The impact of toxic leaders

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- Toxic leadership
- Wound clinics

In the previous paper, toxic leadership was described as a destructive pattern of behaviour in which leaders act in self-serving ways, undermine others and create environments in which staff feel controlled, blamed and unsafe(Ellis, 2026). This paper considers the consequences of such leadership for staff, staffing and, critically, patient outcomes. Although the literature often examines toxic leadership across nursing and healthcare more broadly, the issues are also pertinent to specialist areas, such as wound clinics and tissue viability nursing, where safe care depends on continuity, specialist expertise, collaborative working and the confidence of staff to escalate deterioration or challenge poor practice.

Wound care services are rarely delivered by one clinician or one professional group acting alone; instead, they require a web of relationships between different professionals including tissue viability nurses, community nurses, practice nurses, podiatrists, vascular services, care home staff, acute trust staff and patients themselves. The impact of a toxic leader can disrupt this web very quickly. Where staff feel belittled, blamed or ignored, they become less likely to speak up, less likely to innovate and less likely to remain in post. This can translate into delayed review, inconsistent care planning, poorer adherence, missed signs of infection or ischaemia and avoidable deterioration.

Therfore, in this paper we will explore the impact of the toxic leader in order to better understand why toxicity needs to be addressed.

Impact on staff

The first and most immediate impact of toxic leadership is experienced by staff. Toxic leaders commonly create psychological insecurity by the clear and often indiscriminate application of using behaviours such as:

- Criticism.
- Blame.
- Inconsistency.
- Exclusion.
- Micromanagement.

Staff who work in such environments may begin to doubt their competence, become reluctant to ask questions, and avoid raising concerns because they fear ridicule or retaliation. This is particularly damaging in tissue viability practice because specialist nurses are often required to advise others, challenge entrenched practice and advocate for patients whose wounds are deteriorating or whose care is fragmented.

Labrague (2024) identified associations between toxic leadership and a range of nursing workforce outcomes including:

- Reduced satisfaction with work.
- Poorer psychological wellbeing.
- Weaker organisational relationships.
- Reduced productivity and performance.

These findings are consistent with the wider literature on destructive leadership, which links poor leadership (which includes some toxic leadership styles) with distress, reduced commitment and poorer team functioning (Schyns and Schilling, 2013). In practice, this may mean that staff stop contributing ideas in meetings, avoid complex conversations with colleagues, or simply do the minimum required to avoid attracting negative attention.

For staff who work in wound care and who frequently work across organisational boundaries, the harm may be amplified. Their work depends on credibility and influence rather than direct authority alone. If a toxic leader undermines their confidence, excludes them from decisions or uses them as scapegoats for systemic problems, their ability to influence practice in wards, community teams and wound clinics is weakened. The result is not only personal distress, but a reduction in the specialist nursing function itself. This mirrors the sorts of outcomes seen where weak leaders used micromanagement in order to deflect from their shortcomings or as a result of their out-of-control perfectionism (Vu, 2025)

Impact on staffing and retention

Staffing is one of the clearest routes by which toxic leadership affects services. A leader who repeatedly humiliates, blames or excludes staff may not immediately produce a vacancy on a rota, but they create the conditions in which staff begin to disengage, reduce discretionary effort, seek redeployment or leave an organisation.

Tsapnidou et al (2025) found that toxic leadership contributes to organisational silence, emotional exhaustion, diminished psychological safety and low professional commitment, all of which threaten nurse retention. In specialist services, where

recruitment pipelines may already be limited, the loss of one experienced tissue viability nurse can have a disproportionate effect on the ability of a service to function and needs to be taken seriously.

This is especially important in UK wound clinics because not only is demand for services is high and growing , but many patients also have complex comorbidities such that continuity is central to good outcomes. When skilled nurses leave, wound services may rely on temporary staff, less experienced clinicians or overstretched community teams. This may increase waiting times, reduce the consistency of assessment and documentation, and make it harder to maintain evidence-based care such as compression therapy, pressure ulcer prevention, lower limb assessment and timely referral to vascular or specialist services.

There is also a hidden staffing effect. Some staff remain in post, but withdraw psychologically. They may no longer volunteer to undertake roles which they might if the management of the service was as it should be, for example mentoring students, supporting improvement projects and even challenging unsafe practice. This form of presenteeism can be difficult to see on workforce dashboards, yet it erodes service capacity that is the wound care team may appear staffed, but the energy, confidence and professional curiosity needed to improve patient care have been diminished (Lindström, 2025).

Impact on morale and team culture

Morale is often spoken about as if it is a soft issue, but in clinical practice morale is directly connected to safety, quality and resilience; teams with good morale are more likely to help one another, share learning, notice when colleagues are struggling and remain open to change. Toxic leadership damages these protective factors by replacing trust with suspicion and collaboration with self-protection.

In a wound care team, poor morale may be visible in small but important ways. Staff may stop discussing difficult cases openly. Practitioners may avoid asking for a second opinion because they fear being judged. Documentation may become defensive rather than clinically meaningful. Meetings may become dominated by compliance, blame and performance management, rather than reflective learning and service improvement. Over time, the culture can become one in which staff learn to protect themselves rather than patients.

This is not simply a matter of individual sensitivity. NHS reports and workforce discussions have repeatedly highlighted bullying, blame cultures and poor leadership as threats to staff wellbeing and patient care (Wise, 2022; Maben et al, 2023; British Medical Association, 2023). Such cultures are particularly dangerous where staff need to speak up about pressure damage, delayed referrals, unsafe caseloads or inadequate staffing. If staff believe speaking up will be punished, they may remain silent even when they can see harm emerging.

Impact on patient outcomes

The relationship between toxic leadership and patient outcomes is not always immediate or linear. A patient may not experience harm because a manager was rude in a meeting, however, repeated toxic behaviours create the conditions in which harm becomes more likely. Staff become exhausted, communication deteriorates, learning is suppressed, and turnover increases.

Labrague (2021) found that nurse managers' toxic leadership behaviours were associated with increased nurse-reported adverse events, including:

- Patient falls.
- Healthcare-associated infections.
- Medication errors.
- Complaints from patients and families.
- Poorer reported quality of care.

Although this study was not UK-specific and did not focus on wound clinics, the implications are both relevant and huge. Wound care requires consistent assessment, accurate documentation, timely escalation and coordinated intervention. Toxic leadership weakens each of these safety barriers.

In tissue viability services, adverse outcomes may include avoidable pressure ulcers, delayed healing, wound infection, delayed recognition of vascular compromise, inappropriate dressing selection, poor compression practice, increased pain, avoidable admissions and reduced patient confidence.

A toxic leader may not directly cause these outcomes, but they may create a service environment in which the warning signs are missed, ignored or not acted upon quickly enough because staff are working in an atmosphere of fear and defensive clinical practice (Alshmemri, 2026).

The impact on patients is also relational. People living with chronic wounds often experience pain, odour, exudate, reduced mobility, social isolation and anxiety about healing. They need clinicians who are calm, attentive and able to build trust over time. Staff working under toxic leadership may find it

harder to offer this level of therapeutic presence because they are themselves depleted, anxious or preoccupied with workplace conflict. In this way, poor leadership can reach the patient even when the patient never meets the leader.

Why the wound clinic and tissue viability context matters

Tissue viability nurses occupy a unique position within the NHS; they are often expected to provide expert clinical care, educate others, influence policy, support audit, prevent avoidable harm and contribute to strategic service development. Recent commentary has argued that leadership capability is now fundamental to the tissue viability nurse role because services are increasingly shaped by integration, organisational mergers, service reconfiguration and cross-boundary working (Battaglia, 2026). This makes toxic leadership especially damaging because it undermines precisely the capabilities that modern tissue viability services require.

A healthy tissue viability service needs openness, curiosity and constructive challenge. It needs staff who can ask why a pressure ulcer developed, whether a pathway is working, whether compression has been delayed, or whether patients are being passed between services without ownership. A toxic leader is likely to interpret these questions as criticism, disloyalty or as a threat to them, their leadership and abilities. When that happens, opportunities for learning are lost and staff learn to avoid the very conversations that improve care.

The risk is therefore not only that toxic leadership makes staff unhappy, but also that it narrows the service's ability to think, learn and respond. In wound care, where small delays can become large harms, this narrowing can be hugely clinically significant.

Conclusion

Toxic leadership has profound consequences for staff, staffing, morale and patient outcomes. It damages confidence, reduces psychological safety, contributes to emotional exhaustion and increases the likelihood that staff will disengage or leave. In wound clinics and tissue viability services, where safe care depends on continuity, specialist knowledge and cross-boundary influence, these effects are especially significant.

The harms associated with toxic leadership are not confined to staff experience. They can affect the quality, consistency and safety of care received by patients. For this reason, toxic leadership should be understood as a clinical governance issue as well as a workforce issue.

In the next paper, we will consider how leaders can recognise toxic traits in themselves and begin the work of changing their behaviour before harm becomes embedded in the culture of their team or service.

References

Alshmemri M (2026) The dark side of nurse-manager leadership: toxic leadership behaviours, adverse-event reporting, and care quality – an interpretive descriptive study. *BMC Nurs* 25: 329. doi: 10.1186/s12912-026-04506-1

Battaglia S (2026) Beyond clinical expertise: Why leadership capability is essential for tissue viability nurses in a transforming NHS. *Wounds UK* 22(2): 77–9

British Medical Association (2023) 'Corrosive culture' of bullying remains in parts of NHS. London: BMA

Ellis P (2026) What constitutes toxic leadership? *Wounds UK* 22(2): 70–1

Labrague LJ (2021) Influence of nurse managers' toxic leadership behaviours on nurse-reported adverse events and quality of care. *J Nurs Manag* 29(4): 855–63. doi: 10.1111/jonm.13228

Labrague LJ (2024) Toxic leadership and its relationship with outcomes on the nursing workforce and patient safety: a systematic review. *Leadersh Health Serv (Bradf Engl)* 37(2): 192–214. https://doi.org/10.1108/LHS-06-2023-0047

Lindström A (2025) Toxic leadership in nursing: a systematic review of its professional and organizational challenges. *Open J Nurs* 15; 382–99. doi: 10.4236/ojn.2025.156029

Maben J, Aunger JA, Abrams R, et al (2023) Interventions to address unprofessional behaviours between staff in acute care: what works for whom and why? A realist review. *BMC Med* 21: 403. doi: 10.1186/s12916-023-03102-3

Schyns B, Schilling J (2013) How bad are the effects of bad leaders? A meta-analysis of destructive leadership and its outcomes. *Leadersh Q* 24(1): 138–58.

Tsapnidou E, Moudatsou M, Katharakis G, et al (2025) The impact of toxic leadership on nurse retention: a scoping review. *Healthcare (Basel)* 13(18): 2341. doi: 10.3390/healthcare13182341

Vu TT (2025) Micromanagement: a systematic literature review and future research agenda. *Sage Open* 15(4): 21582440251383211. doi: 10.1177/21582440251383211

Wise J (2022) NHS faces leadership shake-up after review finds evidence of discrimination and bullying. *BMJ* 377: o1419. doi: 10.1136/bmj.o1419