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Effective nursing leadership as a catalyst for person-centered care and positive nursing-patient interactions: evidence from a public Ghanaian hospital

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Abstract
Person-centered care (PCC) is crucial to patient engagement in healthcare enhancing patients' participation in critical care decision-making, increasing care disclosure, reducing medication errors, and promoting satisfaction with care outcomes. Healthcare management and leadership practices contribute to effective communication and interactions between healthcare providers and patients, which is vital for quality PCC outcomes and patient perceptions of care providers. However, little is known about how nursing leadership influences PCC and clinical interactions in the Ghanaian setting, which this study saw as a gap and aims to fill. This paper reports data from interdisciplinary exploratory qualitative research to examine the impacts of nursing leadership practices on nurse-patient relationships and care outcomes. Nurses (11), patients (22), and caregivers (11) participated in the study. Data were gathered in Ghana through interviews, focus groups, and participant observations and analyzed thematically. The three themes which emerged were: *hospital leadership and the nursing staff, healthcare management practices,* and *communication barriers* regarding how nursing leadership impacts PCC. Poor relationships between nurses and hospital leaders affected nurses' caring practices. Management practices, including an annual rotation of nurses across different patient wards and exigent patient record management routines, negatively impacted care delivery and patient-provider interactions. These leadership practices and the strained relationships between nurses and hospital leaders potentially derail effective PCC. Nursing and hospital managers must embrace transformational leadership and healthcare management practices, especially in resource-scare settings, that foster a trusting care culture and/or environment for therapeutic nurse-patient relationships to thrive and for PCC to be actualized.

Keywords Healthcare administration · Health communication · Healthcare delivery · Nursing leadership · Nurse-patient interaction · Person-centred care · Ghana · Sub-Saharan Africa

1 Background

Global health discourse has shifted toward putting patients and their care at the center of patient-provider interactions [1]. This move is generally recognized as promoting patient or person-centered care (PCC), which requires patients' care needs, values, beliefs, and circumstances to be respected and to guide provider-patient clinical

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interactions [2–5]. When healthcare providers respect and adopt PCC, patients and their families are empowered to participate in care decision-making, resulting in positive healthcare outcomes and perceptions of care [6–8].

Effective communication in nurse-patient clinical interactions is crucial to enhancing PCC [9, 10], as it promotes patient disclosure, understanding of clinical processes, and engagement in care planning and self-management practices [9]. Poor communication breeds misunderstanding and conflicts between patients, caregivers, and providers [11, 12]. Moreover, research evidence revealed that medical errors, patient-provider conflicts, and length of hospital stay increase when there is a lack of adequate and therapeutic communication between healthcare providers and patients/caregivers [13, 14]. These interactional outcomes could derail PCC.

Furthermore, effective communication is critical in nurse-nurse and nurse-nurse manager interactions, demonstrating the unique position communication occupies in healthcare [13]. Mhlongo [15] explored nurses' perceptions of nurse-nurse communication during bedside handover and found that effective communication between nurses was vital to providing high-quality care. Furthermore, undesirable adverse health outcomes occur when nurses fail to communicate essential patient information effectively to their colleagues during nursing bedside handover [15]. Timing of the handover, lack of confidence, experience, and use of local languages were reported to impact communication and nurse-nurse relationships [15].

Effective nursing leadership promotes better communication and PCC in healthcare institutions, inspiring and motivating nurses to deliver better care [16–18]. Henderson [19, p.1891] argues that effective leadership is premised on good communication because nursing "leaders who are willing to listen, tolerate alternative ideas, and accommodate periods of ambiguity" can propel high-quality care outcomes.

Healthcare facilities, including hospitals, require effective leadership and management practices to drive positive institutional culture, interprofessional interactions, and care collaboration, which are imperative for PCC [20, 21]. Today's nurses manage, lead, and collaborate in teams for effective care delivery and complex interactions; as a result, their active participation in healthcare decision-making beyond the patient ward or unit is crucial [21, 22]. There is evidence that effective nursing leadership drives communication to reduce workplace conflicts, burnout, and turnover among healthcare professionals, thereby elevating job satisfaction, especially among nursing staff [20, 22].

Also, effective healthcare leadership creates supportive environments that enhance trust in the workplace, promote staff empowerment, provide new direction, and avoid manipulative practices to effect control [18, 23, 24]. Pabico [24] believed that nursing leaders can create supportive environments to facilitate staff engagement as partners, promote resilience, and build confidence in their staff to promote organizational stability. To achieve this, it is advised that leaders must promote open and honest communication to foster trust and create a culture of belonging [24]. Moreover, studies have shown that good nursing leadership and management can promote interprofessional collaboration to enhance quality care [17, 20, 25].

Research in Ghana has revealed toxic leadership behaviours and practices among many nurse managers [26, 27]. For instance, Dartey-Baah et al. [26] examined the relationship between toxic leadership, pay satisfaction, and the leader-member relationship among public sector nurses in Ghana. The study revealed that toxic leadership practices negatively affected nurses' relationships with their leaders and that nurses, who were not happy with the leadership style of their managers, often had confrontational exchanges with them [26]. Similarly, Ofei et al. [27] explored how toxic leadership among nurse managers affects nurses' job satisfaction and productivity in Ghana. The study found that many nurse managers exhibited egoistic leadership behaviours, which forced nurses to either report late to work or leave early, leading to 59% of other nurses being overworked [27].

Another study by Ofei and Paarima [28] investigated nurse managers' leadership styles and their effects on nurse retention in Ghana. Data obtained from 348 nurses indicated that various leadership styles, including transformational, laissez-faire, transactional, autocratic, and participative were experienced by nurses [28]. Nurse retention was reported to be positively correlated with transformational leadership style compared to transactional and laissez-faire styles [28]. Ofei and Paarima [28] concluded that effective leadership is critical to ensuring safe and satisfying patient health outcomes.

Despite research evidence about the impact of nursing leadership on nurses' job satisfaction, retention, and healthcare delivery [29], less is known about the impacts of nursing leadership on PCC and nurse-patient relationships in Ghana. The main objective of the current study was to explore how nursing leadership affects nurse-patient interaction and PCC outcomes in a hospital setting. Two research questions were examined: (a) What nursing leadership practices promote or impede care delivery and nurse-patient relationships? (b) How does effective nursing leadership influence PCC in Ghanaian hospitals?

1.1 Nursing leadership theories

Transformational leadership and distributed leadership theories guided the analysis and situated the discussion of the research findings. Sullivan observes that "today's rapidly changing healthcare environment demands highly refined management skills and superb leadership" practices.[21, p. 2] Healthcare leadership and management involve leading and managing others, allocating resources, making critical decisions, communicating with staff, and resolving conflicts [21]. Leadership is also about providing direction and focus to empower others, influence change, and achieve a common goal [29]; as a result, leaders require prudent management skills and foresight.

Transformational leadership inspires, motivates, and encourages interpersonal relationships between leaders and followers to achieve an organization's common goal, objective, or values [16, 21]. Transformational leaders empower their followers by creating unity, trust, and collective purpose to achieve their organization's vision [16, 29]. On the other hand, distributed leadership values sharing responsibility and creating a network of supportive teams and a culture of shared leadership practices [16]. Leaders who practice distributed leadership engage in collaboration, delegation of roles, mediation and consensus-building to strengthen individuals and teams toward innovativeness [30]. In the hospital setting, ward in-charges, nursing managers, and healthcare administrators must embrace shared, inclusive, dynamic, and collaborative leadership roles based on context-specific demands to enhance quality care delivery, interprofessional interaction, and provider-patient relationships [31].

These theories emphasize relationships, effective communication, innovativeness in leading and managing change, collaboration and teamwork, distributing roles, and creating an enabling environment [16, 18, 25]. Studies examining the relevance of these leadership styles in nursing and healthcare management (see Cummings et al. [29], Gunzel-Jensen et al. [30], and Beirne [31]) have touted their relevance; hence, their use as an analytical lens in this article. Moreover, leadership and management practices are contextual and influenced by institutional rules, regulations, culture, and the broader social setting, which makes these leadership theories crucial as analytic tools in this study.

2 Methodology

2.1 Study design

An integrated qualitative research design was implemented in this study by drawing ideas from institutional ethnography, interpretive phenomenology, and critical discourse studies to explore nurse-patient communication and how nursing leadership practices influence PCC. Details about this study approach are reported in the first author's doctoral dissertation.

2.2 Study setting

This study was conducted in a public hospital in Yendi, located in the Northern Region of Ghana. The hospital serves as a referral center for many district hospitals in the eastern enclave of the region. Anecdotal evidence revealed poor management practices, leading to negative experiences of provider-patient relationships and severe shortages of specialist healthcare professionals and daily healthcare consumables. This situation impacted healthcare quality and delivery and nurses' job satisfaction, which motivated the larger study, part of which data is reported here.

2.3 Participants and sampling

Participants for the larger study, part of whose data are reported here, included nurses (n = 11), patients (n = 22), and caregivers (n = 11). However, only data from the 11 nurses and participant observation are reported in this paper. The 11 nurse participants were recruited across nine patient units by word of mouth and the use of recruitment posters distributed via public notices and across all the patient wards in the hospital. A few nurses facilitated the process. Nurses who had at least three years of practice experience in the hospital, were proficient in Dagbani and/or English, and provided voluntary consent were included in the study. Patients were included if they were 18 years and older, had recovered from their illnesses, and could participate in interviews for at least 25 min. Caregivers (patient relatives who supported the patient in the hospital) 18 years of age and older who were proficient in Dagbani and/or English were included to share their personal experiences on the topic. Participants who were below age 18 and could not speak Dagbani and/or

English were excluded. Participation in the study was voluntary, and only those who met the inclusion/exclusion criteria and provided prior informed consent were recruited for data collection.

2.4 Data collection

Data from in-depth individual interviews (n = 11) and participant observation (about 500 h) conducted over five months (December 2021 to April 2022) are reported in this paper. All interviews with nurses were conducted in English, recorded with a voice audio recorder, and transcribed verbatim, while notes were taken during participant observations. Interviews explored nurses' communication practices, experiences of patient rights, and how institutional culture, norms, and practices affected care delivery. Participant observations targeted daily nurse-patient interactions and clinical and communication practices within specific clinical spaces (e.g., patient admission, medication rounds, and interactions at the nurse station). The observations were conducted in a manner being mindful of clinical procedures, and only at specific spaces with no or minimal disruption to nursing caring practices.

2.5 Data analysis

Data were manually coded inductively [32, 33], analyzed using reflexive thematic [34, 35], and critical discourse analytic approaches [36, 37], and reported through narratives, text boxes, and ethnographic descriptions. See Kwame [38] for details about the various data analytic approaches employed in the larger study. Three broad themes around leadership practices were developed to understand how nursing leadership influences PCC in the study setting. The themes are (i) hospital leadership and the nursing staff; (ii) healthcare management practices; and (iii) communication barriers.

The University Behavioral Ethics Committee (Beh-ID: 2690) and the Ghana Health Service Ethics Review Committee (GHS-ERC: 005/11/21) granted ethics approvals for this study.

3 Results

Three critical themes emerged from the data about how leadership practices impacted nurse-patient relationships, communication, and caring practices. These themes and their subthemes are presented herein.

3.1 Participants' demographics

Eleven nurses, consisting of seven males, participated in the study. Most of the nurses were Dagomba. Except for one nurse, the rest were married. The nurses had an average age of 33 years and an age range of 26–40 years. They were all bilingual speakers (English plus another Ghanaian language) and had tertiary-level educational qualifications. Table 1 provides additional demographic characteristics of the nurse participants.

3.2 Hospital leadership and the nursing staff

This theme described the relationship between the nursing staff and the hospital leadership, comprised of the matron, the medical superintendent, and the hospital administrators. Three subthemes characterized these relationships.

3.2.1 Nurses' safety and professional development

Many nurses reported that hospital leadership did not care about the nursing staff's safety and professional development. It was revealed that patients or caregivers abused a few nurses, and the hospital leadership did not act. Other nurses lost valuables while on duty, yet the hospital leadership did nothing. These events and incidents led many nurses to believe that their leaders did not prioritize their welfare, as captured in the field notes below.

> *Nobody fights for nurses in this hospital. When you get a problem, you are on your own. When there is a problem with a nurse, and you take it to the matron, they don't give it serious attention. (Field notes, documented on March 2, 2022)*

Table 1 Nurses' demographic data

Code	Gender	Age	Specialize	Years worked
N1	M	32	RN/GNP	4
N2	M	32	RN/Paed N	9
N3	M	38	RN	5
N4	M	32	RN/GNP	6
N5	F	40	Midwifery	10
N6	F	33	RN/Enroll Nurse	4
N7	F	38	Midwifery	6
N8	M	31	Enroll Nurse	3
N9	M	33	GNP	6
N10	F	28	Midwifery	5
N11	M	26	GNP	8

GNP general nurse practitioner, *RN* registered nurse, *Paed N* paediatric nurse

Also, our data revealed that several nurses were denied the opportunity for further studies. As illustrated by the excerpt below, many nurses reported needing support for further studies, which did not happen; as a result, the nurses believed that the hospital leaders did not care about their professional growth and development.

The hospital leaders don't care about us, and that affects us. I may want to go and further my education, but since the hospital doesn't care about me or my welfare. I am less motivated to work. Yeah, the treatment the hospital leaders give to many nurses is not fair. (N11)
I have worked elsewhere before coming here. There, if you want to go for further studies, they [the leaders] will not disturb you. They will even support you. In some facilities, they will facilitate that for you. So, nurses there will feel that their work is being appreciated. Because no matter how high the person goes, he will definitely come back to offer his/her services to the facility. (N4)

These excerpts reflected some perspectives of nurses regarding their feelings about the hospital leadership's regard for nurses' welfare and professional development.

3.2.2 Sour relationships and power abuse

This subtheme describes nurses' perceptions about their relationship with their leaders and how power was exercised. Many nurse participants revealed that there were poor relationships between the nursing staff and the hospital leadership which prevented some newly posted nurses from coming to the hospital.

Yes, and as doctors are not here, not that they are not willing to come. But they hear about the place. 'If you go there, this or that is what happens.' Will they come here? And theirs is not like nurses, where they can just push you anywhere. And the nurses too, sometimes they will post five of them here and only one will come. The rest will not come. They hear about the poor leadership here, and those things discourage nurses from working here. (N5)

Some nurse participants also reported instances of power abuse, disregard for nurses' welfare, and other incidents to show how they felt about their relationship with their leaders.

I can't speak for other facilities, but for this hospital, it's just an over-exercise of power by the management, and that's not helping at all. People are even afraid to go to them when they have problems. (N8)

Participant observation data revealed unjust discipline against nurses. Some of these unjust actions were reported by nurses, across various patient wards, to illustrate how the hospital leadership overextended their managerial powers.

Today, I heard that a nurse was once arrested because someone went and reported something about that nurse to the matron, and without proper investigations or inquiring from the nurse, the management called for the nurse's arrest. I heard this person was a senior nurse who administered blood infusion to a severely anemic child who was brought to the children's ward as an emergency case. The nurse was arrested the next morning on the complaints of a clinician who

argued that the nurse was not qualified to prescribe for the patient, and the hospital management sided with the clinician, which resulted in the nurse being arrested. (Field notes, documented on February 4, 2022)
Another nurse narrated how their colleague was bullied for voicing his concerns. The nurse said they had heard the hospital was provided with PPEs when Covid-19 hit, but the hospital management was quiet about these PPEs. So, their colleague posted a question on the hospital's WhatsApp page asking why nothing was being said about such PPEs. After his post, the hospital management blocked his salary for months because he asked about the PPEs. (Field notes, documented February 6, 2022)

Many nurses reported several events and incidents that occurred in the hospital to demonstrate their assertion of power abuse against the nursing staff which resulted in distrust and a sour relationship between nurses and the hospital leadership.

3.2.3 Lack of motivation for nurses

Staff motivation by healthcare leaders can encourage hard work and a positive workplace culture. However, some nurse participants shared negative experiences regarding motivation in the hospital. A nurse stated, "… motivating staff is just something that is not there at all. The staff is not motivated" (N8). Other nurses reported similar views as reflected herein.

No, there is no motivation in this hospital. It's rather worse here. I am not seeing such things here. There is no just motivation of any sort. Yes, it's a challenge. (N4)
One of the challenges is motivation. As a nurse, … we need to be motivated. Not necessarily being given money. So, yes, lack of motivation is one of the barriers to effective patient-provider relationships. (N11)

Nurse motivation was a vital concern for many nurses in the hospital, as it was discussed often at the nurses' station. Complaints about lack of motivation are reflected under the heading "*Administrative challenges*" in the following narrative.

There seem to be internal relationship problems between nurses and the hospital management, a critical one of them being the lack of staff motivation. Nurses are complaining about not being motivated in this hospital. Others even said that when nurses are due for paid study leave, management doesn't want to help them get it, which demoralizes many of the nursing staff. (Fieldnotes, documented Wednesday, March 9, 2022)

For some nurses (e.g., N11), motivating staff did not have to be in monetary form. It was noted that acknowledging and recognizing staff for their contribution to care delivery and words of encouragement are some ways to motivate nurses, as reflected in the following quote.

At other hospitals, they have incentives for nurses. Here, nothing is going on. Nothing, though I am not so interested in those things. Even motivating words are enough. These will encourage you to work. (N5)

Other nurses noted that granting nurses who have served for many years and want to pursue further studies a leave with pay, and/or giving out awards, including certificates of merits, could be significant forms of motivating hardworking staff.

3.3 Healthcare management practices

This theme covers the healthcare management practices that impact care delivery outcomes and nurse-patient relationships. Many management practices were observed as negatively impacting PCC and nurse-patient communication and therapeutic relationships. The following subthemes further expand on this theme.

3.3.1 Lack of visiting hours

Interview and observation data show that visitation in the hospital was problematic. Nurses, patients, and caregivers noted that either there were no visiting hours in the hospital, or these were not adequately regulated. As a result, people could move in and out of the patient wards as they pleased. One nurse remarked, "The truth of the matter is that we don't have visiting hours" (N9). A detailed narrative about the theme of visiting hours is reflected herein, as the issue became recurrent in many discussions at the nurses' stations across different patient units.

On February 21, 2022, I asked a nurse if there were visiting hours for the ward, and the nurse said no. He said the entire hospital does not even have visiting hours, and they were fed up enforcing visiting hours because the hospital does not have one. Again, while at a patient ward on March 8, 2022, I asked the nurses about visiting hours for the ward. A male nurse there said that visiting hours were not being enforced. He said there used to be security guards at every ward's entrance, but since Covid-19 started, the guards were removed. Now, "patient relatives come in and out of the ward as they please, and we cannot enforce the visiting hours because we are usually busy with patients," the nurse said. (Field notes, documented March 8, 2022)

Because of the lack of enforced visiting hours, nurse-caregiver conflicts were common when nurses wanted to limit entry into the patient wards.

3.3.2 Annual rotation of nurses

Another healthcare management practice which affected the relationship between the hospital leaders and nurses was the annual rotation or reshuffling of nursing from one unit to another. This management practice caused conflicts between nurses (e.g., charge nurses and their colleagues) and between nurses and nurse managers, as illustrated in the following excerpts.

Yes, those annual changes should be like two years. It shouldn't just be yearly. A year is too short. For those changes, if you come to a patient ward, at least you should stay there for two years before they change you. So, yes, this is a challenge. (N5) The annual rotation of nurses in wards does affect us negatively and positively. If they take you from one unit to another, you probably won't do the same things. You will learn, but you have to adapt to their culture. (N6)

A few nurses accused their ward-charged nurse of recommending their reshuffling, while others blamed the nursing manager for not being fair and firm with the internal transfers, as suggested in the quote below.

Some nurses are unhappy with the annual changes (nurse rotations). But why should this be the case? A nurse recently complained that he was transferred to the children's ward. He said he left his leave period some time ago and returned to work when the hospital was short-staffed, yet he was moved to a different ward. He claimed that some nurses have refused to obey the changes, and nothing happened to them. He believed that someone had told the matron something bad about him. The nurse seems to suggest that the nurse manager has an informer/whistleblower among them. (Field note, documented on January 10, 2022)

As the above excerpt shows, these aggrieved nurses felt that the process was not transparent and/or not implemented fairly across different wards. This data also hinted at whistleblowing, a subtheme I will discuss later.

3.3.3 Patient records management

Another leadership issue affecting nurses' care practices, relationships with patients/caregivers, and the nursing leaders was patient records management. A nurse noted that many patients complained about how long they had to wait for their folders at the patient records unit. As a result, these patients and caregivers blamed the nurses, believing that the nurses were not doing their work.

Patients can come and spend several hours without seeing a clinician or not being talked to. So, they will feel very sad, and you can see and hear it from them. They are unhappy with the situation they found themselves in, [and] sometimes, they even talk to your face and blame us. (N8)

A ward charge nurse explained how patients' experiences at the patient record unit affect the relationship between nurses and patients/caregivers.

For my unit, one of the things that causes problems is the waiting time. Apart from that, it's the patient records department, how to get their folders, patients delay there and sometimes they blame us. They think we are the cause. (N2)

Furthermore, a nurse noted how managing patient records in the hospital affected their caring duties and called for regular in-service training to keep up with changing trends in the nursing profession.

Here, things don't get improved. At other places, they no longer use folders, here we are still using folders, and we need some training to keep improving the staff's capacity. There is nothing like that here. And you know, as days go by, patients'

medications change. But if there is no in-service training for the staff to keep them updated, something will even change, but others will still hang on to it. So, I think this issue is a challenge here. (N4)

3.3.4 Whistleblowers and spies

The nurse participants revealed that the nursing leadership had frustrated unity among the nursing staff by identifying and planting some nurses among the staff to feed the leaders information. A few nurses reported that whistleblowing and spying disrupted the nursing staff's collective power as individual nurses were often identified and punished for minor commissions and omissions. The following narratives conveyed the feelings of some nurses about whistleblowing and spying in the hospital.

Mr. X (name withheld for anonymity purposes) said nurses are often reported to the hospital management. He narrated how he was reported to management for selling things to patients when he was rather against that act. The nurse said there is whistleblowing in the hospital among nurses, where staff report their colleagues to management, and when the person reported is summoned, the identity of the one who reported him/her is often hidden/not revealed. (Field notes, documented Tuesday, March 29, 2022)

Also, there was a discussion at the nurses' station about spies among them and how that affected their ability to demand or lead change in the hospital, which was captured in the following field notes.

A blood pressure monitor was giving incorrect readings. The nurse who was using this device realized that the battery was dead, so he asked his colleague to go to the matron's office to pick up new batteries. I asked the nurses what would happen if the matron was not around, and they could not get the battery. The nurses said there would not be any work. One of them said they would just sit there. The senior nurse said, "As for this hospital, things are very bad, and we could not do anything because some nurses in the hospital spy on others for management. Some nurses have become very close to the management to feed them information about happenings in the wards. This culture weakens the nurses' front, and we can't fight for anything." (Field notes, documented on January 31, 2022)

Hence, whistleblowing and spying were viewed by nurses as affecting their collective voice and generated a poor relationship with the hospital management.

3.4 Communication barriers

The theme of communication barriers relates to the communication challenges that exist between nurses and the hospital leadership. These barriers, including communication gaps and structural bureaucracies, affected the nurses' relationships with their leaders and nurses' motivation to deliver PCC.

3.4.1 "The communication gap between us is wide"

Several nurses stated that there was a huge communication gap between them and their nurse managers, making it difficult for nurses to reach out to management regarding their professional and personal challenges. This communication gap is reflected in the following comments.

Another factor is communication between the nurses and the management. Most times, the communication gap is very wide because is like we are not close, at times, something can be happening, and the communication is not there. The communication system should be enhanced to ensure that all nurses can get closer to the management. (N11)
As for our leaders, they don't listen to people. They are not good listeners (0.7), [ok]. I don't know why. Instead of them listening, they don't. When you have an issue, you don't know who to send your problem to. Sometimes, when you even go to them, they shout at you. So, they don't care about what we say. And that's not how to rule [lead] people. (N5)

These communication barriers were maintained through the culture of fear and silence, as a nurse (N5) indicated, "We don't often meet to discuss things because here there is no freedom of speech. Sometimes, you will say something, and you could be reported to management."

Furthermore, communication barriers affected patient disclosure, as a nurse noted:

Sometimes when they come you ask them questions, they will give you answers and later you will find out that they had given you contradictory [inaccurate] answers. So, that one is always a challenge when you are going to take care of that patient. Other times, when there is good communication, the patient will tell you everything that you need to know to help them. You may not even ask about those things, but they give you the additional information that can help you care for them. (N4)

Thus, effective communication potentially affects the accuracy of patient disclosure. Moreover, effective communication between nurses and their managers could promote better care delivery if nurses were listened to and supported to manage their personal and professional job-related challenges.

3.4.2 Leadership bureaucracies

Another communication barrier identified in the data was leadership and/or administrative bureaucracies, regarding accessing resources for care delivery, as noted in the excerpt below.

The bureaucratic nature of the hospital affects our work. There are instances when you need oxygen, and a simple call should have gotten you that. But no, you must talk to this or that person before you get it. (N4)
The problem is just the hierarchy. You can't express your frustrations, feelings, or opinions to them. They will block your salary for months. (N8)

Aside from administrative bureaucracies, other nurses indicated that the lack of clear leadership structure and oversight regarding the work of nurses affected communication between the nursing staff and the nurse manager.

Institutional structures, as in bureaucracies, y' know, when (0.4) may be authority don't want to take up issues when they trickle down and feel that someone should have added responsibility, while someone could have been doing that at ease, where simple issues could have been kept, and barriers overcome. (N9)

A few other nurses believed that the removal of some of the hospital leaders would promote better leadership and service delivery. For instance, a nurse suggested that we include the following questions in the interview protocol for nurses regarding the hospital leaders.

Researcher: Is there any other question you think is essential that I may include in my interview guide? Something you think can provide additional essential data on the topic of research.
N8: Yes, the questions I would have loved you to add are:

1. *If you had the chance to recommend or suggest that one of the top officers should be transferred or replaced, who would that be?*
2. *Are you okay with how the hospital, facilities, and services are being run in this hospital?*
3. *Should the higher-ranked officers of this hospital be supervised, and by whom?*

From this dialogue, it can be inferred that some nurses disliked the leadership style of specific hospital leaders. Based on participant observations, several nurses felt that the offices of the matron, the medical supervisor, and the hospital administrators were merged because issues concerning nurses were being handled by the medical supervisor instead of the matron (who was the hospital's chief nursing officer). Others felt that there was no separation of powers, checks, and balances because these three offices appeared to act as one, whether a problem at hand was nursing, medical, or administrative-related.

4 Discussion

This study explores the impact of nursing leadership in promoting effective nurse-patient communication and PCC and found that poor nursing leadership practices affected nurse-patient, nurse-nurse relationships, and PCC outcomes. Our results are discussed relative to nursing management and patient care outcomes.

4.1 Nursing management

The kind of leadership practiced in the hospital affected nursing care practices and caring relationships. As a result, some nurses become emotional when patients/caregivers disagree with them.

Poor nursing leadership implicated human and material resource management in the healthcare institution (e.g., the oxygen case). Many newly posted nurses and doctors refused to serve in the hospital due to perceptions of poor leadership practices. Research revealed that transformational leadership seems a natural fit for nursing managers since nursing is traditionally influenced by its roots in providing social and ethical human services to alleviate human suffering from illnesses [21]. Furthermore, this leadership style can promote practical co-existence between nurses, their colleagues, and patients across various healthcare settings [21]. Nonetheless, the lack of transformational leadership in the study setting affected nursing management, as evidenced in the relationship between the nursing staff and their leaders. Hence, to encourage nurse retention and efficient healthcare resource management, including the nursing staff, the hospital's leadership ought to embrace transformational leadership philosophies.

Our study also revealed that many nurses lost the passion to continue working in the hospital due to mistrust between them and their leaders, lack of motivation, and feelings that their welfare was being neglected. For nurses to feel valued, motivated, and passionate about their work, they must have a trusting relationship with their healthcare managers. From a human-centered perspective of nursing leadership, Leclerc et al. [39] argue that recognizing the expertise, contributions, and values of nurses who serve at the point of care is crucial to delivering high-quality care. Furthermore, Leclerc et al. [39] advised that nurse managers and leaders must be interested in their staff's development, growth, and empowerment in critical decision-making. In this study, we found that nurses' participation in care management requires special attention, especially given the context of human and material resource scarcity. Leclerc et al. [39] observed that showing sincerity, care, and interest in the personal and professional needs of the nursing staff potentiates staff satisfaction and passion for their job.

A critical finding of this study was that poor communication and major communication gaps between care providers and their managers, whether at the patient unit or higher management level, are detrimental to effective care delivery. When nurses cannot access healthcare resources because of bureaucratic structures or cannot reach out to their managers and leaders during critical moments because of fears of being reprimanded, disgraced, or even neglected, the care provided is compromised [19]. Transformational and distributed leadership principles advocate effective and transparent communication, active listening, and dialogue between nursing managers and their nursing staff [16, 30]. This study's results support previous research on nursing leadership in Ghana, especially regarding the lack of inspirational communication by nurse managers [40]. Our results corroborate Aberese-Ako et al.'s [41] finding that most Ghanaian hospital managers cannot implement transformational and distributed leadership practices because of contextual challenges, including resource constraints, procurement bureaucracies, and external pressures.

Where there is minimal trust between leaders and their followers, some leaders may adopt unprofessional practices to exert control over their followers. Many nurses in our study were afraid to speak up, while others believed the hospital leadership planted whistleblowers within the ranks. Although Ghana has laws on whistleblowing (Whistleblowers' Act, 2006 (Act 720)), which encourage reporting unprofessional and corrupt practices in public institutions, cultural factors seem to hinder enactment [42]. Besides, the Whistleblowers Act targets corruption more than healthcare malpractices [43]. Moreover, speaking up and advocating for patients and other vulnerable groups has been a virtue in nursing practice; nonetheless, whistleblowing is considered unprofessional practice in many professional spheres, including healthcare institutions [44]. Nursing managers and healthcare leaders must institute alternative crime-reporting mechanisms that are less disruptive to relationships and trust. As found in this study, nurse burnout, poor worker motivation, and the culture of silence could influence nurse staff's negative work attitudes, including lateness, absenteeism, and pilfering.

4.2 Patient care outcomes

Good leadership practices can promote a positive care culture and environment for nurse-patient interactions and trusting relationships. Nonetheless, many patients and caregivers mistrusted nurses. Patients and caregivers blamed nurses for long wait times when accessing their folders. Mistrust between nurses and patients/caregivers leads to conflicts, misunderstanding, and disrespect, affecting PCC philosophies [45]. Nursing managers and leaders need

to build a culture of trust to foster PCC practices. Poor leadership practices, nurse shortages, and work overload can affect nurses' emotional and mental state, leading to reactive violence and substandard care [46].

Lastly, our study uncovered that communication challenges affected patient disclosure which could have compromised care quality and patient wellbeing. This finding supports previous research that reported that effective and open communication between patients and providers promoted patient engagement in their care, allowed patients to ask questions about their health, and enhanced positive perceptions of care and healthcare providers among patients [9, 10, 13, 14].

Our results revealed that certain leadership practices and resource constraints affected nurse-patient interactions and care delivery, which could compromise PCC outcomes. Leadership bureaucracies impacted on ease of access to critical care resources, including oxygen for emergency use, nursing staff retention, and medical doctors. Data revealed that some newly trained nurses and medical doctors refuse their posting to the hospital because of perceptions of poor leadership and lack of motivation. The shortage of nurses and medical doctors impacted efficient care delivery, as patients and caregivers had to wait for hours to be attended by clinicians. These findings confirmed the results of previous studies that effective leadership practices directly affect care quality in Ghana [47] and Pakistan [48], thereby underscoring the relevance of transformational leadership in shaping healthcare service quality.

Challenges in accessing patient folders and managing visiting hours were described as affecting nurse-patient/caregiver relationships. Accessibility challenges in the patient record department led to delayed care as patients and caregivers had to wait several hours before retrieving their folders to access care. Additionally, nurses had difficulty enforcing visiting hours, which compromised patient safety and the amount of time patients needed to rest after medication rounds, thereby straining the relationships between nurses and patients. Our findings corroborate the work of Abuosi et al. [49] who reported that the patient safety culture in Ghana is influenced by supervisor and hospital management support systems and practices. Abuosi et al. [49] observed that, to minimize adverse events in medical and care practices and ensure patient safety, nursing and hospital managers must enhance healthcare professionals' teamwork, effective communication, and organizational support for efficient patient record keeping. These can be achieved through transformational and distributed leadership practices.

5 Conclusion

This paper explored the influence of nursing leadership practices on PCC and communication in a Ghanaian healthcare setting. Results demonstrate that effective leadership can empower and motivate nurses. Nursing leadership practices that value trust, communication, and the unique contributions every staff brings to the healthcare setting promote a positive culture. Our results show that staff motivation and attention to nurses' personal and professional development needs are critical to enhancing PCC. Effective communication promotes good relationships between nurses and healthcare managers/leaders, with other nurses, and patients/caregivers. Nurse leaders, healthcare managers, and administrators in Ghana and other resource-poor contexts must embrace transformational and distributed leadership practices to enhance communication and PCC in their healthcare facilities.

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Author contributions AK conceived the topic, collected data, and drafted the manuscript. PMP supervised the project, edited the article for language and grammar, and reviewed it for intellectual content. AK and PMP read and approved the final version of the article.

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Data availability Data used in this article are part of a doctoral research project and can be made available from the corresponding author upon reasonable request.

Declarations

Ethics approval and consent to participate Approval was obtained from the ethics committee of the University of Saskatchewan and the Ghana Health Service Ethics Committee. The procedures used in this study adhere to the tenets of the Declaration of Helsinki. Informed consent was obtained from all individual participants included in the study. The authors affirm that the research participants provided informed consent for research publications.

Competing interests The authors have no competing interests to declare that are relevant to the content of this article.

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