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Leadership competencies: Tools for the promotion of quality in health care

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ABSTRACT
At this moment 'shared leadership' is in discussion. This means to delegate more autonomy to those who work on all levels of organizations as well as to give them the chance to become individuals and also citizens capable of changing things and assuming reponsibilities in order to direct their actions in search of the already planned objectivities. The structure of the old administration has to make room to new ones which should be more flexible, wider and more decentralized, thus creating autonomy, pro-activity, and conditions for every single one to assume leadership. The hospital is not an outsider in this process and goes also through a renewed form of thinking and planning. In this sense, both Medicine and the other multidisciplinary areas of health has assumed different roles within its care activities linked to the patient until health management, thinking not only about managing with leadership skills, but also interacting with new times and methods, becoming audacious from mechanisms like a lot of attention and emotion, intelligence and self-development to break paradigms of a professional profile. This study sought to analyze the Leadership Competencies as tools for the promotion of quality in health care, based on Explanatory Research and

meta-analysis in a hospital, with 37 graduated and specialized health professionals.

Keywords: Shared Leadership, Competence in Leadership, Quality.

1 INTRODUCTION

Much is said and written about what a successful leader should do and how to be respected by the team. However, little is said about how to achieve competencies in a fast-changing and globalized world. What is indispensable for leader training? This question is largely responsible for the quality and scope of vision of leaders.

Enterprises and businesses linked to the health sector need vision and precise strategies, since the focus is linked to the treatment of people who need special attention to their basic needs.

The exercise of leadership requires from this professional analytical skills, management skills, empathy, whose strength attributed to a leader is in his "inner life", revealed in his way of being and acting, in his passions, security, creative vision, determination for an idea, a cause or project, objectivity to innovate and change, withstand pressure frustrations, persuade, captivate, seduce and demand, among other personal attributes.

It is necessary for leaders to have exceptional and differentiated training, since their mission is also accomplished through human relations. Thus, the priority in the formation of a leader is his degree of self-knowledge and his level of psychological maturity.

It is suggested that leaders must have the humanistic societal value, without which no one can realize themselves.

Leaders must know how to love, not contrast. "Knowing how to love" means knowing how to give something where the other increases his identity, knowing how to serve the other. Therefore, no one can be great, fully realize himself, if he does not pass through the function of serving society.

The worst crime is the murder of the inner core of the individual. Whoever kills his own light or allows the light of another to be killed is also against himself, against his brothers, against life.

Currently, shared leadership and its competencies are the subject of debate. For Warren, Gretchen & Thomas (2001) research results suggest that this will be the leadership model of the future, as it is the one that seems to respond best to the needs of organizations that have undergone mergers, acquisitions or joint ventures.

Within its approach, the study of leadership has always dealt with contradictory aspects, making it evident that what is coherent at a given moment may not be able to explain reality later on (BERGAMINI, 1994).

This work aimed to analyze the Leadership Competencies as tools for promoting quality in health care.

2 METHODOLOGY

The methodological procedure used in the Research was Meta-analysis, raising the objectivity of literature reviews, with research synthesis, research review or systematic review. It was specially developed to integrate the results on the same research question in a systematic literature review.

Representative sample with thirty-seven (n=37) Nurses Graduated, Specialists, who occupy different positions, directly admitted to the Intensive Care Center (ICU), working in the morning, afternoon and evening shifts and who consented to participate in the study after the researcher's orientation and signing the Informed Consent.

For data collection, a form was used to fill in information obtained from the study population and response items to a closed questionnaire structured by interview by agenda, composed of four objective questions, two of them based on the Likert scale.

3 RESULTS AND DISCUSSION

For the analysis of the results, the "on-site leadership competencies" were considered as a reference, through comparison with the answers obtained in the closed questionnaire by interviewing the nurses.

The Nursing philosophy of the Institution, supported by the theoretical framework of Jane Watson's philosophy and science of caring (BORK, 2003), derived from a humanistic vision, aims at promoting health and not only curing diseases.

In order to achieve these prepositions, the Nursing care model adopted is presented, which is the Shared Practice described by Marie Manthay (BORK, 2003).

The Nursing system of the Hospital under study believes in the scientific foundation as a foundation for clinical and professional development, and it is hoped to contribute to the enhancement of nursing practice.

A nursing theory is a relatively specific and concrete set of concepts and propositions that explain or characterize phenomena of interest to nursing science - people, their environment, their health and nursing itself.

For Ferraz (1995), caring is the essence of nursing practice and involves human acts in the process of assisting the individual, group or community, characterized by interconnected actions, endowed with feelings. The inherent objective of nursing care is comfort, essential in nursing care and complementary to the therapeutic component of hospital care.

Therefore, it is imperative to adopt tools that are supported by scientific knowledge and promote nursing care, based on an institutional philosophy and a theoretical model.

This philosophy presupposes the development of interpersonal and individual care, supported by a Shared Nursing Decision Management Structure, decentralized, open and based on scientific evidence and undisciplinary work.

It bases its activities on the patient, highlighting him first, and basing its decisions on clinical judgment, on the one that best meets his needs, seeking his active participation in decisions about his treatment. In shared nursing practice, the patient is integrated into decision-making and participates in the planning and implementation of care.

Shared Practice organizes the provision of nursing care developed by nurses, technicians or nursing assistants, actions are planned, performed or delegated according to levels of knowledge and competence. In this model, the need for care is assessed, a care plan is drawn up, implemented and considered with regard to the patient to the nurses' interventions.

The provision of care in Shared Practice is characterized by the application of skills of several professionals, in a model where the nurse identifies, coordinates and monitors the implementation of all the care necessary to meet the needs of each patient under his/her responsibility, within a given period.

Undoubtedly, the adoption of a philosophy and a model of care necessarily involves the construction of the identity of the nurse in an institution. It is not an easy task, on the contrary, its complexity requires the participation and involvement of all the members that make up the team of nurses.

They also require the questioning and reflection of these professionals on their aspirations, roles and objectives as a professional body. Table 1 shows the list of nurses by work shift, length of employment, time in the institution, position, gender and participation in a nursing support group.

Table 1- List of nurses by work shift, time in profession, time in the institution, position, gender and participation in a nursing support group.

	Shift of Work	Time of Profession	Time in Institution	Position	Sex	Participation in group of Nursing support
1	M/T	16 years	16 years	Manager of Nursing	F	NO
2	M/T	09 years	08 years	Coordinator of Nursing	F	YES
3	M	13 years	05 years	Assistance	F	YES
4	M	13 years	11 years	Assistance	F	YES
5	M/T	19 years	10 years	Supervisor of Practice	F	YES
6	T	21 years	9 years	Assistance	F	YES
7	N	12 years	8 years	Assistance	F	NO
8	M	15 years	8 years	Assistance	F	YES
9	M	17 years	7 years	Assistance	F	YES
10	N	10 years	7 years	Assistance	M	YES
11	M	14 years	6 years	Assistance	F	YES

12	N	11 years	5 years	Assistance	F	YES
13	N	10 years	5 years	Assistance	F	YES
14	M	26 years	15 years	Assistance	F	YES
15	T	10 years	4 years	Assistance	M	YES
16	M	10 years	4 years	Assistance	F	YES
17	T	1 year	4 years	Assistance	F	YES
18	N	7 years	3 years	Assistance	F	NO
19	M	18 years	4 years	Assistance	F	YES
20	N	7 years	3 years	Assistance	F	YES
21	T	7 years	3 years	Assistance	F	YES
22	M	4 years	2 years	Assistance	F	YES
23	T	8 years	2 years	Assistance	F	YES
24	N	4 years	2 years	Assistance	F	YES
25	M	4 years	2 years	Assistance	F	YES
26	N	16 years	2 years	Assistance	M	NO
27	N	8 years	2 years	Assistance	F	YES
28	M	6 years	2 years	Assistance	F	YES
29	T	10 years	1 year	Assistance	F	YES
30	N	6 years	1 year	Assistance	F	YES
31	N	7 years	1 year	Assistance	F	YES
32	M	4 years	7 months	Assistance	F	NO
33	M	3 years	7 months	Assistance	F	YES
34	T	1 year	7 months	Assistance	F	NO
35	N	3 years	6 months	Assistance	F	NO
36	N	8 years	6 months	Assistance	F	NO
37	M	3 years	6 months	Assistance	F	NO

Source: Prepared by the author, Veloso (2020).

Descriptive statistics - Table 1

f1: time <= 5years f1:time<=5years f2: 5< time <= 10years f2:time>5years f3: time>10years

Table 2- Descriptive statistics -Table 1

Ttempprof	Count	Percent	tempinst	Count	Percent
f1	9	24,32	f1	20	54,05
f2	15	40,54	f2	17	45,95
f3	13	35,14	N=	37	
N=	37				

Source: Prepared by the author, Veloso (2020).

Table 3- Descriptive statistics -Table 1

bandwidth	Count	Percent	Nursing	Count	Percent
Assistance	34	91,89	No	9	24,32
Other	3	8,11	Yes	28	75,68
N=	37		N=	37	

Source: Prepared by the author, Veloso (2020).

Table 4- Descriptive statistics - Table 1

Sex	Count	Percent	Position	Count	Percent	Shift	Count	Percent
F	34	91,89	Assistance	34	91,89	M	14	37,84

M	3	8,11	Coordinator	1	2,7	M/T	3	8,11
N=	37		Manager	1	2,7	N	13	35,14
			Supervisor	1	2,7	T	7	18,92
			N=	37		N=	37	

Source: Prepared by the author, Veloso (2020).

Table 5- Descriptive statistics - Table 1

Variable	N	N*	Mean	StDev	Minimum	Q1	Median	Q3
tempprof	37	0	9,757	5,866	1,000	5,000	9,000	13,500
timeinst	37	0	5,435	3,61	1,000	5,000	5,000	7,000

Source: Prepared by the author, Veloso (2020).

Variable Maximum	Mean=average	Q1= first quartile
Tempoprof 26,000	Median=median	Q2=third quartile
timeinst 16,000		

Prof. time is a variable with a Normal (Gaussian) distribution.

Time institution is a continuous variable with approximately Normal distribution.

Analyzing Table 1, 37 (thirty-seven) nurses from different positions participated in the research - Management, Nursing Coordination and Supervision and Nursing Assistance; institutional time - ranging from 06 (six) months to 16 (sixteen) years in the Company: time of profession - between 03 (three) months and 16 years; gender; participation in Nursing support groups.

The clarity that all change comes with challenges and perspectives permeates all planning of the new structure from the beginning. Research reports that Participatory Management is an organizational model that can be adapted to nursing services, having already been implemented in American, Canadian and English hospitals (BORK, 2003).

In the survey 37.8% of the nurses work in the morning; 35.1%, in the evening; 18.9%, in the afternoon 8.1% work as off-duty coverage in the morning and afternoon shifts, as needed by the duty roster.

The nurses interviewed, nine nurses have up to five years of profession; fifteen, between six and ten years of profession; thirteen, above ten years of profession.

This means that 75.68% of these nurses have extensive professional experience in Nursing, having already experienced some experience with different types of leadership. Regarding the time in the institution under study, 54.0% of the nurses have up to five years; 46.0%, above five years in the hospital in question.

Assuming that the Shared Decision Structure has only been implemented for a short period of time - less than five years, it is inferred that a large proportion of the interviewees have a greater knowledge of the new structure, since they participated in its implementation, and have been following its development, analyzing its results and sensitizing those newly hired nurses.

The vast majority of the nurses interviewed (91.9%) assume the care function, managing their immediate peers in their rental unit. Only 8.1% of the total number of nurses in the survey occupy a management position. This favors a better parameter of the results of the evaluation of the Shared Decision Structure, since it does not infer an ideological character of "positions of trust".

The great prevalence in the survey is women, reaching 91.9% of respondents, as pointed out in the survey, This also portrays the predominance of the female figure in the health area.

Of all respondents, 75.7% actively participate in some nursing support group. This reinforces the nurses' engagement in the Shared Decision Model, since from these groups, the current organizational structure improves the identification and daily exercise of successes and deviations, in order to redesign processes, minimize conflicts, involve professionals in the adoption of practical improvements in Nursing, according to Table 6.

For example, in the hospital under study, there are teams and small assistance groups divided by specialties, whose purpose is to research, improve, apply proposals to improve health care through scientific studies. With this, their results become a reference in the hospital area at the national level, with dissemination of their methods and procedures through courses, symposia, congresses.

The survey describes that 83.8 of the respondents agree and strongly agree with the first leadership competency (Applied knowledge in organizational theories) as a determinant in building the Shared Nursing Decision Model. None of the nurses strongly disagreed.

It is important to highlight the equity of responses between indifferent (13.5%) and strongly agree (13.5%) among nurses, which suggests a certain difficulty in understanding this competence in the organizational model under study.

In the second leadership competency (Applied knowledge in systems, values and social relationships), 86.5% of nurses agree and strongly agree with the statement that this competency determines the construction of the Shared Nursing Decision Model.

In this third leadership competency, (Knowledge applied in ethical foundations and social responsibility), none of the interviewees disagreed with the statement that this competency contributes to the construction of the Shared Nursing Decision Model.

Of the respondents for this leadership competency, (Applied knowledge in economic and cultural globalization), 75.7% with the statement that this competency determines the construction of the Shared Nursing Decision Model. None of the nurses disagreed.

The percentage of responses for indifferent, as shown in the graph above, was high in relation to the other leadership competencies, 24.3%. It seems, at first glance, that the vision of nurses in large hospitals is restricted in relation to what happens around them. Hence the high This fifth leadership competency, (Skills in planning and implementing public relations activities) points out, among the

interviewees, 78.4% agreement that this competency determines the construction of the Shared Nursing Decision Model. None of the nurses disagreed.

In the competency of Skills in organizational development, according to Graph 14, 89.2% agree and strongly agree that this competency determines the construction of the Shared Nursing Decision Model. Of all the nurses in the survey, only 2.7% strongly disagree with the assertion.

The seventh leadership competency, was accepted by 82.9% of nurses as a determinant in building the Shared Nursing Decision Model. Of the respondents, 5.4% strongly disagreed above.

Regarding the eighth leadership competency, Graph 16 (Skills in allocating material and financial resources), 75.7% confirm the statement that this competency determines the construction of the Shared Nursing Decision Model, against the opinion of 5.4% of the interviewees, who disagree and strongly disagree with this statement.

The survey pointed out that the ninth leadership competency (Skills in human development), 94.6% approve the statement that this competency determines the construction of the Shared Nursing Decision Model. None of the interviewees disagreed with this statement.

The survey indicated that 91.9% of nurses approve the statement that this competence, (Skills in various learning strategies) determines the construction of the Shared Nursing Decision Model.

In the competency of Skills in problem solving and decision making, Graph 19, 94.6% of the nurses in the survey approve the statement that this competency determines the construction of the Shared Nursing Decision Model. Of the respondents, 5.4% disagreed with this statement.

The competency of Knowledge applied in small group work shows that 81.1% of respondents approve the statement that this competency determines the construction of the Shared Nursing Decision Model. Of the total number of nurses, 2.7% disagreed with this statement.

This result demonstrates the reality of their professional routine, since multi- and interdisciplinary teamwork is indispensable for successful patient care.

The fourteenth leadership competency, (Applied knowledge in interpretation of laws, regulations and policies) is confirmed by 73.0% of nurses as a determinant in the construction of the Shared Nursing Decision Model.

This research showed that 70.0% of nurses agree with all Nursing activities as fundamental to the exercise of leadership.

It is observed, specifically in political activity, that 59.5% of respondents are indifferent to this factor as important for the leader to play his role with the team.

Of the respondents, 100.0% agree and strongly agree with the statement that activities such as concern for staff development and rapid decision making in nursing care are important to ensure the success of the Shared Decision Model.

Of all nurses, 8.1% disagreed with the statement that activities such as participation in administrative services and political activities, computer knowledge is important to ensure the success of the Shared Decision Model.

Of the respondents, 86.5% agree and strongly agree with the statement that activities such as performing nursing procedures are important to ensure the success of the Shared Decision Model. Of the total nurses, 5.4% disagree with this statement.

In the survey, 86.5% of nurses agree and strongly agree with the statement that activities such as receiving and passing on duty are important to ensure the success of the Shared Decision Model. Of those respondents, 8.1% disagree and strongly disagree with this statement.

None of the interviewees disagreed with the statement that developing and/or enforcing standards and routines are important to ensure the success of the Shared Decision Model.

None of the interviewees disagreed with this statement. Nursing, in particular, is concerned with the professional profile and, through knowledge of its Code of Ethics, guides all its actions.

4 CONCLUSION

Participatory management is based on humanism, as it is based on respect and integration of human values, the needs of people and work. It considers the worker as an active being in the organization, with the capacity to develop his role with autonomy and to participate effectively in decision-making related to the work processes of the services.

The organizational structure is flexible and adaptable, there is greater reliability in informal interactions and decisions are decentralized. This proposal fosters personal and professional growth, contributing to the worker feeling more motivated and recognized.

One of the rights is the autonomy of the user, considering that for him to make decisions or participate in decisions regarding his treatment and well-being, two conditions are necessary: freedom and competence to decide.

Competence means having the necessary clarification for decision making; freedom presupposes having the possibility of choice. Thus, in parallel with Participatory Management, it means that there should be a socialization of knowledge and a redistribution of power, because in order to be able to decide, the professional will have to have the opportunity of choice and competence, covering knowledge, skills and attitudes.

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