Leadership Competencies, Workplace Civility Climate, and Mental Well-being in El- Azazi Hospital for Mental Health, Egypt

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Abstract

Background: In light of the coronavirus pandemic, a team leader's ability to attain and maintain healthy workplaces is crucial. Nurse leaders should aim to mitigate workplace anxieties by promoting team cohesiveness, mutual support, and the wellbeing of members. **Aim**: This study was conducted at the beginning of COVID-19 pandemic to assess the effect of leadership competencies on workplace civility climate and mental well-being at an Egyptian hospital for mental health. **Design**: Descriptive correlation design was used. **Tools**: Measures used were leadership competencies, workplace civility climate, and the Warwick-Edinburgh mental wellbeing scale. Results: more than half of the sample were satisfied with leaders' competencies, three quarter of them rated the workplace environment as respectful, and more than three quarter of them reported moderate or good mental wellbeing. Statistically significant correlations were found between leadership competencies and both workplace civility climate and mental well-being. **Conclusion:** leaders at El Azazi Hospital were assessed as proficient and providing a positive civility climate, but were not sensitive to the mental wellbeing of staff. **Recommendation**: Future research to investigate what specific factors affect mental well-being among psychiatric nurses rather than leadership competencies is recommended.

Keywords: Leadership competencies, Mental well-being, Civility climate

Introduction

In stressful times such as the COVID-19 pandemic, healthcare teams must perform at their most effective and sustainable levels (**Greenberg & Tracy, 2020**). However, healthcare skills and resources to respond to a health disaster in Britain, the United States and similar jurisdictions were built up over decades (**Mustafa, Farver, Bierer, & Stoller, 2019**).These researchers reported that after hours, relaxation for healthcare workers include socialising with work colleagues, spending time with family, or playing sport. In early 2020, the pandemic struck and these social gatherings were not available. Further, healthcare staff found that they were in a different work environment, using personal preventative equipment, strengthened work practices, engaging with a disease which had no effective counteragents and were forced to accept they were unable to prevent a patient's demise, which Greenberg and Tracy described as 'moral injury'. The sense of moral injury occurred when a healthcare worker's ability to respond was inadequate. This is an instance where leadership, particularly of extended teams

of intermingled healthcare professionals becomes crucial (**Greenberg & Tracy, 2020**).

Nurse leaders can influence team performance, communications, and patient care by promoting a principled, collaborative, and inviting working environment. These qualities contrast with instances or even workplace cultures of incivility, which are at the least unhelpful and at the extreme, degrading for individuals (**Edmonson, Bolick, & Lee, 2017**). Qualities of nurse leaders can assist the overall development of an organisation, so that staff selection, performance measures, and training should focus on complementary competencies (**Sortedahl, Ellefson, Fotsch, & Daley, 2020**). **Sortedahl et al.** found that managing change, conflict resolution, and prioritising tasks predominated amongst skills organisations desired for nurse managers.

In a review of global attributes for nurse leadership, **Heinen, van Oostveen, Peters, Vermeulen, and Huis (2019)** classified these as clinical, professional, health policy, and health systems knowledge and skills. In the United States, **Warshawsky and Cramer (2019)** found that nurse managers described themselves as competent after about six years' experience, then from year 7 they considered their skills and knowledge as proficient. This was achieved through first experience, then continuing graduate education**.** A study by **Abou Hashish and Fargally (2018)** at Alexandria Medical Research Institute hospital found that nurse leadership was at the first level in engaging with their team in problem solving and decision making, and that leadership training would be beneficial.

Returning to competency based standards for recruitment or performance measures, **Ruben (2019)** also advocated

for leaders 'motivation, productivity, accountability, communication, and judgement' (**Ruben, 2019**).Whilst **Al Habib (2020)** found leadership had a significant relationship with organisational performance, employee retention, and satisfaction in healthcare, the study referred to hospital administration rather than nurse teams. There were several studies identified that associated nurse leadership styles with team members' satisfaction and turnover intentions, however, the rigour of the data collection and analysis was not satisfactory e.g. (**Falatah and Salem, 2018**). Other references reported contradictory findings, for instance **Magbity, Ofei, and Wilson (2020)** in Ghana found that laissez faire and autocratic leadership styles led to increased intention for nurses to leave. However, in Iran, **Pishgooie, Atashzadeh-Shoorideh, Falcó-Pegueroles, and Lotfi (2019)** reported that laissez faire leadership was conducive to nurses staying with their organisations. **Pishgooie et al. (2019)** concluded that a successful nurse leader should be clear in communicating organisational values, show empathy, and support team members' suggestions and ambitions.

There were Egyptian studies on the effect of nurse leadership style on team performance. **Ahmed, Ata, and Abd-Elhamid (2019)** associated enhanced team innovation with a transformational leadership style, whilst **Ali, Saad, and Alshammari (2020)** found benefit for nurse leaders and their teams from a workshop on authentic leadership traits. However, a study by **Ibrahim, El Sayed, Attala, and Elmezin (2016)** was inconclusive

Civility is a relatively new concept that takes a different perspective to a negative bullying and isolation research

focus (**Armstrong, 2017**). Armstrong instituted a nurse workplace training program to recognise incivility, reduce the instances of this behaviour, and increase nurses' confidence in responding to these incidents. Focussing on perceptions of civility characteristics, **Porath, Gerbasi, and Schorch (2015)** concluded that people in a United States' biotechnical firm sought out those who were considered civil (friendly and competent) for advice and leadership. Also in the United States, Clark, Sattler, and Barbosa-developed and tested a workplace civility index for psychometric variables; this has been used recently by **Hickson (2019)** and **Howard and Embree (2020).** Others have used the **Clark et al. (2018)** index as a reference for their own measures, such as **Tiwari and Sharma's (2019)** 'dignity in the workplace' scale in India. Recently, **Atashzadeh - Shoorideh, Moosavi, Balouchi, and Riley (2020)** reviewed the in/civility environment for nurses, finding that of 61 papers from 1997, incivility was reported at 50.1 per cent.

Again, in the United States, **Authement (2016)** explored an ethics statement (code of conduct) to assist nurse students with issues concerning civility, whilst in Egypt, **Salem and Ebrahem (2017)** found linkages between stress and a psychosocial working environment. One academic paper used an amended workplace civility scale in Egypt, that of **Hossny, Qayed, and Yoyssef (2015)**. The respondents were new nurses (<2 years' experience) who rated the three hospitals in Asyut City, lower Nile as low civility workplaces.

In Malaysia, **Abu Bakar and McCann (2018)** associated a friendly leadership style (servant leadership) with politeness (civility), finding that politeness in workplace communications enhanced team performance. However,

Naiditch (2018) stated that politeness as an aspect of civility fluctuates with culture, where social interactions are defined over the generations so that politeness/impoliteness and civility/incivility may be associated differently between cultures and between generations. In Israel, **Itzkovich, Dolev, and Shnapper-Cohen (2020)** found that (in) civility was associated two psychological measures of ethical conduct and quality of work life. Civility encourages warm, friendly, other-oriented behaviours and conveys competence for those who possess and present social skills. They become alert to others, respectful, and adjust their behaviour to social circumstances **(Porath, Gerbasi, & Schorch 2015**). Whilst there a good civility climate has benefits for the team and the organisation, this environment also assists in patient care (**Oppel & Mohr, 2020**).

However, wellbeing is a psychological trait rather than an aspect of workplace behaviour and difficult for leadership intervention, particularly in a stressful working environment such as intensive care centres **(Adams, Chamberlain, & Giles, 2019**). The concept of mental wellbeing for nurses could be comparable to research into job satisfaction, which was the focus of a literature review on emergency centre workers in hospitals by **Schneider and Weigl (2018).** Schneider and Weigl found that wellbeing/satisfaction was based on a convivial and structured workplace environment, and together with satisfactory remuneration these factors were conducive to satisfaction/wellbeing for healthcare workers. Using a sample of mental health nurses in England (London), **Oates (2018)** found that the participants has a relatively low opinion of their overall wellbeing, but developed their own methods of managing stress in their own time, such as exercise, listening to

music, activities in nature, and mindfulness time. The nurses needed a distinct barrier between work and home life, although they reported the use of insights from patient care in their own way. In a Dutch mental health facility, **Der Kinderen, Valk, Khapova, and Tims (2020)** also associated a servant leadership style with a high workplace civility climate and eudemonic (virtuous) wellbeing for staff. In Iran, **Dehvan, Kamangar, Baiezeedy, Roshani, and Gheshlagh (2018)** advocated for family and maturity as building resilience in mental health nurses. Similarly, in Australia, **Foster, Roche, Giandinoto, and Furness (2020)** advocated in resilience training for undergraduate nursing students, especially in mental healthcare. This is important, as in a review by **Johnson et al. (2018)** found that mental healthcare workers exhibited higher stress levels and poorer wellbeing than their peers in other healthcare sectors.

Again, the concept of wellbeing for Egyptian mental health (psychiatric) nurses was diffused into other domains, such as job stress and self-efficacy (**Zaki, 2016**), and job satisfaction and identity (**Kabeel & Eisa, 2017**). Both showed low 'wellbeing' results

Significance of the study

Developing leadership competencies for healthcare leaders has received widespread attention in western countries, because effective leaders in healthcare organizations has been recognized as important for organizational success. Thus, self-assessment of personal leadership competencies in healthcare delivery organizations is viewed as a way to adapt and modify healthcare programs and to encourage continuous professional development across organizations (**Hahn & Gil Lapetra, 2019**). We argue that,

examining leadership from a competency perspective allows health care organizations in both academic and clinical setting to understand different dimensions of leader qualities and capacities and to identify the weaknesses and the strengths in leaders' behaviour to improve. Moreover, the examination of leader competencies and their link to workplace civility climate and the mental well-being will add to our knowledge how leaders influence employees in terms of workplace civility climate and the mental well-being.

Methods

Research design

This study had a descriptive correlation design to collect data, which were then analysed quantitatively to find relationships and determine outcomes for leadership competencies, and aimed to assess the effect of leadership competencies on workplace civility and mental well-being in an Egyptian hospital, El Azazi Hospital for Mental Health.

Sample

Convenient sample was used for this study comprised the qualified and employed (staff) nurse population. 150 nurses out of 160 participated in the study.

Setting

El Azazi Hospital, for Mental Illness at Abo-Hamad City, Al Sharqia Governorate, Egypt. It considered one of the most populated provinces in Egypt. The hospital was established in 2004 and in 2020 had 250 beds.

Study Tools:

The survey began with participant demographics. The first measure was a self-inventory of leadership knowledge and skills devised by the **Minnesota State University (2013)** comprising the following themes (as adapted):

• Leader self-knowledge: Understand self and others, acts with integrity (14 items)
• Leader as team builder: Values diversity, communicates effectively, build trust (12 items)
• Leader - manager: Build client service orientation, builds organizational talent, and demonstrates good stewardship (15 items)
• Leader-innovator: Articulates vision and mission, builds organizational capacity to meet future challenges, and demonstrates effective decision-making (19 items).

A five-point Likert scoring system for self-assessment was used from Minimal to Skilled. Those domains responding to minimal (1) and limited (2) were designated at a novice level, those from adequate (3) to competent (4) were designated as proficient for the item, and the final, skilled, was considered a specialist. These domains were adapted from United States' publications on evaluation: novice, advanced beginner, competent, proficient, and expert (**Benner, 1984; Dreyfus & Dreyfus, 1980**).

The next measure was the perceived workplace civility climate scale (**Ottinot, 2008**). This instrument assesses employees' perceptions of whether and by how far their organisation tolerates aggressive verbal behaviour: intolerance, response, and policies and practices. It was adapted and used in a healthcare environment by **Gazica and Spector (2016)** and more recently reviewed as an instrument (**Layne, Nemeth, & Mueller,**

2020). Of the original 24 items, 13 were used for this research. A six-point scale for a perception was used from strongly disagree (1) to slightly disagree (3), and slightly agree (4) to strongly agree (6). Thus 50 per cent was adopted as the division between a climate of incivility (1-3) and civility (4-6).

The last measure was the Warwick-Edinburgh mental wellbeing scale developed by the Scottish healthcare agency (**Tennant et al., 2007**). The scale remained in use in student nursing research; examples are a Chinese version (**Dong et al., 2016**), and another cultural comparison nusing Slovenia and Northern Ireland data (**Cilar, Barr, Štiglic, & Pajnkihar, 2019**). Scoring on occurrences was five-point, from none of the time (1) to all of the time (5). Thus, a possible score ranged from 14 to 70. The results were classified as low (14 -41), moderate (42 – 55), or high (56 – 70).

Data collection and analysis

Sufficient questionnaires were printed and distributed by the researchers from 1st to 15th March 2020 at each unit where staff nurses were working. Notices were placed in nurses' locations explaining the nature of the survey with contact details. The completed surveys were collected in a large folder by the researchers from the participants at their units by hand in the morning and afternoon shifts. Answering the questionnaire took about 20 to 25 minutes.

Of the 160 surveys distributed, 10 were ineligible as they were not fully completed, thus 150 were accepted. Data from these surveys were entered into a Microsoft Excel database and the IBM SPSS 22 statistical software package was used for data analysis. Descriptive statistics were obtained as frequencies and percentages, Pearson correlation

analysis was used for inter-relationships among quantitative variables, together with simple linear regression analysis. The significance level for all statistical analyses was < 0.05 (p value)

Administration and ethics

This study was approved by the Research Ethics Committee of faculty of Nursing, Zagazig University on (2/2/2020) and from the medical and nursing director at the El-Azazi Hospital on (23/2/2020). The survey instrument included a purpose statement, identified the lead author and contact details, and noted the hospital's approval. The participants were informed that their participation in the study was voluntary, they may choose not to participate, and anonymity and confidentiality of the data were assured. Consent was established by the completion of the questionnaire.

Validity and reliability of the Instrument

The three measures (including participant demographics) were merged into one questionnaire, translated into Arabic. Reverse (back) translation was conducted on all instruments. Three members from the Faculty of Nursing at Zagazig University conducted the content validity of the Arabic version of the instruments. Internal consistency of the instrument was measured using Cronbach's alpha. The alpha coefficients for the items were: Leadership competencies, 0.989; Workplace civility climate 0.925; and Warwick-Edinburgh mental wellbeing, 0.940. These results indicated high reliability of the questionnaire.

A pilot study of the Arabic version of the new instrument was conducted with the assistance of 15 nurses (10% of the sample), selected randomly to ensure the clarity and understanding of the items as presented and to calculate the time involved in the task. No modifications to the survey was made. Thus, data obtained from the pilot study were included in the study results.

Results

Table 1 described the characteristics of the 150 nurses in the sample. They were predominantly aged in their 20s (25-29 years). 76 % were females. Next, the majority of the sample (66%) were working in male wards, and the majority of the respondents were team member nurses. The analysis showed that the majority (73.3%) of respondents were not university graduates, but had trained in an institute or otherwise had obtained a diploma of nursing. Correspondingly, the majority (52.6%) also had less than 11 years of experience, so that there may be an issue with future mentoring as a means to attract more university-qualified nurses.

The first variable in table 2 was self-knowledge. For this category, 44 per cent were classified as novices, and the majority (56%) were proficient. Similarly, in team building, 44 per cent were again novices and 53.3 per cent considered themselves proficient in this competency. A lone individual (0.7%) was a specialist in this area. A minority (41.4%)

considered that they were novices in performing as a manger, whilst the remainder (58.6%) were proficient in this ability. Again, 42.7 per cent were novices when attempting to introduce innovation, whilst the majority (56.6%) were adept at this competency; as well, one individual (0.7%) considered himself or herself superior in this skill. Consequently, 43 per cent self-rated as novices in leadership skills (or rated their supervisors as such) and with the exception of one or two people, the

majority (56%) self-rated or rated their leaders as proficient leaders. The remaining one per cent corresponded to missing data and the specialist category.

The third analysis was for the perceived workplace civility climate scale. This was a descriptive result, where 75 per cent of the sample rated their workplace as a civilised (polite) environment, whilst 25 per cent did not.

The final items analysed were from the mental wellbeing scale, where the majority (52%) reported a moderate level of wellbeing, whilst over one-quarter (26%) of respondents said, they had low mental wellbeing, and the remaining 22 per cent were happy at work.

Table 3 showed a statistically significant (positive) correlation between leadership competencies and both workplace civility climate and mental wellbeing for the data, also between workplace civility climate and mental well-being scales (p value = 0.000).

Table 4 and 5 show the relationships between leadership and workplace civility regression, and mental wellbeing regression, respectively.

A significant effect of leadership competencies on workplace civility climate is shown at table 4. The table also indicated a significant (positive) impact of leadership skills on the workplace civility climate, as when leadership values increased by one unit, then the climate increased by 0.16 of a unit. The model's r^2 value was 0.469, indicating that leadership competencies explain 47 per cent of the variance in civility climate levels.

Again, table 5 revealed a significant effect of leadership competencies on mental wellbeing for the selected sample. The table also indicated a significant (positive) influence for leadership attributes on mental wellbeing; when leadership competencies increased by one unit, then the mental wellbeing increased by 0.09 of a unit. The model r^2 value was 0.254, indicating that leadership competencies explained 25 per cent of the variance in mental wellbeing levels.

Table 1 distribution of personnel characteristics of studied sample, from El Azazi Hospital (n=150)

Descriptor		No	Percentage
Age by year	<20 years	11	7.3
	20 to 24 years	36	24.0
	25 to 29 years	42	28.0
	30 to 34 years	38	25.3
	35+ years	23	15.3
	Total	150	100.0*
Gender (sample)	Male	36	24.0
	Female	114	76.0
	Total	150	100.0
Workplace	Male wards	99	66.0
	Female wards	51	34.0
	Total	150	100.0
Title	Nurse	91	60.7
	Head of unit	19	12.7
	Supervisor	35	23.3
	Head nurse	5	3.3
	Total	150	100.0
Qualifications	Diploma	50	33.3
	Institute	60	40.0
	Bachelor	38	25.3
	Master	1	0.7
	Others	1	0.7
	Total	150	100.0
Experience	<5 years	38	25.3
	5 to 10 years	41	27.3
	11 to 15 years	37	24.7
	16 to 20 years	17	11.3
	> 20 years	17	11.3
	Total	150	100.0*

* rounding error

Table 2 frequency and percentage distribution of Leadership competencies subscales (n = 150)

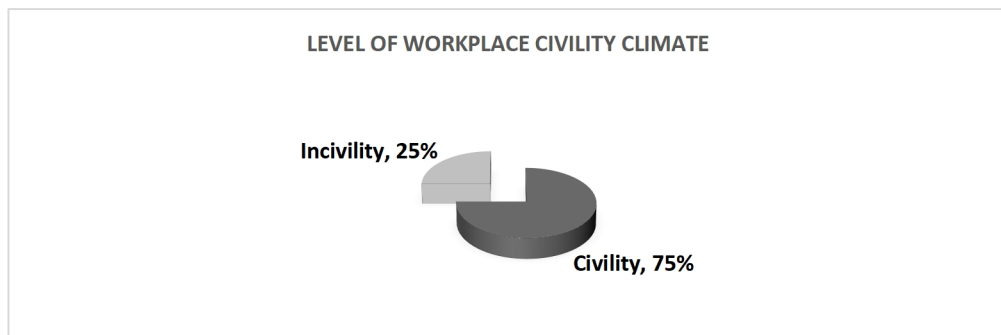| Leader characteristics	Minimal F-%	Limited F - %	Adequate F - %	Competent F - %	Skilled F - %
Self-knowledge	25 (17%)	41 (27%)	50(33%)	34(23%)	0
Team builder*	24 (16%)	42 (28%)	52(34.6%)	28(18.7%)	1(0.7%))
Perform as manager	28(18.7%)	34 (22.7%)	50(33.3%)	38(25.3%)	0
Innovator	27 (18%)	37(24.7%)	47(31.3%)	38 (25.3%)	1(0.7%)

* 147 responses (98% total)

Figure (1) distribution of Workplace civility climate from the view of studied sample (n=150)
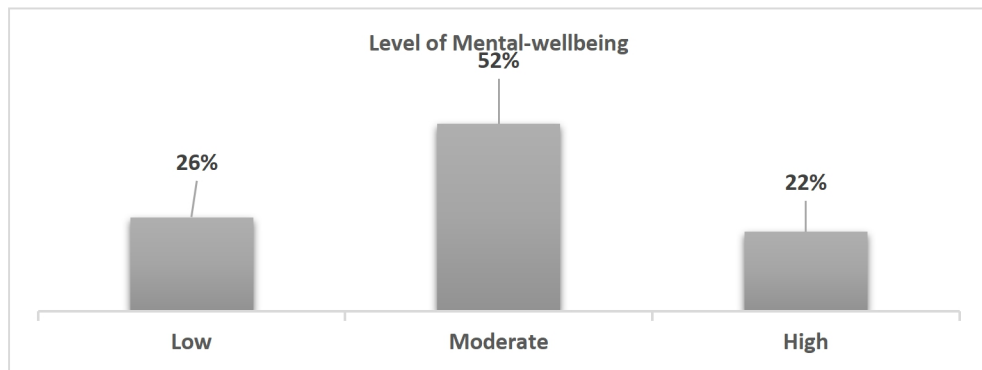

Figure (2): Total Level of Warwick-Edinburgh Mental Well-Being in studied Hospital

Table3 Correlation results for leadership, civility, and wellbeing scales

		Leadership competencies	Workplace civility climate	Mental wellbeing scale
Leadership competencies	Pearson r	1	.685**	.504**
	Sig. (2-tailed)		0.000	0.000
Workplace civility climate	Pearson r	.685**	1	.368**
	Sig. (2-tailed)	0.000		0.000
Mental wellbeing scale	Pearsonr	.504**	.368**	1
	Sig. (2-tailed)	0.000	0.000	

Table 4 Summary of leadership competencies and workplace civility climate; regression results.

Model	Independent variables	Coefficients	t	r^2	Sig.
1	(Constant)	18.676	7.080	0.469	0.000
	Leadership competencies	0.158	11.444		0.000

Table 5 Summary of leadership competencies and mental wellbeing regression

Model	Independent variables	Coefficients	t	r^2	Sig.
1	(Constant)	30.614	12.706	0.254	0.000
	Leadership competencies	0.090	7.107		0.000

Discussion

Whilst this research barely predated the 11 March 2020 declaration of the COVID-19 pandemic by the **World Health Organisation (2020)**, it was a timely undertaking as health workers' function and readiness to respond had never been more critical. Leadership, both from supervisors' attributes and the responses of the team to those qualities were crucial to meeting the pandemic challenge, or the team's ability to respond to other crises (**Greenberg & Tracy, 2020**).

Overall, just over half (56%) of the research sample of 150 nurses at the El Azazi Hospital for Mental Health rated themselves or their supervisors as proficient leaders, whilst 43 per cent were not confident of the leadership within

their hospital. This scepticism may have resulted from the participants' average age in their twenties (52%).Equally of concern, nearly three-quarters (73.3%) of the participants lacked university degrees, although this may have reflected the convenience sampling technique, professional nurses may have declined to participate.

Of interest, 39.3 per cent of the El Azazi study sample were leaders, and just under a half (47.3%) had over 11 years' experience as nurses. Although there was no assessment of leaders' self-ratings per se, it could be assumed that leaders with experience over six years would consider themselves proficient. This result agreed with **Warshawsky and Cramer (2019)**, who showed that nurse managers' experience was associated with self-ratings of proficiency. Further, **Ali et al. (2020)** considered professional

development intervention improved leadership among Egyptian nurses. However, in Makkah, Saudi Arabia, **Alomairi, El Seesy, and Rajab (2018)** found that a low rating for first-line nurse managers could be attributed to their promotion by other factors besides competence.

For the purposes of this paper, **Benner's (1984)** five career progression categories were reconfigured as three: novice, proficient, and specialist nurses. Nevertheless, with the exception of two responses, participants in this study did not rate nurse leadership past proficient. This finding corresponded to those of **Abou Hashish and Fargally (2018**) and **West et al. (2016).** Despite the majority of the participants in this study rated all the four subscales of leadership competencies as proficient, more efforts still needed to enhance the leadership competencies to the specialist/skilled level in El-Azazi hospital. Especially that, leadership competencies have considerable effect on civility climate level as shown from the regression model. Where, leadership competencies explain 47 percent of the variance in civility climate levels. **Clark (2016)** mentioned that nurse leaders play a key role in fostering healthy workplaces by consistently modelling professional behaviours and addressing unacceptable behaviours.

The result for the workplace civility climate for El-Azazi hospital was that three-quarters of the nurse participants reported their workplace as civil. This result was in the same direction with **Sleem and Seada (2017)**, who reported higher levels of perceived workplace civility climate among staff nurses working at main Mansoura University Hospital, Egypt. While, this was not supported by **Hossny et al. (2015)**, or a recent study by **Atashzadeh-**

Shoorideh et al. (2020), although the results were borderline (49% to 51%) in two instances.

For the mental wellbeing questions, 52 percent of the nurses at El Azazi hospital were moderately happy and 22 percent were quite happy at work; but one-quarter (26%) of respondents said they had low mental wellbeing. This result due to the demanding and complex work within mental health care organizations that places nurse well-being at risk**. Adams et al. (2019)** pointed out that as a psychological trait; mental wellbeing was difficult for hospital administrations to improve other than maximising workplace conditions and selecting staff who displayed resilience. Healthcare staff could also relax outside work, such as with family, socialising, and enjoying solitary activities **(Dehvan et al., 2018; Foster et al., 2020; Oates, 2018).** However, **Der Kinderen et al. (2020)** considered nurses' ethics, organisational values, and high workplace civility important, as **Johnson et al. (2018)** surmised that mental healthcare workers had poorer wellbeing than other healthcare sectors. There were no comparable Egyptian results using derivatives of the Scottish mental wellbeing scale; however, there were similar mental health nurse survey items under domains of job satisfaction and self-efficacy whereby findings of low 'wellbeing' occurred (**Kabeel & Eisa, 2017; Zaki, 2016**).

The analysis further resulted in a significant (positive) correlation between leadership competencies and both the workplace civility climate, and mental wellbeing measures. This was aligned to leadership attributes that offered teams support and encouragement in their work, and promoted team cohesiveness. This outcome was consistent with several other studies and the finding is important for all

heath care during the aftermath of the pandemic (**Ali et al., 2020; Fawzy, 2017; Greenberg &Tracy, 2020**). However, the lower effect of leadership traits for ElAzazi hospital's staff wellbeing reflected the nurses' individual differences and resilience (**der Kinderen et al., 2020; Foster et al., 2020;Oates, 2018**).

Conclusion

This research concerned leadership competencies in relation to civil working environment, and to nurses' mental wellbeing in El Azazi mental healthcare hospital in Egypt. It was found that despite considerable pressures from the COVID-19 pandemic on healthcare teams, low educational qualifications and a young nurse staff profile, the hospital was achieving better results than expected. More than two thirds of the staff nurses rating themselves or their supervisors as proficient, and three-quarters considered their workplace climate as positive/satisfactory. However, more than half rated their own mental well-beingas moderate. Further, significant association between leadership competencies and both of workplace civility climate and mental well-being was detected among the studied sample, which in turn could improve the outcomes for their patients.

Recommendations

- Future research to investigate what specific factors affect mental well-being among psychiatric nurses rather than leadership competencies is recommended.
- Nurse Managers should strive to provide interventions to improve mental well-being among staff members.
- In-service training program to improve the competency level among nurse leaders is recommended.

- Promotion rules should depend on competency level rather than age factor.
- The organizations should set needed competency requirements for their leadership team.

Conflict of interest

There were no conflicts of interest.

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