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PETRINELLA ONETIA FIANA REYNOLDS

Resonant leadership practices of nurse managers in the hospital setting

Ribeirão Preto

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Dissertation presented to the University of São Paulo at Ribeirão Preto College of Nursing to obtain the title of Master of Science, Nursing Graduate Program in Fundamental Nursing.

Research Line: Management of health services and nursing.

Advisor: Prof. Dr. Andrea Bernardes

Ribeirão Preto

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DEDICATION

This dissertation work is dedicated to my late father whose confidence in me never wanier even unto his passing. Your last words of encouragement to me has been a constant reminider that I can achieve anything if I put my mind to it and work hard towards it. “Never limit yourself, you can do it”.

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ABSTRACT

REYNOLDS, P.O.F. **Resonant leadership practices of nurse managers in the hospital setting.** Dissertation (Master in Health Sciences) – Ribeirão Preto College of Nursing, University of São Paulo, Ribeirão Preto, 84 pp.

Introduction: Nursing managers play a pivitol role in hospital's management; and with it comes a great responsibility, from assisting with patient care and saftey to promoting quality work life of the nurses and also supporting the changes that arises with these responsibilities. In doing so, it is required of them to be a source of empowerment to the nurses so they are able to perform their duties using the best practices necessary. Additionally, nurse managers are required to ensure staff commitment by creating and maintaing a work environment that is promotes quality patient care. **Objective**: The aim of this study is to analyze resonant leadership style among the nurse managers at the Georgetown Public Hospital from the perspective of nurse managers and registered nurses. **Method:** this was a cross-sectional survey, where the data was obtained from managers and registered nurses at Georgetown public hospital. Hard copy questionnaires were distributed to randomly selected nurses and nurse managers. One hundred seventy-one (171) were completed, representing a response rate of 62%. The resonant leadership questionnaire was used for both nurses and nurse managers. The SPSS program version 23 was employed. For the quantitative variables, the following descriptive measures were calculated: mean, standard deviation, median and minimum and maximum values. To calculate the association between sociodemographic and work variables and resonant leadership, the ANOVA test was used. A significance level of 5% was employed for deciding the outcome of each statistical test conducted. **Results:** In this study, nurses perceive their managers to have moderate levels of resonant leadership practice in the setting. The maximum rating was a perfect 50. The arithmetic mean rating is 33.1 and this almost ideally coincides with the median, which is 34.0. The standard deviation is 9.5 and this, together with the mean suggest there are no extreme values. The results of this study show that resonant leadership was practiced at a moderate level in the hospital's acute care setting. This study demonstrate that resonant leadership does not depend on the

sub categories of the demographic variables except for the age when the managers evaluated themseves. Ressonant leadership is not associated with the work variables. **Conclusion:** The result findings suggest that resonant leadership is sometimes encourage to be practiced or that there is a lack of organizational support for such practice. This gives a negative implication that the nursing fraternity of the hospital are somewhat unaware of this leadership style or that the continuous education curriculum for nurses at this hospital may not have resonant leadership and emotional intelligence on their agenda.

Keywords: Resonant Leadership; Emotional Intelligence; Nursing.

RESUMO

REYNOLDS, P.O.F. **Práticas de liderança ressonante de enfermeiros gerentes em ambiente hospitalar.** Dissertação (Mestrado em Ciências da Saúde) - Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, Ribeirão Preto, 84 pp.

Introdução: Os gerentes de enfermagem têm papel fundamental na gestão hospitalar. Isso inclui facilitar o cuidado, garantir a segurança do paciente, melhorar a qualidade de vida profissional dos enfermeiros e promover processos de mudança que atendam a esses fins, o que exige que os gerentes capacitem estes profissionais para cumprir suas obrigações usando as melhores práticas. Além disso, exige que os gerentes garantam o compromisso dos enfermeiros de de fornecer um ambiente de trabalho ideal, mantendo ótimo nível de atendimento, alta qualidade e segurança do paciente. Objetivo: analisar o estilo de liderança ressonante entre os enfermeiros gerentes do Hospital Público de Georgetown, sob a perspectiva de enfermeiros gerentes e enfermeiros registrados. **Método**: trata-se de pesquisa transversal, cujos dados foram obtidos junto a gerentes e enfermeiras do hospital público de Georgetown. Questionários impressos foram distribuídos para enfermeiras e gerentes de enfermagem selecionados aleatoriamente. Cento e setenta e um (171) foram concluídos, representando uma taxa de resposta de 62%. O questionário de liderança ressonante foi usado para enfermeiras e gerentes de enfermagem. Foi utilizado o programa SPSS versão 23. Para as variáveis quantitativas, foram calculadas as seguintes medidas descritivas: média, desvio padrão, mediana e valores mínimo e máximo. Para calcular a associação entre variáveis sociodemográficas e de trabalho com a liderança ressonante, foi utilizado o teste ANOVA; o nível de significância de 5% foi empregado. **Resultados:** neste estudo, os enfermeiros percebem que seus gerentes têm níveis moderados de prática de liderança ressonante no cenário investigado. A classificação máxima foi de 50 pontos. A média aritmética foi 33,1, a mediana foi de 34,0 e o desvio padrão foi de 9,5 o que, sugere que não há valores extremos. Os resultados deste estudo mostram que a liderança ressonante foi praticada em um nível moderado no ambiente de cuidados intensivos do hospital. Este estudo demonstra que a liderança ressonante não depende das subcategorias das

variáveis demográficas, exceto para a idade, na autoavaliação dos gestores. A liderança ressonante não está associada às variáveis de trabalho. **Conclusão:** Os resultados encontrados sugerem que a liderança ressonante algumas vezes é incentivada a ser praticada ou existe uma falta de suporte organizacional para tal prática. Isso dá uma implicação negativa de que a fraternidade de enfermagem do hospital conhece pouco esse estilo de liderança ou que o currículo de educação continuada para enfermeiros desse hospital pode não ter liderança ressonante e inteligência emocional em sua agenda.

Palavras-chave: Liderança Ressonante; Inteligencia emocional; Enfermagem.

RESUMEN

REYNOLDS, P.O.F. **Prácticas de liderazgo resonante de los directores de enfermería en el entorno hospitalario. Disertación** (Master en Ciencias de la Salud) **-** Escola de Enfermagem de Ribeirão Preto, Universidade de São Paulo, Ribeirão Preto, 84 pp.

Introducción: Los gerentes de enfermería tienen un papel fundamental en la gestión hospitalaria. Esto incluye facilitar la atención, velar por la seguridad del paciente, mejorar la calidad de vida profesional del enfermero y promover procesos de cambio que cumplan con estos propósitos, lo que requiere que los gerentes capaciten a estos profesionales para que cumplan con sus obligaciones utilizando las mejores prácticas. Además, requiere que los gerentes garanticen el compromiso de las enfermeras de brindar un entorno de trabajo ideal, manteniendo una atención óptima, alta calidad y seguridad del paciente. Objetivo: analizar el estilo de liderazgo resonante entre las enfermeras gerentes en el Hospital Público de Georgetown, desde la perspectiva de las enfermeras gerentes y enfermeras tituladas. **Método:** se trata de un estudio transversal, cuyos datos se obtuvieron de gerentes y enfermeras del hospital público de Georgetown. Se distribuyeron cuestionarios impresos a enfermeras y directores de enfermería seleccionados al azar. Se completaron ciento setenta y uno (171), lo que representa una tasa de respuesta del 62%. El cuestionario de liderazgo resonante se utilizó para enfermeras y gerentes de enfermería. Se utilizó el programa SPSS versión 23. Para las variables cuantitativas se calcularon las siguientes medidas descriptivas: media, desviación estándar, mediana y valores mínimo y máximo. Para calcular la asociación entre variables sociodemográficas y laborales con liderazgo resonante se utilizó la prueba ANOVA; se utilizó el nivel de significancia del 5%. **Resultados:** en este estudio, las enfermeras perciben que sus gerentes tienen niveles moderados de práctica de liderazgo resonante en el escenario investigado. La clasificación máxima fue de 50 puntos. La media aritmética fue 33,1, la mediana fue 34,0 y la desviación estándar fue 9,5, lo que sugiere que no existen valores extremos. Los resultados de este estudio muestran que el liderazgo resonante se practicó a un nivel moderado en el entorno de cuidados intensivos del hospital. Este estudio demuestra que el liderazgo

resonante no depende de las subcategorías de variables demográficas, excepto la edad, en la autoevaluación de los directivos. El liderazgo resonante no está asociado con variables laborales. **Conclusión:** Los resultados encontrados sugieren que a veces se alienta a practicar un liderazgo resonante o existe una falta de apoyo organizacional para dicha práctica. Esto da una implicación negativa de que la fraternidad de enfermería del hospital sabe poco sobre este estilo de liderazgo o que el plan de estudios de educación continua para enfermeras en ese hospital puede no tener un liderazgo resonante e inteligencia emocional en su agenda.

Palavras-clave: Liderazgo resonante; Inteligencia emocional; Enfermería.

LIST OF TABLES

LIST OF ABBREVEATIONS

EERP-USP	University of São Paulo at Ribeirão Preto College of Nursing
EI	Emotional Intelligence
RL	Resonant Leadership
TLR	Total Leadership Rating
USP	Universidade de São Paulo

SUMMARY

INTRODUCTION

1 Introduction

Nurses and midwives constitute at least fifty percent of the healthcare workforce (GAPFON, 2017). Nurses, therefore, are the pillars of healthcare delivery and the hospitals most respected resource. Their efficacy and competence are key to ensuring patient satisfaction. (EVENHART, 2013).

The responsibility and knowledge are vested in the nursing profession to provide quality holistic care at every level of care (OIYIRA, 2106). Nurses' main source of contact is with the client which care is provided to. Cares that include, offering of direction regarding to patient ethical standing and standards and giving information about procedures that maybe performed by themselves, team members and or other health personnel. In doing this, nurses are truthful, precise and detailed and this gives an assurance of quality (IOM, 2004).

Health-related outcomes maybe determined by the leadership style that the nurse may adopt. That leadership style may either give a positive or a negative impact on health care. ALLIO, 2005, noted several core qualities or characteristics that cannot be thought, these include compassion, and creativity also charisma are needed to have effective leadership. The character that an individual displays is the foundation of one's ethical standing or behavior. It includes a deep sense of integrity, courage, trustworthiness and the determination to do well (ALLIO, 2005).

Nurse leaders at all levels of the healthcare system have a great responsibility towards the organization's achievement, patient outcome, and the quality of care given. However, these obligations can be made a reality through a variety of skills and competence that entails fiscal management, strategic planning, negotiations, and quality process analysis (CUMMINGS, 2002).

In the nursing profession there are challenges and despite these challenges nurses continue rise above them; they exhibit the ability to cope and change these challenges into possibilites for improvement, the exact meaning of resilience.This definition applies to nurse leaders who take up the mantle not to avoid or prevent stressful situations but strengthen their capacity to deal with them instead (AL-MOTLAQ, 2018).

Often the role or position of leadership is misinterpreted in healthcare. It is commonly associated with persons who are in a formal position, for example ward managers and nursing directors. However, this role of leadership may not necessarily be official; that is, those appointed for a managerial role with formal responsibilities concerning people and resources. Due to the role that nurses' play daily, regarding their ability to effect change, influence patient safety, and give holistic patient care, they may not realize that they are operating in a leadership role, but it is informal (MARQUIS and HUSTON 2012, DALY et al, 2014). Additionally, CURTIS, 2011 noted that in the scope of nursing professional roles and practices leadership is institute but not limited to. All nurses operate in that aspect of leadership whether it be formal or informal.

The nursing profession is distinguished by its exclusivity on humanism. It is people-centered, and nursing leadership styles in this profession is greatly influenced in this area (SELLGREN et al., 2006). These leadership styles can be characterized either as task- focused leadership or as relational leadership.

Relational Leadership styles includes leadership styles such as transformational leadership, resonant leadership, emotional intelligence and participatory leadership (COPE et al, 2017). These leadership styles are commonly distinguished by their focus on relationships and people. The advantages of this type of leadership style are that it has a high association of baring positive results in relation to staff and job satisfaction, organizational commitment, stress reduction and improved health and well-being of an individual but more so positive patient outcome. The practice of this leadership style does not only benefit the person(s) practicing it but affects other people and their surroundings (CUMMINGS, 2012).

The practice of task-oriented leadership solely, however, may unfortunately bare the opposite results than that of relational leadership. CUMMINGS, et al., 2010, suggested that organizations development and constant practice of relational leadership will build healthy relationships in the workplace and improve nurse retention and foster a spirit of confidence- building among the staff (LASCHINGER et al 1999).

Resonant leadership is where the individual (nurse leader) can relate when there is a presence of uncertainty and additionally motive others in the work place. These leaders just not motivates but they exudes a creative passion for their work that

triggers subordinates to be inspired, they work along with the subordinates towards a common goal. They have great communication skills. Resonant leaders' uses emotional intelligence in their leadership style and with this; it plays a major role in building and sustaining relationships (BOYATZIS AND MCKEE, 2005).

An emotional intelligent leader is one who occupies the position of a manager or leader that provides timely feedback to their followers and is cognizant of the significance that feedback will cost. Moreover, it stimulates contentment, success and efficacy. Additionally, proliferate performance among the subordinates who are emotionally in tuned (GOLEMAN et al, 2013).Leaders normally have a high-energy drive, which can be exhibit as either hostile or friendly.

Emotional intelligence is founded on four distinct components: awareness of own emotions and others around them and how those emotions are managed and used to facilitate performance (PASTOR, 2014). Emotional intelligence leaders like resonant leaders work in unison with their followers; they are in sync with their followers emotions and this results to positive encouragement to the followers (SQUIRES et al., 2010; BAWAFAA et al., 2015).

Nursing leaders carry a considerable amount of duty to uphold the standard of the organization by ensuring an optimal practice environment that result in quality patient care. Therefore, leaders in the hospital should be proactive in establishing resonant leader within and throughout their organization (CUMMINGS, 2004).

1.1 Justification

Leadership in healthcare has changed significantly over there years, this is attributed to the global trends such has new technology implementation and an aging populace (GOH, 2018).These changes are occurring quickly and therefore, nurse leaders need to be readily equipped to manage these changes. The leadership style that is practiced by nurses will have a significant impact on the care given to patients in their keeping (HOUSER, 2003, PAGE,2004, WONG, 2007,HAVING 2011). It will either benefit the both the patients, staff and institution or none at all.

The information on nursing leadership style practiced by the staff is paramount; it will act as a conductor for actions to areas affected. It is also justified since there are studies that are backing the view that nursing relational leadership styles such as resonant leadership (SQUIRES, 2010, WONG et al 2013) can positively affect quality of care in health institutions.

In this sense, the following research questions arise:

What is the level of practice of resonant leadership from the perspective of nurse managers and nurses at the Georgetown Public Hospital? What is the relationship between the level of resonant leadership and demographic variables (age, gender, ethnicity, marital status, education) of nurse managers and nurses at the Georgetown Public Hospital? What is the relationship between the level of resonant leadership and work variables (work duration, specialty, work status) of nurse managers and nurses at the Georgetown Public Hospital?

1.2 Problem Statement

According to the Institute of Medicine's (IOM) Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes: "nursing is a critical factor in determining the quality of care in hospitals and the nature of patient outcomes" (IOM, 1996, p.92).

The role that nurse managers and leaders have is critical towards hospital management. This role entails assisting patient care and ensuring patient safety, quality of work-life enhancement for nurses, and supporting change processes that serve these ends (EVERSON-BATES, 1992; MCNEES-SMITH, 1997). This requires the managers and leaders to be able to encourage their nurses to perform their obligations using best practices. It, also, requires managers to ensure the nurses are committed to an optimal work environment whilst maintaining a high level of quality care and patient safety.

However, there has been reports that the relationship between nurse managers and nurses have grown more tense, leading to less openings for nurses to communicate their concerns about patient care and their roles with their managers (BLYTHE, et al 2001). Studies showed that nurses perceive that they are underrepresented in the healthcare organization (BLYTHE, et al 2001); thus, restricting them to have a meaningful role in decision making and promotion of change to improve processes that are relevant to the role of nurses, the quality of work-life and patient care.

These situations does not only affect the nurses emotional and physical wellbeing but also their competence, productivity, job performance, and obligation towards their organization. Failure to offer nurses with a significant voice in the healthcare system management will eventually lead to adverse effects in the workplace environment and organizational culture and functioning, and this ultimately results in lower-quality patient care (ASIRI, 2016).

OBJECTIVES

2 Objectives

- To analyze resonant leadership style among the nurse managers from the perspective of nurse managers and nurses.
- To identify the association between the level of resonant leadership and demographic variables of nurse managers and nurses.
- To identify the association between the level of resonant leadership and work variables of nurse managers and nurses.

LITERATURE REVIEW

3 Literature Review

There are many definitions of leadership in respect to several different theories presented across many disciplines (HOWIESON &THIAGARAJAH, 2011). Armstrong (2009, p.4) defines leadership as: ‘the process of getting people to do their best to achieve the desired result. It involves developing and communicating a vision for the future, motivating people, and gaining their engagement. Adding to that definition, Northouse (2013, p.5) defined this competence as "a process whereby an individual influences a group of individuals to achieve a common goal". Whilst Kouzes and Posner (1995), defined leadership as “the art of mobilizing others to want to struggle for shared aspirations” (p. 30).

This process is achieved when the leader humbly conveys a clear vision of the impending future that aligns with the follower(s) morals and principles, which the follower(s) can easily understand and interpret, then putting that vision into present-time action steps (WINSTON et al., 2006). Despite the current standing or status of the organization, the vision can be materialized. From a collaborative effort between leaders and follower, through meaningful and positive communication that draws and facilitates ideas and opinions from the follower (PASTOR, 2014). When the vision is clear, it allows the followers to operate without constraints and work through any ambiguity towards a goal of shared insight that results in persuading the follower to have a change in perspective about the state of the organization and see its desirable condition that is worth committing resources towards its achievement (WINSTON et al., 2006).

Leadership is focused mainly with the interaction of leaders with other individuals. This interaction has several factors involved, social interactions, emotional awareness and emotional regulation and these factors have an effect on the quality of the interaction.

In organizations, it is imperative for the leaders be able to solve complex social issues that may arise; their effectiveness is crucially dependent on this attribute. Having a good understanding of one own emotions and control of same is of valued importance when leaders interact with their followers. (PASTOR, 2014). Social

intelligence can affect the success in the work of managers and leaders in a more important way than traditional mental intelligence.

Nursing leadership has a vast difference from general leadership due to its influence on clinical practices; for the simple fact, that nurse leaders have actions towards their responsibility that will determine the outcome of the healthcare practice environment (CURTIS, 2011).

They are deemed as experts in their field of practice, and like any other leader they are qualities that are expected of them to posed approachable, effective communicators, and being able to empower others. These experts motivates others by identifying with the morals and beliefs of their followers about nursing and care of their practice (HUGHES, 2017). Additionally, nurses have great appreciation for leaders in the clinical setting who have strong moral capacity and embraces the same.

The demonstration of confidence is a key leadership skill that an effective leader should posed. Knowing and performing task that needs to be completed, with a proactive attitude towards that goal and approaching patients with confidence and competence that will determine better patient outcomes. Effective leadership may not necessarily be a natural talent, but with appropriate training in particular knowledge and skills, effective leadership can be developed (GILTINANE, 2013; FISCHER, 2016).

Effective leadership is an essential requirement to sustaining quality care in the hospital. Leaders, through their words and action, can alter and transform culture by influencing the way others see reality (CARILLO, 2010).

Nursing leaders within the hospital settings have the responsibility to enhance the nursing work environment by practicing appropriate leadership styles and use empowering strategies, which will allow the nursing staff to be a part of the decision-making process (ASIRI, 2016).

Additionally, emotional capacity of an individual is an additional element for good leaders. Emotional capacity is conveyed as being kind, understanding, sincere, and friendly. Further, a good leader is require to have emotional intelligence - the ability to scrutinize one's own and others' emotions to direct thinking and actions. Thus, a person's emotional intelligence mirrors his or her ability to distinguish, use, and express thoughts and emotions in response to another person (GOLEMAN 2002).

There are many leadership theories and styles. One of them is resonant leadership (RL) which is an ideal building block that can be used by nurses to promote quality care in the work environment. Resonant leaders, are great leaders who are emotionally in tune with others, working harmoniously (think and feel), and head towards their targets in the same way with them. In addition, they preserve their values and live passionately (CUMMINGS, 2004; LUTZO, 2005; BOYATZIS & MCKEE, 2005). Resonant leadership is distinguished from other theories of leadership by its foundation on emotional intelligence. Goleman first defined emotional intelligence as "the capacity for recognizing our feelings and those of others, for monitoring ourselves, and for managing emotions in ourselves and our relationships (GOLEMAN, 1998, p.317). It is “the ability to perceive and express emotion, assimilate emotion in thought, understand and reason with emotion, and regulate emotion in the self and others” (MAYER, SALOVEY & CARUSO, 2000, p. 396). Additionally, Goleman concluded with a straighter forward definition of emotional intelligence: “the ability to recognize and regulate emotions in self and others” (GOLEMAN, 2001, p.14).

Buried in the depths of relational leadership styles is resonant leadership (RL) whose strength is built mainly from emotional intelligence (EI). Research has shown that emotional intelligent leaders remain resourceful in the times of challenges through their usage of emotive components such as hope, mindfulness and compassion, which are all traits of resonant leadership (RL) BOYATZIS & MCKEE, 2005). However, it is through resonance that leaders are able to connect with others genuinely. Resonance allows leaders to use positive emotions to draw and influence followers to express their best in every situation and motivates followers to always strive for better (GOLEMAN et al., 2002). Resonance can be maintained by the use of three concepts mindfulness compassion and hope (BOYATZIS & MCKEE, 2005).

Resonant leadership reflects the art of hearing their workers’ undesirable feelings yet responding empathically. In periods of change and even disarray, they remain empathic and supportive, and exhibit a wide range of EI skills (GOLEMAN, et al., 2002). Resonant leaders are empathetic, passionate, committed, and could read people and groups accurately. They give hope and courage in moving toward a new and exciting future, enabling those around them to be the best they can be (BOYATZIS, 2008).

Goleman (2002) posited that empathy - the ability to comprehend another's emotions - has been reported the key for resonant leadership. Resonant leaders are great achievers and colleagues; they are leaders who willingly give their time, expertise and knowledge, to others thus empowering those around them. Emotional intelligence competencies can be learned and used depending on the situation at hand (GOLEMAN, 2002).

Resonant leadership is inclusive of four leadership styles: visionary, coaching, affiliative, and democratic approaches, whereas dissonant styles include pace-setting and commanding (GOLEMAN, 2002).

GILMARTIN & D'AUNNO (2007) noted that nurses preferred managers who were more hands on and emotionally intelligent inclined and, as such, were linked to teamwork, stress reduction and empowerment. WALLIS, et al (2013), posited that teamwork requires the members in supervisory position to be emotionally intelligent. Research found that effective nurse leaders were characterized as very cooperative and more connected with their followers. They use their personal values to encourage performance. These nurse leaders ensure that there is appropriate resources (inclusive of human resource) are available to achieve optimal care quality and patient outcomes (GILMARTIN & D'AUNNO, 2007).

Emotional intelligent leaders are focused and they have a full range of command under their care. They are very much in touch with their feelings that they are able to control their impulses and how those impulses are viewed by others around them .They are very perceptive and they do not allow distractions to deter their work (GOLEMAN, et al., 2002).

Daniel Goleman developed components of emotional intelligence which includes self -awareness, self-regulation, motivation (defined as "a passion for work that goes beyond money and status", empathy for others and social skills, such as proficiency in managing relationships and building networks are crucially central to leadership (GOLEMAN, et al., 2002). It was posited that the effectiveness and efficacy of resonant leaders is exhibited by those with high emotional intelligence (EI), who portrayed resonant leadership.

Having high emotional intelligence produces stronger and more solid interpersonal relationships along with self-motivation and that of others. Leaders with

high emotional intelligence are high performers; they are proactive, innovative and creative. They work better under pressure and have better adaptation to the changes, and, not least, self-reconciliation. The higher level a person has in an organization, the more essential it is to have emotional intelligence and, in contrast, the less important become technical skills (PASTOR, 2014).

Emotions are contagious and just like resonant leadership, dissonant leaders use emotional quotient to operate (POONGOTHAI, 2020). The emotions of a leader act as a powerful driver towards persons' moods around and ultimately their performances.

Dissonant leaders are found to be task-oriented leaders who lack emotional intelligence and tend to be negative (GOLEMAN, 1998). They operate from an autocratic standpoint where they lack empathy, are socially distant, and maintain an emotional distance from their staff. An autocratic leadership style prevents nurses' empowerment because there is no participation in inclusive decision-making. (KUOKKANEN& LEINO-KILPI, 2001).

Their focus mainly on the completion of tasks and growth of the organization (Xirasagar, 2008) rather than developing a relationship(s) (Hibberd & Smith, 2006) within the workplace. Cummings et al. (2005) found that nurses who worked with dissonant leaders reported great difficulty completing the task and attend to important patient needs in comparison to working with a resonant leader. Dissonant leaders range from the "abusive tyrant who shouts and humiliates their subordinates - to a manipulative sociopath" (GOLEMAN et al., 2002). However, some dissonant leaders can be very subtle, using a charmed and sociably exterior to mislead and manipulate.

Dissonant leaders commonly practice the Pace-setting leadership style, which focuses on performance, meeting goals, and deadlines as the top priority, they may leave employees feeling pushed too hard by their demands.

Secondly, commanding leadership that uses an autocratic approach to work, expect immediate compliance with orders, without an explanation. They are controlling, give less or no praise to employees, but criticizes easily (GOLEMAN, 2002).

Effective leaders utilize the four resonance building styles- Visionary, Coaching, affiliative and Democratic. However, they also use the pace-setting and commanding

at times but with an amount of self-discipline which ensures control over the impulse to be impatient, get angry or attack (GOLEMAN, 2000).

Beyond resonant leadership, there are many different leadership styles. Each leader has his or her unique style of leadership. Their effectiveness and outcome will vary based on the leadership style chosen, context and personal concern.

The goal of transformational theories is that leaders transform their followers through their motivating nature and captivating personalities. The principles are flexible, guided by set standards. These attributes provide a sense of belonging for the followers as they can easily identify with the leader and its purpose (BURNS, 1978).

A transformational leader creates a positive and mature work environment, by inspiring others, possessing an optimistic attitude, being genuine and encouraging. Research has shown that there are positive association with a transformational work environment. It improves job satisfaction, encourages organizational commitment, nurse retention and also heightened perception of nurse self-efficacy, and engaged and empowered employees (FAILLA AND STICHLER, 2008; NEILSON et al., 2009; WEBERG, 2010). Transformational leadership is well suited for today's workforce, which has a competitive and fast-changing environment. These leaders act more as teachers and coaches; they are effective motivators (EADLY, 2003).

On the other hand, Bass & Avolio (1994), posited that transactional leaders focuses on exchange. In this type of leadership style reward is given to the followers based on their performances. Transactional leadership ensures that employees complete task according to expectations while transformational leadership guides employees to exceed expectations (MASI & COOKE, 2000).

According to authentic leadership theory, authentic leaders are perceptive and self-aware. They are principled and have high moral standards; they engage in well decision-making and offer themselves wholeheartedly to others (AVOLIO & GARDNER, 2005). Authentic leadership demonstrations four core behaviors: balanced processing, relational transparency, an internalized moral perspective, and self-awareness.

Balanced processing involves making important decision based on inputs from both the nurses and leader. Authentic leaders, through their openness and acceptance of others they encourage others to feel comfortable to disclose their needs, goals and

areas they need to develop. They have a strong sense of ethics and personal integrity that act as a moral compass (AVOLIO & GARDNER, 2005). Nurses therefore can be inspire by their leaders as role model for acting with personal integrity and promoting ethical treatment of other people.

Authentic leaders with high levels of self-awareness gives them an insight of their strengths and weaknesses which allows them to develop more honest relationships with the nurses on their unit and encourages others to be open and accepting of one another (AVOLIO & GARDNER, 2005; GARDNER et al, 2005 apud LASCHINGER et al., 2015).

CONCEPTUAL BACKGROUND

4 Conceptual Background

The emotional intelligence theory is a valuable framework that is dynamic and evolving, and has the ability to translate the practice of resonant leadership within nursing practice.

Over the years, it has been used as a guide for research in different fields, such as education, psychology, neuroscience, business management and more so clinical health practices. However, more specifically it has been the topic of research in areas, such as leadership, job performance, retention and satisfaction, gender differences, and nursing (CHERNISS, 2010). Moss (2006) posited that emotional intelligence is related to the enhancement of any role in nursing, more specifically nursing leadership. Besides, Cummings, Hayduk, and Estabrooks (2005) described that the role of emotional intelligence leadership is able to diminish the negative impact of organizational restructuring on nurses.

Emotional intelligence is concern with “the ability to carry out accurate reasoning about emotions and the ability to use emotions and emotional knowledge to enhance thought” (MAYER et al., 2008, p 511). It is a combination of interaction of intelligence and emotions (MAYER, SALVOVEY & CARUSO, 2004). Therefore, it refers to one managing one’s own emotions and have a full understanding of same (CHERRY, 2018).

The concept of emotional intelligence has a long and involved history that dates back from the 1900s where Thorndike first conceptualized social intelligence and where Salovey and Mayer first conceptualize emotional intelligence (SALOVEY, et al.1990). Additionally to Salovey and Mayer work in EI, there were other authors, such as Bar-On and Goleman, who built on this work and created other definitions of EI. These definitions all have similarities: individuals can be aware of the emotions of themselves and others and how those emotions are handled with others around them.

While there are similarities between the definitions, there are also some differences. Salovey and Mayer believed that EI is a cognitive ability that can be learned whilst Bar-On believes that it was a personality trait possessed by individuals. However, it was Goleman who combined both concepts on emotional intelligence and

conceptualize that EI is both a learned ability and personal trait. Goleman's work expanded more, reporting on its competency-based framework that consists of four main domains and nineteen related behavioral learned competencies (BOYATZIS & MCKEE, 2005; GOLEMAN, 1998A; GOLEMAN et al., 2002). Personal competencies comprise self-awareness and self-management (how aware we are of our emotions and how we manage them in various situations). Social competencies comprise of social awareness and relationship management (how aware are we of the political social and decision network within organizations and how we manage relationship conflict, teamwork, and emotions in the workplace) (GOLEMAN, 2002). More recently, it has gain recognition in the nursing field.

Emotional intelligence determine how we act, including problem-solving, decision-making, self- management and leadership (FALTAS, 2017)

It may be the main tool that nurses use to carry out daily activities and complete various roles. There is no emotional intelligence without empathy. In healthcare, its empathy that will determine the level of trust among the nurse and peers and with the patients. Additionally, if it is utilized correctly it may build relationships and effective communication.

Research suggests that the emotional intelligence of leaders is two times more important than intelligence or expertise in predicting leadership success (SINGH, 2013). Goleman's competencies of EI allow leaders to view themselves in an holistic manner, from introspection (understanding and controlling of emotions), behavioral changes (being able to adapt in situations and have a positive outlook on things), influence (being able coach and mentor others), empathetic (ability to build relationships through trust and manage conflicts) and becoming an inspiration to others within the organization (FALTAS, 2017).

Emotional intelligence is observed when a person demonstrates the competencies that constitute self-awareness, self-regulation/management, relationship management, and social awareness at appropriate times and ways in enough frequency to be effective in any situation (BOYATZIS, et al., 2000).

Therefore, it can be concluded that emotional intelligence competencies allows resonant leaders to respond positively in stressful situations. Resonant leaders using

emotional intelligence skills and competencies enables them to have stronger ties with their followers (KOMAN & WOLFF, 2008).

Emotional intelligence is a key component of resonant leadership (GOLEMAN, 1995) and it plays an important role in nursing practice. When it comes to patient care, emotions, moods and sensitivity has a fundamental part to play in relation to how we act and think as individuals. Emotional intelligence is more than self- awareness or managing emotions, it give nurses the confidence to perform, to think beyond and to be more involved. It equips nurses to be more supportive of their patients and colleagues (RAGHUBIR, 2017).

METHODOLOGY

5 Methodology

5.1 Research Design

A quantitative cross-sectional approach was used in this study. This research is non-experimental because no intervention was introduced to the participants and no variables were manipulated (SOUSA, 2007).

The survey method was utilized “because it is the best method for the gathering and description of original data concerning phenomena in a population too large to be directly” (BABBIE & MOUTON, 2001:232). This research serves the purpose of obtaining the opinions of nursing personnel involved in the practice of resonant leadership among themselves and managers.

5.2 Place of Study

The target population for this study comprises registered nurses and managers employed at the Georgetown Public Hospital Corporation (GPHC). The Georgetown Public Hospital Corporation (GPHC) is a board controlled and managed tertiary health facility. The GPHC is in Georgetown, the capital city of Guyana. It is the only public referral and teaching hospital in the country’s public health structure. It has a bed capacity of 600 beds. According to the Guyana Census Report 2016, Guyana has a population of 0.7 million people. The GPHC has six (6) in-patient departments consisting of twenty-four (24) units/wards with a total of six hundred and fifty (650) nurses. Therefore, serves as a stable source of data on registered nurses and nurse managers, which includes registered midwives, ward managers, junior and senior departmental supervisors.

5.3 Population and Sample Size

The proposed sample size was two hundred and seventy-five (275) respondents that was inclusive of nurse managers (registered midwives, ward managers, junior and senior departmental supervisors) and registered nurses. Of the questionnaires that were randomly distributed, 171 were completed and returned for data analysis (121 registered nurses and 50 managers), representing 62% response rate. It is important to highlight that midwives act in managerial roles in the absence of managers.

5.4 Sampling Technique

According to Gentles, Charles, Ploeg, and McKibbon (2015), sampling is defined as the act, process, or technique of selecting a representative portion of a population to determine the characteristics of the whole population. Random sampling is the preferred method for choosing a sample from a given population for survey research (CRESWELL, 2014). The drawing of a random sample depends on whether the researcher is able to identify and reach the researched population. Simple random sampling was used to select the sample for this study. Simple random sampling provides less sampling bias compared to other sampling methods.

5.5 Inclusion and exclusion Criteria

The inclusion criteria for this study are:

- Registered nurses with the General Nursing Council, Guyana;
- More than three years of work experience;

The exclusion criteria for this study include:

- Those who are on vacation or leave of absence of any kind.

5.6 Instruments

The Resonant Leadership 10-item scale was used to collect data. It was a self-administered questionnaire that comprises of a self and supervisor version. This scale was used to evalute resonant leadership practice of both register nurses and nurse managers. The scale focuses on two areas “Self” and “leader/supervisor”, however in this 10-item scale the questions are the same for both the “self” and “Leader”. The register nurses and managers both evaluate themselves and leaders (supervisors). The resonant leadership scale (CUMMINGS, 2006), is a sub-scale of the Alberta Context Tool (Estabrooks et al., 2009,2011), that uses a 5-point Likert-type scale (1= strongly disagree, 5= strongly agree). The participants indicated the extent to which they feel theie immediate supervisor displays this type of leadership behavior and themselves (Appendix A). The score varies from 10 to 50 and the higher the score, the more resonant that leader is.

A sociodemographic questionnaire was added to the Resonant Leadership Scale with the following variables: types of respondentes; gender; age; ethnicity; marital status; education; work duration; specialty; and work status.

5.7 Data collection Procedures

The researcher visited the various in-patient units of the Georgetown Public Hospital to collect the data. Formal ethical approval was sought and granted before the data collection was done. The questionaire was distributed individually to the nurses and mangers on the various units and they were given time to complete the survey and same was uplifted once completed at a later time.

5.8 Data Analysis

Data was analyzed using the IBM-SPSS, version 23 for Windows (SPSS, Inc. ChicagoIl, USA). For sociodemographic characterization, descriptive analyzes of simple frequency were performed for nominal or categorical variables. For the quantitative variables, the following descriptive measures were calculated: mean, standard deviation, median, and minimum and maximum values.

The researcher used inferential statistics to explain possible relationships among the variables in this study. Independent variables are all categorical, and so the researcher used the analysis of variance (ANOVA) to assess whether the mean total leadership rating is dependent on particular groups within each of the demographic and work variables. A significance level of 5% $(\alpha = 0.05)$ was employed for deciding the outcome of each statistical test conducted.

5.9 Ethical Consideration

The researcher sought permission from the administration of the Georgetown Public Hospital Corporation to carry out the research and IRB. Study was approved by Research Ethics Committee under the protocol n. 593/2019 (Appendix B). Subsequent contact between participants and the researcher will be direct. Creswell (2003), states that the researcher must respect the rights, needs, values, and desires of the informants. Miles and Huberman (1994) list several issues that researchers should consider when analyzing data. They caution researchers to be aware of these and other issues before, during, and after the research had been conducted. These include the following:

- Informed consent (Do participants have full knowledge of what is involved?)
- Harm and risk (Can the study hurt participants?)
- Honesty and trust (Is the researcher being truthful in presenting data?)

- Privacy, confidentiality, and anonymity (Will the study intrudes too much into group behaviors?)

- Intervention and advocacy (What should researchers do if participants display harmful or illegal behavior?).

Therefore, appropriate steps should be taken to adhere to strict ethical guidelines to uphold participants' privacy, confidentiality, dignity, rights, and anonymity.

I) **Informed consent**

The Researcher informed the participants – the nurses - of the purpose, nature, data collection methods, and extent of the research before commencement. Further, the Researcher explained to them their typical roles; In line with this, the Researcher obtained their informed consent in writing in the format given in Appendix C**.**

II) **Harm and risk**

In this research study, the Researcher guaranteed that no participants will be placed in a situation where they might be harmed as a result of their participation, physical or psychological.

III) **Honesty and trust**

Adhering strictly to all the ethical guidelines serves as standards about the honesty and trustworthiness of the data collected and the accompanying data analysis.

IV) **Privacy, Confidentiality, and Anonymity**

The Researcher ensured that the confidentiality and anonymity of the participants were maintained through the removal of any identifying characteristics before the widespread dissemination of information. The Researcher ensured that the participants' names were not used for any other purposes, nor any information shared that reveals their identity in any way.

RESULTS

6 Results

The analysis starts with descriptive statistics for each of the variables used in the survey. These include frequencies, measures of location, measures of spread, and representative charts.

The researcher obtained a sample of the three statuses of nursing staff: registered nurses, midwives, and managers. Table 1 below shows the distribution of the nurses by work status. The vast majority of the respondents surveyed were the registered nurse (70.8%) of the sample, followed by the registered midwives (15.8%) and managers (13.5%). As midwives act as managers in their absence, these two statuses will be grouped together.

Table 1 - Sociodemographic and work characterization of the nursing team according to the types of respondent, gender, age, ethnicity, marital status, education, work duration, specialty and work status. Guyana, 2021.

Variables	Categories	n	%
Types of respondent	Registered Nurse	121	70.8
	Registered Midwives	27	15.8
	Managers	23	13.5
Gender	Female	157	91.8
	Male	14	8.2
Age	At most 30	77	45.0
	31-49	83	48.5
	50-69	11	6.4
Ethnicity	African	114	66.7
	East Indian	16	9.4
	Amerindian	7	4.1
	Other	34	19.9
Marital Status	Single	97	56.7
	Married	66	38.6
	Divorced	8	4.7

Education	Diploma	91	53.2
	BScN	72	42.1
	Other	8	4.7
Work Duration	3-7 years	79	46.2
	8-12 years	53	31.0
	13-17 years	22	12.9
	18 years and above	17	9.9
Specialty	Med- Surgery	66	38.6
	Critical Care	54	31.6
	Pediatric Care	20	11.7
	Maternal-Child	28	16.4
	Mental Health	3	1.8
Work Status	Register Nurse	121	70.8
	Register Midwife	27	15.8
	Ward Manager	15	8.8
	Junior Departmental Supervisor	7	4.1
	Senior Departmental Supervisor	1	0.6
Total		**171**	**100.0%**

Source: author, 2021

Table 1 detailed the frequency distribution of nursing staff of GPHC where females represented 91.8% of the respondents (157) while males were the remaining 8.2% (14).

The nursing staff was divided according to age ranges where the most popular range was 31-49, which represented 48.5% (83) of the sample. This was closely followed by the age category 'At most 30', which had 45.0% (77) of the respondents. Only 6.4% (11) of the sample was 50 years or older.

The three main ethnicities are Amerindians, Africans, and East Indians. These were classified separately and considering that all other ethnicities are relatively few in numbers, they were classified as one group: 'Other'. Of these, the Africans accounted

for the majority 66.7% (114). Those in the 'Other' category accounted for 19.9% (34), East Indians with 9.4% (16), and trailing behind with 4.1% (7) nursing staffs are Amerindians.

Three categories for marital status were used, showing that 56.7% (97) are single; this was followed by 38.6% (66) who are married and 4.7% (8) who are divorced.

The education was subdivided by the highest qualification obtained. Only 4.7% (8) of the nurses had their highest level of education as sub-diploma. Those with Diploma accounted for 42.1% (72) and those with BScN topped the table with 53.2% (91). There was no respondent with the qualification at or above the Masters level.

The distribution of nursing staff by years of service shows that most of them work for 3 – 7 years (46.2% - n=79). The numbers decreased as the years of service increased with category 8 – 12 years having 31.0% (53), category 13 – 17 years having 12.9% (22), and the final category of 18 or more years of service accounted for the remaining 9.9% (17) of the nursing staff.

Med-surgery and critical care were the most popular specialty with 38.6% (66) and 31.6% (54) of the respondents respectively. Maternal-child and Pediatric care were next with 16.4% (28) and 11.7% (20) of the nursing staff respectively. Only 1.8% (3) nursing staff were attached to Mental Health.

According to the work status, the majority 70.8% (121) of are registered nurse. The frequencies then diminished with increasing status: registered midwives 15.8% (27), ward manager 8.8% (15), junior department supervisor 4.1%, and one senior department supervisor.

Table 2 - Descriptive analysis of the resonant leadership scale domains as rated by managers about themselves (SELF) Guyana, 2021

Variables	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Look for feedback even when it is difficult to hear	5 (2.9)	-	43 (25.1)	86 (50.3)	37 (21.6)
Act on values even if it is at a personal cost	3 (1.8)	7 (4.1)	40 (23.4)	83 (48.5)	38 (22.2)
Focus on successes rather than failures	-	6 (3.5)	35 (20.5)	76 (44.4)	54 (31.6)
Support teamwork to achieve goals/outcomes	-	2 (1.2)	14 (8.2)	67 (39.2)	88 (51.5)
Calmly handle stressful situations	1 (0.6)	5 (2.9)	58 (33.9)	69 (40.4)	38 (22.2)
Actively listen, acknowledge, and then respond to requests and concerns	1 (0.6)	1 (0.6)	39 (22.8)	79 (46.2)	51 (29.8)
Actively mentor or coach performance of others	1 (0.6)	7 (4.1)	36 (21.1)	84 (49.1)	43 (25.1)
Effectively resolve conflicts that arise	1 (0.6)	4 (2.3)	65 (38.0)	70 (40.9)	31 (18.1)
Engage others in working toward a shared vision	1 (0.6)	3 (1.8)	32 (18.7)	82 (48.0)	53 (31.0)
Allow others freedom to make important decisions in their work	-	11 (6.4)	39 (22.8)	71 (41.5)	50 (29.2)

Source: Author, 2021.

Table 2 is a summary table of the ratings of the ten resonant leadership variables. The ratings were done by the respondents and relate to their leadership style. Just over 50% of the respondents agreed that they ‘Looks for feedback even when it is difficult to hear’; in total, 71.9% agreed or strongly agreed. Only 2.9% strongly disagreed, while 25.1% selected the neutral option. The next variable ‘Acts on values even if it is at a personal cost’ saw 5.9% of respondents either disagreeing or strongly

disagreeing; 23.4% were neutral, 48.5% agreed and 70.7% either agreed or strongly agreed.

None of the respondents strongly disagreed with the next variable ‘Focuses on successes rather than failures', only 3.5% disagreed and 20.5% were neutral. The majority 76% either agreed or strongly agreed. Only 1.2% of the respondents disagreed with the statement 'Supports teamwork to achieve goals/outcomes'; 8.2% were neutral and the vast majority of 90.7% either agreed or strongly agreed. Note that this is the only variable that had more than 50% strongly agreeing with the respective statement. 'Calmly handles stressful situations' had a total of 3.5% disagreeing or strongly disagreeing with this statement; on the other hand, 62.6% either agreed or strongly agreed; the neutral option accounted for 33.9%, which is the second-highest among all other statements.

‘Actively listens, acknowledges, and then responds to requests and concerns’ saw only 1.2% or two respondents selecting disagree and strongly disagree; 76% selected either agreed or strongly agreed.

Note that this statement along with the ‘Supports teamwork to achieve goals/outcomes’ boasted the lowest total disagreements among all other variables. ‘Actively mentors or coaches performance of others' saw a total disagreement of 4.7%; neutral accounted for 21.1%, while the total for agreeing and strongly agree stood at 74.2%. Note that the agree option was just less than 50%.

Effectively resolves conflicts that arise' had a total disagreement at 2.9%; neutral was the highest across the other statements and stood at 38.0% and the combined agree and strongly agree accounted for 59%. The respondents responded to the statement 'Engages me in working toward a shared vision' with 2.4% total disagreement, neutral with 18.7%, agree accounted for 48%, and combined with strongly agree yielded 79%. 'Allows me the freedom to make important decisions in my work' saw the highest disagreement of 6.4%, and total agreement stood at 70.7%.

Table 3 - Descriptive analysis of the resonant leadership scale domains as rated by nurses about their supervisors. Guyana, 2021.

Variables	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Looks for feedback even when it is difficult to hear	7 (4.1)	36 (21.1)	47 (27.5)	47 (27.5)	34 (19.9)
Acts on values even if it is at a personal cost	8 (4.7)	49 (28.7)	51 (29.8)	40 (23.4)	23 (13.5)
Focuses on successes rather than failures	9 (5.3)	36 (21.2)	46 (27.1)	45 (26.5)	34 (20.0)
Supports teamwork to achieve goals/outcomes	9 (5.3)	13 (7.6)	62 (36.3)	42 (24.6)	45 (26.3)
Calmly handles stressful situations	12 (7.0)	31 (18.1)	53 (31.0)	48 (28.1)	27 (15.8)
Actively listens, acknowledges, and then responds to requests and concerns	10 (5.8)	27 (15.8)	61 (35.7)	41 (24.0)	32 (18.7)
Actively mentors or coaches performance of others	12 (7.0)	32 (18.7)	58 (33.9)	43 (25.1)	26 (15.2)
Effectively resolves conflicts that arise	11 (6.4)	30 (17.5)	66 (38.6)	42 (24.6)	22 (12.9)
Engages me in working toward a shared vision	7 (4.1)	30 (17.6)	53 (31.2)	54 (31.8)	26 (15.3)
Allows me freedom to make important decisions in my work	11 (6.4)	29 (17.0)	50 (29.2)	54 (31.6)	27 (15.8)

Source: Author, 2021.

NB: One respondant left questions Three(3) and question Nine (9) unanswered.

Table 3 represents the ratings of the nursing staff regarding their supervisor's resonant leadership. Neutral and agree options were most popular among the respondents for the first statement 'Looks for feedback even when it is difficult to hear', disagree, strongly agree, and strongly disagree follows with figures 21.1%, 19.9%, and 4.1% respectively. 'Acts on values even if it is at a personal cost' had neutral having 29.8%, total disagreement with 33.4%, and total agreement with 36.9%. 'Focuses on

successes rather than failures' saw neutral having 27.1%, total disagreement with 25.5%, and total agreement with 46.5%. 'Supports teamwork to achieve goals/outcomes' saw neutral topping with 36.3%, the total agreement had 50.9% and total disagreement had 12.9%. 'Calmly handles stressful situations' neutral again topped with 31.0%, 43.9% went to a total agreement, while 25.1% represented total disagreement.

‘Actively listens, acknowledges, and then responds to requests and concerns’ saw neutral responses topping with 35.7%, while total agreement had 42.7% and total disagreement had 21.6% of respondents. Neutral continues to top with 33.9% towards the statement ‘Actively mentors or coaches performance of others'; total agreement had 40.3% and total disagreement had 25.7%. The trend continues for 'Effectively resolves conflicts that arise' where neutral accounted for 38.6%, total agreement accounted for 37.5% and 23.9% opted to disagree and strongly disagree. 'Engages me in working toward a shared vision' saw agree and neutral toping with 31.8% and 31.2% respectively. The total agreement was 47.1% while the total disagreement was 21.7%. 'Allows me the freedom to make important decisions in my work' saw agree as to the most popular response with 31.6%, neutral followed with 29.2%, the total agreement was 47.4% and total disagreement was 23.4%.

Of the ten statements, the neutral response was most popular on eight occasions. The other two had agreed as most popular.

Along with the above variables, total ratings for resonant leadership were obtained for the supervisor ratings and the self-ratings by respondents. These were obtained by adding the ratings for the ten statements for each respondent. The total ratings can range between a minimum of 10 correspondings to a respondent giving all 'strongly disagree' responses, and a maximum of 50 correspondings to a respondent giving all 'strongly agree' responses.

The first two columns of Table 4 below show the summary statistics for the resonant leadership ratings by staff about themselves (SELF). The minimum total rating observed was 19 while the maximum rating was a perfect 50. The arithmetic mean rating is 39.7 and this almost ideally coincides with the median, which is 40.0, and standard deviation is 5.31; there are no upper extreme ratings.

Table 4 - Descriptive analysis for total leadership ratings – Self and Supervisor. Guyana, 2021.

	Total Leadership rating (SELF)	**Total Leadership rating (SUPERVISOR)**
Mean	39.7	33.1
Median	40.0	34.0
Std. Deviation	5.31	9.50
Minimum	19.00	10.00
Maximum	50.00	50.00

Source: Author, 2021.

The first and third columns of Table 4 show the summary statistics for the resonant leadership ratings by staff about their supervisors. The minimum total rating observed was a perfect 10 suggesting that at least one respondent strongly disagreed with all statements about the resonant leadership of their supervisor. The maximum rating was a perfect 50. The arithmetic mean rating is 33.1 and this almost ideally coincides with the median which is 34.0. The standard deviation is 9.5 and this, together with the mean suggests there are no extreme values.

In order to identify possible relationships between the level of resonant leadership and the nurses and managers, the dependent variable was 'Total leadership rating'; the factor variable is 'managers and registered nurses', and, therefore, the researcher used the analysis of variance (ANOVA) to assess whether the mean total leadership rating is dependent on either of these two groups. The ANOVA analyses are presented below.

All the self-ratings with the manager and nurse variable were examined. The Tables 5, 6 and 7 below provide summary ANOVA statistics for assessing whether the mean for the total leadership rating (TLR) of oneself differs for managers and registered nurses.

Table 5 - Comparison of the frequency, means, standard deviation, minimum and maximum of the total leadership rating between managers and registered nurses and the probability values (p) associated with the ANOVA test. Guyana, 2021.

	Nurses	**Managers**	***p***
Frequency	121	50	
Mean	38.9	41.6	
Std. Deviation	5.07	5.47	**0.003**
Minimum	19.00	31.00	
Maximum	50.00	50.00	

Source: Author, 2021.

Table 5 shows the descriptive statistics for nurses and managers. There are 121 nurses whose average TLR (self) is 38.9. There are 50 managers with a mean TLR (self) of 41.6.

The result is significant (p=0.003) and the nurses are more likely to rate their resonant leadership lower than the managers.

Regarding possible relationships between the level of resonant leadership and the demographic variables (gender, age, ethnicity, marital status, and education), the ANOVA analyses are presented in Table 6.

Table 6 - Comparison of managers 'self-assessments (SELF) and registered nurses' assessments of their supervisors with demographic variables. Guyana, 2021.

Characteristics	Categories	n	%	Self	Supervisor
				p	p
Gender	Female	157	91.8	0.794	0.120
	Male	14	8.2		
Age	At most 30	77	45.0		
	31-49	83	48.5	**0.046**	0.064
	50-69	11	6.4		
Ethnicity	African	114	66.7		
	East Indian	16	9.4	0.109	0.633
	Amerindian	7	4.1		
	Other	34	19.9		
Marital Status	Single	97	56.7		
	Married	66	38.6	0.385	0.511
	Divorced	8	4.7		
Education	Diploma	91	53.2		
	BScN	72	42.1	0.100	0.587
	Other	8	4.7		

Source: Author, 2021.

For the managers who evaluate themselves, Table 6 shows that p-value of 0.046 is significant, so that there is sufficient statistical evidence to suggest that the mean TLR is dependent on age range. Using the Tukey HSD multiple comparisons (post hoc), the researcher established that the mean TLR for nursing staff age at most 30 is different to those of age 50-69 years.

Regarding registered nurses, who evaluated their supervisors, it is noted that there are no statistically significant results.

Based on the analyses above, the researcher concludes that the mean TLR does not depend on the subcategories of the demographic variables except for the age where the TLR (SELF) depends on the age group. Therefore, the answer is that TLR (supervisors) does not depend on demographics. In other words, gender, age, ethnicity, marital status nor education level affect the way that the nursing staff rated their supervisors. On the other hand, the answer is that TLR (self) only depends on the age of the respondents. More specifically, nursing staff in the age category at most 30 are more likely to give a low rating of themselves than the age category 50 – 69.

The possible relationships between the level of resonant leadership and the work variables (work duration, specialty, and work status) are shown in the Table 7 below.

Table 7 - Comparison of managers 'self-assessments (SELF) and registered nurses' assessments of their supervisors with work variables. Guyana, 2021.

Characteristics	**Categories**	**n**	**%**	**Self**	**Supervisor**
				p	**p**
Work Duration	3-7 years	79	46.2		
	8-12 years	53	31.0		
	13-17 years	22	12.9	0.323	0.608
	18 years and above	17	9.9		
Specialty	Med- Surgery	66	38.6		
	Critical Care	54	31.6		
	Pediatric Care	20	11.7	0.324	0.271
	Maternal-Child	28	16.4		
	Mental Health	3	1.8		
Work Status	Register Nurse	121	70.8		
	Register Midwife	27	15.8	**0.014**	0.191
	Ward Manager	15	8.8		

Junior Departmental Supervisor	7	4.1
Senior Departmental Supervisor	1	0.6

Source: Author, 2021.

For the managers who evaluate themselves, Table 7 shows the p-value of 0.014, which significant so, it is possible to conclude that there is sufficient statistical evidence to suggest that the mean TLR (SELF) is dependent on work status. The Tukey HSD multiple comparison (post hoc) test, did not identify the particular group within work status that is different from the others. This may be because the p-value (0.046) is close to the significance level (0.05). However, it does not take away from the fact that age plays a determining factor in TLR (SELF).

The researcher examined the ratings of the supervisors, as given by the nursing staff, concerning the work variables. According to this category, it is noted that there are no statistically significant results.

Based on the analyses above, the researcher concludes that the mean TLR does not depend on the subcategories of the work variables for both rating self and supervisor. Therefore, the answer is that TLR does not depend on work variables. In other words, work duration, specialty, nor work status affect the way that the nursing staff rated themselves and their supervisors.

DISCUSSION

7 Discussion

The purpose of this study was to assess the resonant leadership style of nurse leaders as perceived themselves and by registered nurses.

In terms of demographic data of the study sample, the majority of the studied nurses were females (91.8%) while males were the remaining 8.2%. In addition, the result of this study showed that a little over half of the population of nurses had a diploma in nursing.

Based on the findings of this study, it was concluded that the mean TLR does not depend on the subcategories of the demographic variables except for the age where the TLR (self) depends on the age group. Therefore, the answer is that TLR (supervisors) does not depend on demographics. In other words, gender, age, ethnicity, marital status nor education level does not affect the way that the nursing staff rated their supervisors. On the other hand, the answer is that TLR (self) only depends on the age of the respondents. More specifically, nursing staff in the age category at most 30 are more likely to give a low rating of themselves than the age category 50 - 69.

This finding is consistent with Walter and Scheibe (2013) study, where the results showed no clear positive or negative relationships between age and its effectiveness on leadership. However, they concluded that the relationship between leader's age and their effectiveness. Contrary to these findings, Stami et al. (2018) reported that being young, female, but also have higher levels of employment and higher levels of education were all predictors of emotional intelligence. There is the assumption that being female is a predictor of high EI or transformational leader character, which could be related to the fact that females have learned behaviors, resultant from nurturing, which make them naturally more adaptive with their feelings and more capable to sustain relationships.

The findings of this current study showed that there is sufficient statistical evidence that suggested that the mean TLR for nurses is different from that of managers. The nurses are more likely to rate their resonant leadership lower than the managers. This may attribute to the findings where a majority of the nurses who fall in

the category for years of service was the 3 - 7 years, which had 46.2% (79) nursing staff. However, Shipley, Kackson aqnd Segrest (2010) found that EI increase as work experience increase. In contrast to these findings, Alabdulbaqi et al. (2019) found that there was no statistically significant relationship between years of experience and Emotional intelligence.

There was a decrease in numbers as the years of service increased, with category 8 - 12 years having 31.0% (53), category 13 – 17 years having 12.9% (22), and the final category of 18 or more years of service accounted for the remaining 9.9% (17) of the nursing staff. This latter percentage represented those in managerial positions, thus giving reference to Stami et al. (2018) who explained that confidence, experience, skills of sociability are assumed to be gained as a consequence of higher levels of employment and education.

Good leadership is about having not only exceptionally high levels of self-awareness but also the ability to apply this knowledge in practice (MANSEL, 2019). Nurse Managers were found to be more empathic or more engaging than those who have a higher degree. Conley (2017) in their study found that communication, problem solving, and the exercising of autonomy in leadership practice were key for nurse managers to be more engaging with their followers. Additionally, having a higher education provided them with the opportunity to have those leadership skills.

In this study, nurses perceive their managers to have moderate levels of resonant leadership practice in the acute setting. The maximum rating was a perfect 50. The arithmetic mean rating is 33.1 and this almost ideally coincides with the median, which is 34.0. The standard deviation is 9.5 and this, together with the mean suggests there are no extreme values.

Contributing to this, in evaluating themselves, the vast majority of managers agree or strongly agree with the 10 items; 90,7% of them support teamwork to achieve goals/outcomes; 79% engage others in working toward a shared vision; 76% focus on successes rather than failures; and 76% actively listen, acknowledge, and then respond to requests and concerns. The numbers of managers that disagree or strongly disagree is very low; only 6.4% disagree that they allow others freedom to make important decisions in their work.

On the other hand, when evaluating managers, registered nurses showed a higher percentage of disagree and strongly disagree, as well as being neutral in several situations. 33,4% disagree and strongly disagree that managers act on values even if it is at a personal cost; 26,5% that they focus on successes rather than failures; 25,7% that they actively mentor or coach performance of others; 25,2% that managers look for feedback even when it is difficult to hear; 25,1% that they calmly handle stressful situations.

It is important to highlight that when registered nurses evaluate leaders, the number of disagreements is much higher than when compared to leaders' self-assessment. This shows that leaders self-assess themselves as more resonant; compared to the assessment of those they lead.

This is an important result, since in healthcare institutions, the nurse managers play a vital role in influencing supportive staff nurse practice environments. Their roles are not only to supervise the units but serve as leaders to the staff (LASCHINGER et al., 2009). The impact of nurse managers is realized through their style of leadership and that leadership style will either have a positive or negative impression on the staff and ultimately patient outcome (NORTHOUSE, 2012).

Cummings (2018) rationalized that healthcare leaders focus more primarily on task completion and performance management rather than spending critical time and thought to create or maintain relationships with staff members. Boyatzis & Mckee (2013) and Cummings (2010) noted the relationship-oriented leadership style triggers positive emotions and as such resonant leadership practice, which is a relationship-oriented leadership style, creates this positivity among employees. Resonant leaders can institute a culture of support in the work environment (BAWAAFAA, WONG & LASCHINGER, 2015). Additionally, this support can stimulate proactive behaviors among the staff (SCHWEPKER et al., 2019). Therefore, it is paramount for leaders to construct and maintain meaningful relationships that are essential for staff cooperation and negotiations CUMMINGS et al, 2018).

Resonant leadership is important in the work environment because these leaders can impart confidence and strengthen social ties among their followers, which provides them with the strength to meet the demanding emotional requirements in the high-pressure healthcare setting. Resonant leaders' practice of emotional intelligence

supports managing the moods and emotions of their own and their employees, which creates a positive impact on employee's attitudes at the workplace (HASSAN et al, 2019).

Mckee et al (2008), Boyatzis (2007) and Goleman (2002), noted that even though emotional intelligence can never be fully understood, however, there are several ways to build the competencies of emotional Intelligence.They reported that emotional intelligence development is possible through training, leadership, coaching and professional and occupational excellence. These educational and training programs should be well planned and structured and every so often, they should be done to improve the leadership competencies of both nurse managers and the nursing staff. Bakshawan et al. (2016), found that after the implementation of a well-planned and organized program about situational leadership and emotional intelligence the nursing leaders showed improved leadership effectiveness.

Ali et al. (2020) recommended that managers in the healthcare setting should strive for an environment that fosters a mindful leadership style for both themselves and employees and has a culture where a positive attitude for and at work is not just for the followers but also for everyone. When employees notice their peers and managers caring for and helping others, this stimulates them to demonstrate sociably desirable behaviors, which is otherwise a challenging task (ZULUETA, 2016).

Worldwide there is a fight for health care organizations to empower nurses and have their productivity increased despite the many challenges faced. The practice of resonance among nurses and managers is paramount; the relationship between this leadership style practice and the staff perceptions of the same is important for nursing managers and leaders, to create a work environment that encourages and facilitates a high level of commitment among the nursing staff (ASIRI, 2016).

CONCLUSION

8 Conclusion

The main objective of the study was to assess the level of resonant leadership practice of nurse managers perceived by the register nurses of the Georgetown Public Hospital. The results of this study show that resonant leadership was practiced at a moderate level in the hospital's acute care setting.

This study demonstrate that resonant leadership does not depend on the sub categories of the demographic variables except for the age when the managers evaluated themselves. The study also concluded that resonant leadership is not associated with the work variables, so work duration, specialty, nor work status affect the way that the managers rated themselves and the registered nursing rated their supervisors.

These findings suggest that resonant leadership is sometimes encouraged to be practiced or that there is a lack of organizational support for such practice. This gives a negative implication that the nursing fraternity of the hospital is somewhat unaware of this leadership style or that the continuing education curriculum for nurses at this hospital may not have resonant leadership and emotional intelligence on their agenda.

Organizational support for the practice of relationship-oriented leadership styles must be encouraged. The healthcare setting needs to be led by leaders who demonstrate skills of relationship-oriented leadership, who shows concern not only for themselves but also for their subordinates and the organization at large. Teamwork should be a top priority, effectively communicating with others and they are willing to collaborate to achieve set goals for the staff patients, organization, and themselves.

Overall, the findings suggest that nurse leaders in the hospital acute setting can improve on their leadership style by adopting strategies that will enhance their job performance and work environment and also patient care and satisfaction.

Future research is needed to explore the commonly practiced leadership style in that acute care setting and their effects on current nursing practices.

IMPLICATION AND RECOMENDATIONS

9 Implication and Recommendations

It has been proven, while managers handle the procedures necessary to complete the tasks, it is leaders who motivate their subordinates to follow the path to the goal and complete the task willingly and enthusiastically.

Some implications arise from the results of the present study. Nurse leaders, managers, and/or charge nurses can use data from this study to develop effective nursing strategies in the area of continuous education for both nurse managers and register nurses that would enhance their leadership style.

Communication and teamwork are the backbones of the organizations and it safeguards patient safety. It is important for the voices of the nurse to be heard, in doing so a supportive and communicative work environment should be made that promotes trust, respect, and dignity.

A channel of communication, whether it be verbally or written should be open where nurses can speak freely to their managers about situations without fear or any ramifications. Effective communication brings about trust and that is majorly influenced by nurse managers' role, level of professionalism, and commitment to the profession.

If nurses are provided with the opportunity to have their thoughts and opinions considered and included in decision making it can enhance staff satisfaction and ultimately performance.

Having leaders who possess outstanding leadership qualities and skills and also having equally passionate followers are vital for any organization's success. Therefore, it is of prime importance that nursing leaders take the advantage of utilizing a relationship-oriented leadership style, such as resonant leadership to be practice in the work environment, along with its emotional intelligence competencies, which gives a guaranteed change for the better for both nurse and patients. By doing this, nursing practices and job performance will improve, quality patient care will be given and patient satisfaction will be met.

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APPENDICES

Appendices

Appendix A - Questionnaires

A.1 Sociodemographic Questionnaire

Please tell us a little bit about yourself and your workplace.

Personal History

1. Gender: □ Female □ Male

2. Age: _____ years

3. Ethnicity: African □ East Indian □ Amerindian □ Others □

4. Marital Status Single □ Married □ Divorced □

4. Highest Degree Obtained: □ Diploma □ BScN □ MScN □ Other, Please

Explain: _____

Work History

5. How long have you worked at this institution? _____

6. Specialty area of your current unit:

□ Med-Surgery □ Critical Care □ Pediatric Care □ Maternal-Child

□ Mental Health □ Other, please explain _____

7. What is your category of nursing? RN □ RM□ WM □ JDS □ SDS □

A.2 Resonant Leadership Questionnaire (Observer / Leader)

Resonant Leadership Scale - Observer (Cummings, 2008)

Leadership

In answering the following, please focus on the formal leader of the *clinical program or unit where you work the majority of your time*.

Please indicate your level of agreement with the following statements.

1=Strongly Disagree	2= Disagree	3=Neutral	4=Agree	5=Strongly Agree

The leader in my clinical program or unit …	1	2	3	4	5
1. Looks for feedback even when it is difficult to hear.	☐	☐	☐	☐	☐
2. Acts on values even if it is at a personal cost.	☐	☐	☐	☐	☐
3. Focuses on successes rather than failures.	☐	☐	☐	☐	☐
4. Supports teamwork to achieve goals/outcomes.	☐	☐	☐	☐	☐
5. Calmly handles stressful situations.	☐	☐	☐	☐	☐
6. Actively listens, acknowledges, and then responds to requests and concerns.	☐	☐	☐	☐	☐
7. Actively mentors or coaches performance of others.	☐	☐	☐	☐	☐
8. Effectively resolves conflicts that arise.	☐	☐	☐	☐	☐
9. Engages me in working toward a shared vision.	☐	☐	☐	☐	☐
10. Allows me freedom to make important decisions in my work.	☐	☐	☐	☐	☐

A.3 Resonant Leadership Scale (Cummings, 2008)

Self

In answering the following, please focus on **YOUR** own leadership behaviours at work

Please indicate your level of agreement with the following statements.

1= Strongly Disagree	2= Disagree	3=Neutral	4=Agree	5=Strongly Agree

As a nurse leader I…	**1**	**2**	**3**	**4**	**5**
1. Look for feedback even when it is difficult to hear.	☐	☐	☐	☐	☐
2. Act on values even if it is at a personal cost.	☐	☐	☐	☐	☐
3. Focus on successes rather than failures.	☐	☐	☐	☐	☐
4. Supports teamwork to achieve goals/outcomes.	☐	☐	☐	☐	☐
5. Calmly handle stressful situations.	☐	☐	☐	☐	☐
6. Actively listen, acknowledge, and then respond to requests and concerns.	☐	☐	☐	☐	☐
7. Actively mentor or coach performance of others	☐	☐	☐	☐	☐
8. Effectively resolve conflicts that arise.	☐	☐	☐	☐	☐
9. Engage others in working toward a shared vision.	☐	☐	☐	☐	☐
10. Allow others freedom to make important decisions in their work.	☐	☐	☐	☐	☐

Appendix B – Ethical Approval

Institutional Review Board FWA00014641

Ministry of Public Health

Brickdam, Georgetown, GUYANA

Telephone: 592-22-61224

e-mail: cmoguyana@gmail.com/cmo@health.gov.gy

Memo

To: Petrinella Reynolds
From: The Chairman, IRB Ministry of Health
Date: 15/07/2019
Re: IRB Approval of New Protocol # 593/2019

The Ministry of Public Health's IRB has reviewed the request for approval of protocol # **593/2019** entitled "***The relation of resonant leadership & quality management in the hospital setting"***, and has approved the protocol for the maximum allowable period of **one year**. This IRB approval expires ***June, 2020.***

As a reminder, the IRB must review and approve all human subjects' research protocols at intervals appropriate to the degree of risk, but not less that once per year. There is no grace period beyond one year from the last IRB approval date. It is ultimately your responsibility to submit your research protocol for continuation review and approval by the IRB. Please keep this approval in your protocol files as proof of IRB approval and as a reminder of the expiration date. To avoid lapses in approval of your research and the possible suspension of subject enrollment and/or termination of the protocol please submit your continuance request at least six weeks before the protocol expiration date.

Upon completion of your research a Report **MUST** be submitted to the Board.

Any problems of a serious nature should be brought to the immediate attention of the IRB and any proposed changes to the protocol should be submitted as an amendment to the protocol for IRB approval before they are implemented.

If you have any questions please contact the ***IRB Administrator*** or the ***IRB Chairman*** on **226-1224**.

Chief Medical Officer
M. Smith
Ministry of Public Health Guyana

Dr. Shamdeo Persaud
Chief Medical Officer/
Chairman, Institutional Review Board

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Appendix C – Informed Consent

C1. Informed Consent

Master's in Fundamental Nursing Degree/Student Research Project

Consent to participate in Research Study

Study Title: The relation of resonant leadership and quality management in a hospital setting

Investigator: Petrinella Reynolds

Written Consent

I confirmed that the researcher has explained the elements of informed consent to the participant.

The subject knows that their involvement is voluntary and that they do not need to answer all questions. The purpose of the research and the risk and benefits have been described. The methods as well as the time commitment have been outlined. The participant understands issues of confidentiality.

Participant Signature: …….

Witness Signature: …….

C.2 Letter of Information

Introduction

I am inviting you to take part in our research study named above. This form provides information about the study. You do not have to take part in this study. Taking part is entirely voluntary (your choice). The researcher will be available to answer any questions you have. You may decide not to take part, or you may withdraw from the study at any time. This will not affect your employment status in any way.

Purpose of the Study

According to the Institute of Medicine's (IOM) Committee on the Adequacy of Nurse Staffing in Hospitals and Nursing Homes: "Nursing is a critical factor in determining the quality of care in hospitals and the nature of patient outcomes" (IOM, 1996 p92). Over the years, there has been a significant depletion of nursing workforce in hospitals; hence the remaining body of nurses is being overworked just to compensate for the lack of. Effective nurse leaders play an important role in staff nurse retention, and ultimately, in the quality of patient care (Mackoff & Triolo, 2008). Anecdotal evidence suggested that shortage in nursing staff has a negative impact on the quality of patient care, which results in increased mortality rate, frequent readmissions, patient dissatisfaction and depletion in job satisfaction and quality management. The purpose of this study is to identify the association between resonant leadership adopted by nurses and managers and quality management in Georgetown Public Hospital

Procedures for this Study

The proposed project is a single -phased project spanning a period of 1 year and consisting of one element: surveys. The survey component of the study consists of a comprehensive questionnaire assessing quality management and resonant leadership among nurses and managers. I will obtain a random sample of 275 nurses from the selected units of the hospital. If you are not a direct care nurse, you should not participate in this study.

What You Will Be Asked to Do

You will be asked to complete a survey, which should take approximately 20 minutes of your time. You may decide whether to complete the survey on your own time or at work.

Survey questions may ask about the leadership (Resonant) practice of yourself and your clinical leader at your current work environment, and perceptions about your leadership skills and your supervisor leadership. Once you have completed your survey, please return same to the researcher. All data will be stored in a locked cabinet in a secure room.

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Risks and Discomforts to You if You Participate in the Study

There are no anticipated burdens, harms or potential harms for participation in this study.

There is a chance that you may feel uncomfortable answering questions about the hospital nurse manager on the survey. Care will be taken to ensure confidentiality of survey data and we will respect your privacy. Also, you will not have to answer any questions if you feel uncomfortable.

Benefits to You if You Participate in the Study

Nurses will not be guaranteed any direct benefits as a result of their participation in this study. However, this study will indicate reasons why there may be a dissonance relationship between management and the care given by nurses. This information is useful for understanding what might constitute priority actions and which areas should be targeted. It will also permit better monitoring of progress on the various dimensions of caring practices within the hospital. The findings are important to understanding how to simultaneously stem the flight of nurses from hospital bedside care and improve patient satisfaction with care. As a result, this information can be used to inform policy and organizational initiatives that will make these roles attractive to future nurse leaders.

Voluntary Participation and Withdrawing from the Study

Before deciding to participate, you should know that you do not have to take part in the study. Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your employment status. If, during this study, new information becomes available that may relate to your willingness to continue to participate, this information will be provided to you by the investigator.

Costs Associated with the Study

Participation in this study will not result in any expenses to you.

Confidentiality and Privacy

For the surveys, no identifying information of participants will be linked to the data.

Individual responses will not be reported. If the results of the study are reported in a publication, this document will not contain any information that would identify you.

Contacts for Study Questions or Problems

If you have any further questions about this study, please feel free to contact me at the number below. I would very much appreciate your participation in this research project.

If you choose to participate in the survey, please return your completed written questionnaire to the researcher / office. If you choose not to participate, please return the blank questionnaire, after which you will not be contacted further. Thank you very much for considering our request.

What are my research rights?

You indicate your voluntary agreement to participate by completing and returning this questionnaire. You do not waive any legal rights by signing the consent form. You will be given a copy of this letter of information and consent form once it has been signed.

Sincerely,