Module 01: Communication, Guidance and Counselling

Lesson 03: Critical Discussions, Management Styles and Preparing Trainees for "Special" Situations

GIZ sub-project:

MANILA - Modern Approach to Nursing Instructional Learning Advancement

Development and implementation of a blended learning qualification for instructors for nursing practice in the Philippines

Contents

1. Learning Objectives:

At the end of this lesson:

- You are familiar with critical discussions and can deal with theoretical and practical learning difficulties.
- You know how to handle learning difficulties and can explain how these difficulties can be overcome and how trainees can be supported.
- You can recognise behavioural problems as a cause of learning difficulties and discuss them.
- You are familiar with the "escalation level model" as a tool for conflict resolution in care and can explain its application.
- You know how to handle addictive behaviour and can apply appropriate responses and measures as a trainer or practical instructor.
- You have learnt how to prepare trainees for "special" situations. Using the example of end-of-life care, you can communicate with patients and relatives in an appropriate manner.
- You can explain the three leadership styles according to Kurt Lewin.
- You know the continuum model of Tannenbaum and Schmidt and can explain its individual steps.
- You can distinguish between transformational and transactional leadership behaviour.
- You know the limits and applications of management styles in nursing.
- You can explain the four sub-competences that make up the competence to act.

2. Critical Discussions

Critical discussions are an essential part of professional interaction, especially in nursing, where teamwork and the quality of patient care are top priorities. Critical discussions are an important tool in nursing to ensure the quality of work, improve the working atmosphere and promote the personal and professional development of employees. A well-conducted critical discussion can help to improve performance, clarify misunderstandings and improve the working atmosphere.

2.1 Critical Discussions - Learning Difficulties

Learning difficulties among nursing staff can lead to poor performance and errors that affect patient care. Particularly in the case of learning difficulties, critical discussions offer a structured opportunity to identify problems, analyse causes and offer targeted support. Through these discussions, nursing staff can improve their skills and thus strengthen the overall team performance.

Theoretical learning difficulties

Problem: A carer has difficulty understanding and applying theoretical knowledge from further education or training courses.

Example: A carer does not fully understand the latest hygiene guidelines and therefore does not apply them properly.

Solution in the critical discussion:

1. **Positive attitude:** "I can see that you are making a great effort to understand the new guidelines."
2. **Criticism:** "I have noticed that there are still some uncertainties in the implementation of the hygiene guidelines."
3. **Offer solutions:** "How about if we organise additional training or mentoring for you? Regular team meetings in which we clarify specific questions could also be helpful."
4. **Positive concluding remark:** "I am sure that we will master this challenge together."

Practical learning difficulties

Problem: Difficulties in applying practical skills, e.g. when carrying out care techniques.

Example: A carer has problems placing a venous access correctly.

Solution in the criticism dialogue:

1. **Positive attitude:** "I've seen that you always work very carefully and thoroughly."
2. **Express criticism:** "However, I have noticed that you find it difficult to place a venous access correctly."
3. **Offer solutions:** "We could arrange for you to practise this technique with an experienced colleague or in a special training session. It could also be helpful to give feedback directly after you have carried it out."
4. **Positive concluding remark:** "I am confident that with the right support you will soon be able to master this technique."

Time management and organisational learning difficulties

Problem: Difficulties in organising and prioritising tasks.

Example: A carer has difficulty completing all tasks on time during a shift.

Solution in the criticism dialogue:

- **Positive attitude:** "I really appreciate your commitment and dedication."
- **Expressing criticism:** "I have noticed that there are sometimes delays in completing tasks."
- **Offer solutions:** "Perhaps we could draw up a plan together on how you can prioritise your tasks better. We could also consider time management training."
- **Positive concluding remark:** "I am sure that together we will find a way to organise your tasks more efficiently."

Critical discussions are an indispensable tool in day-to-day care work, especially when it comes to learning difficulties. A structured and empathetic approach allows problems to be addressed and resolved effectively. This does not only lead to a better quality of care, but also to positive professional development for nursing staff and a more harmonious working environment.

2.2 Dealing with Learning Difficulties Among Nursing Students

In nursing, it is not uncommon for trainees to have learning difficulties. An effective trainer or practice supervisor plays a crucial role in overcoming these difficulties and supporting the trainee. Here are nine strategies on how a trainer can respond to learning difficulties:

1. **Systematic structure of the learning content (common thread)**

A structured learning plan helps trainees to maintain an overview and work through the content step by step.

Example: When learning wound care, the instructor can provide a clear schedule: from disinfection to the application of dressings and documentation. This plan is regularly reviewed and discussed.

2. **Initially limit the subject matter to the most necessary amount of information**

Avoid excessive demands by initially providing only the most important information.

Example: In the introduction to administering medication, only the basic principles and the most common medications are discussed at first. More complex aspects such as interactions and special cases follow later.

3. **Use different methods and training resources**

Various learning methods and resources help to make the subject matter clearer and easier to understand.

Example: In addition to theoretical explanations of blood pressure measurement, practical exercises, videos and demonstrations can be used to deepen understanding.

4. **Eliminate sources of distraction**

A calm and focussed learning environment is crucial for successful learning.

Example: During vital sign monitoring training, a quiet room is used where there are no disturbances from other activities or people.

5. **Regular repetition and practice of the tasks with increasing difficulty**

Repetition consolidates what has been learnt and gradually increasing the level of difficulty prepares for more complex tasks.

Example: Initially, the trainee practises applying simple dressings. After several repetitions, more complex dressing techniques such as compression bandages are introduced.

6. **Creating an atmosphere that promotes learning**

A positive and supportive learning atmosphere motivates trainees and promotes learning success.

Example: The trainer promotes open communication, praises progress and encourages questions. Mistakes are seen as learning opportunities and not as failures.

7. **Enabling a sense of achievement**

A sense of achievement motivates trainees and increases their self-confidence.

Example: Once a blood sample has been successfully taken, the trainee receives positive feedback and is encouraged to take the next steps.

8. **Positive reinforcement even for small learning progress**

Even small advances should be recognised and positively reinforced.

Example: If the trainee manages to measure the correct vital signs correctly, this is recognised and encouraged to continue practising.

9. **Allow for (short) recovery phases**

Regular breaks are important to maintain concentration and performance.

Example: After intensive training sessions on care planning, there is a short break during which the trainees can relax before continuing.

Dealing successfully with learning difficulties in nursing training requires careful planning, empathy and the ability to respond flexibly to trainees' needs. By adopting a structured approach, utilising different teaching methods and creating a supportive environment, trainers can positively influence the learning process and help trainees to improve their skills. The consideration of individual learning speeds and regular positive reinforcement are decisive factors for learning success.

2.3 Critical Discussions - Behavioural Problems

Learning difficulties in nursing trainees can often be caused by behavioural problems. These abnormalities are deviations from socially defined norms in a negative sense and often occur in young adults who are looking for their place in the adult and working world. This phase is characterised by uncertainty, disorientation and an ongoing search for values.

Behavioural problems as a cause of learning difficulties

- **Aggressiveness**

Cause: Frustration, excessive demands or a lack of conflict resolution skills can lead to aggressive behaviour.

Example: A trainee reacts aggressively to criticism or instructions, which leads to a tense working environment and impairs their ability to learn.

Instructor's response: The instructor should make it clear that aggressive behaviour will not be tolerated, but at the same time support the trainee by training them in conflict resolution strategies and addressing possible causes of aggression.

- **Provocations**

Cause: A need for attention or a testing of boundaries.

Example: A trainee makes provocative remarks or shows disrespectful behaviour towards colleagues or superiors.

Instructor's response: The instructor should set a clear boundary and address the provocative behaviour. At the same time, he can try to fulfil the need for attention through positive reinforcement for good behaviour.

- **Inhibited behaviour**

Cause: fear of making mistakes, lack of self-confidence or social anxiety.

Example: A trainee does not dare to ask questions or actively participate in tasks.

Trainer response: The trainer should create a supportive and encouraging learning environment where the trainee feels safe to ask questions and accept mistakes as part of the learning process.

- **Lies**

Cause: Fear of consequences, failure or a need to present oneself better.

Example: A trainee gives false information about their skills or progress on tasks.

Instructor's response: The instructor should make it clear that honesty is expected and that lying is not acceptable. At the same time, they should create a basis of trust so that the trainee does not have to fear negative consequences for honest behaviour.

- **An inclination for convenience**

Cause: Lack of motivation, lack of interest or a feeling of being overwhelmed.

Example: A trainee shows little commitment and avoids additional tasks or efforts.

Trainer's response: The trainer should set clear expectations and goals and emphasise the importance of commitment and initiative. At the same time, he or she can motivate the trainee by offering interesting and challenging tasks that arouse interest.

Dealing with behavioural problems

When dealing with behavioural problems, the trainer should find a balance between clear guidance and supportive supervision.

- **Demonstration of consequences**

Behavioural abnormalities should not be tolerated. The trainer must clearly communicate which behaviours are unacceptable and what consequences they will entail.

- **Showing understanding**

Despite the necessary consequences, the trainer should also show empathy and understand that these behavioural problems are often an expression of underlying insecurities and fears.

- **Offer of support**

The trainer should signalise that they are willing to support the trainee and find solutions together. This can be done through counselling, additional training or regular feedback meetings.

- **Positive reinforcement**

Successes, even small advances, should be recognised and praised in order to strengthen the trainee's self-confidence and encourage positive behaviour.

- **Creating an atmosphere conducive to learning**

An environment characterised by openness, respect and support helps to reduce behavioural problems and increase motivation to learn.

Conclusion

Behavioural problems in nursing trainees can lead to considerable learning difficulties. However, a prudent and supportive trainer can help overcome these difficulties through clear structure, empathy and consistent measures. The balance between clear rules and supportive guidance is crucial in order to both reduce behavioural problems and promote learning progress

Reflection: What behavioural problems among nursing students have you witnessed so far and how do you think should it have been handled best?

2.4 Escalation Level Model

Model for conflict resolution approaches and assistance in nursing care

If no change in behaviour has occurred after several target agreements and feedback meetings, an escalation model is used. This model stipulates that a clearly communicated desired change and lack of success is followed by a direct confrontation. Consequences are then imposed and deadlines set.

Stages of the escalation model

- Target agreements and feedback discussions
- **Target agreements:** Clear and specific goals are set together with the employee, which are aimed at the desired behaviour.
- **Feedback meetings:** Regular meetings in which progress is assessed and constructive feedback is given.
- **Example:** A nurse repeatedly displays unpunctual behaviour. In the discussions, the importance of punctuality for the team and patient care is emphasised and specific goals for improving punctuality are agreed.
- Direct confrontation

    1. **Opening the consequences:** Clear communication of the possible consequences if the behaviour is not changed.
    2. **Setting a deadline:** Defining a period of time within which the desired change must occur.
    3. **Example:** After several discussions, the carer continues to be unpunctual. A further meeting is convened in which the consequences for continued unpunctual behaviour are clearly explained, for example transfer to another ward or the initiation of disciplinary proceedings. A specific deadline is set by which punctuality must be improved.

Application of the Escalation model

1. **Preparation**
    - Collecting evidence: Documentation of all previous discussions, agreements and the lack of changes in behaviour.
    - Clear objectives: Precise formulation of the objectives and the consequences that will follow if they are not met.
2. **Realisation of the conversation**
3. **Direct approach:** Clear and direct communication of the problem and the measures taken so far.
4. **Point out consequences:** Explain the possible consequences of continuing problematic behaviour.
5. **Setting a deadline:** Defining a precise date by which the change in behaviour must take place.
6. Example: "We've already talked about your unpunctuality several times and agreed clear targets. Unfortunately, nothing has changed. If you don't turn up to work on time by the end of the month, we'll have to take disciplinary action."

7. **Follow-up and monitoring**
    - **Ongoing monitoring:** Regular review of whether the agreed targets are being achieved.
    - **Documentation:** Ongoing documentation of behaviour and discussions.
    - **Offer support:** Continue to provide support and resources to help the employee achieve goals.
    - **Example:** Regular short check-ins to discuss progress and offer support.

Exemplary implementation in the care sector

Situation: A carer continually neglects to document patient care, which leads to problems with handover and follow-up.

- **Target agreement and feedback:**
    1. **Objective:** The carer should complete the documentation completely and correctly every day at the end of their shift.
    2. **Feedback:** Regular meetings are held to check whether the documentation is complete and to address any difficulties.
- **Direct confrontation:**
    1. **Confrontation:** "We have already spoken several times about the importance of complete documentation. Unfortunately, this is still inadequate."
    2. **Consequences:** "If this does not change by the end of the month, we will have to take further measures, which may include a written warning or transfer."
    3. **Deadline:** "We expect complete and accurate documentation after each shift by the end of the month."
- **Follow-up and monitoring:**
    1. **Regular monitoring:** Daily review of documentation and weekly feedback meetings.
    2. **Support:** "If you need help with the documentation, I offer to go through the process together and clarify any questions."

Conclusion

The escalation stage model is a structured procedure for conflict resolution in nursing care. It includes the preparation and implementation of target agreements and feedback discussions, followed by a direct confrontation with consequences and a deadline. This enables clear communication and supports a targeted change in behaviour.

Escalation Level Model

The escalation level model, as it is often used in personnel management and conflict resolution, is not a single model developed by a specific person. Rather, it is a generally recognised approach that is used in many leadership and management theories as well as in practice.

However, various theorists and practitioners in the field of management, leadership and organisational development have contributed to the concepts used in such models. The concept of escalating conflicts or problems and dealing with them in a structured way is an integral part of many management and communication theories.

Some of the important contributions to the theory and practice of escalation and conflict resolution come from:

Peter Drucker: As one of the most influential thinkers in the field of management and organisation, Drucker has developed many concepts and principles that have also influenced escalation processes.

Ken Blanchard and Paul Hersey: With their theory of situational leadership styles, they have helped to understand how managers should react differently depending on the situation and manage escalations.

Eric Berne: With the development of transactional analysis and the consideration of ego states, Berne made a significant contribution to how human interactions and conflicts can be understood and resolved.

Marshall B. Rosenberg: With non-violent communication (NVC), Rosenberg developed tools that help to escalate and resolve conflicts in a constructive way.

The specific escalation level model, as practised in many organisations, is therefore a synthesis of various theories and best practices from the fields of management, communication and conflict resolution. There is no single person who is recognised as the sole developer of the model, but it is the result of collective knowledge and practical application over the years.

Reflection: Do you know any other theorists and practitioners in different fields, who contributed models or concepts on dealing with escalation and conflicts? Take some time to research on this and read on what concepts could be effective for your context in the Philippines.

2.5 Dealing with Addictive Behaviour: Reactions and Measures for Trainers and Practice Instructors

Addictive behaviour in the workplace, especially in nursing, can have serious consequences for the person concerned, the team and patient care. As a trainer or practice supervisor, it is important to act sensitively but decisively to ensure the well-being of all involved. Here are steps and measures that can be helpful in responding to possible addictive behaviour:

1. Early detection and observation

- Mindfulness: Pay attention to possible signs of addictive behaviour, such as increased absenteeism, fluctuations in performance, changes in behaviour or physical symptoms (e.g. trembling, restlessness).

Example: Alcohol and illegal drugs

Alcohol:	**Illegal drugs:**
Odour of alcohol Moodiness, irritability and even aggressive behaviour Lack of concentration Unreliability Frequent lateness Decline in the quality of work	Puncture sites Inflammations Increasing lack of interest Restlessness Apathy Decline in the quality of work

- In order to avoid a "false" suspicion, you should check over a reasonable period of time whether the symptoms occur more frequently or regularly.
- Documentation: Document anomalies and suspicions objectively in order to have a basis for discussions.

2. Preparation for the interview

10. Gather information: Inform yourself about addictive behaviour and support measures so that you can present yourself competently in discussions.
11. Quiet setting: Choose an undisturbed and quiet setting for the conversation to create an open and trusting atmosphere.

3. Dialogue

- Direct approach: Address the issue respectfully and directly without making accusations. Example: "I've noticed that you often seem unfocussed and absent-minded recently. Is there something you want to talk about?"
- Use "I" messages: Describe your own observations and feelings to reduce the pressure on the other person. Example: "I'm worried about your health and your work performance."
- Open questions: Encourage the trainee to explain their point of view. Example: "Can you explain to me what's been going on with you recently?"

4. Offer support

- Make offers of help: Draw attention to internal and external support services, such as company health programmes, advice centres or self-help groups.
- Concrete support: Offer concrete support options, e.g. flexible working hours, reduction of workload or referral to specialist centres.

5. Definition of measures and consequences

- Common goals: Define realistic and achievable goals for behavioural change and support together with the trainee.
- Commitment: Communicate clearly what changes in behaviour are expected and what the consequences are if you do not comply. Example: "We expect you to attend the counselling sessions regularly. If there are no improvements, we will have to consider further steps."

6. Follow-up and monitoring

- Regular meetings: Arrange regular meetings to review progress and offer further support.
- Documentation: Document progress and any relapses to ensure continuous support.
- Involve the network: If necessary, involve company health management or external specialist centres to ensure comprehensive support.

Exemplary implementation in the care sector

Case study: A trainee shows signs of alcohol abuse.

1. **Early detection and observation:**

The practice supervisor notices that the trainee often seems tired and unfocussed, occasionally smells of alcohol and makes more mistakes when caring for patients.

2. **Preparation for the interview:**

The practice supervisor finds out about alcohol dependency and possible offers of help in the company and looks for a quiet place for the discussion.

3. **Dialogue management:**

The practice supervisor addresses the trainee directly and respectfully: "I've noticed that you often seem tired and unfocussed recently and have made mistakes in patient care. That worries me. Can you explain to me what's going on?"

4. **Offer support:**

The practice supervisor offers the trainee support, refers to the company health management system and suggests making an appointment with the company social counselling service.

5. **Definition of measures and consequences:**

It is agreed that the trainee will take part in regular counselling sessions and have weekly feedback meetings with the practice supervisor. It is also made clear that there will be consequences under labour law in the event of further abnormalities.

6. **Follow-up and monitoring:**

The practice supervisor holds weekly meetings to review progress, documents developments and remains in contact with the company social counselling service.

Conclusion

Dealing with addictive behaviour requires sensitivity, determination and a structured approach. Through early recognition, prepared and respectful discussions, clear objectives and continuous support, trainers and practice supervisors can help affected trainees to get the help they need and find their way back to stable working behaviour.

2.6 Preparing Trainees for "Special" Situations - "End-Of-Life Care"

In the 1960s, psychiatrist Elisabeth Kübler-Ross developed a phase model that shows the mental and emotional states that occur during the grieving phase. Caring for the dying is a particularly challenging situation in nursing, for which trainees must be well prepared. The Elisabeth Kübler-Ross

grief phase model offers a structured approach to understanding the emotional experience of dying patients and their relatives and providing appropriate support.

The grief phase model according to Elisabeth Kübler-Ross

Elisabeth Kübler-Ross developed the model of the five phases of dying, which are not necessarily linear, but can serve as a guide:

- **Denial:** Not wanting to acknowledge the diagnosis and imminent death.
- **Anger (Anger):** Anger and frustration about the unjust situation. The initial state of shock is followed by denial, frustration, anger and depression. The low point is often accompanied by open resistance - whether rational or irrational.
- **Bargaining:** Attempts to delay death through negotiations or promises.
- **Depression (depression):** Deep sadness and a sense of loss in the face of the approaching end. After the mourning phase and the so-called "valley of tears", however, an opening and curiosity for the new situation follows. In this phase, those affected are ready to learn how to find their way in the new situation.
- **Opening up and acceptance:** Peace with the situation and preparation for death. Finally, they accept and integrate the change.

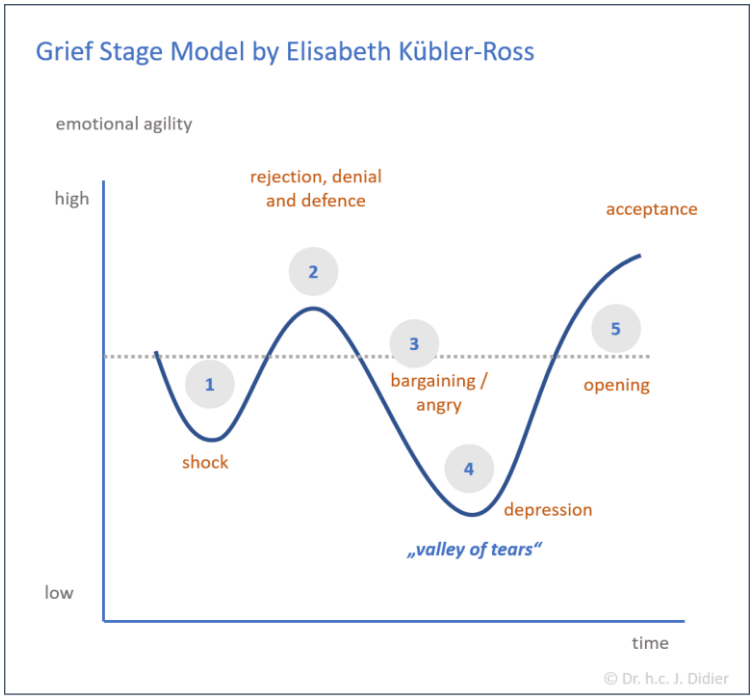

Figure 1: Grief Phase Model according to Elisabeth Kübler-Ross (self-created graphic by Jovan Didier)

Preparing trainees for end-of-life care

1. **Theoretical training**

<u>Understanding the phases:</u>

- Denial: Trainees learn that patients and relatives often initially suppress death. They should listen patiently and not try to break through the denial.
- Anger: Trainees are prepared for the fact that anger is not meant personally. They learn techniques for de-escalation and for understanding the underlying feelings.
- **Negotiating:** Trainees learn that patients and relatives often have unrealistic hopes in this phase. They should remain empathetic, but also respond realistically. Communication is very important here, even if there may be no response.
- **Depression:** Trainees are trained to accept sadness and offer comfort without minimising their feelings. When caring for a dying person, the focus is on their physical, emotional and social needs.
- **Acceptance:** Trainees learn how they can provide support during this phase by offering space for discussions and helping with organisational matters.

2. Practical exercises

Role-playing games:

- Simulations of dialogue situations: Through role-playing, trainees can act out various end-of-life care scenarios to practise their reactions and communication skills.

Observations and reflections:

- Work shadowing: Trainees can accompany and observe experienced carers during end-of-life care. The experiences are then reflected on and discussed.

3. Emotional support

Supervision and exchange:

- Regular supervision sessions: These offer trainees the opportunity to share their experiences and receive professional support.
- Discussion groups: Sharing experiences and challenges in the group to process feelings and learn from each other.

Self-care:

- Stress management techniques: Trainees learn self-care techniques such as breathing exercises, meditation and relaxation techniques to help them cope better with emotionally stressful situations.

4. Communication strategies

Empathetic dialogue:

- Active listening: Trainees learn to listen actively in order to recognise the needs and feelings of patients and relatives.
- I-messages: Using I-messages to express your own feelings without attacking the other person. Example: "I realise that this situation is very difficult for you and I would like to help you as much as I can."

Non-verbal communication:

- Body language: Conscious use of facial expressions, gestures and posture to signal comfort and understanding.

Exemplary implementation in the care sector

Case study: An elderly patient receives a terminal diagnosis and shows signs of the various stages of grief.

1. **Denial:**

Reaction of the trainee: The trainee listens patiently when the patient says: "That can't be true, the doctors must be wrong." He confirms the patient's feeling: "I understand that this is difficult to accept."

2. **Anger:**

Reaction of the trainee: When the patient says angrily, "Why is this happening to me?", the trainee remains calm and says, "It's understandable that you're angry. This situation is very unfair."

3. **Negotiate:**

The trainee's reaction: When the patient says, "I'll do anything if I only have a year left," the trainee responds with compassion, "It's normal to have thoughts like that. I'm here to support you."

4. **Depression:**

Reaction of the trainee: The trainee simply sits with the patient, holds their hand and says, "It's okay to be sad. I'm here with you."

5. **Acceptance:**

Reaction of the trainee: The trainee talks calmly with the patient about their wishes for the remaining time and helps with the organisation of visits and personal matters.

Conclusion

Preparing trainees for end-of-life care with the help of Elisabeth Kübler-Ross' grief phase model enables them to better respond to the emotional needs of dying patients and their relatives. Through theoretical training, practical exercises, emotional support and targeted communication strategies, trainees can learn to deal with these difficult situations professionally and sensitively.

3. Leadership and Management Style

Leadership refers to the personal exertion of influence on the behaviour of others in order to achieve jointly set goals. This influence is adapted to the respective situation and takes place through personal relationships, i.e. through communication and interaction. Leadership always takes place within social units, i.e. within groups. The leadership process of a group is about steering movement towards the group's objective (locomotion) and promoting cohesion within the group (cohesion).

There are numerous criteria for classifying leadership in the literature. Leadership theories aim to describe, explain and predict the conditions, structures, processes, causes and consequences of leadership. In this way, they also support the well-founded design of leadership. Among other things, leadership theories show the relationship between the leader, the led and leadership success.

Leadership styles, on the other hand, offer a purely descriptive analysis of a leader's long-term, fundamental behaviour towards those they lead. The leadership style represents a fundamental attitude that is reflected in the behaviour of managers towards their employees. It represents a consistent and recurring pattern of behaviour that remains relatively stable in the long term and independent of different situations. Leadership involves personally influencing the behaviour of others in order to achieve certain goals. These goals are usually pursued by finding, making, implementing and executing decisions and by controlling their effects.

3.1 The Three Classic Leadership Styles According to Kurt Lewin

"The three classic leadership styles go back to Kurt Lewin (1890-1947), the founder of modern social psychology, and his empirical studies. In 1937 and 1938, Lewin and his colleagues White and Lippitt investigated the effect of different leadership styles on group atmosphere, productivity, satisfaction, group cohesion and efficiency in groups of boys at the Iowa Child Welfare Research Station. The result of this study was the first differentiation between authoritarian, cooperative and laissez-fair leadership styles. These still exist today in a further developed form in many leadership style approaches" (Hummel, 2012, p. 43).

▶ Authoritarian Management Style

The authoritarian leadership style, according to Hummel (2012, 43f), "also called directive or autocratic leadership style, is a very hierarchical leadership style. Until the middle of the 20th century, influenced by industrialisation, it was considered the most widespread leadership style. The defence forces are a typical example of an application in which the authoritarian leadership style is used.

The authoritarian management style is characterised by a very high degree of task orientation and a clearly structured hierarchy. The line manager takes on a primary role here. He clearly sets himself apart from the employees and places himself above them. The line manager has sole decision-making authority. The employees are merely assigned tasks and are not asked for their opinion or involved in the decision-making process. The superior demands unconditional obedience from them. Contradiction and criticism are not tolerated. The supervisor does not provide any help in the fulfilment of tasks. In the event of failure, the employee is punished. However, responsibility remains with the superior. Firm rules and instructions ensure a high level of discipline and every employee knows their clearly assigned area of responsibility.

Advantages

- Ability to act quickly even in crisis situations
- Clarity of the competences
- Good control of employees
- Improved influence on work performance in the short term

Disadvantages

1. Lack of employee motivation.
2. Restriction of personal freedom.
3. Overburdens superiors → Wrong decision
4. Employees see no need to think for themselves or take the initiative.
5. Relations with employees are often cool and distant.
6. The superior's feeling of superiority often leads to a defiant reaction from his employees. They respond with poor performance or even non-performance" (Hummel, 2012, p. 43f).

▶ Cooperative Management Style

According to Hummel (2012, p. 45), the cooperative leadership style, also known as the democratic leadership style, "can be seen as the counterpart to the authoritarian leadership style. The cooperative leadership style emphasises teamwork. The line manager places himself on the same level as his employees. The manager actively involves his employees and subordinates in the decision-making process. Decisions are only made after a discussion involving all employees and managers. Employees are involved in the running of the company. Mistakes are discussed in the group, not penalised! Goals are explained by the line manager and assistance is given in the event of problems. The focus here is on open dialogue, discussion and mutual respect.

Upper management is relieved of subordinate tasks, allowing them to focus on their actual tasks. Tasks are assigned to employees to carry out on their own responsibility, allowing employees to assume responsibility. Independence and creativity are encouraged, which helps employees to identify with the company's goals.

Advantages

- Employees can develop their creativity;
- Goals are pursued jointly ("we-feeling")
- There is a pleasant working atmosphere (high motivation and satisfaction)
- Employees co-operate with each other.
- The supervisor is relieved. The risk of a totally wrong decision by the line manager is reduced.

Disadvantages

- The speed of decision-making often decreases because everything is discussed in the community.
- The endeavour to please everyone leads to:
  - Unclear decisions, as compromises are made
  - Discipline suffers

- Important decisions are postponed to a later date" (Hummel, 2012, p. 45)

▶ Laissez-Faire Management Style

According to Hummel (2012, p. 46), the laissez-faire leadership style is often not regarded as a leadership style in the literature, "as this style does not involve leadership at all. As the translation of "laissez-faire", "let do", suggests, this style gives employees complete freedom. The entire decision-making power lies with the group/team. Employees determine their own work organisation, tasks and goals. In addition, there are no fixed rules and everyone works independently. The line manager only takes on a passive role here. They do not intervene in what is happening. Often the line manager does not give any feedback on performance. Ultimately, this means non-management, which is why the term "laissez-faire management style" is, strictly speaking, paradoxical.

Advantages

- ▶ Self-determination of tasks → high motivation

Disadvantages

- Not everyone can handle this freedom → Disorientation
- Little interest in tasks
- High dissatisfaction
- No "we-feeling" present
- Employee performance is reduced to the minimum" (Hummel, 2012, p. 46).

A contribution to the leadership continuum according to Tannenbaum and Schmidt after

"Leadership Styles Explained (Kurt Lewin)" by Expert Programme Management (03.04.2020, 16:57 min.)

3.2 The Continuum Model of Tannenbaum and Schmidt

The continuum model by Robert Tannenbaum and Warren Schmidt is a simple and clear model. It was developed in 1958 and is based on Kurt Lewin's leadership styles. The two authors combined Kurt Lewin's poles of "authoritarian" and "democratic" in a continuum. In this bipolar continuum with seven behavioural classes, leadership behaviour is classified according to the extent to which authority is applied by the superior and the extent of the employees' freedom of choice. This leadership approach is based on only one factor, one dimension (hence the one-dimensional leadership approach): participation. (Hummel, 2012, p. 47)

"Tannenbaum and Schmidt (Tannenbaum, Robert/Schmidt, Warren 1958/1973) conceptualise the continuum of authoritarian vs. delegative leadership with the gradations patriarchal, consultative, consultative and participative. The continuum of directive versus participative leadership has subsequently been incorporated into various leadership styles and concepts (Hersey, Paul/Blanchard,

Kenneth H. 1993). As a rule, directive leadership implies that the leader takes an active role in problem-solving and decision-making. In contrast, participative leadership assumes a varying degree of participation by those being led, which can range from consultation or active involvement in decisions to sole decision-making by those being led [...]." (Business Dictionary, 2016)

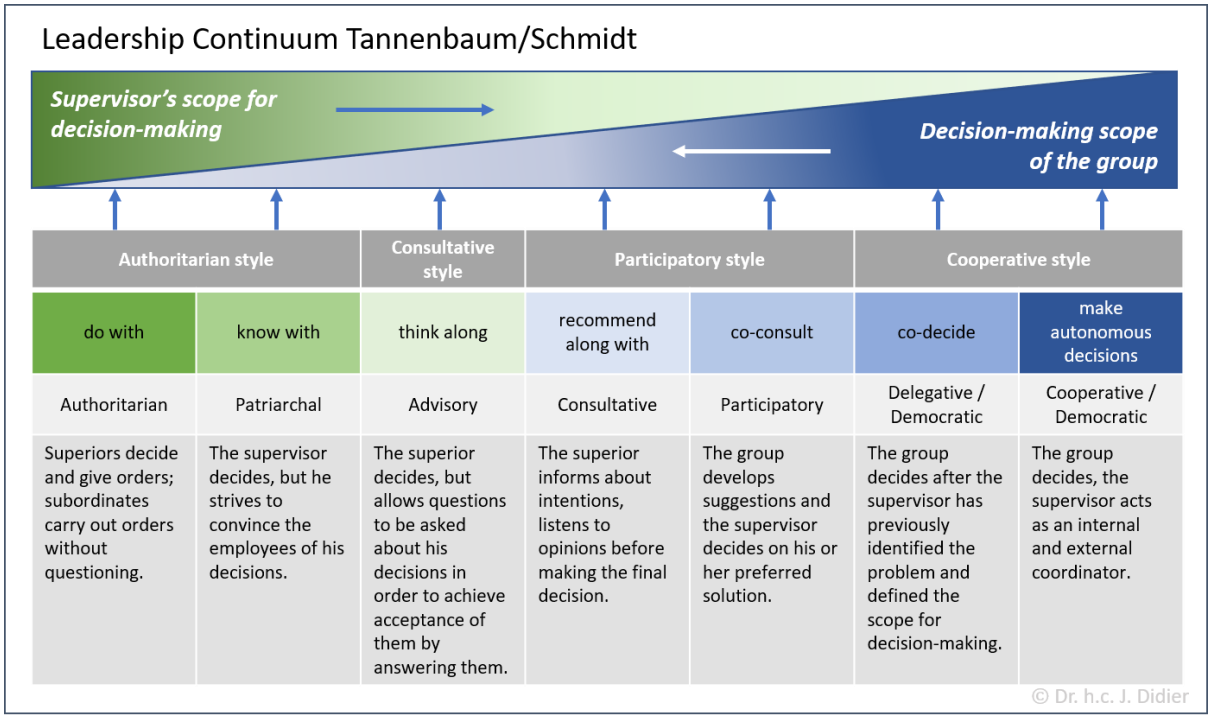

Figure 2: Leadership continuum according to Tannenbaum and Schmidt (self-created diagram by Jovan Didier)

The continuum model is a classic model of leadership theory that emphasises the flexibility and adaptability of leadership styles. It describes a continuum from authoritarian to democratic leadership styles and shows how managers can adapt their behaviour to the situation at hand. The model emphasises that there is no "one right" leadership style, but that the most effective leadership style depends on the specific circumstances.

Stages of the continuum model

The continuum comprises several levels that represent the degree of employee involvement in decision-making processes. These levels range from an authoritarian style, in which the manager has sole decision-making authority, to a democratic style, in which employees are significantly involved in the decision-making process.

1. Authoritarian (tell)

The manager makes decisions and communicates them to the employees without seeking their opinion or approval.

Example:

- A nursing manager alone decides on a new shift plan and informs the team of the decisions made. The nursing staff have no influence on the decision.

2. Patriarchal / argumentative (sell)

The manager makes a decision, explains it to the employees and tries to win their approval through arguments and persuasion.

Example:

- A nursing manager decides on a new nursing routine and explains the reasons and benefits of this change to the team in order to promote acceptance and understanding among the nursing staff.

3. Consultative (consult)

The manager proposes a decision and obtains the opinions and suggestions of the employees before making a final decision.

Example:

- A nursing manager has an idea for improving the patient service and discusses it in a team meeting to receive feedback and suggestions for improvement from the nursing staff.

4. Co-operative (participate)

The manager presents a problem, discusses it with the employees and makes a decision together with them.

Example:

- A care manager presents a problem relating to the organisation of working hours and invites the team to work together to propose solutions and choose the best solution.

5. Delegative (delegate)

The manager sets the framework and limits, but leaves the decision to the employees.

Example:

- A care manager gives the team the task of developing a new method of patient care, but makes it clear that the final decision is made by the team as long as it remains within the established guidelines.

6. Democratic (abdicate)

The manager leaves the decision-making process entirely to the employees, giving them the responsibility and confidence to find the best solution.

Example:

- A care manager allows the team to decide independently how they can improve the care process for a particular patient and only intervenes to provide support if necessary.

Application of the model

Tannenbaum and Schmidt's continuum model is particularly useful in nursing, as it emphasises the importance of leaders' adaptability in a dynamic and often stressful environment. Different situations require different leadership styles:

- In emergencies: An authoritarian style may be required to make quick and clear decisions.
- For routine tasks: A consultative or co-operative style can increase employee motivation and commitment.
- For long-term projects: A delegative or democratic style can promote the creativity and willingness of carers to take responsibility.

Conclusion

Tannenbaum and Schmidt's continuum model shows that there is no one-size-fits-all solution in leadership. An effective nursing leader must be able to flexibly adapt their leadership style to meet the needs of the situation and achieve the best possible results. By applying this model, nurse leaders can create a supportive and collaborative work environment that promotes quality care and employee satisfaction.

A contribution to the leadership continuum according to Tannenbaum and Schmidt after

"Management Courses" by Mike Clayton (23.01.2024, 15:06 min)

3.3 Transformational and Transactional Leadership Behaviour in Nursing Care

Transformational and transactional leadership behaviours are two key approaches in nursing leadership that have different effects on the work environment and employees. Transformational leadership behaviour focuses on inspiring and motivating employees by setting visionary goals and fostering a strong commitment to the values and mission of the care sector. In contrast, transactional leadership behaviour is based on clear, structured exchange relationships between managers and employees. Here, the focus is on concrete goals, rewards and consequences. Both leadership styles play an important role in nursing by addressing different aspects of employee management and motivation.

3.3.1 Transformational Leadership Behaviour

Transformational leadership behaviour aims to bring about profound changes in employees through inspiration and motivation. This type of leadership focuses on the needs and potential of employees in order to maximise their commitment and performance. Transformational leaders encourage their employees to surpass themselves and achieve their personal and professional goals.

Key aspects:

- Inspiring motivation: Managers communicate a clear vision and inspire their employees to pursue this vision.
- Intellectual stimulation: Employees are encouraged to think creatively, develop new ideas and find innovative solutions.
- Individual consideration: Managers pay attention to the individual needs and abilities of their employees and promote their personal development.
- Idealised influence: Managers act as role models whose behaviour and values are admired and imitated by employees.

Application in care:

In nursing, transformational leadership behaviour can help to improve the working environment, increase the satisfaction and commitment of nursing staff and improve the quality of patient care. For example, a nursing manager can promote creative approaches to improving the quality of care through regular team meetings and workshops. They can also respond to the individual needs of nursing staff by offering further training and career opportunities.

Example:

A nurse manager inspires her team by communicating a vision for patient-centred care. She promotes creative thinking through brainstorming sessions and encourages her staff to develop innovative care methods. She supports the individual development of her staff through regular feedback sessions.

3.3.2 Transactional Leadership Behaviour

Transactional leadership behaviour is based on a clear exchange between managers and employees. It focuses on the management of tasks and compliance with rules and regulations. This type of leadership emphasises rewards for good performance and sanctions for failure to achieve goals.

Key aspects:

- Contingent rewards: Employees receive rewards (e.g. recognition, financial incentives) for achieving defined targets.
- Management by exception: Managers only intervene when deviations from standards or problems occur.
- Clear structures and rules: Clear expectations, tasks and responsibilities are defined.

Application in care:

In nursing, transactional leadership behaviour can help to ensure compliance with care protocols and increase efficiency in day-to-day work. It is particularly suitable in environments where strict regulations and standards must be adhered to, such as in hospitals or care homes.

Example:

A nursing manager implements a system in which nursing staff receive rewards for complying with hygiene standards. Regular checks and audits ensure that the standards are adhered to. In the event of deviations, immediate measures are taken to ensure the quality of care.

3.3.3 Comparison and Combination of Leadership Behaviour

Transformational leadership behaviour promotes innovation, motivation and personal development, which leads to a committed and high-performing team in the long term. Transactional leadership behaviour, on the other hand, ensures that standards are adhered to and that day-to-day operations run smoothly.

Successful leadership in care can be a combination of both approaches, with transformational behaviour promoting long-term goals and development, while transactional behaviour ensures day-to-day operations and compliance with standards. Through this combination, care organisations can both maintain high quality standards and create a motivating and supportive working environment.

A contribution to the transformational and transactional leadership behaviour of:

"Leadership Styles: Which Type of Leader Are You?" by SkillsPacks (23.07.2015, 2:49 min)

3.4 Leadership Styles in Nursing Care

The leadership style approach developed historically from the personalistic approach, which focussed on the personality traits of managers. It was assumed that successful leaders possess certain characteristics that predestine them for leadership roles. The theoretical progress of the leadership style approach is that leadership success is no longer explained exclusively by the personality of the leader, but by the leadership style, i.e. the way in which a leader acts.

However, this approach comes with its own challenges. On the one hand, leadership style is often interpreted as a stable behavioural pattern of a manager. On the other hand, empirical research shows that managers actually adapt their behaviour to the situation at hand. This means that a fixed leadership style does not always bring the desired success, but that the manager's ability to adapt to different situations is crucial.

Limits of the leadership style approach:

- **Variability of leadership behaviour:**

  Managers vary their behaviour depending on the situation. Sticking to one management style, even when situations change, is therefore not always successful.

- **Complexity of leadership success:**

  Leadership success cannot be categorised across the board. Different aspects of leadership behaviour influence different aspects of leadership success.

- **Role of the guided:**

  The behaviour of those being led is also important. Success depends not only on leadership behaviour, but also on how those being led react to it.

A further theoretical development of the classic leadership style approaches is the "path-goal theory", which explains the relationship between the behaviour of those being led and leadership behaviour in terms of motivation theory. This theory emphasises that managers should motivate and support their employees in order to achieve jointly set goals.

Application in care

In nursing, it is crucial that managers are flexible and can adapt their management style to the situation at hand. This means that they must be able to combine different leadership styles and apply them as required.

Examples of care:

- Situation-specific customisation:

  Depending on the situation, a nursing manager must apply different leadership styles. In emergency situations, an authoritarian leadership style is necessary to make decisions quickly and effectively. In everyday situations, a democratic leadership style can be used to motivate and encourage the team.

- Motivation and support:

  By applying the path-goal theory, a care manager can motivate and support staff to achieve common goals. This could be done through regular feedback sessions, clear goal setting and the provision of resources.

- Consideration of the guided behaviour:

  The nursing manager should consider the behaviour and needs of the nursing staff. Through open communication and interactive collaboration, the manager can ensure that employees feel supported and valued.

Success in managing nursing staff depends not only on the personality traits of the manager, but also on how flexible and adaptable they can apply their management style. By taking into account the specific situations and needs of nursing staff, managers in the care sector can create a positive working environment and improve the quality of care.

4. The Four Sub-Competences of the Competence to Act

At an operational level, competence is defined as the ability that enables an individual to fulfil a task in a targeted manner based on their knowledge and responsibility against the background of an understood task. It is therefore one of the **key qualifications** of a good employee or manager. In this case, we speak of **action competence**.

> *Action competence is understood as the ability to fulfil operational tasks and solve problems in a task-oriented, targeted, situation-specific and responsible manner. This can be done alone or in a team, depending on the work organisation.*

The **ability to act** is also relevant in the personal environment. It enables individuals to make decisions, shape their environment through their actions and remain aware of possible consequences. It therefore means not only the action itself, but also a reflective approach. As this is of particular importance in all areas of life, comprehensive competence to act (correctly) at all levels also means greater success in the sense that the individual can make meaningful, purposeful and satisfactory decisions.

Since we are already talking about "action", the corresponding competence also means the ability to make a good decision regarding the **options for action**. Being able to choose a meaningful and effective course of action in the first place is a prerequisite for shaping the world (or smaller: the environment) according to one's own wishes, ideas and standards. At the same time, this results in the ability to take the initiative, which is particularly advantageous in social situations and creative processes.

Action competence includes the ability to perform nursing tasks according to requirements and situations, to solve problems and to assume responsibility, both alone and in a team, depending on the organisational circumstances.

Action competence enables nursing staff to make informed decisions, organise their working environment and consider the possible consequences of their actions. It does not only mean active action, but also a reflective approach. Comprehensive action competence leads to more effective and satisfactory decisions and thus contributes to success.

In nursing, professional competence covers four key areas:

1. **Personality competence**: the ability to understand and control oneself and one's emotions, which leads to a stable and empathetic care attitude.

2. **Social skills**: the ability to communicate and work effectively in a team and to deal with patients and their relatives.

3. **Methodological competence**: the ability to apply appropriate methods and procedures to carry out care tasks.

4. **Professional competence**: the necessary specialised knowledge and practical skills to carry out nursing tasks in a qualified manner.

Personal and social skills play a central role in care and are already shaped during early childhood development. The framework in which these competences develop is determined by society and the communication culture of the individual's environment. A lack of communicative support can lead to these social and self-centred skills not being developed sufficiently.

For nursing staff, it is crucial that all four components of action competence - personal competence, social competence, methodological competence and professional competence - are interlinked in order to fulfil their tasks effectively. The integration of these competences makes it possible to successfully master the complex demands of everyday nursing care. A corresponding diagram illustrates this connection and the importance of comprehensive action competence in nursing practice.

Figure 3: The Four Sub-competencies of Action Competence (self-created graphic by Jovan Didier)

Within personal, professional, methodological and social skills, a distinction can be made between different stages or levels, which are shown in simplified form in the following diagram. These three stages or levels should be achieved in each of the competence areas, with the goal being to reach the third stage. It can be seen that it is not only important to acquire various skills and abilities, but also to be able and, above all, willing to apply them afterwards.

Three levels of action competence

	Action of Competence			
	Technical Competence	Methodological Competence	Social Competence	Personal Competence
Level 1	Have specialist knowledge	Know different methods	Being able to perceive others in their individuality	Have a self-image that is realistic
Level 2	Ability to apply professional knowledge	Be able to apply methods	Being able to communicate with others	Know how to act convincingly
Level 3	Act professionally and with commitment	Be willing to use methods	Be willing to communicate with others	Be willing to take on social responsibility

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Figure 4: Three levels of action competence (self-created graphic by Jovan Didier)

In nursing, the four areas of competence are decisive for the quality of care and the effectiveness of nursing staff. Each area plays a specific role and contributes in different ways to comprehensive competence.

1. Personal competence

Explanation: Personal competence refers to the ability to understand and manage oneself and one's own emotions, strengths and weaknesses. In nursing, this also includes self-reflection and personal growth.

Examples:

Self-confidence: A carer is aware of their own limits and seeks support when necessary to avoid being overwhelmed.

Resilience: Despite stressful situations or emotional strain, the carer remains calm and able to act.

Empathy: A carer can put themselves in the shoes of patients and their relatives and show compassion, which leads to better patient care.

2. Social competence

Explanation: Social competence refers to the ability to communicate and work effectively with other people. In the care sector, this includes both interaction with patients and teamwork.

Examples:

Communication skills: A carer can communicate clearly and sensitively with patients and their relatives in order to clarify needs and wishes.

Teamwork: A carer works well in a team, supports colleagues and contributes to a positive working atmosphere.

Conflict resolution: In the event of differences of opinion or conflicts within the team or with patients, the carer can find constructive solutions and mediate.

3. Methodological competence

Explanation: Methodological competence encompasses the ability to apply suitable procedures and techniques to complete tasks efficiently and effectively. In nursing, this means using appropriate nursing approaches and working methods.

Examples:

Care planning: The carer can create individual care plans based on the patient's specific needs and health conditions.

Documentation: The nurse uses standardised documentation methods to correctly record the care processes and the patient's progress.

Time management: The nurse organises their tasks in such a way that all patient needs are met efficiently and on time.

4. Expertise

Explanation: Professional competence refers to the specific knowledge and practical skills required to fulfil nursing tasks properly. This includes medical knowledge, nursing techniques and an understanding of health conditions.

Examples:

Medical knowledge: The carer is familiar with the clinical pictures and treatment approaches and can apply this knowledge in care planning and implementation.

Nursing practice: The carer carries out professional nursing techniques, such as the correct administration of medication or wound care.

Emergency management: The carer is able to act quickly and correctly in emergencies by applying appropriate first aid measures and emergency protocols.

Together, these four areas of expertise form the basis for comprehensive competence in nursing. Nursing staff who are strong in all four areas are better able to fulfil the complex requirements of their profession and ensure high-quality patient care.