Abstract:

Aim: To use qualitative methods to investigate emotional intelligence and its relationship to nursing leadership.

Background: Strong, effective leadership is a core component of effective healthcare organisations and significantly affects care quality. Improving leadership quality is related to displaying effective leadership characteristics. Emotional Intelligence (EI) is the ability to understand one's own feelings and to accurately assess and respond to the feelings of others. It links to other concepts such as self-awareness, self-management, social awareness and social skills, all of which are vital in leadership roles. However, insufficient research explores EI in nursing leadership from the perspective of nurse leaders.

Design: A qualitative study using interpretive phenomenological analysis

Methods: A purposive sample of Band 7 Sister/Charge Nurses/Team Managers (n=5) from one Health Board. Semi-structured interviews were audio recorded and analysed using interpretive phenomenological analysis in four stages.

Findings: Four clusters of themes were identified, each with 2-3 themes within them. These clusters were: Sensing others – the empathetic leader; Experiencing the affected sense of self; Strategies employed to build the team; Reading the flux of the organisation.

Conclusion: Despite the lack of familiarity of the concept of EI within the nurse leaders interviewed, it was evident in the narrative of their 'lived in experience' that they were able to reflect some of the core values of EI within their leadership roles. However, due to the significant barriers identified surrounding time, pressure and poor staffing levels, their potential to become more effective EI leaders was impeded. Pressure and competing priorities have a detrimental effect on effective leadership. Nurse leaders should take advantage of the great power of emotions and its role in EI to positively influence followers within healthcare in order to achieve excellent patient care.

Introduction

Effective healthcare organisations must have strong leadership at every level from the Board to the ward (King's Fund, 2012). However, the Francis Report (Department of Health [DH], 2013) identifies a breakdown in leadership behaviours as being one of the reasons for the service failures that arose in Mid Staffordshire. Furthermore, an issue asserted was that the hospital leaders had passed on behaviours to their staff that were more concerned with hitting targets than caring for patients. Understanding the intricacies of characteristics that enhance leadership should therefore be a goal of any healthcare organisation. Nurse leaders play a central role in securing high quality patient care and service delivery (Kings Fund, 2012). Emotional intelligence (EI) is reported as central to effective leadership within the NHS and a foundation for outstanding quality of care (Carragher & Gormley, 2017).

Background

There are several conceptual definitions of EI (Salovey & Mayer 1990, Bar-On 1997, Goleman 1995), yet they all share similar theoretical foundations which include the ability to monitor one's own and others′ feelings and emotions to predict and nurture inter-personal effectiveness and guide behaviour (Mansel, 2017). In response to the Francis Report the National Health Service (NHS) Leadership Model (NHS Leadership Academy, 2013) recognises that personal qualities such as self-confidence, self-control, and self-awareness, which are core competencies within EI, are part of the foundation of effective leadership. The underpinning theory developed from research by Storey & Holti (2013, p. 6) states that an effective leader should use 'soft intelligence' rather than 'hierarchical imposed targets', and should listen, validate and engage with positive and negative emotions. Emotional abilities such as: 'Perceiving emotion, facilitating thought using emotion, understanding emotions and

managing emotions' are the four-branch model of the ability-based model (Mayer *et al*, 2016, p.294) which is the exemplar (Elfenbein & MacCann, 2017).

Research regarding EI and healthcare has focused on undergraduate nursing students' leadership (Duygulu, Hicdurmaz & Akyar, 2011); academic performance (Fernandez, Salamonson & Griffiths, 2012); curriculum (Carragher & Gormley, 2017; Codier & Odell, 2014; Foster et al, 2015). Furthermore, Codier (2015) and Rankin (2013) emphasise the importance of using EI screening as admissions criteria. The new Nursing and Midwifery Council (2018) standards of proficiency acknowledge the importance of EI for registered nurses. The attributes of EI capabilities are especially valued in professional nursing and claimed to be important for effective nursing leadership (Akerjordet & Severinsson 2008, Feather, 2009).

In the current context of healthcare delivery, the quality and effectiveness of services offered are becoming more important than ever as they develop within a rapidly changing and increasingly complex set of conditions. While leading the provision of these changing health care services, nurses are expected to effectively communicate with those they are serving and to positively affect and influence them. During this process, nurses are supposed to get to know and understand themselves, the emotions and thoughts of the individuals they care for and interact with and exhibit appropriate behaviours. Yet there are limited empirical studies of EI among nursing professionals to support this claim despite putative links between EI and quality of care, a core driver for organisational success in any healthcare organisation.

Leadership literature suggests that the role of the unconscious phenomena of individuals can be related to leadership through leadership behaviour based on how they perceive the world and react accordingly (George, 2000; Macaleer & Shannon 2002; Rao, 2006; Smith &

Hughey, 2006). In a healthcare environment it is desirable to identify a leadership model that offers longevity in the relationship between leaders and followers. The association between EI and specific leadership styles has received academic attention with the work predominately focused on transformational leadership style (Harms & Crede, 2010).

Several authors describe a positive related link between EI and leadership style: Jin, Seo, & Shapiro (2008); Parker and Sorensen, 2008; Harms & Crede, 2010; Cavazotte et al., 2012; Lopez-Zafra, Garcia-Retamero, & Berrios Martos, 2012. The need to enhance leadership capabilities with the identification of the traits or characteristics associated with EI is a paramount consideration for the success of any organisation.

In high risk industries, leadership is recognised as an essential characteristic of safety management (Zohar, 2000). Leadership in healthcare is no different from other areas where safety is crucial. In 'Safety First' (DH, 2006), the predominant message was about strengthening leadership to make patients safe. Patient safety is never automatically assured, it requires the constant attention of leaders and continual support of the workforce, without that, risk grows. Engaged followers work more effectively and more productively which leads to better outcomes for patients and the organisation (West, Dawson, Admasachew & Topakas, 2011). However, engaging followers is a significant leadership challenge, particularly in difficult times.

Therefore, it is logical to explore and understand the world of eaning of nurse leaders' lived experience. IPA is particularly useful for the analysis of the emotionally intelligent leader for its specific focus on participants' perceptions of their experiences and their attribution of meanings to those experiences (Prins 2006; Smith & Eatough 2006; Smith 2004).

THE STUDY

Aims

The purpose of this interpretative phenomenological (IPA) analysis study was interrogate EI in nurse leadership.

Objectives:

- To explore and attempt to understand how nurse leaders made meaning or sense of their own emotional intelligence capabilities.
- To explore how nurse leaders perceived or demonstrated the essence of qualities and behaviours related to EI within their leadership roles.
- To explore the potential value of EI in nurse leadership, and barriers to its realisation, within the current context of NHS nursing.
- To identify recommendations for future research, education or training in relation to EI.

Design

To address the apparent gap qualitative studies on this topic, the study utilized interpretative phenomenological analysis (IPA) (Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009). Interpretative Phenomenological Analysis (IPA) is an approach to qualitative research involved with exploring and understanding the lived experience of a specified phenomenon (Smith & Osborn, 2003). This type of inquiry considers the complex and multivariate nature of individuals and social influences (Creswell, 2008; Smith et al., 2009) and specifically focuses on the participants' perceptions of their experiences and their attribution of meanings (Prins, 2006; Smith 2004; Smith & Eatough, 2006). This methodology offers a unique insight into EI competencies that might otherwise be missed in structured surveys or experiments and well suited for accessing tacit, taken for granted, intuitive understanding of an experience (Tracy, 2013). It is argued that qualitative research is too impressionistic and subjective, with findings relying on the researchers' often-unsystematic views about what is significant and important (Bryman & Bell, 2013). However, the strength of IPA lies in uncovering people's experience to achieve a better understanding of how people think and their individual

behaviour. IPA is also interpretative, and engages with 'double hermeneutic' in which the researcher is trying to make sense of the participant trying to make sense of their experiences (Smith & Osborn, 2003; Smith et al. 2009). It was this philosophy which guided every stage of the research process, from the choice of setting to the process of analysis.

Sample/Participants

Various sample sizes have been used for IPA, typically from 1 to 15 (Bramley & Eatough, 2005). However, there is no 'right' sample size (Smith & Eatough, 2006). It is asserted that the difficulties in analysis of large data sets may result in the loss of 'potentially subtle inflections of meaning' (Collins & Nicolson, 2002, p. 626) and exploring data in-depth from large samples can lead to superficial understanding (Smith & Osborn, 2003). A consensus towards the use of smaller sample sizes has emerged (Smith, 2004; Reid, Flowers & Larkin, 2005) with five or six participants being recommended as a reasonable sample size (Smith & Osborn, 2003).

This study sample consisted of registered Band 7 Sister/Charge Nurse/Team Managers, defined as an experienced senior nurse who was responsible for a clinical area to include the leadership of staff and delivery of patient care. Participants were invited from a list of ward/team nurse leaders provided by the Head for Mental Health Services and Head of Nursing (n=37) within a single health board in South Wales. An email invitation was issued to the participants detailing the nature, purpose and process of the study. A total of 5 nurse leaders volunteered to participate in the study. All five participants were female. Four participants were within the 50-59 age brackets and one within the 40-49 age bracket. The professionals had a combined total of 81 years of experience as nurse leaders. In line with

IPA, this sample was chosen as a defined group for whom the focus of the study had relevance and significance (Bryman, 2012).

Data Collection

Semi-Structured Interviews

Semi-structured interviews were employed, which were audio-recorded, transcribed verbatim, and then analysed using IPA as outlined in Table 1. (Smith & Osborn, 2003; Smith et al. 2009). With semi-structured interviews, it is helpful to prepare an interview plan. This was merely a guide to facilitate a natural flow of conversation as it was important to follow the participants' unexpected and unprompted accounts rather than specific questions in sequence (Smith et al., 2009). The researcher adopted the usual approach in IPA using a prompt sheet to guide the semi-structured interviews.

Data analysis

Table 1: Biggerstaff and Thompsons's (2008) Analytical Model

Transcripts were coded according to Biggerstaff and Thompson's (2008) analysis stages as follows.

Ethical considerations.

Ethical approval was given byg Swansea University Collage of Human and Health Sciences Ethics Committee. Permission was given by the Health board where the study was conducted. All nurse leaders received information about the aim of the study, a proposal of dissemination of the results; confidentiality was assured and their right to withdraw at any time. Interviews were carried out in a private location at times convenient to the participants.

Rigour

In IPA studies, the analysis considers the interpretation of one researcher and does not seek to find a single answer or validity, but rather a coherent and authentic account that is attentive to the words of the participants (Pringle *et al* 2011). The utilization of a reflective diary by the researcher assisted in supporting the decisions taken in the research process.. It is recognised that IPA is subjective as a qualitative research approach as it is improbable that any two researchers analysing the same data will arrive at the precise same clusters and themes. According to Smith and Osborn (2008) the value of IPA is that the findings are attuned to issues which could be usefully explored in existing literature. It is asserted that the outcome of this study is not to generalise results but a deeper understanding of experiences from the perspectives of the participants (Maykut and Morehouse 1994). However, the authors acknowledge their own position as professionals and academics may have influenced their interpretation of the findings and collation of themes.

Findings

The main themes that emerged from the analysis can be found in Table 2.

Table 2

Sensing others: The empathic leader

The data suggested that empathy is an inherent expectation and should characterise all health care professions. Empathy is a connection and is about letting people know that they matter.

The emotional connection allows the nurse leaders to be mindful of what staff and patients are experiencing. Empathy is therefore paramount as a component of 'great' leadership.

Understanding the feelings of others

Accurately reading emotions is an essential process in being aware of the feelings of others (Aurora, et al., 2010). The nurse leaders in this study were clear that their role involved supporting colleagues through an awareness of what they were thinking and feeling.

P.1: *"Because you do have to tune in to everybody's needs and be empathetic about what is going on in their lives and that kind of thing. Again, the strong points, if you are going to develop them in a strong productive way you have to be tuned into those things".*

Empathy isan attitude of life, which can be used to attempt to encounter someone, to communicate and understand others' experiences and feelings (Halpern, 2003). In this case empathy was valued as part of a relational approach to leadership. It is interesting here however that the distinction between leadership and management is not made explicit by the participants but is implicit in the text.

P. 2: *"Some do. talk about their feelings and you appreciate that but you can also keep an eye on them, and just tell them, well look you know where I am, I am here, just let me know, and once they know that, that makes a difference. ... It's the relationship you develop with them".*

This quote also suggests that empathy, as a component of EI, develops over time, in line with the idea that this is a relational issue.

Cultivating the skills and values that people require to care compassionately and effectively

This emerged through all the interviews as a core theme. It was clear that intrinsic aspects of role satisfaction were related to the emotional engagement in caring.

P 4: *"...and if they (staff) are happy they tend to look after people with a lighter heart and it's not a chore it's, you know, caring is one of those professions where it's in us, you nurture, you want them (patients) to get better"*

The idea that EI, or its components, could be developed actively in colleagues emerged during the analysis.

P 2: *"An awareness. You can nurture it in somebody, if you can pick up that somebody is showing these tendencies, that they can come tell you, look something is not right with so and so, this morning, keep an eye, see if you can have a word with them later"*

This shows a degree of compassion for colleagues that is in line with current requirements for better teamworking and speaks to the context of care.

Perception of the lack of empathy from others

According to Goleman *et al.,*(2013), empathetic people are outstanding at recognising and meeting the needs of followers. However, two participants reported a lack of perceived empathy from senior managers:

P 4: *"You want to take people with you and you care for your team and my manager and manager above. That I can't fault they are both excellent, but you go beyond that there does not seem to be that empathy, does not seem to be that caring.''*

It is clear that these aspects of EI were viewed as desirable by colleagues.

P 5: *'People in more senior positions don't realise how important it is to acknowledge other people's part in the process and make them feel that they are doing a good job.''*

The lack of perceived empathy from the senior leaders could be due to the absence of personal contact and 'leading from a distance'. It could be interpreted by the first author that there is a greater need for collaboration between senior managers and nurse leaders as the display of empathy makes people feel valued and understood as individuals (Kellett *et al* 2006).

Experiencing the affected sense of self

An understanding of the world people live in provides a rich source of ideas and avenues for comprehending and exploring their lived experience, which in turn informs and deepens our understanding of reality (Smith *et al* 2009).

Feeling over burdened

Chalmers-Mill (2010) suggests that there should be a positive interaction between EI leadership skills and understanding of the development needs of their staff. Nevertheless, due to the pressures of organisational processes, staff appears to be losing out on completing Personal Development Reviews (PDR), reflective practice and other opportunities to develop their careers:

P 3: *"Time is a huge issue, not enough time to do everything. All these audits to do, 9-10 every month we have to do and every 3 months another 4 on top that we have to do".*

This seems to indicate that the administrative workload associated with a leadership role could negatively impact on the manifestation and expression of EI. .

West and Dawson (2012) examined engagement scores in a NHS staff survey and found that appraisals proved to be a significant factor in predicting employee engagement. Furthermore, patient satisfaction was significantly higher in trusts with higher levels of employee engagement.

P 2: *"If you are going to be a leader you have to have time to be a leader really. Time, I think is a big problem. You are always pushed for time and of course, as always, if someone wants something it is always your staff that actually do without as you drop that, to deal with someone else, you know, because someone needs these numbers by today".*

This is illustrated by previous work by The King's Fund (2013) in a report on patient-centred leadership which took place after the publication of the Francis Report. They found that 51% of nurse leaders when asked what the biggest barrier to increasing quality of care was, they stated 'time and/or resources.'

P 4: *"I do try and meet up with them (team) regularly and just see how things are going. But it is hard because it means that if you do that you have to put something else to one side. The time I have to spend data collecting, I feel like a glorified admin, I can't do supervision as often as I would like. The staff are losing out because I have to crunch numbers or pull this together or pull that together".*

This supports the dominant NHS leadership approach known as 'pacesetting' leadership style (Kings Fund, 2014) illustrated by laying down demanding targets, leading from the front, and collaborating little – and is the consequence of the health service focusing on process targets.

Nurse leaders related their experience of their managers as more focused on the delivery of targets than engaging patients and staff.

P 4: *"I don't think senior managers understand the pressure team leaders have at the moment to produce all this data collection, most of the pressure comes from above really. It's about massive amount of auditing, data collection you have to report on which takes you away from actually driving the service forward. And that is hugely frustrating".*

According to Kings Fund (2012), there is growing research that the NHS needs to depart from the command and control, target-driven approach. Time is identified as a barrier to employing EI in healthcare leadership. There appears a tendency to carry out urgent tasks at the expense of highly important tasks.

Awareness of feeling stressed and anxious

Effective leadership places huge demands on the shoulders of one person. According to Van Rooy and Viswesvaran (2004) the effects of emotions and work in general is understudied. Yet, this study identified that all participants experienced negative emotions due to workload pressure. Stress and anxiety in the workplace can be related to a number of factors, not the least being managing the impact of the role on the self.

P 2: *"I have been off on periods of stress as I have bottled things up".*

It is interesting to see that the participant here allocates blame for the stress to herself, for her lack of effective coping mechanisms, rather than on other factors that might be affecting her response.

P 3: *"I was on leave last week and I didn't sleep Sunday night thinking...oh!!!! What am I going into tomorrow morning".*

Again, the stress of the job is evidence, and extends into other aspects of life. The participants show that it may be operational factors and cultural factors which impact upon EI and their experience in leadership roles.

P 1: *"There is always a blame culture going on and it is always someone else's fault and that goes through the whole organisation and it does not matter what they say, you can't get away from that, it's true it is there. I think that makes people anxious and I think they are not going to get supported if something goes wrong they are going to be blamed".*

Research in higher education indicates the lack of EI in leaders as the root cause of stress and conflicts within the workplace (Smith & Hughey, 2006). All participants in this study noted the negative feelings associated with organisational pressures and perceived lack of support for their demanding leadership roles. This may affect their ability to manifest EI and use it in their roles.

Strategies employed to build the team

According to Goleman *et al* (2013), teamwork goes beyond mere work obligations, which was evident in the data collected. Informal rewards in recognition for a job well done and 'thank you' were identified. These relate to the following themes of positive feedback, gathering people together, reading the flux of the organisation, leading from a distance and poor staffing levels.

Positive feedback

Positive feedback featured as a means of supporting and motivating colleagues and addressing the culture within the clinical setting.

P 2: "*we had a particularly, heavy, couple of weeks due to staffing a big issue, it was my thank you, to them, it's a thank you for them, for their support and hard work".*

Being able to recognise the need to offer staff rewards of some kind is clearly a component of reading the mood of the staff and using EI to foster a supportive culture.

P 5: " *Well done. So good feedback is very important".*

The concept of feedback is viewed positively.

P 1 "*..... and I know that I am forthcoming with praise quite a lot in the meetings. Loads of praise. I don't agree with criticisms either".*

The association of praise and positivity with the leadership role may be linked to leaders' awareness of needing to manage people's experiences within the clinical team.

Gathering people together

Cultivating social connections as a simple act of gathering around the table helps builds bonds. Studies have found that social connectedness has been shown to increase happiness and a sense of belonging (Mauss *et al* 2011).

P 5: *"Another thing I like to do, to encourage people, is every so often have a team breakfast and I will bring in nice things to eat.....a reward for hard work".*

Again, this demonstrates an awareness of the need to generate a positive working environment.

P 3: *"I bought food in the other week because we had a particular, heavy couple of weeks due to staffing, a big issue".*

Although there is more work to be done addressing the underlying operational issues which bring about these working conditions, larger changes take significant time. It is clear that elements of managing staff feelings and experiences are related to the perception of leadership in this setting, suggesting that EI is more than simply addressing issues when staff have 'problems'. This is evident in the following theme.

Reading the flux of the organisation

The participants were all politically astute with an understanding of political forces within this time of austerity. Nevertheless, the lack of perceived support they receive was apparent.

Leading from a distance

P 5: *"Managers are leading from a distance. People that manage the managers don't do walkabout enough".*

Walkabouts are befitting with calls for Health Boards to be doing much more to exercise clear and visible leadership to improve the quality of care their organisations provide (DH, 2013):

P 2: *"Quite often you don't see anyone from the top until something has gone wrong. You're the one that is carrying the can, you're the one that's held to account".*

This speaks to the two-way process of EI – as something which benefits the team, and as something which benefits the leaders. Working in a punitive culture seems particularly challenging.

P 1: *"When something goes wrong they come down like a ton of bricks, it would be nice to see them once a year, people do respond to it, it means a lot, you know, and it is supporting the leaders as well".*

The NHS Modernisation Board's Annual Report 2000-2001 (DH, 2002) acknowledged that senior management in the health services must increase their contact with front-line staff to improve service delivery and effective change. Yet, the Francis Report (DH, 2013) detailed some of the worst failings in care due to a lack of clear and visible leadership.

Poor Staffing Levels

It is difficult to maintain professional standards due to time constraints and if you are under-resourced. The Francis report explicitly stated that poor staffing levels at Mid Staffordshire led to poor quality care (DH, 2013) and participants in this study agreed:

P 5: "*I think you need more nurses as well, nurses become paperwork heavy and if people are sitting writing up this, that or the other, really time has been taken away from the patient"..* This speaks to the impact on professionals as well as on patients.

P 2: "*As a manager I was there with the rest of them, feeding people, bathing people because we did not have the staff on the floor. Where is the quality of care?"*

Two participants reported being included in the staffing numbers due to staff shortages, thus taking time away from their leadership roles. This finding supports the RCN (2009)

investigation into the pressure placed on ward leaders and suggests that there may be scope to consider how such demands would impact on EI

Discussion

It is evident that EI is a complex and bidirectional phenomenon or quality which requires leaders to manage self whilst supporting and managing others. Empathy is regarded as an inherent trait of EI (Austin, Evans, Goldwater & Potter, 2005). Empathy, expressed in terms of joy, sorrow, excitement, misery, pain and confusion in healthcare enables healthcare professionals and patients to work together (LeCompte, 2000). EI in nurse leadership seems to be the buffer between the 'frontline' workforce and the organisational factors which impact upon their roles, but this seems to place a considerable burden on nurse leaders.

The NHS Leadership Academy in their paper 'Towards a New Model of Leadership for the NHS', stress the importance that leaders in a healthcare setting should seek to help create a climate which facilitate positive emotional attributes such as compassion, commitment, empathy and optimism (Storey & Holti, 2013). The findings of this study support this, demonstrating a critical role for empathy, part of the 'Social Awareness' of EI, (Goleman *et al.*, 2013). Empathy is therefore paramount as a component of 'great' leadership and management in healthcare for at least three reasons. Firstly, the 'increasing use of teams', described by Goleman as, 'cauldrons of bubbling emotions'. Secondly, the 'rapid pace of globalization' (growth and development in healthcare with miscommunications readily leading to misunderstandings) and thirdly, the 'growing need to retain talent' (Goleman, 1998). It is clear from this study that operational and staffing factors require a skilful management of the workforce which in turn requires sensitivity and EI.

The NHS Leadership Model (NHS Leadership Academy, 2013) recognises that personal qualities such as self-confidence, self-control, self-knowledge, personal reflection, resilience, determination and self-awareness are part of the foundation of effective leadership. This study echoes these qualities, and highlight that self-awareness, as a component of EI, is a bi-directional quality which enhances effective leadership. According to Goleman *et al.* (2013), characteristics of a self-aware individual include emotional self-awareness, accurate self-assessment and self-confidence. It would seem that the nurses in this study use EI to mediate between the organisation and the workforce in the light of factors which are not easy to change. But the personal impact of working in this way needs further exploration.One of the foundations of effective leadership is the development of a deeper awareness of your own self through reflective practice.. Being insightful about emotions and their influence on management decisions and practice lends to the development of the characteristics of self-awareness (Salovey & Mayer, 1990). It is clear the the participants in this study exhibited a good degree of self-awareness but only in relation to the impact of their roles, particularly in terms of stress levels. It would seem that the use of EI requires a certain degree of resilience towards a multiplicity of organisational factors affecting staff, but the drain on nurse leaders needs further investigation.

Good leadership is not only about having exceptionally high levels of self-awareness, but also the ability to apply this knowledge in practice. The organisational factors that impede this may be addressed more proactively if leaders are able to use EI, as it promotes the growth of reflection on and awareness of influences that can affect leadership in healthcare. Channeling this into team building seems an important aspect of effective leadership. This study demonstrates the relationship between self, team and environment and suggests how practitioners can consciously work with this triadic relationship. Whilst it is no surprise that

working conditions and stress emerged as one theme, it is clear that the expression of core values of EI was also important for these leaders. This echoes other research, such as that by Slaski and Cartwright (2002) who reported significantly lower stress and distress, higher morale, improved perceived quality of working life and significantly better health in managers with higher EI. It was evident in the narrative of their 'lived in experience' that the leaders in this study were able to reflect some of the core values of EI within their leadership roles. However, due to the significant difficulties identified surrounding time, pressure and poor staffing levels, these factors would appear to supress their potential in becoming effective EI leaders. This study supported the view by the RCN (2009) and Ham (2014) that pressure and competing priorities had a detrimental effect on effective leadership, suggesting that changes in the context of nursing are also required to ensure organisations can optimise the potential of their resources. Most importantly, nurse leaders should take advantage of the great power of emotions and its role in EI to positively influence followers within healthcare in order to achieve excellent patient care.

This study supported the findings over the decades and in response to many NHS failings, of the lack of perceived support for nurse leaders by senior managers, and highlights the need for a less hierarchical approach to managing healthcare organisations. EI is not only important for the success of individuals in a healthcare organisation but also more important as individuals rise through leadership positions, and crucially, appears to impact on quality of care. It may mean that EI is a critical factor for effective leadership in healthcare EI becomes more significant in the higher levels of the organisational hierarchy. The key challenge is to develop leaders within healthcare with the right values who will implement a culture of emotionally intelligent caring. Aspiring leaders should consider improving levels of EI competencies which can be intentionally learned by those who are willing to learn and

continuously work on, thus enhancing leadership effectiveness (Kakariasen & Kakariasen Victoroff, 2012).

The ability to manage and read emotions is an important skill for any health professional and has the potential to enhance patient care. This study adds to the limited body of knowledge on EI in nurse leadership. However, further research and different methodological approaches are required in order to enrich and to achieve a deeper understanding of EI linked to nurse leaders, followers and patient care, and organisations themselves should prioritise action to overcome barriers to effective expression of nurse leadership. The time and resources spent in this manner are likely to result in greater efficiency and longer-term savings in the use of resources. At the same time, barriers between the staff who work 'at the coal face' and those in leadership positions must be eroded.

High-achieving individuals often demonstrate high intelligence, strong personality types and high EI. Their personal, social and organizational effectiveness is often strongly influenced by their self-awareness and social awareness as a foundation for their skill and ability to manage themselves and others in all types of situations and circumstances. It is vital therefore to educate the nurse leaders of the future in developing and using EI in their leadership roles, and in addressing the structural and cultural aspects of leadership practice, including outmoded expressions of hierarchical position, to ensure that the positive qualities of EI can be expressed by all staff regardless of the context of care.

Limitations

The authors acknowledge that leadership success is more complicated than a single dimension such as EI. Due to the small and purposive sample available for the study, results

may not be generalizable beyond the specific population from which the sample was drawn, and caution should be applied to avoid over-generalising beyond the study locality (Bryman, 2012). It should be noted that this study utilised a sample of nurse leaders which may have included more motivated individuals from within the profession, which may have skewed the thematic findings.

Conclusion

There are two dimensions to the conclusions and recommendations that arise from this study. Firstly, in terms of policy, the most significant finding of this research is that there are significant professional challenges identified by leaders, in relation to time, pressure and poor staffing levels. These factors would appear to supress their potential to become more effective EI leaders. This study has supported the views of the RCN (2009) and The King's Fund (2014), that pressure and competing priorities have a detrimental effect on effective leadership. Policies should reflect the value of the emotional dimensions of leadership and should allocate sufficient time and resources to staff engagement and activities which could enhance their ability to develop and actualise EI in their professional life. An urgent review of the data collection and targets imposed upon nurse leaders should be carried out. Organisations, policy-makers, and nurse leaders must work together to empower nurse leaders to apply EI in healthcare.

Secondly, in relation to practice, it is clear that before nurse leaders can even start to discuss EI or improving it, it would appear that there is a need for greater understanding of the term and its meanings, and how its dimensions may be implicit in existing behaviours and attributes. Despite the lack of familiarity of the concept of EI within the nurse leaders interviewed, it was evident in the narrative of their 'lived in experience' that they were able to reflect some of the core values of EI within their leadership roles even when they did not

define these concepts as EI. Senior management should increase their visibility in the clinical area, perhaps through more frequent walkabouts, to improve the quality of care.

We conclude that nurse leaders should take advantage of the great power of emotions and their role in EI to positively influence followers within healthcare in order to achieve excellent patient care. However they should also provide feedback on operational issues which impact on the experience of the workforce, and explore the ways in which they use intrinsic and extrinsic rewards to enhance their ability to manage their teams.

The following key elements appear to be essential in ensuring emotionally intelligent nurse leadership: understanding the concept of EI in healthcare leadership;, recognising that this will enhance nurse leadership approaches; placing a high priority on overcoming barriers to effective nurse leadership; committing time and resources to making it happen; ensuring the support of senior management through their demonstration of presence, and visible and emotionally intelligent leadership at all levels of the organisational hierarchy. A recognition of the bidirectional nature of EI and the bifacing role of nurse leaders, at the intersection of the wider body of staff and the higher levels of the organisation, and their perception of their role as mediating between these two elements, would enable future work to address how to optimise EI in leadership whilst continuing to use it as a tool for service quality improvement.

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Figures and Tables

Table 2:

CLUSTERS	THEMES
Sensing others: The empathic leader	Understanding the needs of others
	Cultivating the skills and values that people require to care compassionately and effectively with others
	Perception of the lack of empathy from others
Experiencing the affected sense of self	Feeling over burdened
	Awareness of feeling stressed and anxious
	A state of mind (feeling)
Strategies employed to build the team	Positive feedback
	Gathering people together
Reading the flux of the organisation	Leading from a distance
	Poor staffing levels