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# First-Line Nursing Home Managers in Sweden and their Views on Leadership and Palliative Care

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**Abstract:** The aim of this study was to investigate first-line nursing home managers' views on their leadership and related to that, palliative care. Previous research reveals insufficient palliation, and a number of barriers towards implementation of palliative care in nursing homes. Among those barriers are issues related to leadership quality. First-line managers play a pivotal role, as they influence working conditions and quality of care.

Nine first-line managers, from different nursing homes in Sweden participated in the study. Semi-structured interviews were conducted and analysed using qualitative descriptive content analysis. In the results, two categories were identified: embracing the role of leader and being a victim of circumstances, illuminating how the first-line managers handle expectations and challenges linked to the leadership role and responsibility for palliative care. The results reveal views corresponding to committed leaders, acting upon demands and expectations, but also to leaders appearing to have resigned from the leadership role, and who express powerlessness with little possibility to influence care. The first line managers reported their own limited knowledge about palliative care to limit their possibilities of taking full leadership responsibility for implementing palliative care principles in their nursing homes.

The study stresses that for the provision of high quality palliative care in nursing homes, first-line managers need to be knowledgeable about palliative care, and they need supportive organizations with clear expectations and goals about palliative care. Future action and learning oriented research projects for the implementation of palliative care principles, in which first line managers actively participate, are suggested.

**Keywords:** End-of-life, first line managers, leadership, older people, palliative care, qualitative analysis.

## INTRODUCTION

Sweden, like many other countries, has an ageing population. In the western world nursing homes (equal to care homes and residential age facilities) [1] are common sites for older people to spend their last part of life [2-4]. In 2012 approximately 93,000 Swedish people over 65 years lived in nursing homes, and approximately 19% of those were 80 years or older [5].

Residents in nursing homes often have a complex blend of life-limiting conditions over a long period of time, and accordingly they may have various palliative care needs during their illness trajectory. Traditionally, palliative care has mainly been provided for patients with cancer diagnoses, often in the late phase of the disease, but the needs of care according to palliative principles, with a much earlier onset,

are now stressed for all people with progressive and/or life-limiting conditions, including older people [6]. Within palliative care dying is regarded as a normal process. Through the integration of physiological, psychological, social and existential aspects of illness and dying, palliative care is intended neither to hasten nor to prolong dying, but rather to promote wellbeing until death, by providing relief from distressing symptoms [7]. Swedish guidelines [8] ensure older people right to adequate palliative care, regardless of care place. Quality indicators of palliative care are stated on national level and care providers are advised to register quality-of-care-related information about their patients'/residents' last week of life, in a national palliative register [8].

The multiple diseases and symptoms that older people often have can make it difficult to identify and manage the last period of life [9, 10]. To provide adequate palliative care for older people thus requires both geriatric, and palliative expertise. Interventions in nursing homes have been performed to ensure older people's access to palliative care [cf. 3, 11]. Despite these incentives, the literature reveals that

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in Sweden and other western countries, residents in nursing homes often do not have access to palliative care competence; neither *via* staff in the nursing homes, nor from external consulting palliative care-specialists/teams [12-15]. Accordingly, it is reported that many older people in nursing homes receive insufficient palliative care, e.g. inadequate management of pain or other symptoms [16-19], and that there is lack of communication about end-of-life issues [20-22]. Shortage of competence in leadership and management, alongside with lack of competence among health care staff, limited resources, and unsupportive health care organisations have previously been recognised to be barriers to the implementation of palliative care in nursing homes [9, 23, 24].

In Sweden, since 1992, the county councils have the responsibility for the provision of medical care, while the local municipalities are legally obliged to meet the needs for social services [25]. An older person's need for nursing home care is determined by an assessment process carried out by a municipal care manager in co-operation with the old person and his or her family, and in consultation with other professionals. Assessment criteria differ between municipalities, but the person's level of dependency and cognitive impairment is often decisive [25]. In the nursing homes, different professionals have different employers and obey under different jurisdictions. Primary care physicians who have medical responsibility for the residents, physiotherapists and occupational therapists are hired by the county councils, while first line managers (FLM) registered nurses, enrolled nurses and care assistants are employed by the local municipalities or private entrepreneurs [26].

First-line managers are key players in nursing homes, as they have a pivotal role in influencing both working conditions and quality of care through their leadership [27-29]. Accordingly, FLMS need to be both leaders and managers, as these two functions are crucial to achieve high quality of care [30]. The position of FLMS in nursing homes can be described as an intermediate one: they are positioned between politicians and higher-level management on the one hand, and staff and residents on the other. These groups place different demands on the manager [31]. Wolmesjö [31] has shown that both politicians and managers give priority to knowledge about management, and personal qualifications of the manager, while FLMS, emphasize that the contextual knowledge of care for which they are responsible is important for a good leadership.

The focus of leadership is to influence others to fulfil the goals for high quality care, and to promote personal development among members of a group, whereas management is a process directed towards fulfilling the goals of an organisation [30]. The assignment of the FLMS has developed over the years, moving from caring and nursing to administration with responsibility for the services provided, the budget, and the employees [31]. In their role as leaders, they have been shown to influence the working life of staff in various care settings [32, 33].

Working in palliative care contexts has been shown to be rewarding [34, 35] but the ethical and emotional challenges of facing death on a regular basis are also known to be potentially stressful [36, 37]. In addition, value conflicts in organisations where palliative care principles are not fully

(or not at all) implemented, may arise between the staff members' own ambitions to give good/high quality palliative care and organisational constraints such as lack of time and resources [26, 38, 39], insufficient support from general practitioners (e.g. reluctance to prescribe appropriate medication) and lack of palliative care training [14]. Such constraints have also been shown to bring about stress of conscience among staff in nursing homes [40]. Nursing home staff report seldom being offered support and encouragement by their leaders [26, 37, 40, 41], and they experience few opportunities for continuing education and supervision related to every day work with older people [42].

The literature on nursing homes reveals insufficient palliative care for older people. The influence of FLMS' leadership on staff satisfaction and quality of care in nursing homes is stressed, and lack of leadership competence is pointed out as one barrier for the implementation of palliative care. However, in the context of nursing homes, studies about FLMS' leadership, especially those that investigate the perspective of the managers themselves, are sparse. Therefore, in this study we aimed to investigate first-line nursing home managers' views on their leadership and related to that, palliative care.

## MATERIALS AND METHODOLOGY

### Setting and Participants

The present study took place within the wider context of a care development project; PVIS (Swedish abbreviation for 'palliative care in nursing homes'), aimed at providing knowledge about palliative care, through education to staff in nursing homes within the Stockholm County Council area in Sweden, in 2007- 2011 [43]. Approval to conduct the study was granted by the regional ethical review board of Karolinska Institutet, Stockholm (no. 2009/5:9).

Nine (9) FLMS from 9 nursing homes where staff participated in the PVIS project were invited by e-mail, in which written information about the project was provided. All nine FLMS agreed to participate, and signed a written informed consent prior to the interviews. Seven of the FLMS were registered nurses, one was an occupational therapist, and one had a bachelor's degree in behavioural science. The participants had been managers in their nursing homes for 2-5 years. The nursing homes each had 4-6 units with 9-12 residents in each unit, and were equally divided between being run by municipalities and being run by private entrepreneurs, all financed through the municipalities.

### Data Collection

Semi-structured individual interviews were conducted in 2010-2011, by the second author, at each manager's office. Each interview lasted between 35 and 60 minutes. An interview guide was developed, based on related existing literature about palliative care for older people, and about leadership in nursing homes. The main areas were for the questions were: formal professional education, experience of leadership in the specific context e.g. *"Please, describe your previous experience of being a leader in care for older people?"* understanding of palliative care e.g. *"How do you view your own knowledge about palliative care for older*

people?” views of leadership in nursing homes, and views of their own role in staff training and development of quality of care at the end of life for residents in nursing homes e.g. “*What do you regard to be important in your role as a leader, in relation to the provision of care to the residents?*”. The interviews were digitally recorded and later transcribed verbatim by a professional.

### Data Analysis

The interviews were analysed using qualitative descriptive content analysis. The aim of content analysis is to attain a condensed and broad description of a phenomenon [44]. The analysis was performed according to the following steps. First, the transcribed interviews were read to achieve immersion in the data and to obtain a sense of the whole. The next step was to organise data, which involved coding; that is, writing notes and comments in the texts that were related to the participants’ descriptions of leadership and views of responsibility to describe all aspects of the content. The coded text units were sorted into subcategories on the basis of differences and similarities. Subcategories with similar content were grouped together under categories. Each subcategory was named using content-characteristic words, and the categories were named according to the overall content of their subcategories [44]. The first and the last author performed the analysis. This was done in close co-operation and continuous dialogue about the emerging categories. The results were repeatedly critically discussed between all authors, to ensure trustworthiness [45].

## RESULTS

The results illustrate how the FLMs handled challenges and expectations around the content and quality of care that they experienced linked to their role as leaders in the nursing homes. The FLMs sparsely related their leadership role to matters around death and the residents’ needs of palliative care, and when they did, they mainly focused on the importance of establishing principles and routines that would facilitate a ‘good’ dying process. Two categories in which the results will be further outlined were identified: *embracing the role of leader* and *being a victim of circumstances*.

### Embracing the Role of Leader

In this category, the FLMs described how they embraced and understood their role as a leader. The category consists of three subcategories: *seeing one’s own needs and shortcomings*, *encouraging and developing one’s staff*, and *standing up for one’s staff and clients*.

#### *Seeing One’s Own Needs and Shortcomings*

Some FLMs said that to be a committed leader they had to recognise the significance of competent and well-functioning staff. Maintaining an effective team and a good relationship with their staff was a continuous challenge. This awareness prompted them to plan developmental or organisational changes within their nursing home very carefully, and to involve their staff in the processes. In

relation to this, they also expressed their own need for continuous development of leadership skills.

Developing as a leader some FLMs found to be a real challenge, but at the same time they expressed excitement over their leadership role. Some of them said they had modelled their leadership style by observing the actions and qualities of some people they admired or had worked with. The qualities they described included: “*being patient, being a good listener, looking after the interests of others, being a good communicator or speaker, and being someone who is prepared to work, who gets the work done, and who is available to help out.*”

Recognising their own need to develop in their leadership role, some FLMs talked about participating in workshops and education on leadership, and that this training had contributed to enhancement of their leadership quality and management skills. Also, as leaders, they had established a support network within their area of work, and this had for example made requests for help or advice easier.

### Encouraging and Developing Staff

In this subcategory, FLMs described how they perceived an encouraging and developing leadership style to be essential for supporting and enabling their staff to provide good care.

The most important matters for their role as leaders were the wellbeing and functioning of the staff. Two goals for care, during the last phase of a resident’s life that were mentioned by the FLMs were that the person should be relieved from physical pain, and not have to die alone. These goals however, demanded a certain kind of closeness to the residents’ dying process that the FLMs articulated to be emotionally stressful for staff members, especially those who were young and/or inexperienced:

If there is no one there [next of kin] we make sure that we sit with the resident. And in the [staff] group we also need to respect each other’s feelings when sitting there. It is hard work. Emotional. (FLM 5).

The often unfamiliar and awkward feelings among staff around death and dying were described by the FLMs as important to recognise and respect in order to be able to support the individual, and to ensure a ‘good’ death for the residents.

The FLMs talked about being aware of how their leadership style affected the staff members’ job satisfaction and commitment to work. They said that showing their trust in staff contributed to staff’s motivation, and they believed it was important that the staff members were given opportunities to develop their professional skills: “*Leadership style contributes to job satisfaction when you have the skills to prevent and solve conflicts*”. (FLM 5) The FLMs outlined that if their team was to function effectively, they in their role as leaders needed to encourage their staff members to continue their training and development in various areas, including palliative care:

I think there are some changes that I have influenced in my ward. I have encouraged my

nurses to attend services to upgrade their skills and to go do some outside studies. (FLM 7).

Some FLMs acknowledged their own responsibility for initiating structured discussions around palliative care e.g. in regular staff meetings: *"If I do not enable time for these discussions, my staff will not recognise the importance of palliative care"*. (FLM2) To get their staff to set their own personal and professional objectives was described as a pathway to the development of commitment to, and competence in palliative care.

### **Standing Up for One's Staff and Clients**

The FLMs were aware that problems in the organisation, such as conflicts between staff members, could be reflected in the everyday care of the residents, and that their actions as leaders could have an indirect influence on the quality of care: *'If there is patient mistreatment, it is I who is responsible and it is up to me to decide how to react'*. (FLM 4).

Some FLMs also said that the organisational climate, including job satisfaction, work commitment, and cooperation, was of great importance for the success to maintain quality of care: *"It's really important that staff can feel safe, that they can knock on my door at any time and that it's not taboo to talk about feelings."* (FLM 5).

Staff becoming more knowledgeable about nursing and palliative care was described by the FLMs to have had a positive influence, both on organisational climate and staff members' ways of approaching residents and their next of kin. The following excerpt was drawn from a longer description about the importance of the fact that the whole care unit, after the education programme in palliative care, now worked together in order to provide good palliative care:

I think they (the care staff) always have been good, but now I can see a real development in how to communicate and more openly discuss with the patients and family members about the end of life. It's a more open and supportive discussion today. (FLM 1).

Some FLMs also described their role of team builder; they saw teamwork as an important part of effective leadership. They stressed the notion that everyone had to learn to work with each other to ensure that goals were achieved, and their leadership was highlighted in terms like: *'developing people, delegating authority, and empowering and enabling others by listening to ideas, encouraging active participation, removing bureaucratic barriers, giving people the tools to do the job, removing obstacles that hinder team performance, encouraging and supporting creativity and imagination'*.

One FLM described achieving good teamwork as *'having happy staff who are willing to do that little extra.'* (FLM 8) This manager was overwhelmed by her staff's support in relation to the efforts they made in order to manage the everyday work in the nursing home. The quotation above was extracted from a description of staff members' willingness to come back to work to do an extra shift to

cover for someone else, when she, as a manager, had asked them to do so.

Collaboration and partnership were also recognised as important aspects of their work. Establishing good relationships with staff and developing a committed team was considered to contribute to effective leadership. The support that the FLMs received from their staff as a result of these established relationships was acknowledged to be an important contribution to their success as leaders.

### **Being a Victim of Circumstances**

This category highlights descriptions of leadership attributes and challenges connected with managing the role of leader. It consists of three subcategories: *being overwhelmed by tasks, having one's hands tied up, and letting go of responsibility*.

#### **Being Overwhelmed by Tasks**

Even though they were confident in their ability to take on the role of leaders, some of the FLMs said that certain management issues challenged them. Those issues were related to administrative problems such as limited economic resources, shortage of nurses, poor communication channels and skills, poor documentation, unclear job descriptions and responsibilities, excessive work overload, and lack of leadership support. The shortage of resources was explicated to often be the reason for the omission of mandatory routines, for example to document in the palliative care register: *'No, I have not opened it [the register]... I feel that I don't have time to do that'*. (FLM 6) They also described how lack of time contributed to increased stress levels, and how factors such as those described above were associated with decreased job satisfaction and performance. For example they stressed the importance of facilitating opportunities for staff to reflect upon the dying process of a resident in order learn and improve care, and at the same time how administrative workload hampered focusing on these care related tasks:

For the moment I have a terrible workload. One should make some effort after each death, you know, taking the time talking [with staff] about how it all went, did it turn out to be as good as it could possibly get, could we have done something differently. (FLM 3).

The FLMs said that they perceived these more structural matters to be out of their power, as those were consequences of economic constraints within the wider organisation.

#### **Having one's Hands Tied Up**

The FLMs said that their skills in leading their work units and motivating their staff were important for success in providing good quality of care. At the same time some of them described how *'their hands were tied up'*, as they constantly had to ask for adequate resources from the organisation. They emphasised the importance of having qualified and competent staff, but felt constrained when they had to fight against, as they said, *'efficiency and economy'*. The FLMs also noted that the organisation lacked clear

visions or directions about palliative care within the nursing homes. One participant said:

... well...I guess that we have some kind of policy in that...at the end of one's life it should be like this and that and...we should have some extra and so if there are no next of kin around...and one should have pain relief and so... (FLM 7).

Having one's hands tied up was described as an obstacle to lead, which was for example, stressed in situations when organisational changes were introduced according to FLMs. They said that they seldom saw guidance from the management of the organisation, and there was no overarching strategic plan to guide them into the future. Instead they said that goals and plans for the organisation were randomly altered: *'I had visions and we had long-term plans, but these plans often change'*. (FLM 6).

### **Letting Go of Responsibility**

Some of the FLMs said that at times they felt more like 'followers' than leaders. In relation to their staff, they described how personal commitment to their work was of great importance, and said that as a leader they tried to be supportive and cheerful. On the other hand, they talked about the need for staff members to do continuous training and education in order to sustain good quality of care, and that staff members themselves had to take responsibility for such matters. Additionally, when conflicts arose among staff members, some FLMs described handing over the responsibility for solving the conflicts to the staff members themselves. They as leaders were more *'victims of circumstances'*. In addition, if concerns were raised about the quality of care, for example when and how to give palliative care to a resident, they said that this was not their responsibility, but something for the registered nurse or the responsible physician.

When the FLMs were asked what they regarded to be good practice in palliative care in their nursing homes, some talked about details as if they themselves were not really involved in the process of ensuring good palliative care:

... well... it's about having someone there with you and having pain relief, someone to listen if they wish for something...I can imagine that this is the most important... (FLM 5).

The FLMs were themselves often not actively involved in the development of care but they often expressed an engagement to encourage their staff nurses, who they believed were the ones who were best fitted to set the standards for palliative care in the nursing homes.

## **DISCUSSION**

The FLMs' views on leadership and palliative care within their nursing homes revealed two diverse and somewhat conflicting patterns. The first comprises views of themselves as leaders who acted upon the demands and expectations placed on them by the organisation, the staff, and the residents, and who showed an awareness of their own shortcomings and an understanding of the need to develop their leadership skills. The other pattern comprises

descriptions of leadership in which the FLMs portrayed themselves as being powerless in the face of demands from both organisation and staff, with little possibility as leaders to influence the care quality, including implementation of palliative care principles. It is notable that the FLMs who were interviewed in this study, talked rather sparsely about leadership responsibility related to palliative care, despite the fact that their nursing homes had previously been part of a major education programme (PVIS) [43]. They however did talk about the positive influence of the education programme on staff's ways of discussing and approaching palliative care matters, and about their own brief knowledge that accordingly limited their possibilities of taking leadership responsibility for palliative care in the nursing homes.

In a survey by Froggatt & Payne [46], care home managers displayed diverse understandings about the definition of end-of-life and when palliative care was to be provided to the residents. In our study, the FLMs talked about palliative care only in relation to the very last week or days of the residents' lives. Considering the amount of complex life limiting conditions and accordingly, early onset of palliative care needs among many nursing home residents [9, 10], this late phase perspective is inadequate.

As the results reveal, nursing home leadership is challenging and sometimes perceived as overwhelming. Having limited resources, experiencing work overload, and struggling with poor communication channels were matters that some FLMs saw no way of overcoming. These challenges are also important from an ethical viewpoint. Ethical stress related to informal and formal decision-making may arise when leaders perceive their individual values to be in conflict with organisational norms [47]. The descriptions given by some FLMs of being forced to make changes according to organisational directives, and thereby not being able to achieve the goals they as leaders had set for themselves and for the development of care, exemplifies the conflict between organisational goals and the humanistic values that are intrinsic to palliative care for older people [24, 31, 37].

Experiences of lacking power in the face of "the system" have already been described among both staff and residents in a Swedish nursing home context [38, 48]. The FLMs in our study who expressed powerlessness also showed a passive approach towards their perceived inability to fulfil their moral obligations as leaders of ensuring good quality of care. Such obligations included using the palliative care register, becoming informed about and implementing guidelines for palliative care, and making sure that they and their staff had sufficient competence in palliative care for older people. Instead, they described being overwhelmed by the expectations and demands from higher organisation levels as well as from staff and residents. Organisational support, staff competence, and a committed nursing leadership are all factors that have been outlined as being both challenging and vital for the success of implementing palliative care principles in nursing homes [14].

In our study, we understand the FLMs who embraced their leadership as belonging to the group of leaders who are recognised for their transformative and authentic leadership, which is described in the literature as being appreciated in palliative care [35, 49]. Moreover, FLMs acknowledged their

own need for competence, they were knowledgeable about the needs of both their staff and the residents, and they took action in solving problems and developing standards for care. Committed leadership, which is maintained in close cooperation with staff, has been reported to be supportive and provide guidance for personal growth and handling of difficult situations among staff members [35]. It is also reported to have a positive influence on the effectiveness palliative care [14, 49, 50].

In the study, FLMs did not make explicit distinctions between managing and leading when they talked about their own leadership; although both perspectives were present in their descriptions. The organisation of care for older people in Swedish nursing homes requires FLMs to balance between being good administrative managers on the one hand and being skilled nursing leaders for their staff on the other [24, 32, 49]. The FLMs play an integral role in creating the health care work environment. There is a strong positive relationship between leadership behaviour and staff 's job satisfaction, productivity, and organisational commitment [51]. Additionally, organisational support, staff and leadership competence, and a committed nursing leadership have been shown to be vital for the success of implementing palliative care in nursing homes [14].

Lack of leadership support from higher management levels is well recognised from studies in similar or related contexts, and is known to influence leaders' abilities of effective and sufficient possibilities to lead [cf. 51, 52]. In our study, the FLMs showed diverse attitudes towards their own need to develop their contextual (nursing management and knowledge about palliative care principles) leadership competence. High workload, little feeling of being in control or being able to influence organisational circumstances, lack of leadership support, and unclear job descriptions seemed to overshadow their own possibilities and desires for personal development. It is likely that the Swedish model for care of older people with the divided responsibilities between the county councils and the local municipalities contribute to unclearness about who is responsible for the implementation of palliative care principles and linked to quality of care, to the difficulties of being a leader in nursing homes that the FLMs describe in this study.

### Study Limitations

Although the characteristics of leadership descriptions were extracted from interviews with nursing home FLMs, we do not know how their leadership really affected the working environment or quality of palliative care in their units, as we did not observe any leader-staff interactions. Moreover, we have as yet little indication of organisational structures, type of physical environment, and financial circumstances under which the nursing home FLMs worked, although these factors were described as being important components for leadership experiences. Despite these limitations, this study adds to the discourse on leadership qualities in palliative care within nursing homes.

### CONCLUSION AND IMPLICATIONS

The results highlight views corresponding to committed leaders who acted upon demands and expectations, and who

were aware of their own shortcomings and need for personal development. However, there are also views congruent with leaders who appear to have resigned from taking the role of leader, and who express powerlessness towards demands and expectations, with little possibility to influence the quality of care through their leadership. Another finding that echoes previous research about barriers towards implementation of palliative care in nursing homes, is that despite acknowledging the importance of providing good care to the residents until death, the FLMs perceived their own limited knowledge about palliative care to hamper their possibilities of taking full leadership responsibility for the development of care (including implementation of palliative care principles) in their nursing homes.

Being a FLM in a nursing home today poses many challenges. In their role as leaders, managers need to balance between being good administrators and competent leaders of nursing care. They also need to fulfil demands and expectations from the organisation as well as from staff and residents. Nursing home FLMs do not only need leadership skills and knowledge about palliative care needs for older people; they also need supportive organisations and leaders, with clear expectations, goals, outspoken areas of responsibility about the implementation of palliative care principles and values. Action and learning oriented intervention studies, in which FLMs are actively participating, and that are aimed at implementing palliative care principles for a cultural change of nursing home care, are suggested.

### ABBREVIATIONS

FLM = First-line manager

PVIS = Swedish abbreviation for a care development project in which the study took place (Palliative Care in Sweden)

### CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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