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ORIGINAL ARTICLE

Nurse leaders' perceptions of workload and task distribution in public healthcare: A qualitative explorative study

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Abstract

Background: Unreasonable workload and work-related stress can reduce nurse leaders' job satisfaction and productivity and can increase absence and burnout. Nurse leaders' workload in public healthcare settings is relatively unresearched.

The Aim: The aim of this study was to investigate nurse leaders' perceptions of workload and task distribution with relation to leading work tasks in public healthcare.

Research Design, Participants and Research Context: A qualitative explorative design was used. The data material consisted of texts from interviews with nurse leaders in public healthcare (N = 8). The method was inspired by content analysis. The COREQ checklist was used.

Ethical considerations: Informed consent was sought from the participants regarding study participation and the storage and handling of data for research purposes.

Findings: Six main themes were found: *Increased and unreasonable workload*, *Length of work experience as nurse leader affects perception of workload*, *Number of staff and staff characteristics affect perception of workload*, *Versatile and flexible task distribution*, *Working overtime as a way of managing high workload* and *Insufficient time for leadership mission*.

Conclusion: The workload for nurse leaders in a public healthcare setting was perceived to be unreasonable. Common measures for managing high workload included working overtime, delegating work tasks and organising more staff resources in the form of additional staff. How nurse leaders perceive their workload was linked to both the number of staff and staff characteristics. These should both be considered equally important when determining staff levels and measuring nurse leaders' workload. Future research should focus on investigating workload and task distribution from nurses' perspectives.

Relevance to Clinical Practice: Through this study, greater understanding of workload and the diverse work of nurse leaders in a public healthcare setting has been revealed, which can be used to further develop the framework for nurse leaders' work.

KEYWORDS
nurse leaders, public healthcare, qualitative, task distribution, workload

1 | INTRODUCTION

During the past decade, the effects of globalisation and how it rapidly changes the nursing field have garnered attention (Thompson & Hyrkas, 2014). The importance of optimising nurse management and leadership has been noted by leading health organisations, and the development of these areas has been addressed in both current and future global strategic plans (World Health Organisation, 2016).

In Finland, a draft government proposal concerning health and social services reform is currently under review (The Ministry of Social Affairs and Health, 2020). The aim of the reform is to decrease health inequalities, increase well-being through improved service availability and accessibility, secure a skilled workforce and limit cost increases (The Ministry of Social Affairs and Health, 2020).

The nurse leader role has changed significantly in recent decades (Gantz et al., 2012; Nilsson & Waldemarson, 2008; Thompson & Hyrkas, 2014). Nurse leaders today engage in little patient-related work; they instead predominantly lead, develop and steer nursing activities in line with stated organisational goals (Nilsson & Waldemarson, 2008). Such work requires nurse leaders to have ever greater knowledge of economic matters, profession-related quality development and workplace development (Nilsson & Waldemarson, 2008). Additionally, nurse leaders should facilitate healthcare that is as environmentally, societally and financially sustainable as possible (Nilsson & Waldemarson, 2008; Nyholm et al., 2018; Rich et al., 2013). Nurse leaders must have knowledge of and be capable of managing many different things such as the recycling of disposable plastic and waste, an aging population, fewer new workers entering the field, and increasing healthcare costs must be taken into consideration (Janssen & Moors, 2013; Vogt & Nunes, 2014). Central to healthcare organisations, nurse leaders are expected to be receptive to and demonstrate understanding with all parties in an organisation (Larsson, 2008; Lee & Cummings, 2008; Skytt et al., 2007). Often considered to be 'in the middle' between top leaders and staff nurses (Larsson, 2008), as representatives for other workers nurse leaders are tasked with creating and sustaining a supportive and healthy work environment (Duffield et al., 2011). Effective nurse leaders have been found to increase staff nurse retention and job satisfaction (Duffield et al., 2011; Hewko et al., 2015).

What does this paper contribute to the wider global clinical community?

- We found that nurse leaders in public healthcare experience high workload, which is often managed by working overtime. High workload, however, can compromise well-being and health.
- When nurse leaders in public healthcare experience unreasonable workload, leadership might suffer because of insufficient time for the leadership mission.
- Staff characteristics (personality, health status, well-being) affect perception of workload, thus might be important to take into consideration alongside the number of staff a nurse leader in public healthcare is responsible for and leads.

1.1 | Background

There are specific stress factors and roles associated with leadership in healthcare. Researchers have found that healthcare leaders are both central to an organisation and exposed to high demands and work-related stress (Tengelin, Arman, et al., 2011). Leaders should maintain control; be rational, intentional, illuminated; and maintain a polished 'ideal leader' image (Cregård et al., 2018; Tengblad, 2012). Leaders are expected to be capable of managing uncertain and/or sudden organisational events and emotional stress; they should demonstrate flexibility, be able to handle an unrealistic number of relationships in an organisation and be knowledgeable in an administrative way (Cregård et al., 2018). Moreover, in the healthcare sector leaders are also expected to be healthcare specialists (Cregård et al., 2018).

Workload can be defined as the amount of work an employee is expected to complete in a specific time plus the amount of effort required to complete the job (Nixona et al., 2011). The number of work hours needed, level of productivity and mental expectations for a job can also be included when calculating workload (Spector & Jex, 1998). There are both quantitative aspects (the amount of work needed to complete a job) and qualitative aspects (the mental capacity) (Nixona et al., 2011). Perceived heavy workload has been linked to physical symptoms and feelings of anxiety, depression and/or frustration (Spector & Jex, 1998).

Workload, organisational climate, productivity and values are factors that impact nurse leaders' job satisfaction (Lee & Cummings, 2008). In one study of nurse leader job satisfaction, 70% of those examined were satisfied with their job, 68% were likely to recommend nursing leadership as a career choice but 72% were planning to leave their position in the next five years (Warshawsky & Havens, 2014). The most common reasons why nurse managers might intend to leave a position include burnout, work overload, not being able to guarantee patient care quality, career change, retirement, lack of recognition and career advancement (Hewko et al., 2015; Warshawsky & Havens, 2014). The time that nurse leaders have for staff interaction, mentoring and coaching might

be increased through evaluation of reporting requirements and the time spent on meetings (Warshawsky & Havens, 2014). When nurse leaders are supportive and inspiring, staff nurses' job satisfaction has been seen to increase (Cowden et al., 2011; Cummings et al., 2010). In a study of nurse leaders who had already left their position, the reason to leave was linked to reorganisation and other changes and the overall work situation was influenced by their relationship with their head of department (Skytt et al., 2007). In that study, negative influences were unclear conditions, lack of support, implementation of changes, staff matters and economy. Positive influences included personal, organisational and practical support and opportunities for development and education.

In another study, healthcare leaders' personal experience was seen to play a significant role in their ability to set boundaries (Tengelin, Kihlman, et al., 2011). Among others, personal experience was seen to influence healthcare leaders' use of time in relation to controlling their work hours, stress and recovery when not at work. Other factors seen to clearly affect healthcare leaders' ability to set boundaries were working with unclear goals, the extent to which one was invested in work tasks and own perceptions of what constitutes a good leader.

Healthcare leaders tend to spend most of their working time in meetings and communicating (Wikström et al., 2013). Communication and reflection on day-to-day dilemmas might reduce stress and improve time priorities, which increases the possibility of recovery for healthcare leaders (Tengelin, Arman, et al., 2011; Wikström et al., 2011; Wikström et al., 2013).

The concept of sustainability has been investigated primarily in the private sector, industry or the fields of economics, sociology or ecology (Avery & Bergsteiner, 2011; Bärlund & Perko, 2013; Davies, 2007; Hargreaves & Fink, 2004; Nyholm et al., 2018; Schroeder et al., 2013). Sustainable leadership should permeate an organisation as a whole, where ecological, social, economic and cultural aspects all complete each other (Bärlund & Perko, 2013). Sustainable leadership involves investing in interaction, social justice and a culture of implementing joint decisions (Davies, 2007) and can also be considered a culture in which long-term solutions are sought (Avery & Bergsteiner, 2011). Nyholm et al. (2018) underline that well educated, dedicated and good leadership is essential for sustainable care. However, for care to be sustainable, it must also be financially manageable, safe for patients and evidence based (Salmela et al., 2017). In organisations with sustainable leadership, overall end results and the consequences and outcome of the activities undertaken are the primary drivers, not profit (Hargreaves & Fink, 2004).

Burnout among nurses is a growing social problem (Suzuki et al., 2009), and a key reason underlying this can be related to the concept of workload (Kitaoka-Higashiguchi & Nakagawa, 2003; Warshawsky & Havens, 2014). In a study of leaders at a university hospital in Japan, researchers found that a high number of patients and workload together with an increased number of co-worker conflicts increased nurses' risk for developing burnout (Kitaoka-Higashiguchi & Nakagawa, 2003). Researchers have also found a connection between work-related stress and unreasonable workload (Labrague et al., 2018; Rauhala & Fagerström, 2007). Work-related stress can lead to reduced job satisfaction, productivity and work accomplishment, can increase absence (Rauhala & Fagerström, 2007) and is expensive (Rodham & Bell, 2002). There appears to be a culture of acceptance around nurse leaders' work-related stress, and there is very little knowledge on how to solve the problem (Labrague et al., 2018). Moderate work-related stress is linked to a lack of resources, economic responsibility and workload (Labrague et al., 2018). To reduce work-related stress and its consequences, it is important to strengthen nurse leaders' social support and encourage job control (Labrague et al., 2018). In one study of registered nurses' working time in a hospital setting, researchers saw that nurses spent several hours on non-patient-related tasks, including administrative tasks and other associated tasks such as transporting and serving (Antinaho et al., 2016). In a similar study in a burn centre setting, researchers found that 30% of nurses' work tasks were administrative and not directly related to patient work (Ravat et al., 2014). Having nurses engage in non-patient-related tasks is not a cost-effective use of resources and does not improve patient care. Delegating administrative tasks to non-specialised officials can therefore be recommended.

According to Cregård et al. (2018), complexity is a concept strongly associated with healthcare today, in both the public and private healthcare sectors. From a public healthcare point of view, complexity can be considered a project that simultaneously includes both things that can be planned for and anticipated and those that cannot. Organisations today are very complex, due to information and technology developments and even the inclusion of new and different professions. Such complexity can be viewed as an uncontrolled whole and, consequently, chaos can be considered inherent to complex systems (Cregård et al., 2018). For nurse leaders, the amount of time they spend on interacting and building relationships with staff seems to positively impact job satisfaction, but larger staff numbers per nurse leader are linked to increased stress and dissatisfaction for both nurse leaders and staff (Cummings et al., 2010; Warshawsky & Havens, 2014).

The COVID-19 pandemic has challenged and shaken healthcare systems throughout the world. It has led to increased pressure on leadership and sector-related working patterns and necessitated the 'faster than ever' development of new strategies (Ahmadi et al., 2020). While the concept of workload with regard to number of staff per nurse leader has been investigated in hospital settings, mostly among staff nurses and nurse leaders (Brown et al., 2013; Cummings et al., 2010; Lee & Cummings, 2008; Warshawsky & Havens, 2014), the same concept in public healthcare settings is relatively unresearched. Warshawsky & Havens, (2014) even find that that the optimal number of staff that a nurse leader should manage is not yet fully researched. In this study, we elected to investigate public healthcare nurse leaders' workload using a qualitative perspective.

2 | AIM

The aim of this study was to investigate nurse leaders' perceptions of workload and task distribution with relation to leading work tasks in public healthcare.

3 | RESEARCH QUESTIONS

How do nurse leaders in public healthcare perceive their workload? How is work in daily practice apportioned and delegated with regard to leading work tasks and in relation to workload?

4 | METHODOLOGICAL ASPECTS

A qualitative explorative design was employed in this interview study. The method was inspired by content analysis (Graneheim & Lundman, 2004). The data material consisted of texts from interviews with nurse leaders in a public healthcare context. The COnsolidated criteria for REporting Qualitative research (COREQ) checklist was used (File S1).

4.1 | Data collection, data analysis and ethical considerations

The setting was a public healthcare organisation in an urban area in the south of Finland. Strategic selection was used to select the sample. Working as a nurse leader in a public healthcare context comprised the inclusion criterion. Semi-structured interviews were performed in 2020 and 2021 with eight ($N = 8$) nurse leaders (all female), aged between 30–56. All those invited agreed to participate. The first researcher conducted the interviews, and the interviews were digitally recorded and transcribed. Following discussion, the researchers concluded that the sample size was adequate, because saturation of data occurred. The participants' work experience as nurse leaders varied from 8 months to 15 years. The participants' titles (public healthcare nurse, special healthcare nurse, nurse) and educational levels (Master's in Health Sciences, Health Business management degree) also varied.

As a first step, the first researcher contacted the head nurse leader at the study setting by telephone to verbally convey information about the study and ask for ethical permission to conduct the study. The head nurse leader thereafter received by e-mail information about the study as well as a study invitation letter, which the head nurse leader subsequently sent by e-mail to all subordinates who met the inclusion criterion. The intention underlying the invitation letter was to find those working as nurse leaders at the setting, that is, those 'in between' the top leaders and the workers (Larsson, 2008). Nurse leader locums (temporary workers) were also asked to participate in the study, regardless of the length of their work experience as nurse leaders, to elicit different points of view. The first researcher then contacted by either e-mail or telephone all those who had agreed in writing (by e-mail) to participate in the study, to give a detailed presentation of the study and schedule interviews. Participants were asked about their workload and how work in daily practice was apportioned and delegated with regard to leading work tasks and in relation to workload. An interview guide was used to guide the interviews, and follow-up questions were asked as needed. For more information about the interview questions, please see Table 1.

The interviews were conducted either face-to-face in a separate room at the healthcare organisation included in the study or by videoconference with at-home participants using their personal computers, because of the COVID-19 pandemic. The interviews lasted about 30–50 min, and all interviews were recorded and transcribed.

Content analysis was conducted with inspiration from Graneheim and Lundman (2004). The first researcher conducted the interviews and transcribed the interviews verbatim. Codes were used to replace participants' personal data. Initially, both researchers first individually read the interviews several times, then, later jointly analysed the interviews to extract meaning units. These meaning units were then condensed, coded and placed into different themes perceived to describe the meaning of the data (Graneheim & Lundman, 2004). Both researchers discussed and agreed on the final main themes. For an example of the data analysis, please see Table 2.

TABLE 1 Interview questions

How do you experience your workload? (Has the COVID-19 pandemic affected your workload?)
What tasks are part of your daily work?
How do you allocate time for tasks?
How would you describe the tasks with regard to leading and delegating tasks?
What do you think about your workload in general?
How many staff do you supervise and what do you think about the number of staff?
What tasks do you consider to be leading tasks?
What do you think about your workload and the tasks that need to be dealt with during a single workday in relation to the working hours available during one work shift?
Do you think that the working hours are sufficient for completing the leading tasks?
Which tasks are administrative tasks in your opinion?
What administrative tasks do you have?
How many working hours do you spend on administrative tasks?
Do you feel that you have control over the number of work tasks you have?
Which factors influence your experience of having control over the tasks?
Can you influence the number of work tasks you have?
Do you feel that you have the time to accomplish the tasks you need to perform within working hours?
How could leadership and the apportionment of workload be developed?

TABLE 2 Example of the data analysis

Meaning unit	Condensed meaning unit	Code	Main theme
And then contemplating, how many I could lead, [if you look at it] …then there's a good number of us because it's a good group that can be easily managed and where you know others and see each other on a daily basis. *Well I say it like this, that it purely depends, if you can say it in this way, in which way [staff] are ill, that if you have a lot of occupational health consultations and [staff] are, like, in many ways feeling ill, then there are a lot of different illnesses, so it surely consumes your resources.*	*And then contemplating, how many I could lead* *…depends… in which way [staff] are ill* *[staff] are, like, in many ways feeling ill, then there are a lot of different illnesses*	Number of staff Staff characteristics, health and well-being	Number of staff and staff characteristics affect perception of workload

The ethical principles of the Finnish Advisory Board on Research Integrity (2012) were taken into account during the entire research process. The participants' dignity, integrity, right to self-determination and confidentiality regarding the oral information were also taken into consideration. Prior to the start of the study, the head nurse leader at the healthcare organisation where the research was conducted was contacted by e-mail and informed about the study, with the aim to seek permission for the study. Thereafter, ethical approval to conduct the study was sought and provided from the healthcare organisation where the research was conducted. The first researcher provided all those involved in the study with information about the study purpose, voluntary participation, confidentiality, intention to publish and the right to withdraw from the study at any time. Written, informed consent was obtained from all the participants.

5 | FINDINGS

Six main themes were found: *Increased and unreasonable workload*, *Length of work experience as nurse leader affects perception of workload*, *Number of staff and staff characteristics affect perception of workload*, *Versatile and flexible task distribution*, *Working overtime as a way of managing high workload* and *Insufficient time for leadership mission*. All themes and described and discussed below. See Table 3 for an overview of the study findings. For an overview of the study findings, please see Table 3.

5.1 | Increased and unreasonable workload

Most of the participants described their workload as being high or even unreasonably high. Over a three-week period, the participants' overtime hours varied from 3 to 80–h. Overtime hours were linked to the number of staff being managed, and those participants who worked in pairs or teams with other nurse leaders had significantly fewer overtime hours than those who worked alone. The participants perceived that their workload had increased following the onset of the pandemic, partly attributing what they described as an ever growing and even more unreasonable workload to the pandemic. Various participants explained how their workload had increased significantly because of the pandemic, and some even found it necessary to prioritise tasks or even leave tasks undone.

> *'Corona has definitely brought some extra spice, because at the same time that you must do such basic things that are part of the healthcare station's work, so now even other things need doing, which in practice means that there are several more demands on what needs doing and that falls on the public healthcare nurse'*
>
> (P5).

Another participant noted that:

> *'Since Corona came so has the work increased and sometimes it is too much work. It must be prioritized and then you must dare leave things undone, so that it doesn't go so far that you think your [desk] needs to be empty when you start work the next day'*
>
> (P2).

The participants also mentioned that one result of the pandemic was that additional staff were needed, which entailed more individuals for the participants to manage.

> *'So, this Corona has affected this workplace in the way that there have come more workers than jobs. Which means that it has entailed a fairly large staff management as [an] extra'*
>
> (P6).

5.2 | Length of work experience as nurse leader affects perception of workload

There were differences between how less-experienced (less than a year's experience) and more-experienced nurse leaders perceived their workload. Most less-experienced nurse leaders maintained that they spent an unnecessary amount of time on further training and seeking information considered routine for more-experienced

TABLE 3 Overview of the study findings

Main themes
Increased and unreasonable workload
Length of work experience as nurse leader affects perception of workload
Number of staff and staff characteristics affect perception of workload
Versatile and flexible task distribution
Working overtime as a way of managing high workload
Insufficient time for leadership mission

nurse leaders. Time management and prioritising work tasks also seemed to be more challenging for less-experienced nurse leaders compared with more-experienced nurse leaders. Some more-experienced participants revealed that they prioritised a focus on staff and left administrative work for overtime. One participant who often worked overtime stated that he/she made the personal decision to personally greet each member of staff every day, in the belief that this could perhaps increase staff productivity and efficiency.

> *'Probably not everything [can be explained]. But most of it. Because there are so many nurses and staff there, plus the doctors come and ask me for advice and I cannot ignore and ask them to ask their supervisors. These are such types of leadership choices…'*
>
> (P2).

One less-experienced participant noted that he/she could occasionally need more time to figure things out but was neither bothered nor stressed about this.

> *'So basically, compared with that other people who have done this work for 20 years who only check absenteeism statistics and invite [someone] to a preemptive discussion, so I must then so to speak start from zero and check what this task entails, which things I must take into consideration, which things that I can do to improve all of this place, and I am not the one who "raises the alarm", so it takes a little time to find out and think about things'*
>
> (P4).

5.3 | Number of staff and staff characteristics affect perception of workload

The number of staff that nurse leaders were responsible for varied significantly between the participants. Of the participants, seven were responsible for between 10–50 staff while one participant worked with up to 450 staff and was directly responsible for 200 staff. Those participants most satisfied with their workload were responsible for between 10–25 staff and perceived that they could easily manage that number of staff. One participant stated:

> *'And then contemplating, how many I could lead, [if you look at it] from that point of view then there's a good number of us because it's a good group that can be easily managed and where you know others and see each other on a daily basis'*
>
> (P5).

Perceived workload and need for help increased when the number of staff a nurse leader was responsible for exceeded 25. Some participants experienced that at least two or even preferably three people (a nurse leader plus 2–3 deputy nurse leaders) were needed to manage between 40–50 staff. One participant was responsible for over 200 staff, together with two other nurse leaders, but this was deemed insufficient. This participant revealed that the other two nurse leaders had just started their positions and were unknown to most of the staff, which in turn led the staff to seek out the participant when help was needed. Yet another participant noted that:

> *'There is enough time if both me and my co-worker are at work. I can have a lot to do if my co-worker is on vacation…It definitely requires two in such a big unit'*
>
> (P1).

The participants maintained that workload was not solely related to the number of staff they were responsible for but that even *staff characteristics (personality, health status, well-being)* were also relevant, especially when there was already an abundance of work tasks to complete. One participant commented:

> *'Well I say it like this, that it purely depends, if you can say it in this way, in which way [staff] are ill, that if you have a lot of occupational health consultations and [staff] are, like, in many ways feeling ill, then there are a lot of different illnesses, so it surely consumes your resources'*
>
> (P7).

Another participant said:

> *'At that point, when the unit is that size [with 25-27 staff], there is no way that a nurse leader can do everything that is required of [him/her], so there needs to be two*
>
> (P6).

5.4 | Versatile and flexible task distribution

All of the participants perceived that the allocation of daily tasks occurred in a versatile and flexible manner. They noted that they would normally start the working day by checking that all scheduled staff were present and, if not, they would seek to cover any absences. They also revealed that during the pandemic nurse leaders were required to participate in an online Teams-software programme

meeting each morning during which they received pandemic-related information from the previous day. The participants stated that they followed the schedule once these tasks were completed, describing the rest of the day as 'continuing automatically'. A few participants noted that morning meetings could set the rhythm for the day.

> *'Well, in a way the meetings provide a rhythm, and there are many meetings. They provide a rhythm to it but as for the rest it's like armor up and ready to go, so when you turn on your computer then it starts from that'*
>
> (P6).

The participants mentioned other tasks that they performed on a daily basis, among others resourcing, recruiting new staff, planning staff shifts and/or scheduling holidays or sick leaves. They even noted that they engaged in preparing and implementing rescue, safety, medical care or self-monitoring plans. Additionally, alongside the Teams meetings and all other aforementioned tasks, they even managed their emails and other digital service messages. Several participants admitted to doing other tasks during meetings if they felt that their time was not being utilised optimally, noting that their time could be spent more beneficially with staff.

> *'Honestly, I often think of the days I have been sitting in a meeting and it doesn't have any direct impact on our daily work here… then I'd rather spend that time on the staff's well-being or on planning and such'*
>
> (P7).

A further task that the participants mentioned and which was considered to be somewhat time-consuming, was maintenance-related work.

> *'Then there were really a lot of things like, you have to call the service company, you have to figure out that some phone wasn't working, lights not working, it was like really a lot of those things. The defibrillator pad had expired, nobody could order a new on, right. Or the specific person was on holiday and I had to figure out like what is this really… And they really take a lot of work time…'*
>
> (P3).

One participant described how being a nurse leader entailed overseeing a multitude of tasks.

> *'…and everything else then in addition I am the maintenance person for our clinic and have to ask for [maintenance] service and ensure that it like gets repaired and be the contact person in basically all small improvement projects'*
>
> (P5).

5.5 | Working overtime as a way of managing high workload

Some participants maintained that working overtime was the only way through which they could feel they had control over their workload. Many participants experienced that they often had to work overtime. *'I have my workload under control if I do 13–14-hour workdays'* (P2).

One single-parent participant could only work during those hours that daycare for his/her child was open and maintained that this helped him/her keep work and private life separate. This participant stated that he/she prioritised work tasks and even left work tasks undone, because working overtime was not possible.

> *'I must quit when my child's daycare closes. This means that I am only at work while the daycare is open…. This daycare thing is my savior/saving… It is why I am in such a good mood and can manage at work because I have limits and simultaneously free-time and work are separated. I also know that other nurse leaders usually sometimes, like, also work during the weekends. Well, I don't, because I have to enjoy life with a 4-year-old. So, I then forget about work and enjoy my private life during weekends and that is also like insanely good for my well-being and resilience'*
>
> (P4).

Teams meetings and managing emails and other digital service messages used up a lot of the participants' time. The participants experienced that they could work more efficiently early in the morning, late in the evening and/or during the weekend, because there were fewer or no interruptions then. The participants even revealed that they managed their workload by working remotely from home whenever possible; there were fewer interruptions at home, because they could only be reached by phone or digital services. Many felt that the constant 'traffic' (unscheduled visits) seen in the office could be challenging and time consuming, especially if there were a lot of administrative deadlines they needed to meet. Some managed their workload by delegating some of the most time-consuming tasks. For instance, shift planning was often delegated to a colleague, who then planned the shifts in addition to their own daily work tasks. Other ways of controlling workload included prioritising or multitasking (performing tasks while participating in meetings).

> *'For example regarding the planning of shifts, so we have one [who does that], my first substitute nurse who does those, she has a list negotiator there and they plan our schedules and plan the shifts and stuff like that. To my second substitute nurse we have delegated the purchasing'.*
>
> (P6).

Another participant noted:

> *'For me it's like that I have [the] Teams [program] open, but I in reality I do other tasks as well'*
>
> (P2).

One participant perceived that one's disposition greatly influenced whether one could manage a high workload as a nurse leader.

> *'Yes, [tasks] can pile up, but actually, if I was a person with a different disposition then I would definitely be at risk for becoming strained, but because I happen to be of a different disposition, in that way that I can forgive myself and show myself mercy, then I can accept the fact that I can't do [as much or be as effective] as other nurse leaders'*
>
> (P4).

5.6 | Insufficient time for leadership mission

Excepting one participant, all expressed concern over what they considered insufficient time to interact with their staff. Several explained that they only had time to perform those tasks considered absolutely necessary, and the common goal was to try to 'survive' each day. This caused the participants to feel inadequate on nearly a daily basis. All of the participants clearly stated that more time was needed with staff: for joint meetings, daily interaction and regular development discussions. The participants even noted that with all meetings being held online during the pandemic they missed meeting staff face-to-face. Furthermore, because of the pandemic, staff relocation to other public healthcare units had become common. According to the participants, this resulted in many units being left with insufficient staff resources and the sense that they were unable to run their units as desired. The majority of participants perceived that more staff or resources were needed to maintain quality standards.

> *'Support possibilities are pretty limited in the case [where] you end up more or less whipping staff so that things get done. We have certain result and quality targets, that all daily contact requests are handled and the care evaluation done the same day. It's like clearly not achieved with this small team, so in that sense more staff are required'*
>
> (P4).

However, the participants revealed that increasing the number of staff could be a dilemma, pointing to the number of staff that they were comfortable managing versus the number needed for a unit to run smoothly without unduly burdening staff. The participants at the same time stated that they without hesitation first focused on what was best for their staff and then focused on their own needs and requirements.

6 | DISCUSSION

The aim of this study was to investigate nurse leaders' perceptions of workload and task distribution with relation to leading work tasks in public healthcare. We found that the public healthcare nurse leaders in this study experienced increased and unreasonable workload. Unreasonable workload can heighten the risk for developing work-related stress and burnout among nurse leaders (Kitaoka-Higashiguchi & Nakagawa, 2003; Labrague et al., 2018; Rauhala & Fagerström, 2007). Work-related stress can not only reduce job satisfaction, productivity and work accomplishment but can also lead to increased absence from work (Rauhala & Fagerström, 2007). It is important to reduce nurse leaders' work-related stress, because consequences such as absence from work are expensive (Labrague et al., 2018). Individually consulting nurse leaders in situations to evaluate work tasks could help provide a clearer and more holistic overview of nurse leaders' workload and also facilitate the determination of actual need for resources.

We also found nurse leaders' length of work experience affects their perception of workload. The less-experienced nurse leaders in this study spent more time on further training and seeking information that more-experienced nurse leaders considered routine. Accordingly, it might be beneficial to review the orientation information given to new nurse leaders, including how new nurse leaders are introduced to the job and workplace and from whom they can seek advice or information as needed. Lack of support is one of the reasons nurse leaders leave their position (Skytt et al., 2007). The possibility to receive training, develop professionality and be supported by one's organisation can be considered job supporting (Skytt et al., 2007).

We saw that both the number of staff and *staff characteristics (personality, health status, well-being)* affect nurse leaders' perceptions of workload. Nurse leaders experienced that they needed more help if the number of staff they supervised exceeded 25 or staff were ill, especially when there was already an abundance of work tasks to complete. We therefore emphasise that these aspects should be taken into consideration when planning resources and staffing for nurse leaders. According to Warshawsky and Havens, (2014), the optimal number of staff that nurse leaders should manage has not yet been fully determined. The new understanding seen in our findings may somewhat address this research gap. To ensure that sufficient resources, support and tools for nurse leaders are secured, we suggest that nurse leaders together with their supervisors regularly review staff numbers and staff characteristics linked to health status and well-being.

The nurse leaders in this study described a versatile and flexible task distribution. Teams meetings provided a rhythm to daily work. One topic that frequently arose was maintenance-related work, that is, the overseeing of repairing/replacing equipment and paraphernalia. Such tasks can be considered non-nursing tasks, which Antinaho et al. (2016) suggest could be delegated to non-specialised officials so that nursing leaders can spend their time on other tasks. We suggest that a general review of tasks

including the frequency of and time spent on individual tasks be undertaken, to ascertain whether the need exists for delegating certain tasks to others.

We saw that overtime was used on a regular basis by many of the nurse leaders in this study to manage high workload. Some chose to focus on staff during working hours, with the consequence that administrative tasks were completed while working overtime. In line with Tengelin, Arman, et al. (2011), we note that the participants had an idea of how they wished to display themselves as leaders and that their own perceptions influenced their use of time. For most of the participants, the more time they spent on overtime, the greater their sense of managing their high workload. However, one participant revealed that his/her private life prevented him/her from working overtime, which he/she connected to increased well-being. We interpret this as one way to set boundaries, which is in line with Tengelin, Kihlman, et al. (2011). The capacity to set boundaries can be linked to improved control of working hours, stress and recovery during free-time and at home. Most participants here nevertheless revealed that when the possibility to work overtime was limited their work 'piled up' and their sense that they could manage their workload decreased. As seen with staff previously, it was also revealed that nurse leaders' disposition greatly influenced whether a high workload was managed.

The participants perceived that they had insufficient time to dedicate to their leadership mission. Among other things, the participants clearly expressed the need for more time with staff, explaining that they only had time for the most essential tasks. Several participants noted that the time they spent in meetings was not utilised optimally and that interacting with staff would have been more beneficial. Warshawsky & Havens, (2014) also suggest evaluating the time spent on meetings and reporting requirements, so that the time spent on staff interaction increases. We suggest that it could be helpful to reflect on day-to-day dilemmas with co-workers, because this, among other things, has been found to reduce stress and improve time priorities (Tengelin, Arman, et al., 2011; Wikström et al., 2013; Wikström et al., 2011).

6.1 | Strengths and limitations

One limitation is that there were only female participants, which may constitute a source of bias, limiting the generalizability and comparability of the findings. The findings might have differed to some extent had male participants also been included. Strengths include the rich data that was collected and that the researchers transcribed all interviews verbatim and discussed the interview questions in order to strengthen reliability. The second researcher was a highly skilled qualitative researcher. The researchers also came together to carefully discuss the analysis and final themes. The findings in this study can be used for reaching an understanding of the diverse work that nurse leaders engage in and the challenges associated with such work.

7 | CONCLUSION

The workload for nurse leaders in a public healthcare setting was perceived to be unreasonable. Common measures for managing high workload included working overtime, delegating work tasks and organising more staff resources in the form of additional staff. How nurse leaders perceive their workload was linked to both the number of staff and staff characteristics (personality, health status, well-being). These should both be considered equally important when determining staff levels and measuring nurse leaders' workload. Future research should focus on investigating workload and task distribution from nurses' perspectives.

8 | RELEVANCE TO CLINICAL PRACTICE

Through this study, greater understanding of workload and the diverse work of nurse leaders has been revealed, which can be used to further develop the framework for nurse leaders' work.

AUTHOR CONTRIBUTIONS

Mikaela Miller contributed to the study conception and design, data analysis, data collection, discussion and drafted the manuscript. Jessica Hemberg contributed to the study conception, design, data analysis, discussion and provided critical reflections.

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CONFLICT OF INTEREST

The authors declare that there are no sources of conflicts.

DATA AVAILABILITY STATEMENT

Research data are not shared.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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