior. None of the nurses saw leadership as the legitimate right to exercise power within the organization to gain the collaborators' obedience. As the situation the professional is involved in determines the relation between leader and led, this reinforces the choice of nurses by excluding them from their way of understanding leadership.

Out of 96 valid responses, 10 (9%) participants indicated other concepts, arousing the need to understand the meanings of leadership for this group. Grouping the meanings of answers to the open question about this theme generated the content analysis category understanding about leadership, with six sub-categories: arouses the potential of the people led; influences people's behavior; seeks results through people; serves the other; establishes the communication process and the ability to involve people.

Considering the frequency of the recording units' distributions in each sub-category, based on data, it could be verified that three categories concentrate the largest number of indications: arouses the potential of the people led, 4 (30.7%); influences people's behavior, 3 (23.1%); seeks results through people, 3 (23.1%), besides a homogeneous distribution among the other sub-categories.

The search for meaning that permeated the information of the 10 (9%) nurses who chose another concept confirmed that, for most of them, similarity exists among the alternatives that define leadership as *a process of exerting influence on people's behavior to achieve goals in certain situations* and a *process of transforming a person's or an organization's behavior*[4].

Thus, the findings confirm that an understanding of leadership exists that is coherent with the Situational Leadership model, adopted at the research institution. It can also be inferred that participants demonstrated commitment to the institutional view and share its values.

After analyzing the content of the sub-categories, it was verified that the nurses' understanding of leadership reflected that the *Leadership Development Program*, called the *Leader-Educator* at the study institution, contributed not only to knowledge acquisition, but also the understand-

* São Paulo Regional Nursing Council (COREN-SP). Worksheet with all nurses registered at COREN-SP, grouped per year and gender, April 2005 [personal message].

ing of leadership and the need to develop effective leaders, departing from the premise that style should adjust to the situation.

Regarding the nurses who consider themselves leaders, it was verified that all 111 research subjects declared seeing themselves as such.

Thus, when analyzing the content of this category, discourse evidenced that, independently of their grouping in some sub-categories, leadership practice was always emphasized as was identified in the nurses' inter-relation with the persons led, in certain situations.

When asking the nurses about the leadership style they practiced, it was revealed that 98 (88.3%) respondents practice task and people-oriented leadership, depending on the situation. Based on these answers, it could be acknowledged that leadership practice is based on the principles of the Situational Leadership model, which centers on the premise that there is not one single leadership style appropriate for any and all situations. In this approach, the leader's behavior towards the people led is emphasized in view of a specific task[8], i.e. it is based on the inter-relation between the leader's task behavior, the leader's relationship behavior and the subordinates' maturity[4].

The nurses' other 13 responses indicated that 11 (9.9%) do not associate the two styles in leadership practice and two (1.8%) informed that do not use any preponderant style.

In view of the question about whether the *Coaching Leadership Program* contributed to the development of the nurse leaders, 107 (96.4%) respondents affirmed that the program served as the base for their growth as Coaching leaders, permitting the construction of the category Coaching leader training. This resulted in eight sub-categories: application of acquired contents; acknowledged of maturity of the people led; improvement of result achievement; respect for the people led; improvement of the leader's performance; contribution to self-knowledge; contribution to the performance of the people led and improvement in task delegation. Only four (3.6%) denied that the training enhanced their capacity.

When they expressed that the training contributed to improve results achievement, the nurse leaders acknowledged that the program's main target was to transform the leaders into mentors and educators of the people they lead in search of concrete results. Four (3,6%) participants denied that the training enhanced their development as leaders.

The nurses defined Coaching, 73 (65.8%) as a high-impact process to increase productivity; commitment to results and to the people's reality, which presupposes willingness to cooperate. Hence, it can be affirmed that they characterize Coaching Leadership as new management alternatives[9].

Among the other population members, two groups of ten (9%) offered different answers the first considered Coaching a relationship in which the leader assesses the people's performance inside the organization; and the second decided not to answer the question. The 5 (4.5%) remaining nurses defined the process as a training leaders should offer to the persons they lead.

The participants' definitions, who considered it a relationship, in which the leader assesses the performance of people inside the organization, can be understood as a process of offering performance feedback to the person being led, which is one of the principles present in the Coaching process.

Among other Coaching concepts issued, 13 (11.7%) respondents manifested themselves, so that the grouping of the answers' meanings lead to a category called the Coaching Process and three sub-categories: leadership practice responsible for the development of the people led: exercise of situational leadership and use of the communication process. It was made explicit that the nurses acknowledged that the Coaching process is inserted in leadership practice, emphasizing the development of the people led, assuming the function of leader-educator. In the subsequent sub-categories, some determinants of the Coaching process were observed: situational leadership and the communication process.

Hence, team professionals will have the opportunity to grow and improve their knowledge, skills and attitudes in nursing care practice. This continuous process demands profound dedication so that this result can lead to care and teamwork quality improvement[10].

The 106 (95.5%) nurses who participated in the study considered themselves coaches, while 3 (2.7%) denied this condition and 2 (1.8%) did not answer.

In content analysis of the answers provided by the nurses who considered themselves coaches in the organization, the category called Being a Coach could be identified, with five sub-categories related to leadership practice: the role of trainer and adviser with 29 (29.6%); feedback practice with 21 (21.4%); achievement of goals and objectives 21 (21.4%) and the remainder 27.6%: responsibility for team development and performance of Coaching skills.

The reasons why the nurses considered themselves coaches are initially related to the fact that they participated in a training program for this purpose. Secondly, they alleged that they assumed the commitment to transform themselves from nurses into leaders and from leaders into coaches. Finally, they acknowledged that being a coach confirmed that the nurses adopted the organizational role the institution wanted.

Nurses' Skills and Attitudes in Coaching Leadership Practice

In this item, the results were described in terms of those aspects of Coaching leadership, according to the research participants, that are related to skills and attitudes for its practice.

Out of 111 nurses who marked the skills coaches need, 64 (57.7%) chose the three categories offered: communication; giving and receiving feedback; gaining power and exerting influence. Another part, i.e. 34 (30.6%) respondents chose the alternative giving and receiving feedback and 29 (26.1%) indicated communication as the paramount coaching skill in leadership practice. Communication represents an extremely important element of nursing leadership. The way a message is transmitted will interfere in the desired result[11].

The skills coaches need emphasize communicating, gaining power and exerting influence as fundamental abilities in Coaching Leadership. In this sense, coaches need to know two-way communication, which involves knowing how to listen to people, facilitating communication, understanding people's problems and viewpoints, to be able to advise and guide. It also involves manifesting ideas, transmitting information and knowledge, experiences and expectations[12].

Another skill coaches need is to give and receive feedback, understood as a relationship of complementary roles, in which one does not exist without the other. Giving feedback is related to exercising some kind of power on the other, whether through the direct control strategy (order), influence or responsibility. Receiving feedback, on the other hand, is also connected with the sense of power, either by influencing or receiving the other person's influence[13].

In consistency analysis, the 20 questionnaire items were assessed and could be used to constitute an attitude scale, without any intent to validate the instrument. These items, however, gave signs that the scale elaborated in this research was acceptable and indicated three inconsistent items.

In the total scale, reliability was high (Cronbach's alpha 0.8835). This coefficient is a measure ranging from zero to one and, the closer to one, the better the reliability[14], indicating that, by observing the instrument through the sum or average of the 20 items, the significance of the nurses' attitudes in Coaching Leadership practice could be measured.

In communication attitudes, out of five assertions made, the highest answer frequencies for four of them were concentrated in almost always, with percentages ranging between 58.3% and 48%, while one assertion concentrated 52.9% of answers in the agreement level always.

As for assertions related to the approach, frequencies for the first three assessments corresponded to 81.9% and 52.2% for the agreement level always. For the next two assertions, they ranged between 45.2% and 43.8% for almost always.

With regard to the assertion about feedback and result achievement, the same distribution of the highest frequencies for the communication attitude was observed, that is: feedback – four between 57.7% and 47.6% for almost always and one 49.5% for always; and, for result achievement, four between 53.3% and 42.9% for almost always and one 75.2% for always.

Thus, the highest mean scores were found for the following attitudes: I clarify the collaborators' doubts about their tasks (4.82); I am at the collaborators' disposal to help them when they are facing some difficulty (4.73); I give instructions and demonstrate how the collaborators should perform the tasks, as needed (4.54); I know how to listen to the collaborators from an interpersonal communication perspective, I acknowledge and value collaborators for what they do or the way they behave (4,49). Highlighting and valuing individual competencies, diluting power in the team, making each member recognize the purpose and meaning of work[15].

The lowest mean scores related to three attitudes: I help to set targets for each collaborator on my team (4.00); I use the preferred communication technique to dialogue with the collaborators (3.98) and I set the term each collaborator needs to achieve goals (3.92).

This study's limitation, however, centers on the fact that the relation between the leadership style the nurses – Coaching leaders adopted in the application of situational leadership could not be identified, as observed in other studies[3,16] that used the same theoretical background.

CONCLUSION

Based on these study results, it can be concluded that: the data on the nurses' profile revealed that all of them occupied leading functions in the hierarchical structure of the nursing department; participants were predominantly women; the population was heterogeneous in terms age, time since graduation and work time at the institution. Almost half of the participants (53 – 47.7%) worked night shifts, while distribution according the morning/afternoon shifts and morning or afternoon alone showed equivalent percentages. Also, 92 (82.9%) had a graduate degree, 81 (72.9%) of whom at Lato Sensu level.

In the nurses' understanding of the leadership concept, 69 (62.2%) indicated it as the process of exerting influence on people's behavior to reach goals in certain situations. Regarding Coaching, 73 (65.8%) respondents defined it as a high-impact process with a view to increased productivity, commitment to results and people's reality, as well as willingness to cooperate.

With regard to the nurses who consider themselves leaders, all 111 research subjects declared themselves as such and 106 (95.5%) assumed the condition of Coaching leaders. When acknowledging themselves as Coaching leaders, the participants unanimously affirmed that they were assuming the role of leaders and the commitment to support the team in order to achieve results. The leadership style the nurses adopted was predominantly task and people-oriented, depending on the situation involved.

In the investigation of the interpersonal skills the coach needs, it was identified that 64 (57.7%) respondents simultaneously chose the three categories offered: communica-

tion; giving and receiving feedback; and gaining power and exerting influence.

The results regarding the nurses' attitudes were obtained based on a Likert scale, which the lead author elaborated, whose full version obtained high reliability scores (Cronbach's alpha 0.8835), was considered easy to apply and comprehensive in the aspects it intended to evaluate.

As for the level of agreement in communication, feedback and results achievement attitudes, out of five assertions presented for each attitude, four indicated the level almost always and one always. For approach attitudes, the agreement level is distributed differently, with three assertions for always and two for almost always. As these attitudes are interconnected, dependent and overlapping in their integration, it could be concluded that the nurses' attitudes revealed the practice of Coaching leadership.

After analyzing the evidenced results, new perspectives emerge for further research to clarify the applicability of the proposed model, to be used to permit the understanding of Coaching Leadership and serve as a reference model for leadership practice in the hospital context.

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