To lead and to be led in municipal elderly care in Sweden as perceived by registered nurses

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Introduction

Nursing leadership

Leadership is an important area in the registered nurses’ (RNs) professional practice (National Board of Health and Welfare 2005, Hyrka¨ s & Dende 2008, Swedish Society of Nursing 2008). Strong leadership is considered necessary for the development of the RNs’ professional role in the municipal care of older people (McKenna et al. 2004). Nursing leadership is essential for promoting evidence-based practice (Newhouse 2007) and consequently a main factor influencing the quality of patient care (Cook & Leathard 2004). RNs need to take their leadership roles seriously. Therefore,
they need to be given distinct prerequisites to lead patient-direct care and nursing (Josefsson et al. 2008). Leadership affects patient outcomes, such as increased patient satisfaction and reduced adverse events and complications (Wong & Cummings 2007). The present study describes RNs’ perceptions of leadership in the municipal care of older people.

Definition of leadership

There is no standard definition of the concept of leadership (Franssén 2004). The concepts of leadership and management are sometimes considered synonymous, which they are not, according to Franssén (2004). Management seeks to produce predictability and order by setting operational goals, establishing action plans, allocating resources, organizing and staffing, solving problems and monitoring results (Kotter 1990, Franssén 2004). Management is a formal position of power and responsibility for operations and budget (Franssén 2004). Leadership, on the other hand, seeks to produce necessary changes by developing a vision of the future and strategies to reach that vision (Pinder 1984). This entails communicating this vision and motivating and inspiring the staff to attain it. Managers perform tasks but leaders are there to provide meaningful tasks (Zaleznik 2004). Leadership is more informal and built on trust (Zaleznik 2004).

Registered nurses’ own leadership and immediate line management

How to manage and lead municipal care (social care and healthcare) of older people is divided by two laws (SFS 1982, p.763, 2001, p.453) and shared by different professions (Carlström 2005, Josefsson 2006, Karlsson 2007). The RNs’ immediate line manager is the residence manager, often with an education in social care. The residence manager organizes and leads both social care and health care (the later on an overall level). However, the residence manager can be an RN (health care educated) with the same duties. Regardless of whether the residence manager is social care or health care trained, there is a need for RNs responsible for the leadership of nursing in patient-direct care (National Board of Health and Welfare 2005, Swedish Society of Nursing 2008). Furthermore, RNs are leaders in patient-direct care, but they have to work as equals with the staff and subordinate to the residence manager (Karlsson 2007). Thus, RNs in patient-direct care usually have no authority to make decisions concerning social care or act as staff leaders. RNs are limited by the fact that others make decisions concerning social care. RNs are expected to see to care holistically, but at the same time, remain within the health care realm (Karlsson 2007). The development of their different professional roles can get out of pace with each other. This creates difficulties in the RNs’ leadership role (Carlström 2005).

Moreover, from 1995 to 2001, the number of managers was reduced from 8000 to 6700 in the municipal care of older people in Sweden (National Board of Health and Welfare 2002). Today, managers are responsible for a large number of employees aside from responsibilities for operations, development and economy. A consequence of this is that the manager seldom meets with fellow workers. Thus, RNs gain an informal responsibility by being among staff members more often than the residence manager and consequently become more involved in management matters (Franssén 2004, Hansson 2006). This creates difficulties in the RNs’ leadership role (Carlström 2005).

Organizational prerequisites for the RNs’ leadership

The organizational prerequisites for the RNs’ leadership can be seen from a systems theory perspective (Katz & Kahn 1989), where the management’s primary task is to facilitate communication between different hierarchical levels within the organization. Thus organizational prerequisites deal, in addition to management by objectives, with facilitation of communication, coordination, role clarity, competence development, as well as decision-making and support (Aronsson et al. 1992).

Moreover, organizational prerequisites for the RNs’ leadership are the consequences of the ‘The Elderly reform’ act (National Board of Health and Welfare 1996). In 1992, municipalities gained medical and social responsibility for people 65 years and older, through the Elderly reform. The municipalities became obliged to offer residential care homes for older people with extensive needs of medical care and social services. Responsibility for older people’s care in Sweden is divided among three authorities acting at different levels: a national, regional and local level. County councils \((n = 21)\) administer hospitals and health care centres. At the local level, the municipalities \((n = 290)\) have been delegated the responsibility to provide care of older people (SFS 1982, p. 763).

After the Elderly reform, RNs were employed in the municipal care of older people. They came to an organization with a culture and tradition different from that for which they had training and experience (Carlström
The transfer of healthcare of older people to the municipalities led to a shift from mainly service tasks during office hours to more personalized, supervised and qualified healthcare 24 hours a day (National Board of Health and Welfare 1996). RNs obtained a new professional role and larger areas of responsibility, which resulted in less time for supervising staff members (SOU 2004, p. 68). The municipalities had no experience of taking responsibility for healthcare or having RNs within their organizations (Tunedal & Fagerberg 2001). There were no demands for medical training of the managers of the residential care homes for older people. This entailed that two professions, social care providers and health care providers, with differing cultures, backgrounds and areas of responsibility were to work together and lead their specific area of care of older people (Carlström 2005, Josefsson 2006). Those with a social care background were often managing those with a health care background.

To conclude, RNs are key figures in the municipal care of older people who are seriously ill with multiple co-morbidities (Josefsson 2006). RNs have the responsibility of leading nursing in patient-direct care (Swedish Society of Nursing 2008). However, there is a paucity of descriptions of RNs’ perceptions of leadership in the municipal care of older people. Thus, it is of importance to investigate RNs’ perceptions of their leadership and immediate line management, as well as leadership’s organizational prerequisites.

**Aim**

The aim was to describe RNs’ perceptions of their own leadership and immediate line management, as well as leadership’s organizational prerequisites in the municipal care of older people.

**Specific research questions**

- What perceptions do RNs have of their own leadership?
- What perceptions do RNs have of their immediate line management?
- What perceptions do RNs have of the leadership’s organizational prerequisites?

**Method**

**Design, setting and participants**

The present study is a part of a larger research initiative with a survey research approach (Polit & Beck 2008). The study is a part of a larger questionnaire survey in the municipal care of older people (Josefsson 2006). The larger project sought to describe RNs’ perceptions of their work situation, the incidence of violence and threats, their education, needs and possibilities for competence development. The target population was a convenience sample including 342 RNs working in the municipal care of older people. In total \( n = 213 \) RNs participated. This comprised 62% of the target population. The RNs worked in patient-direct care as caregivers. They did not worked as nurse managers at any level of management.

The health care system in Sweden consists of 20 county councils at a regional level and 290 municipalities at a local level (SALAR 2005). The municipalities are responsible for residential care homes of older people. The RNs worked at 60 residential care homes with subunits, including those offering daytime activities, in a larger city in Central Sweden. Of these subunits, 33 were in dementia care and 20 were in general elder care where RNs have to deal with a greater scope of various diagnoses. Seven residential care homes had subunits both for dementia care and general care. Subject characteristics are described in Table 1.

**The questionnaire**

The questions used in this study were derived from two questionnaires developed by Aronsson *et al.* (1992) and Hagström *et al.* (1996). These questionnaires have previously been used to gain information about staffs’ perceptions of leadership. Questions for this study were modified to better suit RNs as an occupational group in the care of older people, as the two earlier instruments were designed for physicians and for RNs compared...
with engineers. The questions for this study were carefully selected to suit a larger project in the municipal care of older people (Josefsson 2006).

Four main sections of the questionnaire were developed to meet the aim of this study. The first section asked for demographic and background information, such as age, gender and number of active years as a RN. Year of nursing examination and form of employment were registered as well. The second section explored RNs’ perceptions of leadership and consisted of 35 items in three subsections: RNs’ perceptions of (1) their own leadership; (2) immediate line management; and (3) leadership’s organizational prerequisites in the municipal care of older people. These three concepts are described in the introduction. The first subsection consisted of 11 items, the second subsection consisted of 14 items and the third subsection consisted of 10 items. The majority of questions were designed with response categories on ordinal scales; for example, a Likert scale of 1–5 ranging from ‘not agree at all’ to ‘agree totally’, occasionally with the alternatives ‘not relevant’. The questionnaire contained a limited number of nominal scales. The participants were given the opportunity to add their comments at the end of the questionnaire.

Procedure and data collection

The logistics of the questionnaire and the relevance of the questions were trialled at a seminar of RNs, psychologists, physiotherapists, occupational therapists, lecturers and researchers who were all employed directly or indirectly in the municipal care of older people. The questionnaire was tested on two occasions by 10 RNs working in the municipal care of older people, regarding the logistics and relevance of the questions, usage and expected time to fill in the questionnaire (Altman 1996). A few questions were slightly modified, mainly for clarification.

Participation was voluntary. Data were collected during a 1-year period, in 2004. Local municipal managers with overarching responsibility for care of older people and the managers for each of the residential care homes approved the study.

The residence managers provided the information on the total number of employed RNs and their names. The questionnaires were distributed in sealed envelopes to the RNs, either by their managers or by the principal investigator. The envelope included an introductory letter explaining the purpose of the study, that data would be kept confidential and that the RNs’ identification would be protected. A postage-paid return envelope was also included. Three reminders were sent directly to the RNs when necessary.

Data analysis

The descriptive statistics was performed using the Statistical Package for the Social Sciences (SPSS) for Windows version 17.0 (SPSS Inc., Chicago, IL, USA). The median was used to describe the average value and quartiles were used to describe the spread of data, as the questions were designed with response categories on an ordinal scale (non-parametric level) (Altman 1996). Percentages were used in the text to describe questions designed with response categories on a nominal scale (non-parametric level). The internal loss of data was minimal and data were neither replaced nor imputed.

Ethical permission

This study was approved by the Ethics Committee of Karolinska Institutet, Stockholm (D. no: 317/02).

Results

RNs’ own leadership

A summary of the statistics of how the RNs considered themselves as leaders is shown in Table 2. They maintained a certain degree of leadership responsibility. They were, on average, motivated to invest to a certain extent in competence development with the possibility of gaining greater authority in making important decisions. Few RNs had a keen interest in investing in a professional career in leadership and administration. The results, not presented in Table 2, showed that few of the RNs (n = 212) were criticized for doing too little as leaders (not criticized 81%, criticized 19%).

RNs’ immediate line management

RNs’ perceptions of their immediate line management are shown in Table 3, such as that RNs perceived that their immediate line management had full competence in RNs’ subject field and not always shared the RNs’ view of what competence RNs retained. The results showed that the RNs on average stated they received little feedback for their work performance, through viewpoints or discussions with their immediate line management. The results, not presented in Table 3, showed that a quarter of the RNs (n = 212) reported that they had experienced unsolved, serious, conflicts with their immediate line management during the past year.
Organizational prerequisites for registered nurses’ leadership

A summary of statistics of the organizational prerequisites for RNs’ leadership is shown in Table 4. The RNs’ perceived some vagueness concerning organizational prerequisites for their leadership, regarding who did what in the organization, how decisions were made and possibilities for developing competence. They also perceived that the top levels of management did not insure that all employees worked towards a common goal. A quarter of all RNs (n = 53) stated they were unaware of how competence development in leadership for RNs was organized at work. The majority of RNs (n = 160) perceived their competence development in leadership lacked or required better organization at work. The results, not presented in Table 4, showed that most of the RNs (n = 210) stated there was no organized supervision for RNs, such as an adviser, a supervisor or a mentor (no organized supervision 88%, organized supervision 12%).

Discussion

The main purpose of the present study was to describe nurses’ perceptions of their own leadership and immediate line management, as well as leadership’s organizational prerequisites in the municipal care of older people.

The main results indicated that most RNs considered having leadership responsibilities for a smaller group (59%). All RNs need to lead patient-direct care, in spite of that the results showed that 28% of the RNs felt they had no leadership responsibility and 19% of the RNs had been critizised for insufficient leadership. This could have been because of low leadership expectations for RNs. One explanation, according to Karlsson

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**Table 2**

<table>
<thead>
<tr>
<th>Variables</th>
<th>RNs (n = 213)</th>
<th>Median (quartiles)a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has leadership responsibilities over othersb</td>
<td>3 (3–3)c</td>
<td></td>
</tr>
<tr>
<td>Has leadership responsibilities for a staff</td>
<td>2 (1–2)h</td>
<td></td>
</tr>
<tr>
<td>groupd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of knowledge in leadership required at</td>
<td>2 (1–3)n</td>
<td></td>
</tr>
<tr>
<td>present positionf</td>
<td></td>
<td></td>
</tr>
<tr>
<td>My intermediate position is difficult to handle</td>
<td>3 (2–4)f</td>
<td></td>
</tr>
<tr>
<td>in my responsibility as a leaderb</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff informs me of what I need to know in</td>
<td>4 (3–5)c</td>
<td></td>
</tr>
<tr>
<td>critical situations as a leaderf</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is necessary openness between</td>
<td>4 (3–5)g</td>
<td></td>
</tr>
<tr>
<td>myself, as a leader, and the stafff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss with colleagues, RNs, about</td>
<td>3 (3–3)h</td>
<td></td>
</tr>
<tr>
<td>difficulties regarding leadershiph</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discuss with nursing staff, other than RNs,</td>
<td>2 (1–3)h</td>
<td></td>
</tr>
<tr>
<td>about difficulties regarding leadershiph</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motivated to invest in competence development</td>
<td>3 (2–3)s</td>
<td></td>
</tr>
<tr>
<td>by the possibility to gain greater authority to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>make important decisionsb</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will to invest in a professional career in</td>
<td>3 (1–4)i</td>
<td></td>
</tr>
<tr>
<td>leadership and administrationh</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

aThe 25th and 75th percentile.
bScale range 1 = not at all, 2 = in a low degree, 3 = in a certain degree, 4 = in a high degree.
cFour missing.
dScale range 1 = no group, 2 = a smaller group, 3 = a larger group.
eTwo missing.
fScale range 0 = not relevant, 1 = absolutely not, 2 = hardly, 3 = mostly, 4 = yes, absolutely.
gThree missing.
hScale range 1 = totally disagree, 5 = totally agree.
iThree missing.
jScale range 1 = never, 2 = seldom, 3 = sometimes, 4 = quite often, 5 = mostly.
kScale range 1 = not at all, 2 = in a low degree, 3 = in a certain degree, 4 = in a high degree.
lFour missing.
mScale range 1 = not at all, 2 = in a low degree, 3 = in a high degree, 4 = in a very high degree.

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**Table 3**

<table>
<thead>
<tr>
<th>Variables</th>
<th>RNs (n = 213)</th>
<th>Median (quartiles)a</th>
</tr>
</thead>
<tbody>
<tr>
<td>RNs’ immediate line management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>…have competence in my subject fieldb</td>
<td>3 (2–3)c</td>
<td></td>
</tr>
<tr>
<td>…share my view on what makes up RNs’</td>
<td>4 (3–5)a</td>
<td></td>
</tr>
<tr>
<td>competenced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>…respects my competencef</td>
<td>4 (4–5)</td>
<td></td>
</tr>
<tr>
<td>…judge my work achievement as valuablef</td>
<td>4 (3–5)c</td>
<td></td>
</tr>
<tr>
<td>…appreciates meb</td>
<td>3 (3–4)g</td>
<td></td>
</tr>
<tr>
<td>…is fair and understandingb</td>
<td>3 (3–4)g</td>
<td></td>
</tr>
<tr>
<td>…gives me the information I need to perform</td>
<td>4 (3–5)g</td>
<td></td>
</tr>
<tr>
<td>my work tasksd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>…usually informs me of changes important to</td>
<td>4 (3–5)g</td>
<td></td>
</tr>
<tr>
<td>my workd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>…gives me necessary feedback so I know if I</td>
<td>3 (2–4)h</td>
<td></td>
</tr>
<tr>
<td>am doing a good jobf</td>
<td></td>
<td></td>
</tr>
<tr>
<td>…gives me opportunities to talk with of</td>
<td>4 (3–5)c</td>
<td></td>
</tr>
<tr>
<td>difficulties in my workd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>…is a resource to me in critical situationsd</td>
<td>4 (3–5)g</td>
<td></td>
</tr>
<tr>
<td>…gives me good preconditions to develop in</td>
<td>3 (3–4)g</td>
<td></td>
</tr>
<tr>
<td>my workd</td>
<td></td>
<td></td>
</tr>
<tr>
<td>…gives me feedback for my work performancef</td>
<td>2 (2–3)s</td>
<td></td>
</tr>
</tbody>
</table>

aThe 25th and 75th percentile.
bScale range 0 = do not know, 1 = scarcely, 2 = in certain parts, 3 = to the full.
cTwo missing.
dScale range 1 = totally disagree, 5 = totally agree.
eThree missing.
fScale range 1 = never, 2 = seldom, 3 = sometimes, 4 = quite often, 5 = mostly.
gScale range 1 = not at all, 2 = in a low degree, 3 = in a certain degree, 4 = in a high degree.
hFour missing.
iScale range 1 = not at all, 2 = in a low degree, 3 = in a high degree, 4 = in a very high degree.
The majority of RNs were motivated to develop their competence levels, in order to gain greater possibilities to influence what they considered important decisions. However, few RNs had a will to invest in their own competence development in leadership. RNs considered that the employer hardly allowed opportunities for competence development in leadership. RNs also considered that competence development in leadership required for their current positions were either lacking or in need of better organization. Similarly, Josefsson (2006) found that half of RNs offered competence development at work in the municipal care of older people considered their preferences only occasionally met. The lack of opportunities for competence development in leadership could have depended on different needs in the team with different educational backgrounds, experience and positions in the organization (Aberg et al. 2004), so that the RNs’ competence needs were not always given priority. The results are noteworthy, especially as Karasek and Theorell (1990) stated that a staff with good opportunities for competence development has a relatively large possibility of controlling most situations that occur at work and to influence their own work. Therefore, it is important to create the necessary organizational prerequisites for RNs’ competence development in leadership.

The results pointed out an urgent need of RNs’ competence development and training programmes in leadership, to create high-quality care and sustainable solutions, as pointed out by Harvath et al. (2008) and Ohlsson (2009). There is also a need for management and leadership interventions in the form of coaching and clinical supervision to influence the RNs’ possibilities to improve care quality (Alleyne & Jumaa 2007). A preferred solution is for RNs to gain access to leadership programmes in nursing and health, such as in clinical leadership programmes, leading to quality care and political leadership programmes (Royal College of Nursing 2010).

The results showed that half of the RNs’ immediate line manager had competence in the RNs’ subject area of nursing, which means that the other half had some form of education in social care. Those trained in social care do not have the same possibilities to lead nursing development within municipal health care for older people (Lindholm 2000). It is important for the manager to be knowledgeable of patient-direct care (Fransson Sellgren 2007). Thus, managers need to be trained in nursing (Linholm 2000). Lindholm (2000) showed that when the RN’s immediate line manager held a master’s degree in nursing they included research and nursing development in their management.

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Table 4
Organizational prerequisites for registered nurses’ (RNs) leadership

<table>
<thead>
<tr>
<th>Variables</th>
<th>RNs (n = 213) Median (quartiles)a</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is clarity in who does what in the organizationb</td>
<td>3 (2–4)</td>
</tr>
<tr>
<td>There is clarity in who makes what decisionsb</td>
<td>4 (3–5)</td>
</tr>
<tr>
<td>Decisions are often made beyond the agreed decision chainb</td>
<td>3 (2–3)</td>
</tr>
<tr>
<td>The highest leadership appears to work actively for all staff to work toward the same goalb</td>
<td>3 (2–4.5)</td>
</tr>
<tr>
<td>Support from the managemenb</td>
<td>4 (3–4)</td>
</tr>
<tr>
<td>How well the RNs’ competence development was organized at workb</td>
<td>2 (1–2)</td>
</tr>
<tr>
<td>RNs’ possibilities...</td>
<td></td>
</tr>
<tr>
<td>...to discuss their leadership with someone outside the work unitb</td>
<td>3 (2–4)</td>
</tr>
<tr>
<td>...for sufficient competence development in leadership required in current positionc</td>
<td>2 (2–3)</td>
</tr>
<tr>
<td>...to influence important decisionsd</td>
<td>3 (2–3)</td>
</tr>
</tbody>
</table>

aThe 25th and 75th percentile.

bScale range 1 = totally disagree, 5 = totally agree.

cThree, twonine.

dScale range 1 = lacking, 2 = need of better organization, 3 = well organized.

eFifty-three missing (do not know).

fFive missing.

Scale range 0 = not relevant, 1 = absolutely not, 2 = hardly, 3 = mostly, 4 = yes, absolutely.

Scale range 1 = not all, 2 = in a low degree, 3 = in a certain degree, 4 = in a high degree.
The results of the present study clarified that RNs considered that the immediate line managers appreciated them to a certain degree, were fair and understanding, gave the necessary feedback at work and good prerequisites for development. These were positive results as Karasek and Theorell (1990) pointed out that social support from supervisors had a buffering effect in relation to work-related stress. However, managers did not always provide the information the RNs needed to perform their work tasks. This left room for improvement and showed that RNs perceived deficiencies in the leadership of the immediate line manager and perhaps also in their knowledge of the needs of the RNs to carry out their work.

This study showed that 24% of RNs stated that they had unsolved, serious conflicts with their immediate line management during the past year. To have unresolved serious conflicts with the immediate line manager implies a strained work situation (Karasek & Theorell 1990). This might lead to sick absenteeism and staff turnover (Karasek & Theorell 1990, Fransson Sellgren 2007).

Furthermore, half of the RNs stated they had no or little feedback, either through opinions or discussions from their immediate line management, regarding their work performance. Moreover, the results showed that 88% of the RNs had no organized supervision. Findings are in agreement with previous studies reporting that RNs are often left to their own resources (Fagerberg et al. 2000, Tunedal & Fagerberg 2001). RNs need a supportive context in the municipal care of older people, as RNs participating in clinical nursing supervision with opportunities for structured discussion and reflection could make better decisions, taking care receivers, colleagues and themselves into account (Berggren 2005). It is also important for the RNs' leadership that the manager provides regular supervision and competence development (Karlsson et al. 2009), especially as leadership is usually not included in the nursing programme at a basic level (Ohlsson 2009).

The results showed that RNs perceived the organizational prerequisites rather unclear than clear. There was also a wide range of the RNs’ perceptions, concerning their knowledge of who does what in the organization. Similarly, there was a wide range of their perceptions if it is clarity concerning who makes what decisions. RNs’ also perceived that the highest leadership could work more actively to unite the staff to work towards a common goal. Unclear organizational prerequisites might influence the RNs’ work environment negatively, as well as their ability to lead patient-direct care (Josefsson 2009, Karlsson et al. 2009).

The fact that the RNs perceived ambiguous organizational prerequisites for their leadership might have been due to a lack of clarity in the municipality regarding the RNs’ responsibilities, regarding social care and nursing (Carlström 2005, Josefsson 2009, Karlsson et al. 2009). Ambiguity concerning who does what can lead to care planning without RNs’ participation, thus placing patient safety at risk (Hansson 2006). The RNs’ mission and work description in the municipal care of older people is often unclear (Josefsson 2009). Sometimes the RN is considered as part of the care staff and sometimes more as a consult. It is our opinion that under such working conditions, it is not easy for RNs to take on their role as a leader for patient-direct care.

RNs in our study were not asked if they perceived the line between social care and nursing as indistinct. However, the social care perspective has a salient role in the municipal care of older people in Sweden. Therefore it is possible that RNs’ socialization process towards the perspective of social care in the municipal care of older people, described by Carlström (2005), could lead to unclear organizational prerequisites for the RNs’ leadership and an ambiguous leadership role.

It is important to decide who is to lead the care team and what the respective limits for the different professions are (Karlsson 2007). Clearly defined work tasks are important for different professionals to work well together (Lingås 1992, Carlström 2005). At the same time, it is important to give RNs space for their leadership and to achieve control over their work (Karasek & Theorell 1990).

Finally, a long-term strategy is needed for the RNs’ leadership, to be effective team leaders in the clinical setting and implement quality improvement and ensure patient safety.

Methodological considerations

Although this applies to most questionnaires, the use of the questionnaire in which the participants only answered in domains determined by the researcher might be a weakness (Polit & Beck 2008). On the other hand, participants were given an opportunity to comment at the end of the questionnaire. The internal loss of data was neither replaced nor imputed, as the overall percentage of missing data was low, and as such an approach artificially deflates variability. It is questionable whether the present study’s findings can be generalized to the wider nursing audience. However, the results may reflect the perceptions of RNs working in similar conditions. Nevertheless, these findings have an
important value and are relevant to clinical practice. Considering that dramatic restructuring and reforms of care of older people were made in Sweden, a large proportion of the references are Swedish.

**Conclusion and implications**

The present study identifies factors influencing clinical nursing leadership. RNs need to be more willing to invest in their own competence development in leadership. RNs reported that they had experienced unsolved, serious, conflicts with their immediate line management. Instead, RNs need managers who support them in their leadership role in clinical nursing. There are needs for clear and supportive organizational prerequisites for the RNs’ leadership, such as clear decision-making and possibilities for competence development and training programmes in leadership.

**Acknowledgements**

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**References**


