The experience of being a shift-leader in a hospital ward

Hadass Goldblatt, Michal Granot, Hanna Admi & Anat Drach-Zahavy

Accepted for publication 15 February 2008

Correspondence to H. Goldblatt: e-mail: goldblat@research.haifa.ac.il

Hadass Goldblatt PhD
Faculty of Welfare and Health Sciences
Department of Nursing, University of Haifa, Haifa, Israel

Michal Granot PhD RN
Faculty of Welfare and Health Sciences
Department of Nursing, University of Haifa, Haifa, Israel

Hanna Admi PhD RN
Director of Nursing
Rambam – Health Care Campus, Haifa, Israel

Anat Drach-Zahavy PhD
Faculty of Welfare and Health Sciences
Department of Nursing, University of Haifa, Haifa, Israel


doi: 10.1111/j.1365-2648.2008.04650.x

Abstract

Title. The experience of being a shift-leader in a hospital ward.

Aim. This paper is a report of a study to explore the experience of being a shift-leader, and how these nurses view the management of their shift.

Background. Professional demands on skilled and capable shift-leaders, who competently handle multi-disciplinary staff and patients, as well as operations and information, call for the development of efficient nursing leadership roles. Nevertheless, knowledge of shift-leaders’ perspectives concerning their task management and leadership styles is relatively limited.

Method. Twenty-eight Registered Nurses working in an Israeli medical centre participated in this qualitative study. Data were gathered through in-depth interviews conducted in two phases between February and October 2005: three focus group interviews (phase 1) followed by seven individual interviews (phase 2).

Findings. Content analysis revealed two major themes which constitute the essence of being a shift-leader: (1) a burden of responsibility, where the shift-leader moves between positions of maximum control and delegating some responsibility to other nurses; (2) the role’s temporal dimension, expressed as a strong desire to reach the end of the shift safely, and taking managerial perspectives beyond the boundaries of the specific shift. The core of the shift-leader’s position is an immense sense of responsibility. However, this managerial role is transient and therefore lacks an established authority.

Conclusion. A two-dimensional taxonomy of these themes reveals four types of potential and actual coping among shift-leaders, indicating the need to train them in leadership skills and systemic thinking. Interventions to limit the potential stress hazards should be focused simultaneously on shift-leaders themselves and on job restructuring.

Keywords: focus groups, hospital wards, interviews, nursing, responsibility, shift-leader, time

Introduction

As hospital managers pursue new reforms for providing high quality care in a financially restricted environment, they often conclude that developing nursing staff – and particularly managerial nursing roles – is essential for adapting to the complex healthcare system. Moreover, the growing awareness of patient rights and safety requires all nurses, especially those in managerial positions, to be more accountable for their professional practice. Demands for skilled nurse leaders who
can handle medical staff, peers and other healthcare professionals and ancillary staff, as well as information and finance, have raised the need to develop efficient nursing leadership roles (Ambrose 1995). Indeed, the role of head nurse or ward manager (e.g. Minzberg 1994, Ocker et al. 1995, Fox et al. 1999, Drach-Zahavy & Dagan 2002, Hughes & Kring 2005) has attracted extensive empirical and practical attention, but research into the shift-leader role has been relatively scant. This lack of research is particularly intriguing, given that nursing is a 24-hour shift-work profession and that the shift-leader manages the ward for two-thirds of the time. Consequently, research is needed to develop comprehensive models depicting the essence of being a shift-leader to examine its suitability for future healthcare systems.

In Israel, nurses’ job descriptions are undergoing major reforms, becoming more empowering and authoritative. Influenced by British and Dutch efforts, the National Health Insurance Law was enacted in Israel in 1995 in an attempt to manage competition among the nation’s four non-profit health funds, and also among hospitals. Consequently, nurses operate in a healthcare system that has shifted toward a more profit-oriented climate, emphasizing professionalization in delivering care. Part of this trend includes redesign of the shift-leader’s role. Hospitals in Israel, similar to countries in Europe, the United States of America and Australia, are characterized by separate chains of control and different payment systems for the various professions. Nurses report to superiors within the nursing system, namely head nurses, a nurse manager and a director of nursing (see also Willmot et al. 1999, Drach-Zahavy & Dagan 2002). In other healthcare systems, however, hospitals are mainly dominated by medical staff.

The shift-leader is defined as a Registered Nurse to whom the ward nurse manager has delegated partial authority and managerial roles for a given shift to manage patient care in accordance with the vision and policy of the hospital’s nursing administration (Ministry of Health, Nursing Administration (Israel) 1999). This definition stresses two aspects of the shift-leader’s role. First, the basic requirement for becoming a shift-leader is to be a Registered Nurse. Secondly, although the shift-leader has the authority to develop practice in accordance with patients’ needs, this authority is restricted to a given shift. In the next shift, the shift-leader may function as an allocated nurse, while another nurse is nominated as the shift-leader. These two aspects of the shift-leader’s role are often viewed as a double-edged sword: nurses have more authority to develop practices to meet patients’ needs, but are simultaneously limited to managing the minute-by-minute care on a given shift. Currently this is a position with quite modest financial benefit, and the majority of nurses take it on during their nursing careers in hospitals.

Hence, how can shift-leaders channel their ‘time-constrained’ authority into empowering staff? Are they capable of coordinating care with other role partners? Are they so consumed with routine and emergency management that they have little time and energy left to devote to organizational learning and staff empowerment? The answers to these questions are important, considering the challenges facing healthcare organizations at the beginning of the third millennium, and may serve as a basis for further development of the role.

### Background

Despite the importance of developing the shift-leader’s role, the topic has attracted limited research. Focus group techniques have been used in several studies to identify the criteria that constitute an efficient shift-leader (e.g. Ambrose 1995, Ocker et al. 1995). Example criteria are: awareness of all patients’ needs; ability to prioritize the work load; willingness to assist staff members with heavy or difficult assignments; ability to communicate effectively with medical staff members, peers, other healthcare professionals and ancillary staff (Ambrose 1995). This list shows that the preferred shift-leader, at least in the eyes of nursing management and staff, is able to lead people and tasks, can coordinate the care between multi-disciplinary professionals, and also possesses clinical and managerial skills.

In an attempt to explore the salient roles that shift-leaders actually emphasize in their work to attain quality care for patients, Endacott (1999) used a case study approach. Findings indicated that the onus of patient management lay on the allocated nurse, rather than the shift-leader. Specifically, the results indicated that shift-leaders’ activities fell into four categories: (1) presence, referring to ‘being there’ for patients and staff; (2) information gathering, referring to asking questions about the patients, often relying on the judgment of the allocated nurse; (3) supportive involvement, referring to providing reassurance, practical advice or instrumental aid to the allocated nurse; and (4) directive involvement, which only seldom occurred, and concerned the shift-leader taking over the management of patients’ care. Together, these activities provide valuable information about the ways in which shift-leaders handle peers to achieve quality of care for patients.

Nevertheless, theoretical frameworks of management, both in nursing (e.g. Minzberg 1994, Fox et al. 1999, Drach-Zahavy & Dagan 2002) and in management fields (e.g. Minzberg 1973, Blake & Mouton 1981, Bass 1999), emphasize that managing staff is only one aspect of the managerial role. More information is needed from the nurses’
subjective perspective about the ways in which shift-leaders manage tasks such as problem-solving, ethical and clinical decision-making, and task-prioritizing during busy periods.

The study

Aim

The aim of the study was to explore the experience of being a shift-leader, and how these nurses view the management of their shift from their own perspective.

Design

A qualitative approach was adopted to capture a deep understanding of the meaning of experiences through insightful descriptions of the experience under investigation, as presented through people's narratives and explanations (Moustakas 1994, van Manen 1997).

Participants

The sample consisted of 28 Registered Nurses, of whom 19 had BA degrees and three had MA degrees, while the rest had no academic degree. Twenty-one were female and seven male, and they were working in a large medical centre in Israel. All interviewees were Israeli, averaging 36 years of age and 11 years' work experience.

Data collection

Interviews were conducted in two phases between February and October 2005, using two methods: focus group interviews (phase 1) followed by individual interviews (phase 2). The focus groups were used to identify key themes of the experience of being a shift-leader from the nurses' perspective. This further enabled the composition of questions for more detailed exploration via the individual interviews. During the focus group phase, 21 shift-leaders were interviewed in three separate groups, seven participants in each group. A focus group is an effective tool for gathering data in exploratory studies and brainstorming, when the information on a phenomenon is scant, as in this study (Morgan 1997, Fontana & Frey 2000).

Three of the researchers, two nurses and a social worker, led the focus groups, with two facilitators per session. The groups lasted 90 minutes and were conducted in Hebrew, tape-recorded and later transcribed. Interviewees were asked to share their personal experiences of being a shift-leader by describing, for example, their thoughts and feelings associated with this role. Data from the focus groups were content-analysed (Patton 1990) and several main themes were revealed that composed the individual interview guide.

The second phase included individual in-depth 90-minute interviews with seven additional shift-leaders, conducted by two of the researchers. The purpose of this phase was to obtain more specific and detailed data based on themes that had identified in the first phase and to strengthen the dependability (Lincoln & Guba 1985) of the data. The interview guide addressed topics such as: the differences between the experiences of working as a shift-leader and a staff nurse; the most meaningful conditions that help a shift nurse successfully complete the shift; coping strategies for managing conflicts with staff and patients; and issues the participants felt should be included in a training programme for shift-leaders.

Ethical considerations

The hospital review board approved the study. All participants agreed voluntarily to participate after receiving an explanation of the research aims. In the report below, the participants' names have been changed, to maintain anonymity.

Data analysis

Thematic content analysis was performed, using cross-case analysis, by identifying and coding themes across cases. To increase inter-coder reliability, we analysed the interview transcripts separately and compared our coding and interpretations. Subsequently, we examined their individual analyses comparatively, discussing differences and seeking agreement. The comparison covered the content of the themes and the interpretation of their meaning. Themes disagreed upon were excluded from the findings.

The researchers' subjective perspectives unavoidably shape the research findings (Boss et al. 1996). Two of the researchers were Registered Nurses who had been shift-leaders in the past. Throughout the data analysis process, they did their utmost to reduce a priori assumptions, professional knowledge and personal biases of which they were aware, and that could affect their interpretation of the shift-leaders' experiences. Thus, the study's credibility was maintained (Lincoln & Guba 1985).

Subsequently, following the rule of description (Spinelli 1989) and the criterion of confirmability (Lincoln & Guba 1985), the findings were organized into themes using original citations. Our interpretations were written up separately, but grounded and linked to the data. To avoid placing any
importance upon emerging themes in the analysis process, each aspect of the experience under study was treated with equal value, consistent with the rule of horizontalization (Moustakas 1994).

Findings

Analysis of the results revealed that the essence of being a shift-leader stems from two main themes: (1) ‘Like an octopus – one head, many legs’ – the burden of responsibility, depicting how shift-leaders move between maximum control and relinquishing some control by delegating authority to other nurses and (2) ‘I see the end before I start’ – the temporal character of shift-leaders’ role. Shift-leaders move between two time-frames: on the one hand, focused on the present shift, anticipating arriving at the end of the shift without incident and, on the other hand, extending managerial perspectives beyond the boundaries of the specific shift.

‘Like an octopus – one head, many legs’ – the burden of responsibility

This theme is exemplified by the following participants:

As a shift-leader, I feel like an octopus – one head, many legs.... (Anatoly)

When I am a shift-leader, and am awfully thirsty, I do not allow myself a cup of coffee or even a glass of water. Being a shift-leader is an enormous responsibility – everything has to be exactly as I want before I can calm down and relax.... (Sara)

Being a shift-leader means being everywhere in the ward at the same time, as if the nurse has multiple legs like an octopus. These legs can carry the shift-leader in different directions simultaneously. This experience conveys a strong sense of responsibility, which is the core of the shift-leaders’ role: they need to comprehend and constantly contain the entire picture of the ward’s complex situation at any given moment. This total control facilitates their ability to prioritize and to perform the task accordingly. They are on total alert and are tuned into their professional duties, sometimes even ignoring their basic personal physical needs, such as drinking.

The next two examples once again highlight the main motif in shift-leaders’ experience: responsibility and the need to be in minute-by-minute control of the entire ward. The shift-leader’s role, which deals with life and death matters, is likened here to a battle and therefore requires constant vigilance:

What is the shift-leader’s responsibility? To complete the eight-hour shift peacefully...like going to war. (Adi)

[Before the shift starts] – When I see the ‘SL’ (Shift-Leader) initials by my name [on the shift’s staff list], I automatically start the shift on high alert.... (Rivka)

To remain in maximum control, some shift-leaders implement certain strategies regarding their superiors – the head nurse and physicians, as well as other team nurses and patients – to guarantee smooth running and prevent trouble, complaints and arguments. The following female shift-leader specifies the strategies she exercises for this purpose (emphasized in italics):

First, a shift-leader has to collect as much information as possible about the shift, including patients and the entire staff. You need to write down the important things...I have to confirm that everything has been done, that no patient was forgotten or missed an examination...You need to make sure that medical treatments are given on time and that the physicians have seen all the patients. I constantly check that everything goes like clockwork. (Orna)

The responsibility for maintaining a healthy atmosphere and preventing trouble among staff, patients and families adds to the shift-leaders’ burden. They serve as a buffer for patients’ demands and anger, even if not they, but the physician or medical system in general, are the target:

The anger might come from the patients and their families. For example, there are always complaints – a patient might ring and the nurse doesn’t attend to him; a patient has been hospitalized for three days and no physician has examined him...I am the one who calms them down. (Miriam)

Another way that shift-leaders perceived the maintenance of a pleasant atmosphere is by avoiding conflict with nursing colleagues. They ask indirect questions about a patient’s situation, and avoid giving direct instructions. This style of communication represents a strategy for ensuring long-term collegial relationships:

I give the nurses continuous gentle reminders, in the form of ‘Have we done this or that?’ so as not to offend them when something was done incorrectly. (Shoshana)

Shift-leaders also perceive themselves responsible for managing the medical staff, including the physicians. Handling the physicians, who are not constantly available on the ward, adds a distinctive challenge for the shift-leader.

Physicians are like little kids. You have to treat them gently all the time, soften them up, and make them a coffee or a sandwich...I don’t
mind doing these things – as long as they do what they need to do and carry on working. (Rachel)

In some cases, the shift-leader combines clinical decision-making and care for the physicians by giving their well-being high priority to gain their cooperation (‘make them a coffee or a sandwich’). This position may empower the shift-leader, who manoeuvres the physicians according to the ward’s needs, rather than merely to satisfy them.

Shift-leaders need to consider organizational needs in addition to patients, their families and the staff. One shift-leader stresses his commitment to the organization as the first priority:

I need to bridge between patients and the hospital, mainly for complaints against caregivers or about the treatment approach or malpractice. In such a case, I avoid confronting staff members who have been criticized, as I might appear to be justifying the complaint. (Victor)

Taking into account the shift-leaders’ diverse responsibilities, the question is raised as to whom do they really represent – staff, patients or the organization? The last quote demonstrated how, in a case of patient-staff conflict, despite the empathy toward the patient’s distress, the shift-leader is supposed to soothe the patient and maintain the role of system representative.

Other shift-leaders coped with the mounting levels of responsibility by taking a more supportive approach toward colleagues. This aspect was manifest in most of their narratives as a strong commitment to other staff and patients, whose needs and priorities throughout the shift, together with work assignments, demand a holistic perspective. In the following example, the shift-leader’s commitment to care towards his staff is metaphorically likened to the need to take a deep breath (a metaphor for vitality), and to a machine that consumes energy (the battery metaphor):

In the past, I thought only patients had needs, but today I understand that the staff are also under stress. The focus is still on the patients, but as a shift-leader, you need to respond to your colleagues and receive feedback…to be empathic, you first need to take a deep breath, but sometimes you’re at the end of your tether and need to recharge the batteries. (Anatoly)

A female shift-leader depicts her experiences and assignments through using her senses, both metaphorically and practically, to give full attention to each detail and thus fulfill this responsible role:

I arrive on the ward and look around, to sense the atmosphere, to see what happens, to ask the previous shift-leader about patients with special problems; to smell…to attend to inexperienced nurses – they need an additional 20 pairs of eyes and ears…to observe what happens in their part of the ward. To see if they need help. (Ilana)

Either way, these multiple tasks, as well as the requirement to respond promptly to patients, families and staff members, might result in fatigue and a feeling of emptiness. Hence, the shift-leader’s duty is to enable the team’s mutual emotional support, mainly through sharing feelings and receiving feedback from colleagues. This also promotes the provision of a better professional service that responds to patients’ emotional needs and reduces burnout:

Once the ward is calm, time should be given to the staff’s needs…if I see that a colleague is stressed and reacts inappropriately, I can stop for a minute, try to encourage him and ask how he’s feeling, to prevent a stressful atmosphere. (Anatoly)

So far, the complexity and multidimensionality of the role has been emphasized. In the next theme, the range of responsibility is discussed with regard to the temporal character of this role.

‘I see the end before I start’ – the temporal character of the shift-leader’s role

Shift-leaders’ narratives revealed a continuum of responses with reference to the temporal character of their role. This continuum ranged from a focus on the ‘here and now’, namely, perceiving the present shift as an isolated mission with defined time limits, to a more continuous focus, perceiving the present shift as a link in the chain of shifts that have to be managed. The former pole of the continuum was best described by several shift nurses as the aspiration to arrive at a safe coast, namely to finish the shift safely: ‘To arrive at a safe coast at the end of the shift… I see the end before I start’. (Anna)

Although shift-leaders do not hold a permanent managerial position, they remain continually alert until they arrive home and finally fall asleep:

[When my shift as a shift-leader ends] I get into my car and just sit still. I make a checklist of everything that happened during my shift. Sometimes I wake up in the middle of the night thinking that something might have gone wrong…and then I think about it over and over again, and fall back to sleep. (Clara)

The shift-leaders act concurrently in two time dimensions. In the temporal here and now dimension, they are responsible for performing various minute-by-minute tasks, sometimes at the same time, while simultaneously they are focused toward the near future – the end of the shift (‘I see the end before I start’). This may signify the wish to return home safely,
remove the burden of responsibility as a shift-leader, and re-experience oneself in the next shift as a team member, not the one who is responsible.

Whereas most shift-leaders focus on their performance during the shift, some identify the role’s impact on their overall nursing performance, even when others are the shift-leaders, as if ‘once a shift-leader – always a shift-leader’. They continue to feel responsible for duties beyond their own, and assess clinical situations from a systemic perspective that is characteristic of a shift-leader’s position:

As a shift-leader, I feel more responsible. I view the ward with a more systemic perspective. Before, I used to focus more on the patients’ clinical problems and felt free of other responsibilities. Now I have to solve problems, make a broader assessment of the needs and deal with multiple tasks and unforeseen situations. (Eyal)

We conclude this findings section with the following quote, identifying that to maintain continuity the shift-leader is expected to perceive the ward’s current needs in light of the previous shift and in relation to the next one:

I think that shift-leaders need to be able to identify situations that demand immediate intervention, more than a regular nurse. They need to contain a great deal of information in their heads, to comprehend the whole picture of the current shift, what happened in the previous shift and what is expected in the next. (Ibrahim)

**Discussion**

The findings can be represented as a two-dimensional taxonomy of shift-leadership styles (see Figure 1). The first dimension refers to handling control: from maintaining maximum control at one pole, to yielding control to staff at the other. This dimension has also been identified in previous research (Endacott 1999). The second dimension is novel, and refers to a temporal perspective: from short-term, focusing on the present shift at one pole, to longer-term, taking a managerial viewpoint beyond the boundaries of the specific shift. The crossover of these two dimensions reveals four potential leadership styles, of which only three were identified in our findings.

The first leadership style, represented in the upper left quarter of Figure 1, ‘maximum control/focus on present shift’, was the most characteristic. According to the perceptions of participants who match this style, the core of the shift-leader’s position is an immense sense of responsibility, expressed by strong presence. Responsibility was maintained via various strategies enacted to stay in control, particularly constant supervision, checking up on the work performed by other nurses (Endacott 1999). However, this unique managerial role is transient, determined by shift duration and transferred from one nurse to another and therefore lacks established authority. Our findings further emphasize that this responsibility is restricted to the defined boundaries of a specific shift, focusing on managing the ‘here and now’. This might lead to confusion about its scope: on the one hand, being a shift-leader grants the nurse a temporal sense of competence while, on the other hand, this transitory responsibility results in a sense of burden and stress.

This style of management is identified in the managerial literature as initiating structure or task-oriented (Likert 1961, Kerr & Schriesheim 1974, Yammarino 1996). This literature also reports the advantage of this managerial style as emphasizing a strong focus on doing, allowing managers to achieve the mission for which they are responsible (Minzberg 1973). Nevertheless, this style also has its drawbacks. Such emphasis on doing and the need to constantly be in control might sometimes result in disempowerment of staff. Although not particularly pertaining to shift-leader’s leadership style, researchers have found that head nurses’ control behaviours are associated with nurses’ withdrawal behaviours such as termination, turnover and absence (Sheridan & Vredenburgh 1978). Moreover, managing minute-by-minute care and restricting focus solely to the present shift is related in the literature to diminished ability to learn and transfer to future shifts the vital information, knowledge and lessons learned (Minzberg 1973, Tucker et al. 2002).

The second leadership style represented in the upper-right quarter of Figure 1, ‘releasing control/focus on present shift’, was also prevalent among our shift-leaders. Those demonstrating this style usually gave reassurance or practical advice to colleagues, patients and families and were attentive to staff needs. This behaviour pattern was also identified as typifying shift-leaders’ behaviour in Endacott’s (1999) study. Different aspects of this leadership style involved keeping the peace,
What is already known about this topic

- Shift-leaders receive partial authority and managerial roles from the nurse ward manager for a given shift.
- This role is being promoted as a key mechanism for improving the care of patients in a 24 hour/7 day environment.
- Shift-leaders are seldom involved with bedside nursing, and only intervene when their expertise is required.

What this paper adds

- The rotation in the shift-leaders’ role creates challenges for its enactment.
- Shift-leaders may be more focused on managing the minute-by-minute care of patients, and thus seldom view how insights from their shift can advance forthcoming shifts.
- Shift-leaders may be oriented toward satisfying the interests of colleagues on the same shift at the expense of exhibiting leadership.

preventing conflicts among colleagues and patients (sometimes by appropriate juggling of human resources), and satisfying diverse and even conflicting needs of the different role-partners. Although conflict management has several positive impacts for the ward, shift-leaders’ solutions to problems were often short-term, with the intention of preventing quarrels in their shift, without a real attempt to deal with the root of the problem (Tucker et al. 2002).

This leadership style is identified in the managerial literature as consideration or relationship orientation (Likert 1961, Kerr & Schriesheim 1974, Yammarino 1996). Its clear advantage is the promotion of employees’ satisfaction. Indeed, researchers have found that this considerate leadership style is associated with nurses’ job satisfaction, as well as, albeit to a lesser degree, with client satisfaction (Ott & van-Dijk 2005). In another study, Sheridan and Vredenburgh (1978) similarly found that head nurses’ consideration was inversely associated with tension and termination among nurses, but also with job performance. This finding points to a possible drawback of this managerial style: the desire to satisfy everyone’s needs might harm staff’s performance.

The third leadership style is presented in the lower-left quarter of Figure 1 and relates to maximum control/broad managerial focus. Shift-leaders exercising this managerial style rely on heavy use of control (as in quarter 1), but differ in their temporal perspective, expressed through the option of taking managerial perspectives beyond the boundaries of the specific shift. These shift-leaders seek information overtly by inquiring about patients on arrival at the shift, as well as attempting to discern the staff’s current physical and emotional status, and then move on. Moreover, its contribution lies in active attempts to connect the information gathered to past experience and produce insights for future functioning of the ward. The shift-leaders’ narratives often mention concepts such as ‘systemic approach’ and ‘managerial thinking’.

Although not evident in our findings, a fourth option could emerge from the interaction between the two main themes identified. The lower right quarter represents ‘releasing control/broader managerial focus’, and refers to shared systemic thinking. None of the shift-leaders participating in our study could be characterized by this managerial style. It is possibly determined by the rotational structure of the role, whereby authority is prescribed but is limited to a specific shift. Consequently, the prevalent management style among shift-leaders might be maintenance- rather than recreation-oriented, focusing more on the ‘doing’ and the ‘here and now’ aspects of the job than on planning and proactive problem-solving. This state of affairs supports previous findings that nurses are often oriented toward ‘getting the job done’, thereby exhibiting outstanding managerial skills (Laurent 2000, Tucker et al. 2002). ‘Getting the job done’ makes for reasonably effective practice in a context where the frame is set, and maintenance is the primary aim of management (Minzberg 1994, Laurent 2000).

However, these benefits are at the expense of a more proactive orientation focused on problem-solving and initiating changes to improve quality of care beyond the shift’s boundaries. The apparent lack of change-related function in our sample should not be surprising. A tendency to resist change is a characteristic that has been described amongst postholders in hospitals. An alternative explanation for lack of evidence for the fourth leadership style in our typology is that an approach based on ‘releasing control/broader managerial focus’ is likely to require experience and self-confidence. Perhaps, given the temporary nature of the role, none of those interviewed had acquired this.

Summary of findings

To summarize, we have identified a matrix taxonomy of shift-leadership styles: maximum control/focus on the present shift; releasing some control; and focus on the present shift and maximum control/broad managerial focus, yet with no shift-leader exhibiting the fourth style hypothesized – releasing control/broader managerial focus. Notably, our participants felt the powerful responsibility of the role, often not
mentally relinquishing it for many hours after handing over actual responsibility. It is also evident that tight control is a major feature of their leadership styles.

**Study limitations**

The study was based on a small purposive sample of shift-leaders. As only few exploratory studies have been conducted in this area, we used focus group interviews, which are known to be useful for this kind of study (Morgan 1997), followed by individual interviews. Although such a procedure allows the collection of concentrated amounts of data on the topic of interest (Fontana & Frey 2000) and provides in-depth understanding of the experience of being a shift-leader, claims of representativeness and generalizability can be made only cautiously. This is an acceptable trade-off in qualitative research (Patton 1990, Creswell 1994).

**Conclusion**

The finding that shift-leaders experienced intense role responsibility long after the shift was over points to a major source of stress presented in their job. Interventions to limit the potential stress hazards should be focused simultaneously on shift-leaders themselves, and on job restructuring. Shift-leaders should be exposed to various relaxation strategies, which they could activate during their shift, to cope with mounting stress levels. In addition, learning a broader repertoire of leadership skills such as empowerment of staff-nurses could limit their tendency to use tight control of staff as means of coping with stress.

Job restructuring efforts should focus on attempts to broaden the scope of the role beyond a certain shift, for example, by establishing the shift-leader role as a clear hierarchy on the nurses’ professional ladder. Hence, the nursing directorate should establish an operative definition that will encompass the essential requirements at the candidate recruitment stages. This would possibly require a combination of education and experience, aligned with personal skills such as self-confidence and managerial thinking. In each ward, only limited numbers of nurses would be able to serve as shift-leaders, thereby elevating the status, authority and long-term scope of the role. Finally, we recommended the development of preparatory training programmes for this job. Such programmes should reflect the role’s philosophy, emphasizing leadership skills and systemic thinking.

In light of the scant research on shift-leaders’ role, our findings and recommendations should be viewed with caution. To clarify the essence of this role and develop nursing practice, more research is required to explore the generalizability ability of our findings in other settings. Further research should also link the shift-leaders’ behaviours with various organizational outcomes, such as staff efficacy and satisfaction, quality care and innovation in the unit.

**Author contributions**

HG, MG, HA and ADZ were responsible for the study conception and design. HG, MG and HA performed the data collection. HG, MG, HA and ADZ performed the data analysis. HG, MG, HA and ADZ were responsible for the drafting of the manuscript. HG, MG, HA and ADZ made critical revisions to the paper for important intellectual content. HA obtained funding. HG provided administrative, technical or material support. HG supervised the study.

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