BMC Health Services Research

RESEARCH

Open Access

Exploring influencing factors to clinical leadership development: a qualitative study with healthcare professionals in Flemish nursing homes

Sabrina Nachtergaele[1,2*], Nele De Roo[1,2], Jolien Allart[1,3], Patricia De Vriendt[1,3,4,5], Mieke Embo[1,6] and Elise Cornelis[1,3]

Abstract

Background Nursing homes face a critical need for competent healthcare professionals to deliver high-quality care. Focusing on clinical leadership is crucial for equipping healthcare professionals with the skills necessary to manage complex care needs, collaborate effectively within multidisciplinary teams, and improve care quality in nursing homes. Developing clinical leadership fosters professional growth and enhances healthcare professionals' ability to tackle the challenges unique to the nursing home environment. However, the concept of clinical leadership in nursing homes remains poorly defined and investigated. This study aimed to explore and define influencing factors for the development of clinical leadership within healthcare professionals in nursing homes.

Methods A qualitative study was conducted in Flanders, Belgium, using semi-structured focus group interviews ($n=5$) with healthcare professionals ($n=41$), including nurse assistants, licensed practical nurses, registered nurses, occupational therapists, recreational therapists, psychologists, and gerontologists. Interviews were audio-taped, transcribed, analysed and interpretated by using a thematic analysis based on descriptive phenomenology.

Results Clinical leadership development within healthcare professionals' hinges on four pivotal themes: (1) Cultivating an empowering working environment that fosters open feedback, encourages peer learning, and champions a stimulating learning climate. (2) Nurturing a supportive leadership style in formal leaders that exemplifies role modeling, accessibility, and a coaching approach. (3) Elevating well-developed professional identity through targeted training, experience, and a talent-oriented work approach. (4) Fostering team dynamics marked by commitment, collaboration, support, and trust.

Conclusions The study's findings on the influencing factors for clinical leadership development should be actively applied in nursing homes and guide the creation of targeted training programs and leadership development initiatives. Awareness of these factors are crucial to optimise and to support the development and implementation of clinical leadership in nursing homes in an attempt to reduce the workforce shortages.

*Correspondence:
Sabrina Nachtergaele
sabrina.nachtergaele@arteveldehs.be

Full list of author information is available at the end of the article

Keywords Clinical leadership, Working environment, Leadership style, Professional identity, Team dynamics, Nursing homes

Introduction

Nursing homes play a pivotal role in responding the needs of older individuals experiencing significant age-related declines. These facilities provide essential care and support, enabling residents to lead lives consistent with their aspirations for well-being and quality of life. In Flanders, a nursing home is defined as a residential care facility (public or private) where, in an adapted infrastructure and within an organisational structure, care and support are offered in a home-replacing environment to older persons with complex care and support needs, who reside there permanently [1]. In 2021, approximately 70 000 older persons were living in a Flemish nursing home with an average age of 87 years and of whom 84% had a severe care dependency [2].

Nursing homes, characterised by a resident population predominantly comprising older persons with complex care needs, stand apart from other healthcare settings. Their distinctive nature as complex working environments underscore the pressing requirement for the recruitment of competent healthcare professionals to ensure the delivery of high-quality care [3]. The World Health Organisation (WHO, 2022) recently emphasised the imperative for governments and nursing home managers to address this need by (1) equipping healthcare professionals with empowering competencies to effectively respond to the changing healthcare system; (2) strengthening the development of self-regulated and continuous competency development and (3) safeguarding the well-being of the workforce. Existing evidence underscores the impact of effective leadership on achieving the WHO's goals and statements [4–6]. Leadership is recognised as a key factor in healthcare and crucial for delivering high-quality nursing home care [7, 8]. Engagement in both formal and informal leadership practices can effectively address these challenges, yielding numerous positive outcomes for residents (e.g. improved health outcomes) [9], healthcare professionals (e.g. continuous competency development) and organisations (e.g. healthy workforce) [6].

While substantial research has been conducted on clinical leadership, the concept remains unclear [5]. Initially, the term 'clinical leader' was exclusively applied to healthcare professionals working in an acute hospital setting. Furthermore, clinical leadership was narrowly associated with the job-profiles of nurses who provide day-to-day care, acting as role models who influence, motivate and inspire others based on their values and beliefs, despite lacking formal authority for such influence [10, 11] Although existing evidence in the literature primarily focuses on clinical leadership in nursing, previous studies have indicated that any healthcare professional within a multidisciplinary team can adopt the role of a clinical leader [11]. These individuals, often willing to act as informal leaders, are working at all levels of an organisation [12]. It is important to distinguish them from formal leaders, whose leadership is based on their formal position within a group. Formal leaders are assigned to be leaders as part of their role in an organisation and having a job to organise and direct group members to meet the goals of the organisation, team, or unit [13].

The concept and role of clinical leadership have gained recognition in hospitals; however, research on clinical leadership in nursing homes is scarce and underexplored. In a previous study, the concept and characteristics of clinical leadership in nursing homes were described, providing a clearer understanding of these clinical leaders as passionate healthcare professionals who provide person-centred care, demonstrate strong communication skills, and engage in lifelong learning. They are clinical experts, visionary, committed, resilient, and responsive, and they play a crucial role in strengthening multidisciplinary team-based care [14]. In the literature review presented by Enghiad [5], it is indicated that ambiguity surrounds the concept of clinical leadership, encompassing both the formal role of 'management' and the broader notion of 'leadership.' Recent emphasis on clinical leadership has shifted towards informal leadership exhibited by nurses at the bedside, where personal and professional values align with clinical actions. Notably, most research in this domain has primarily focused on nurses, revealing a significant gap in studies involving multidisciplinary healthcare professionals [5]. To address this gap, it is crucial to focus on designing and implementing interventions that enhance the structures, processes, and outcomes in nursing homes [15].

The imperative to implement effective clinical leadership in hospitals and nursing homes goes beyond enhancing work environments; it is crucial for fostering healthy, functional, and supportive conditions for healthcare professionals [16]. Extensive literature in the hospital setting highlights the positive impact of clinical leaders on teams, resulting in improved outcomes for patients, staff, and the organisation. Clinical leaders play a vital role in ensuring positive and necessary outcomes for residents, such as health outcomes [9, 17, 18], as well as for healthcare professionals, supporting continuous competency development [4, 5, 16]. Furthermore, their influence extends to organisational benefits, encompassing a healthy workforce and the cultivation of an innovation

culture [19]. Recognizing these positive effects, researchers propose that a targeted focus on clinical leadership could potentially address the prevalent recruitment and retention challenges in which nursing homes are currently being faced with [4, 5, 16].

Unfortunately, as a consequence of these retention challenges, formal leaders in nursing homes can't provide specific support to implement clinical leadership in their organisation. Primarily, it is the responsibility of formal leaders to identify the characteristics of clinical leadership in healthcare professionals [20]. Simultaneously, healthcare professionals themselves should be aware of their leadership competencies. Specialised interventions are required to support this awareness because the most limiting factor for developing clinical leadership competencies is that individuals in these roles rarely recognise their own leadership potential [21]. Healthcare organisations should implement mechanisms that promote clinical leadership and provide opportunities for potential clinical leaders to pursue both professional and personal growth [20].

Yet developing characteristics linked to clinical leadership does not appear to be evident, as numerous factors influence the development of clinical leadership competencies in healthcare organisations. Casey et al. [22] identified the following facilitators as key elements of a supportive work context to develop nurses' clinical leadership: motivation, recognition of contributions, teamwork, mutual respect, organisational support and inclusiveness. Chavez and Yoder [10] classified influencing factors of clinical leadership into three categories: integrative collaborative healthcare teams, professional nursing competence, and structural empowerment. In contrast to the sparse literature on influencing factors, more is known about the barriers impeding the development of healthcare professionals. Some of these barriers include educational deficits (poor preparation for a leadership role, deficiencies in nursing curricula, participation in poorly designed clinical leadership programs); task assignment challenges (lack of incentives, poor communication, role conflicts, rejection of leadership roles, lack of vision and/or commitment); lack of confidence, weak interdisciplinary relationships, resistance to change and poor teamwork [16]. Healthcare professionals must cultivate a professional identity as clinical leaders. According to Fitzgerald [18], professional identity for physicians involves a process where the development incorporates the traits, values, and norms of the profession. This concept can be applied to healthcare professionals in the development of clinical leadership.

Given the beneficial effects of clinical leadership on residents, healthcare professionals and organisations, as well as the challenges inherent in nursing homes (such as the complex care needs of residents, the intricate working environment, and the demand for competent healthcare professionals), the aim of this qualitative study is to answer the following research question: "What are the key factors influencing the development of clinical leadership among healthcare professionals in nursing homes?"

Materials and methods

Design

We conducted a qualitative study in Flanders (Dutch speaking Region in Belgium) using semi-structured focus group interviews and a thematic analysis approach based on descriptive phenomenology [23]. The descriptive phenomenology was used to gain an in-depth understanding of the participants' experiences and perceptions related to clinical leadership, particularly since clinical leadership in nursing homes is a relatively new concept. Descriptive phenomenology was chosen to capture the essence of these lived experiences by focusing on how participants perceive their context for developing clinical leadership. This study complies with the Standards for Reporting Qualitative Research (SRQR) [24]. The Ethical Committee of Ghent University Hospital, in association with Artevelde University of Applied Sciences, assessed that, according to the principles set out in the Declaration of Helsinki, a formal application to approval from the Ethical Committee was not required for this study. All participants signed an informed consent form prior to participation, ensuring they were fully aware of the study's purpose and their rights. Participants did not receive any incentives for their involvement.

Context

Belgium has three levels of government, the Federal, Regional, and Linguistic Community Division level, each endowed with different responsibilities. Three distinct regional administrations are responsible for the organisation of nursing homes (Flanders, Walloon, and Brussels). They can range in size, from those with fewer than 50 beds to those with capacities exceeding 150 beds. Moreover, nursing homes can be found in either rural or urban areas, and they adhere to diverse funding models.

Participants

All licensed nursing homes in East ($n=198$) and West Flanders ($n=161$) were contacted, using the registered mailing address of the government website of the nursing home [25]. The main investigator (SN) sent an e-mail with the objectives of the study and a request to forward this email to potentially interested candidates who met the inclusion criteria: Dutch-speaking healthcare professionals employed in nursing homes in East and West Flanders. Nursing home staff who did not directly provide care to residents, such as kitchen workers and

housekeeping assistance, were excluded. Interested healthcare professionals were asked to send an email with an intent of their interest to participate in the study to the main researcher (SN).

Data-collection

Semi-structured focus group interviews were conducted to facilitate discussion among healthcare professionals about clinical leadership in nursing homes. Opting for focus groups in qualitative research proved invaluable, fostering a synergistic process where participants, in a relaxed setting, shared and reflected on their thoughts and experiences. This interactive approach refined individual viewpoints to a deeper level, yielding unique insights not attainable through individual interactions. Furthermore, focus groups are appropriate for exploring the context surrounding healthcare professionals' experiences with clinical leadership in nursing homes [26]. Before the start of the focus group interviews, two researchers (SN and EC) developed an interview guide during several brainstorm sessions (Table 1). To get a rich view on participants experiences, open-ended and non-directive questions were used [23].

The focus group interviews were organised between November 2019 and January 2020. The first three interviews were organised at Artevelde University of Applied Sciences (Ghent), the other two interviews at one of the participating nursing homes (Ghent). Each focus group was led by the main researcher (SN) who was trained in qualitative research techniques. The first focus group was organised with a senior researcher (EC) to guarantee the quality of the procedure. Each focus group followed a similar twofold procedure. After obtaining informed consent, the semi-structured interview guide was used (see Table 1). Participants were first asked to think of a colleague whom they look up to in their role as healthcare professionals. Secondly, they were asked to give a description of this colleague's personal characteristics, defined as typical or noticeable qualities of someone (Cambridge Dictionary, n.d.). Finally, printed cards with characteristics of a clinical leader in hospital and primary care as stated by Mannix et al. [16] were laid out on a table. The participants were invited to choose and discuss relevant clinical leadership characteristics of healthcare professionals in nursing homes. Next, participants were asked to appoint influencing factors to develop clinical leadership in the context of a nursing home. Each focus group interview was audio recorded.

Data-analysis

A qualitative content and thematic analysis was chosen and the different phases and stages of theme development were followed [27]. First, in the initialisation phase each focus group interview was transcribed at verbatim and anonymised, meaning that the main researchers (SN, EC) removed any identifying information. The two researchers (SN, EC) independently and inductively read the transcribed focus group interviews line-by-line, highlighted meaningful units, coded the different units in an Excel file and wrote reflective notes. They used an open coding with in vivo codes, meaning that codes were formed based on the words used by the participants to ensure an open-minded approach. Second, in the construction phase the two researchers reflected on the coding process and compared the similarities and differences to assign the codes to categories in relation to the research question (Table 2). A third researcher (PDV) provided advice throughout the process of thematic analysis of the data. Third, in the rectification phase the two researchers (SN, EC) distanced themselves from the data by gaining advice on the data from a third researcher (PDV) and by performing a member check by presenting a summarised analysis to three participants who corroborated the author's interpretations of the data. This resulted in an in-depth analysis of the data that allowed the naive understanding of the data to evolve into a comprehensive understanding with all data reunited into meaningful themes. Data saturation was achieved after the analysis of the fifth focus group. During the finalisation phase, the researchers (SN, EC) developed a written narrative by describing and connecting the various themes, categories, codes and quotes, providing comprehensive responses to the research question.

Results

In total five focus group interviews were organised. In the first round, three interviews were conducted, involving a total of 19 participants. A second recruitment round

Table 1 Interview guide applied during the semi-structured focus groups

Opening question
Consider a colleague whom you "look up to" in his or her role as a healthcare professional. This may be someone who acts as a role model for you.
Questions to appoint influencing factors to develop clinical leadership in the context of a nursing home
- What do you think is necessary for healthcare professionals to take up their role as clinical leaders in the nursing home? - What are influencing factors to develop clinical leadership in the context of a nursing home?
Closing questions
- Do you have anything else to add? - Is there anything else you would like to say about the content of this focus group?

Table 2 Results of the data-analysis

In vivo codes (Dutch)	Category (Dutch/ English)	*Theme (English)*
Gebrek aan tijd; gebrek aan tijd of aandacht om clinical leadership te detecteren; gebrek aan tijd voor extra aandacht; Tijd; Tijd hebben (proces vraagt tijd); Tijd kunnen invullen; Tijd: vrijgesteld zijn om dit te doen; geen ruimte om creatief te zijn; tijdsdruk	Tijd *(Time)*	***Empowering working environment***
Bewust rekruteren; nieuwe collega's worden opgevangen en goed begeleid; persoonlijkheidstesten	Instroombeleid *(Intake policy)*	
Mogen leiderschap opnemen; verantwoordelijkheid krijgen	Mandaat krijgen *(Recieve mandate)*	
Bevestiging krijgen; complimenten krijgen; conflicten oplossen; dingen bespreekbaar maken; mensen op positieve manier benaderen; positief bekrachtigen; positieve bekrachtiging in rol; schouderklopjes geven; waardering krijgen, op prijs gesteld worden	Open feedbackcultuur *(Open feedback culture)*	
Aangemoedigd worden, een duwtje krijgen; Een "opstapje" hebben; Erkenning krijgen; kansen krijgen; Mogelijkheid hebben om te groeien; Motiveren om eens iets anders te laten doen; nieuwe frisse ideeën; Uitdagen; verantwoordelijkheidsgevoel in team	Stimulerende cultuur *(Stimulating culture)*	
Fouten kunnen maken; fouten kunnen maken; inzetten op een lerende omgeving; kansen geven; kansen krijgen/ geven; Kunnen groeien; Kunnen leren (van elkaar); Kunnen meedenken; Mensen tijd geven zich daarin te ontwikkelen; Ruimte hebben; Ruimte hebben om te groeien; Vrijheid geven; Vrijheid hebben; Vrijheid krijgen/geven	Tijd en ruimte krijgen om te groeien *(Given time and space to grow)*	
Aanwezigheid op de werkvloer (voltijdse krachten); Mooi kader hebben en een volledige bezetting	Volledige personeelsbezetting *(Complete staffing)*	
Administratieve druk; hoge werkdruk; Hoge zorggraad van de bewoners; hoog werktempo en werkdruk; Stress; tekort aan personeel; Werkdruk	Werkdruk *(Workload)*	
Aanwezigheid hoofd; bereikbare hoofdverpleegkundige; Luisterend oor als hoofdverpleegkundige	Aanwezig en bereikbaar zijn *(Be present and accessible)*	***Supportive leadership style of the formal leader***
Als gezag de bovenhand neemt; beleid die er niet mee bezig is; Te strakke regels en structuren; top down leiderschap	Beheersgerichte cultuur *(Management-centred culture)*	
Coachen van teams; Goed "hoofd" hebben (kunnen uithalen hoe en welke collega's moeten groeien); als leidinggevende team kennen	Coachende aanpak *(Coaching approach)*	
Creëren visie van de afdeling; Ondersteuning vanuit de directie, van bovenuit de juiste visie krijgen	Inzetten op visie *(Focus on vision)*	
De manier waarop je als verantwoordelijke ermee omgaat; leiderschapsstijl; stijl van hoofdverpleegkundige	Leiderschapsstijl *(Leadership style)*	
Voorbeeldfunctie leidinggevende	Voorbeeldfunctie *(Role model)*	
Beperkte motivatie; faalangst, zichzelf onderschatten; Gebrekkige intelligentie; Geen ondernemingszin hebben (ruimte krijgen maar niet nemen); Geen voldoening in werk hebben; mensen die zich niet goed voelen; minder zelfvertrouwen; Misschien zelf niet aanvoelen; Moeten uit comfortzone treden; Niet uit comfortzone treden; onvoldoende communicatief zijn; Persoonlijke moeilijke context; persoonlijkheid; prive aangelegenheden; zelfvertrouwen	Gebrek aan professionele identiteit *(Lack of professional identity)*	***Well-developed professional identity***
Gebeurt een stuk natuurlijk; job graag doen	Inzet *(Commitment)*	
Jezelf kunnen zijn; Zelfvertrouwen; zelfvertrouwen boosten; Mensen kunnen zichzelf zijn	Zelfvertrouwen *(Self-confidence)*	
Capaciteiten moeten erkend worden; op eigen talent kunnen werken, kwaliteiten worden gezien; Peilen naar interesses van medewerkers; Taken laten uitvoeren waar zorgverleners goed in zijn; Talenten en interesses van medewerkers centraal stellen; talentgericht werken; werken aan ontwikkeling; Zelf kunnen kiezen hoe taken ingevuld moeten worden	Talentgericht werken *(Talent-focused working)*	
Bijscholingen communicatie; bijscholingen; goede opleiding; iemand die net van school komt; opleiding; opleiding volgen clinical leadership; opleiding tot zorgverlener	Opleiding *(Education)*	

Table 2 (continued)

In vivo codes (Dutch)	Category (Dutch/ English)	*Theme (English)*
Collega's kennen; competenties van personeel herkennen; competenties van personeel moeten herkend worden; duidelijke taakverdeling; een gemengde groep collega's; evenwicht bewaren tussen medewerkers; gericht nadenken "wie zet ik waar in"; Gezamenlijke taken uitvoeren; verschillende persoonlijkheden in team	Complementair team *(Complementary team)*	***Fostering team dynamics***
Constante in het team hebben; een goed plekje in het team hebben; grote betrokkenheid; steun krijgen van elkaar; vertrouwensband hebben	Betrokkenheid *(Engagement)*	
Communicatieproblemen omwille van taal; Diversiteit van medewerkers (32 nationaliteiten)	Diversiteit binnen een team *(Diversity within a team)*	
Mensen die komen en gaan (verloop in een team); Naast het team staan; onduidelijke taakverdeling; onvoldoende ingewerkt zijn; opgeleid personeel vertrekt; sfeer binnen een team; te weinig beschikbare zorgverleners; Veranderingen in team (invallers, vlinders, …); Verloop in een team: kortdurende vervangingen	Gebrek aan een geolied team *(Lack of a well-oiled team)*	
Gebrek aan aanwezigheid van verpleegkundige; gebrek aan ervaring; Gebrek aan goed opgeleid personeel; gebrek aan standvastigheid in een team	Gebrek aan een standvastig team *(Lack of a steadfast team)*	
Anderen meenemen in negatieve spiraal; Neerwaartse spiraal in team; negatief beïnvloeden; Negatief bewustzijn van leiderschap; Negatieve denker; negatieve sfeer in team; tegen zin gaan werken	Negativiteit *(Negativity)*	
Positieve voorbeelden	Rolmodel *(Role model)*	

proved necessary to enhance participant diversity, resulting in two additional focus group interviews with 22 participants. A total of 41 multidisciplinary healthcare professionals, encompassing nurse assistants, licensed practical nurses, registred nurses, occupational therapists, recreational therapists, psychologists, and gerontologics, were recruited for participation in the focus groups (Table 3). The European Qualification Framework (EQF) was used to explain the educational level of healthcare professionals (The council of the European Union, 2017) (Table 4). Among the participants, 25 (61%) healthcare professionals held informal leadership roles, while 16 (39%) healthcare professionals held formal leadership roles. Participants exhibited considerable variation in age, function, and years of experience. The nursing homes where they worked varied in size, location, and financial model. Interview durations ranged from one and a half to two and a half hours.

The analysis of the focus-interviews revealed 4 themes: (1) empowering working environment, (2) supportive leadership style of the formal leader, (3) well-developed professional identity and (4) fostering team dynamics.

Empowering working environment

First and foremost, participants stated that the empowering working environment required an *open feedback culture* characterised by encouragement, positive reinforcement and a willingness to address conflicts openly. In this open feedback culture, it is important to approach colleagues positively, exemplified by expressions of appreciation and affirmation.

> *"That we don't take those strong figures, those role models for granted, so they can be also positively empowered…" (FG3).*
> *"Conflict resolution. Sometimes there are conflicts that have been going on for some time and then they can affect your employees." (FG4).*

Furthermore, a subset of participants underscored the significance of establishing *a stimulating learning culture* within the team. Key components identified included encouragement, supportive foundations, opportunities for growth, motivation for exploration, and a collective sense of responsibility. Participants highlighted the transformative impact of fostering an environment that encourages fresh ideas, challenges, and continuous learning. The following quotes illustrates the scope of responses:

> *"I also think it's important to give employees a lot of freedom. If they are not given freedom, they cannot have wings." (FG3).*

Table 3 Demographic characteristics of the participants of the focus group interviews

Characteristics	Focus group 1 (*n*=5)	Focus group 2 (*n*=5)	Focus group 3 (*n*=9)	Focus group 4 (*n*=9)	Focus group 5 (*n*=13)	Total (*n*=41)
Duration of the focus group	**1h 43min**	**1h 44min**	**1h 46min**	**53min**	**1h 18min**	**7h 24min**
Sex						
Men (n,)	0	0	8	0	4	**12**
Women (n)	5	5	1	9	9	**29**
Age (years)						
<35 (n)	2	4	2	2	8	**18**
35-44 (n)	1	0	4	3	2	**10**
45-54 (n)	0	0	2	1	1	**4**
>55 (n)	1	1	2	1	2	**7**
Work experience (years) (yrs)						
<3 (n)	0	2	0	1	3	**6**
3-5 (n)	0	1	1	1	3	**6**
6-10 (n)	2	0	1	0	3	**6**
>10 (n)	3	2	7	7	4	**23**
Educational degree (EQF)						
Post-secondary education (EQF 4) (n)	0	1	1	4	10	**16**
Graduate education (EQF 5) (n)	0	0	0	2	1	**3**
Bachelor's degree (EQF 6) (n)	3	2	6	2	1	**8**
Master's degree (EQF 7) (n)	2	2	2	1	1	**8**
NH sise (bed capacity, n)						
<50 (n)	0	0	0	0	0	**0**
50-100 (n)	0	0	1	0	0	**1**
100-150 (n)	0	1	4	0	0	**5**
>150 (n)	5	4	4	9	13	**35**
Financial model						
Non-profit (n)	2	0	2	0	13	**17**
Private NH (n)	2	5	3	9	0	**19**
Public NH (n)	1	0	4	0	0	**5**
Location						
Urban (n)	4	5	3	9	13	**34**
Rural (n)	1	0	6	0	0	**7**

Table 4 Overview of participants' healthcare professions, educational degree and corresponding education level (EQF level) [28]

Healthcare profession	Educational degree	EQF level
Nurse assistants	Post-secondary education	EQF4
Licensed practical nurses Recreational therapists	Graduate education	EQF5
Registered nurses Occupational therapist	Bachelor's degree	EQF6
Psychologists Gerontologists	Master's degree	EQF7

> *"I think we have to put more effort into a learning environment in the workplace" (FG3).*

In the context of a stimulating working environment, participants unanimously emphasised the importance of giving healthcare professionals *time and space to grow*, allowing them to experiment and contribute ideas. Some participants identified being *mandated* by the team as a key catalyst for fostering clinical leadership and are granted to assume informal leadership roles.

Furthermore, some participants argued that formal leaders and colleagues must allow healthcare professionals to take responsibility and develop as informal clinical leaders. One participant described it as follows:

> *"If there is a vision or a mindset in the organisation that healthcare professionals are allowed to take up that mandate, informally then… then they are going to thrive in that." (FG2).*

Participants unanimously agreed that *sufficient staffing levels*, also called *a complete staff*, are essential for healthcare professionals to develop their clinical leadership.

To promote clinical leadership development and enhance the retention of healthcare professionals, participants proposed a strategic approach of prioritizing conscious recruitment practices and establishing a robust *intake policy*.

"As a team, if someone new is starting, you have to accommodate that person a little bit. Because if you leave them to their own devices, their first day already, they won't feel comfortable" (FG5).

However, barriers to clinical leadership development were identified, including (1) *time pressure* including insufficient time and attention to identify clinical leadership, limited time for extra attention for resident care and insufficient space for creativity. In addition, challenges arise from (2) overwhelming *workload* such as administrative pressure, high general workload, intense care needs of residents, high work pace, stress and staff shortages.

"Because those care needs have risen so much in recent years, there is little time to do anything extra for residents." (FG3).

Supportive leadership style of the formal leader

The participants unanimously recognised the significant influence of the *formal leaders' leadership style* on the development of informal clinical leaders within the department. As one participant noted:

"The leadership style is very important. You have to be able to recognise capabilities and get them to think about possibilities." (FG1).

Participants expressed the need for formal leaders to serve as *role models*, embodying exemplary behavior to foster clinical leadership development. *Accessibility and presence* were highlighted as crucial attributes, with participants expressing concerns about limited leadership presence, as illustrated by one participant in the following quote:

"…we have some weeks, for example, where we only have our head nurse for two days of the week. That is really too little." (FG5).

A *coaching approach*, wherein the manager understands the team dynamics, coaches teams and discerns individual growth opportunities, was identified as pivotal for clinical leadership development. One participant articulated the essence of this coaching approach as follows:

"I also think, but that is also up to the head nurse, that he or she will say 'hey, I've seen you do this, you're doing it really well.' Can't we do that more often?" (FG5).

To foster the development of clinical leadership, participants stressed the necessity for formal leaders to *focus on vision* by creating a departmental vision and ensuring that it is seamlessly aligned with the nursing home's overarching vision.

"For example, vision of the future, I think they are absolutely not concerned with that in our workplace." (FG1).
"…you should have an overall vision, but you should have the freedom to be allowed to create your own vision of your department" (FG3).

Barriers identified by participants included: (1) a management-oriented culture characterised by excessively rigid rules and structures, and (2) a top-down leadership approach. Some participants indicated that this authoritative management style frequently hindered the development of clinical leaders. One participant expressed it as follows:

"…if you are too strict with your rules and structures, you also prevent healthcare professionals from doing more." (FG1).

Well-developed professional identity

Participants highlighted the significance of possessing a well-developed professional identity and being surrounded by colleagues who share this attribute as crucial influencers in the development of clinical leadership.

Education emerged as indispensable for professional identity development, with participants emphasizing the importance of ongoing training in communication and comprehensive education for healthcare professionals to effectively cultivate clinical leadership skills. One participant articulated the importance of education as follows:

"I do think that is important that at school, social skills or a bit of psychology or dealing with people in a team, that does help in practice." (FG5).

Moreover, participants indicated that fostering clinical leadership development could be facilitated through a *talent-oriented work approach*. This approach involves assessing healthcare professionals' interests and recognising their talents, a crucial step in establishing their professional identity as clinical leaders.

"It is also nice as an employee to be recognised in the things that you do well and if you are then indeed given the opportunity to further develop the things that you like and do well." (FG1).

A well-developed *professional identity* was found to depend on healthcare professionals' dedication and genuine passion for their work, as evidenced by their *commitment* and *enjoyment*. In addition, boosting *self-confidence* was identified as a crucial factor enabling healthcare professionals to perform their professional roles with confidence and contribute positively to their professional identity.

> *"When you have just entered the field, I think it is not so easy to be a role model. If people are less confident, they will take up less clinical leadership."(FG2).*

Despite these positive influences, there was a general consensus among participants that a *limited professional identity* among healthcare professionals served as a barrier to assuming a clinical leadership role. Factors such as limited motivation, fear of failure, a lack of entrepreneurial spirit and reduced job satisfaction were associated with challenges in communication skills and discomfort in taking on clinical leadership roles. Additionally, struggling with demanding personal circumstances, feeling uncomfortable and having lower self-confidence, were cited as hindrances to stepping outside one's comfort zone and developing into clinical leaders.

> *"Some colleagues underestimate themselves, expressing doubts like 'I can't do that,' yet I believe in their capabilities." As highlighted in the quote of FG5, hindering factors often stem from personal struggles: "Personality and situation do matter because someone may have so much on their mind, privately, that it just can't be added."*

Fostering team dynamics

All participants unanimously agreed on the importance of fostering team dynamics in the healthcare setting for the development of clinical leadership. When asked to elaborate, participants highlighted the importance of having 'a team where healthcare professionals have a high level of commitment and work collaboratively towards common goals'.

> *"…if everyone pulls the same rope, you will get further." (FG1).*

A *complementary team*, characterised by knowing colleagues, recognising staff competencies, establishing a clear division of tasks and maintaining a balanced mix of personalities in a team, was deemed integral for facilitating clinical leadership development.

> *"Indeed, I think it's important in team to actually recognise the capabilities of team members and see that as a leader as well" (FG1).*

Active *engagement* in the team ensures that team members consistently find their place within the team, fostering a sense of belonging. Engaged team members not only enjoy their work, but also support and inspire their colleagues, building mutual trust and a supportive connection within the team. This engagement, as described by one participant in the following quote, is a crucial aspect of effective teamwork:

> *"Indeed, in a team, you have those colleagues who hold things together like that, the glue. This is someone who is happy, joyful which actually also makes them a little… how should I put it? Gluing the group together so that you do have a positive vibe." (FG5).*

However, participants also identified barriers, such as the lack of a *well-oiled and steadfast team*, which impedes the development of clinical leaders. Factors like a constant influx and departure of team members, an unclear division of tasks and inadequate onboarding processes, hinder clinical leadership development. The departure of trained staff, fluctuations in team dynamics and insufficient availability of healthcare professionals contribute to a challenging team environment, undermining the cohesion and stability needed for clinical leadership development. The absence of healthcare professionals on the labour market, coupled with a lack of experience and inadequately trained staff, is a barrier to the development of clinical leadership, exacerbated by the general lack of a steadfast team. Consequently, healthcare professionals frequently serve as temporary replacements or transient individuals ("butterflies"), lacking full integration into the unit. This again directly impacts the team's prevailing atmosphere, as was indicated by a participant in the following quote:

> *"Replacements, butterflies, they don't know the unit very well. They are not part of the team and do not cooperate like the other members, which sometimes makes it difficult." (FG1).*
> *"…we are actually constantly looking for employees, but we just don't find them." (FG3).*
> *"It also depends a bit on how far the steadfastness of the team is" (FG5).*

Negativity within a team poses an additional hindrance, as healthcare professionals influenced by pessimistic sentiments, compelled to work against their will, or trapped in a negative spiral can contribute to an unfavorable team atmosphere.

"Some colleagues tend to think critically, but unfortunately, it often takes a negative turn." As expressed by FG1, "this negativity can create a downward spiral within the team."
To counteract negativity, participants in the discussion proposed the importance of having positive role models within teams."

Therefore, to counteract negativity, participants suggested that observing positive *role models* in teams is helpful.

According to FG1, "observing positive behaviors in the collaborative setting, especially through performing joint tasks in multidisciplinary teams, can make it easier to engage someone as a role model."

Moreover, some participants stated that *high diversity* in values and norms among team members appears to have a hindering effect. This diversity, stemming from variations in age generations, cultural backgrounds, or even language barriers, may create challenges within the team dynamic, hindering the cultivation of clinical leadership.

Discussion

This qualitative study, conducted in Flanders (Belgium), aimed to explore and define influencing factors on clinical leadership development within healthcare professionals in nursing homes. The analysis of five focusinterviews with 41 participants from seven different healthcare disciplines revealed four themes, defined as groups or clusters of essential influencing factors on clinical leadership development in the context of a nursing home: (1) an empowering working environment, (2) a supportive leadership style of the formal leader, (3) a well-developed professional identity and (4) fostering team dynamics.

Currently, there is little evidence on factors that influence healthcare professionals' growth into clinical leaders in nursing homes [11]. Our study supports the model described by Cook [29], emphasizing the vital role of the working environment in clinical leadership development. It aligns with the external environment by highlighting empowerment, open feedback, peer learning, and a stimulating learning climate. Additionally, our findings identify practical aspects of a leadership style, emphasizing formal leaders as accessible role models who use a coaching approach. This complements the focus of Cook on the leader's experience. Professional identity, shaped by training and experience, aligns with the internal environment, emphasizing beliefs and values held by clinical leaders. Positive team dynamics, characterised by commitment, collaboration, support, and trust, add a team-oriented dimension to both internal and external environment elements in the model described by Cook. Our study also identifies specific barriers, such as a management-oriented culture, top-down leadership, a lack of professional identity, and challenges within team dynamics, contributing practical insights to clinical leadership development in nursing homes and enriching the theoretical framework of Cook [29]. However, to our knowledge, no research has been conducted in nursing homes which makes the results of this study unique and necessary for healthcare professionals in nursing homes.

Nevertheless, evidence can be found regarding the different influencing factors individually and brings us to some points of discussion.

The first influencing factor is an *empowering working environment* which implies, according to the participants, an open feedback culture, peer learning, and a stimulating learning climate. These findings are in accordance with findings by McCaughey et al. [30] showing that Magnet designated hospitals, who receive special designations for creating excellent nursing practice environments and providing excellent patient care, make investments in the clinical leadership development of their nursing staff [30]. Engaging in an open feedback culture appears to influence the development of clinical leadership. This is consistent with published research which indicates that nurses need training with a focus on conflict resolution and effective communication [4, 11, 28]. Providing healthcare professionals the opportunity for growth aligns with the principles of structural empowerment, a concept recognised in organisations that grant employees access to essential resources for their work. Introducing peer mentors seems to facilitate this process [10, 11]. In addition, structural empowerment influences the degree to which employees perceive the power to accomplish their work and influences collaboration, coordination, and achievement of patient care goals [10]. Next, working within a poor-staffed environment and experience a lack of time and a high workload were already described as barriers to develop clinical leadership [11]. Also, the national shortages of nurses, fiscal constraints, trends toward less skilled nurses and an absence of well evaluated models of care were seen as posing barriers to develop clinical leadership [11]. To date, research has predominantly examined the impact of the work environment on nurses, often within the hospital context [5, 11].

The second influencing factor, the *supportive leadership style of formal leaders* significantly shapes the development of clinical leadership among healthcare professionals. Participants in our study underscored the pivotal role of formal leaders in guiding diverse healthcare professionals toward organisational goals, emphasizing the impact of their style on the competency development of informal clinical leaders. This alignment with transformational leadership principles, where leaders inspire

collective success, forms the basis for clinical leadership development and education [6, 17]. This evidence-based theory is particularly relevant in the complexity of care and the use of multidisciplinary teams. Adopting a relational leadership style optimises the healthcare work environment and empowers all healthcare professionals, not solely nurses [9]. Additionally, employing a coaching leadership style aligns with findings emphasizing the vital role of interrelationships, recognition, trust, and support for effective leadership [11]. Our research reveals that a commitment to a management-oriented culture is detrimental to the development of clinical leadership. This alignment with the findings of Boamah et al. [4] emphasises the need for a transformative shift in leadership conceptualisation, placing frontline staff and clinicians as integral components of the leadership team within organisations. Drawing insights from Magnet designated hospitals, which employ structures like shared governance involving healthcare professionals in decision-making, our study underscores the importance of creating empowering work environments that improve professionals' skills, knowledge, and expertise to influence practice [10, 11]. Nursing homes managers, by providing leadership, support, and strategies for a healthy work environment, can potentially prevent adverse health effects among staff through their effective leadership [6].

Third, the *well-developed professional identity* of healthcare professionals can be shaped, based on participants' experiences, through targeted training, experience, and a talent-oriented work approach. This is consistent with previously conducted concept analysis indicating that professional competence is required of healthcare professionals and it is an antecedent of clinical leadership [10]. This professional competence can be achieved by effective integration of knowledge, skills, individual abilities, and judgment [10, 11]. Our research underscores the significance of a talent-oriented approach to work. However, the existing literature on the influence of talent-oriented working and its connection to the lack of professional identity and clinical leadership development remains limited. Notably, Stanley and Stanley's review [11] is one of the few sources indicating that a lack of self-confidence and experiencing burnout can indeed impact the development of clinical leadership.

Finally, the *fostering team dynamics* that prevail in a team can impact the development of clinical leadership and is marked by commitment, collaboration, support, and trust. Akin to our study, it is crucial to invest in a cohesive team with clearly defined tasks to prevent role conflicts arising from ambiguous role boundaries [11]. These conflicts emerge from the requirement of bedside health professionals to remain clinically focused, while being required to take on management functions and tasks. This leads to tension between their values and beliefs that were focused on quality patient care and the need to move away from the bedside and deal with staffing and resource issues that negatively impacted on their time or attention to direct client/patient care [11]. Thereby, healthcare professionals should clearly communicate how clinical leadership is understood within their department and the respective responsibilities which belong to the role of clinical leadership [5]. Next, mirroring our study, nursing shortages pose challenges in assembling cohesive and resilient teams, acting as potential barriers to the development of clinical leadership [11]. Finally, diverse cultural backgrounds working together in clinical settings caused by the global mobility of the workforce is seen as a limiting factor within our research while research from Mannix et al. [16] cultural perspectives of clinical leadership could also enrich our knowledge and understandings.

This study is the first to examine the influencing factors associated with the development of clinical leadership within healthcare professionals in nursing homes. It is important to note certain limitations within this study. The most important limitation is the fact that the participating group represented only a small percentage of all healthcare professionals working in nursing homes in Flanders. Participants in the first three focus groups were mainly formal nurse leaders and middle management experts. However, in the two last focus groups we expanded the group with healthcare professionals working more directly at the bedside in the same nursing homes, yet no major differences in themes addressed during the focus groups were found. Participants volunteered for the study, which could introduce biases based on their motivation. Nevertheless, healthcare professionals were reached in all hierarchical levels of the organisation. Next, the diversity of healthcare professionals in our focus groups, including those with varying levels of training, was intentional to reflect the composition and dynamics of a typical nursing home team but might be a factor influencing the results. The gap in clinical leadership education at lower levels (EQF4, EQF5) may affect the development of clinical leadership. Despite this, clinical leadership was unanimously recognized across all professional groups.

Because of the small sample size and specific context of nursing care in Flanders, the generalisability of the results may be limited. Additional research is essential to explore and implement concrete programs aimed at developing clinical leadership and optimizing influencing factors. Subsequent research should focus on (1) how different structures and formal leadership styles impact the development of clinical leadership roles, performance, and outcomes and (2) evaluating the effect of these programs

on healthcare professionals' job satisfaction and the overall quality of care provided.

Conclusions

This study succeeds in unravelling the influencing factors that shape the development of clinical leadership among healthcare professionals in nursing homes in Flanders, Belgium. The results provide a comprehensive answer to the research question: "What are the key factors that influence the development of clinical leadership among healthcare professionals in nursing homes?" Participants from multiple healthcare professions and organisational levels identified multiple influencing factors clustered in four themes: (1) an empowering work environment, (2) a supportive leadership style of the formal leader, (3) a well-developed professional identity, and (4) fostering team dynamics. By identifying these influencing factors, subsequent research should focus on the development of targeted tools that foster awareness and facilitate the design of tailored interventions. This approach allows healthcare professionals to effectively evaluate and improve their own contexts.

Acknowledgements
SN: conceptualisation, methodology, data collection, data analysis, writing – original draft preparation, review, and editing. NDR: conceptualisation, methodology. JA: conceptualisation, methodology. PDV: conceptualisation, methodology, data collection, data analysis, review, and editing. ME: writing – original draft preparation, review, and editing. EC: conceptualisation, methodology, data analysis, writing – original draft preparation, review, and editing.

Authors' contributions
SN: conceptualisation, methodology, data collection, data analysis, writing – original draft preparation, review, and editing. NDR: conceptualisation, methodology. JA: conceptualisation, methodology. PDV: conceptualisation, methodology, data collection, data analysis, review, and editing. ME: writing – original draft preparation, review, and editing. EC: conceptualisation, methodology, data analysis, writing – original draft preparation, review, and editing.

Funding
The research was conducted as part of the employment of the authors within Artevelde University of Applied Sciences and without specific external funding.

Availability of data and materials
The data that support the findings of this study are available upon request from the corresponding author, Sabrina Nachtergaele. Due to privacy and ethical restrictions, the data are not publicly available.

Declarations

Ethics approval and consent to participate
The Ethical Committee of Ghent University Hospital, in association with Artevelde University of Applied Sciences, assessed that, according to the principles set out in the Declaration of Helsinki, a formal application to approval from the Ethical Committee was not required for this study [31]. Prior to participating in the study, all participants were presented with an informed consent form. This form clearly explained the purpose of the study and outlined participant expectations. It was emphasised that participation was voluntary and that participants had the right to refuse to participate or withdraw at any time, without repercussions.

The study posed no risks or costs to participants. All data collected were kept confidential, with guaranteed anonymity for all participants throughout the research process.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Author details
[1]Research And Innovation Centre Health and Care, Artevelde University of Applied Sciences, Voetweg 66, Ghent 9000, Belgium
[2]Nursing Department, Artevelde University of Applied Sciences, Voetweg 66, Ghent 9000, Belgium
[3]Occupational Therapy Department, Artevelde University of Applied Sciences, Voetweg 66, Ghent 9000, Belgium
[4]Frailty in Ageing (FRIA) Research Group, Mental health and Wellbeing research group (MENT), Gerontology Department, Vrije Universiteit Brussel, Laarbeeklaan 103, Jette (Brussels) 1090, Belgium
[5]Faculty of Medicine and Health Sciences, Department of Rehabilitation Sciences, Occupational Therapy Research Group, Corneel Heymanslaan, 10, Ghent 9000, Belgium
[6]Department of Educational Studies, Faculty of Psychology and Educational Sciences, Ghent University, H. Dunantlaan 2, Ghent 9000, Belgium

Received: 11 March 2024 / Accepted: 19 September 2024
Published online: 03 October 2024

References

1. https: // codex. vla anderen. be/Zoe ken/Doc ument.as px?DID=10 31639&param=inhoud&ref=search&AVI DS=137 27 86,137 27 87,1 3727 88,137 2843,13 72836,13 72822,1372 824,13 72831,137 2835,137 2844,13 72845,13 72864 [Internet]. 2019. Woonzorgdecreet
2. https://w ww.vlaande ren.be/ stat ist iek-vlaan deren/z org/zor g-en-ond erste uning-v oor-ouderen [Internet]. 2012. Statistiek Vlaanderen.
3. Mcandrew RM, Grabowski DC, Dangi A, Young GJ. Prevalence and patterns of potentially avoidable hospitalizations in the US long-term care setting. Int J Qual Health Care. 2016;28(1):104–9.
4. Boamah SA. Emergence of informal clinical leadership as a catalyst for improving patient care quality and job satisfaction. J Adv Nurs. 2019;75(5):1000–9.
5. Enghiad P, Venturato L, Ewashen C. Exploring clinical leadership in long-term care: an integrative literature review. Journal of Nursing Management. Volume 30. John Wiley and Sons Inc; 2022. pp. 90–103.
6. Backman A, Sjögren K, Lövheim H, Edvardsson D. Job strain in nursing homes-exploring the impact of leadership. J Clin Nurs. 2018;27(7–8):1552–60.
7. Zonneveld N, Pittens C, Minkman M. Appropriate leadership in nursing home care: a narrative review. Leadership in Health Services. Volume 34. Emerald Group Holdings Ltd.; 2021. pp. 16–36.
8. Poels J, Verschueren M, Milisen K, Vlaeyen E. Leadership styles and leadership outcomes in nursing homes: a cross-sectional analysis. BMC Health Serv Res. 2020;20(1):1-10.
9. Boamah S. Linking nurses' clinical Leadership to Patient Care Quality: the role of transformational Leadership and Workplace empowerment. Can J Nurs Res. 2018;50(1):9–19.
10. Chávez EC, Yoder LH. Staff Nurse Clinical Leadership: a Concept Analysis. Nurs Forum (Auckl). 2015;50(2):90–100.
11. Stanley D, Stanley K. Clinical leadership and nursing explored: A literature search. J Clin Nurs. 2018;27(9–10):1730–43. https://onlinelibrary.wiley.com/doi/10.1111/jocn.14145.
12. Ross CA. The benefits of Informal Leadership. Nurse Lead. 2014;12(5):68–70.
13. Scully NJ. Leadership in nursing: the importance of recognising inherent values and attributes to secure a positive future for the profession. Collegian. 2015;22(4):439–44.
14. Nachtergaele S, De Roo N, Allart J, De Vriendt P, Embo M, Cornelis E. Clinical leadership in nursing homes: a qualitative study of healthcare professionals' perspectives on concept and characteristics. Nurs Open. 2024;11(6).

15. Siegel EO, Young HM. Assuring quality in nursing homes: the black box of administrative and clinical leadership-a scoping review. Gerontologist. 2021;61:E147-62.
16. Mannix J, Wilkes L, Daly J. Attributes of clinical leadership in contemporary nursing: An integrative review. Contemp Nurse. 2013;45(1):10–21. http://www.tandfonline.com/doi/abs/10.5172/conu.2013.45.1.10.
17. Fardellone C, Musil CM, Smith E, Click ER. Leadership behaviors of Frontline Staff nurses. J Continuing Educ Nurs. 2014;45(11):506–13.
18. Sfantou DF, Laliotis A, Patelarou AE, Sifaki-Pistolla D, Matalliotakis M, Patelarou E. Importance of leadership style towards quality of care measures in healthcare settings: a systematic review. Healthcare (Switzerland). 2017;5(4):73.
19. Asurakkody TA, Shin SY. Innovative behavior in nursing context: a Concept Analysis. Asian Nurs Res (Korean Soc Nurs Sci). 2018;12(4):237–44.
20. Davidson PM, Elliott D, Daly J. Clinical leadership in contemporary clinical practice: implications for nursing in Australia. J Nurs Manag. 2006;14:180–7.
21. Fitzgerald A. Professional identity: a concept analysis. Nurs Forum (Auckl). 2020;55(3):447–72.
22. Casey M, Mcnamara M, Fealy G, Geraghty R. Nurses' and midwives' clinical leadership development needs: a mixed methods study. J Adv Nurs. 2011;67(7):1502–13.
23. Sawatsky AP, Ratelle JT, Beckman TJ. Qualitative research methods in medical education. Anesthesiology. 2019;131(1):14–22.
24. O'Brien BC, Harris IB, Beckman TJ, Reed DA, Cook DA. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 2014;89(9):1245–51.
25. https://www.zorg-en-gezondheid.be/per-domein/ouderenzorg/woonzorg-centra [Internet]. 2023. Zorg en Gezondheid.
26. Doyle L, McCabe C, Keogh B, Brady A, McCann M. An overview of the qualitative descriptive design within nursing research. J Res Nurs. 2020;25(5):443–55.
27. Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. Nurs Health Sci. 2013;15(3):398–405.
28. Fiset V, Luciani T, Hurtubise A, Grant TL. Clinical nursing Leadership Education in Long-Term Care: intervention design and evaluation. J Gerontol Nurs. 2017;43(4):49–56.
29. Cook MJ. The attributes of effective clinical nurse leaders. Nurs Standard. 2001;15(35):38–44.
30. McCaughey D, McGhan GE, Rathert C, Williams JH, Hearld KR. Magnetic work environments: patient experience outcomes in Magnet versus non-magnet hospitals. Health Care Manage Rev. 2020;45(1):21–31.
31. Carlson RV, Boyd KM, Webb DJ. The revision of the declaration of Helsinki: past, present and future. Br J Clin Pharmacol. 2004;57:695–713.

Publisher's note